CONNECTICUT HOME CARE PROGRAM CHANGES FREQUENTLY ASKED QUESTIONS

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Provider Enrollment

1 Q. I did not attend the CHC Enrollment Workshop and have not yet enrolled as a CHC Service Provider. Where can I get information on how to enroll as a CHC Service Provider?

A. The CHC Enrollment Workshop can be found on the www.ctdssmap.com Web site. From the Home Page click on Provider Services > scroll to the bottom of the page. Under Provider Training, click on the "here" link at the end of the paragraph. Under the "Materials" heading, click on "CHC Workshops". Under the "Training Materials" heading, click on the first "Presentation" link to view the Power Point Presentation on CHC enrollment. The "Application Sample" link is a copy of a completed CHC Service Provider Application for your reference while you are enrolling.

2 Q. I already have an NPI number and currently bill for the pilot program do I need a separate NPI for billing our Adult Day Care?

A. In order to provide Adult Day Care services to CHC clients, effective July 1, 2013, you must enroll as a CHC Service Provider. You are not required to provide an NPI when enrolling as a CHC Service Provider.

3 Q. I am a Home Health Agency do I need to re-enroll to continue servicing CHC clients on July 1, 2013?

A. If you perform only home health services (skilled nursing, home health aide, and therapy services) you do not need reenroll as a home health agency, unless you have received a letter from HP enrollment notifying you it is time to re-enroll.

4 Q. I am a Home Health Agency who provides companion and homemaker services to CHC clients do I need to enroll as a CHC Service Provider?

A. Yes, if you provide any non-medical service (defined as other than skilled nursing, home health aide, or therapy services) to a client covered under the CHC Program you will need to enroll as a CHC Service Provider.

5 Q. Our Agency provides Mental Health Counseling to CHC clients do we need to enroll as a CHC Service provider?

A. Yes, any provider that provides a non-medical service (defined as a service other than skilled nursing, home health aide or therapy services performed by a Home Health Agency) to a CHC client and currently submits their invoices for services directly to an Access Agency, for reimbursement must enroll as a CHC Service Provider.

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6 Q. If I am a non-medical provider why do I need to enroll as a CHC Service Provider?

A. Effective July 1, 2013 you will be required to submit your own claims to HP and you will no longer be able to submit your claims to the Access Agency. If you do not enroll you will not be able to submit your claims to HP and the Access Agency will not be able to submit claims on your behalf, for dates of service July 1, 2013 and forward. Consequently you will not be paid for the services you provide to CHC clients.

7 Q. We are a non-profit organization with volunteer board members do we need to list the members of our board?

A. No, volunteer board members are not required to be listed on the enrollment application.

8 Q. Do we need to list all members of our organization and their social security numbers?

A. You must list all administrative members and those with a 5% or greater interest in the organization. The social security numbers for these individuals are required.

9 Q. How do I check the status of my CHC Service Provider Enrollment Application?

A. Upon submission of your enrollment application you should have taken note of your six-digit Application Tracking Number (ATN). You should have also retained a copy of your application. Once you have this number, you can track the status of your application by going to the www.ctdssmap.com home page > click on Provider > Provider Enrollment Tracking, enter your ATN and the name of your business or your last name, if you enrolled as an individual provider, as it appears on the copy of your application. Click search for your current enrollment application status.

10 Q. Our enrollment is still pending. If we get our letter after July 1, 2013 will we be back dated to July 1, 2013?

A. Yes, the effective date of enrollment is based on the application date and effective date of the program, which is July 1, 2013.

11 Q. Is Allied a Provider Agency?

A. Yes, for the PCA Waiver Program. Individual Personal Care Assistants are contracted with Allied Community Resources in order to provide PCA services to PCA waiver clients and CHC Clients.

12 Q. What is the difference between enrolling as a provider and enrolling as a Trading Partner?

A. In order to service CHC clients you must be enrolled as a Home Health Agency for medical services (skilled nursing, home health aide and therapy services). You must be enrolled as a CHC Service Provider, provider type/spec 57/544 to provide non-medical services (homemaker, companion, meals on wheels, mental health counseling, PERs, etc.) to CHC clients effective July 1, 2013.

You must also be an enrolled Trading Partner, if you wish to submit electronic transactions such as the ASC 270/271 eligibility and ASC 837 5010 claim submission transactions to HP. You do not need to be an enrolled Trading Partner in order to submit claims via the Web portal.

13 Q. If we contract with both SWCCA and AASCC do we need to do two separate enrollments?

A. Only if you contract with each under separate businesses with different tax IDs.

13.1 Q. I was an enrolled CHC Performing Provider can I still enroll at any time?

A. Yes, however, effective August 13, 2013 previously enrolled CHC non-medical performing providers must credential with Allied Community Resources. Contact Allied Community Resources at 860-627-0230.

Secure Web Account

14 Q. Why do I have to set up a secure Web account?

A. You must set up a secure web account to, at a minimum, access the care plans of the clients you service. Once you set up your secure Web account you will have access to a number of Web based tools such as provider account maintenance, client eligibility verification, claim submission, correction and inquiry in addition to the download of your Remittance Advice (RA).

15 Q. How do I set up my secure Web account?

A From the www.ctdssmap.com Web site, click on Information > Publications > scroll to chapter 10 > access section 10.9 for setting up your secure Web account. This section of the chapter provides you with step by step instructions for creating the Local Administrator Secure Web Account, Clerk Accounts and the maintenance of both Administrator and Clerk Accounts.

16 Q. Are the clerk account assigned roles customizable, such as only being able to view Care Plans?

A. The clerk permissions within an assigned role are not customizable. For instance the assigned role of PA inquiry/submission would grant both inquiry and the ability to add PAs.

17 Q. Are there any reporting capabilities from the web when submitting claims so that you have an overview of what we submitted and a dollar amount?

A. The web does not have claim reporting functionality, however, there are Home Health providers who search on pending paid claims, then copy and paste this data to an excel spread sheet for reporting purposes.

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18 Q. Does the Web claim submission tool interface with any scheduling or payroll systems?

A. HP does not support a Web interface with any scheduling or payroll systems.

19 Q. I have set up my secure Web account and have tried to Access the eligibility tab. I am getting a message that my provider ID is inactive.

A. Even though you have set up your secure Web account, you are not an active provider until July 1, 2013, the effective date of the CHC Program Implementation. At that time you will be able to access all of the tools under your secure Web account as the local Administrator or those tools you have been granted permission under your clerk account.

Service Orders

20 Q. If my contract ends with the Access Agency on June 30, 2013, will I continue to receive initial service orders and modifications to existing service orders.

A. Yes you will continue to receive both initial service orders and modifications to existing service orders from the Access Agency Care Managers via telephone or other agreed upon method of communication.

21 Q. I currently only get name and address when I receive an initial service order call from the Care Manager. What other information will I need?

A. You must begin to ask for the client ID and date of birth. The Access Agencies can provide you with the client's 9 digit Medicaid ID (EMS) number and date of birth. You must have the client's Medicaid ID in order to access the client care plan and either the client's Medicaid ID, date of birth or Medicaid ID and client name as it appears on the DSS eligibility file, which can be problematic with hyphenated names and middle initials, in order to verify client eligibility.

22 Q. When I receive the initial service order from the care manager will I be able to go to the Care plan and verify that the service is on the care plan and the number of units of service approved?

A. The Access Agencies have 7 days, once the care plan is approved, to either upload or directly enter the client's care plan to the secure web portal. Once the care plan has been received by HP, service providers will be able to access the client's care plan via their secure web account.

23 Q. I am currently receiving service orders from SWCAA thru an encrypted e-mail system, will those services be available thru the HP Prior Authorization Inquiry?

A. Access Agencies will be uploading all active care plans in effect on July 1, 2013. If you are the service provider on the Care Plan you will have access to the service orders via the Prior Authorization tool on your secure Web account. The exception is the service orders that required PA prior to June 30, 2013. These will remain under the Access Agencies Provider ID. You will have to contact the Access Agency regarding the service orders associated to these PAs.

24 Q. Once Service Orders expire, do they remain viewable in the system.

A. Yes, expired service orders will remain viewable in Prior Authorization history.

24.1 Q. Who do I contact if it has been more than seven days since I have received a service order(s) from the Access Agency and there is no care plan for the service(s) on the web portal?

A. Contact the Access Agency that provided you with the service order.

24.2 Q. Who do I contact if there is a discrepancy between the service orders I received from the Access Agency and the care plan on the web portal?

A. Contact the Access Agency who provided you with the service order.

Care Plans

25 Q. What information do I need to access a client's care plan?

A. You will need your secure Web account ID and password. Once you have logged on to your Provider Secure Web Account, you will need the client's ID number and procedure code(s) for the service(s) to be provided. You can cross reference the service to procedure code from either the service/frequency cross-walk or fee schedule.

26 Q. How do I access the client's care plan?

A. You first must be an enrolled provider who has received their enrollment notification with initial secure web account ID and under separate cover initial Web account and AVRS PIN (passwords). Using these IDs and passwords, you must set up your secure web account and clerk accounts for those in your organization who will be performing Care Plan inquires to access the secure web site. Once a secure account has been set up, the local administrator or clerk will access the client's care plan via the secure site of the www.ctdssmap.com Home Page with their newly created Web ID and Password. Access to the secure site on the Home Page is from one of the three following points of entry. "Provider" box on the left of the page, "provider" drop-down menu or Provider "stethoscope" Icon. Once on the Secure Web Account Home Page, click on Prior Authorization > Prior Authorization Inquiry, enter client ID, click enter to validate that the query is for the correct client and click enter to view all care plan details approved for service. Click on a specific detail to further view units used and available.

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27 Q. Will there be some sort of alert, to notify providers of a change in Care Plan Service Authorization or client eligibility?

A. Providers will be notified via the Access Agencies when there is a change to a service order. Providers should check client eligibility at the start of care to avoid unnecessary claim denials should the client not be eligible. Periodic eligibility verification inquires or routine submission of claims will determine when the ineligible client has been made eligible.

28 Q. I am currently billing Adult Day Care Services to Allied Community Resources for a client. As of July 1, 2013 will I continue to do so or should these services be submitted directly to HP?

A. You should continue to submit the services to Allied Community Resources as you are most likely contracted with them to service a client under a different Waiver Program.

29 Q. Is there a frequency to provide a service one time only or will a date range be used instead?

A. A one-time only service can be added to the care plan in either of two ways:

1. Additional units can be added to the existing service

2. The existing service detail can be end-dated, with a new detail added for the one time only service. A second detail is then added to resume the existing service with an effective date after the one time only.

30 Q. Will authorization frequency no longer be restricted by number of units per day/per week, with only monthly totals being relevant?

A. Authorization frequency is based on the service approved. A frequency can be:

- per day, used for case management **only**
- per week or per month, frequency used for most CHC services, including companion and homemaker services.
- per month, used for monthly ongoing PERS
- per date span, used for Skilled Nursing services
- per year, used for PERS Installation
- Frequency N/A approved in $s, used for highly skilled chore, minor home modifications and Assistive Technology.

Services are approved based on the number of units within the frequency x the span dates of service.

Example: Weekly Frequency.

Chore Services are reimbursed ¼ hr. per unit and are being requested 3 x wk. for 2 hrs. This should = a frequency number of **24 units per week** (3x2 =6 hr. per wk. x 4 units per hr. = 24 units)

In this case, a weekly frequency for chore services is **restricted to 24 units per week**. This is the best choice of frequency to accommodate weekly services provided within a partial week(s) in any given month. Service orders that are weekly and set up with a monthly frequency should be end-dated as soon as possible and resumed with a weekly frequency. Claim recoupments by the provider or adjustments

by the Access Agency may be needed to accommodate shortfalls in units caused by the initial set-up of a monthly frequency. Services billed in excess of 24 units per week will be cutback to 24 and deny with **EOB 5151**, "Units exceed frequency units on care plan."

Example: Weekly Frequency with Onetime Only Service.

To illustrate further, for example Companion Services are reimbursed ¼ hr. per unit and are being requested 3x wk. for 2 hrs.(MWF) for a 2 month period 7/1-8/31/2013. This should = 24 units **per week.** In this case a weekly frequency for companion services is restricted to 24 units per week. Here again a weekly frequency is the best choice to accommodate a weekly service provided within a partial week(s) in any given month. On July 18 a one-time only companion service of 3 hrs. x 4 units per hr. = 12 units of service was needed to take the client to a medical appointment. At this time, the existing order should be

- End dated on July 17th, with units adjusted to (64 units) to reflect the services allowed during this period. A one-time only detail for July 18, 2013, can be entered for 12 units. A third detail is added to resume services on July 18, 2013 thru 8/31/2013 for 208-64 =144 units.

In this example if units exceed those noted for the service spans, the over serviced units will be cut back on the claim and set **EOB 5151**, "Units exceed frequency units on care plan."

Example: Monthly Frequency.

Sometimes a monthly frequency is the best choice. For example: Chore services 1 x per month for 8 hours 7/1-12/31/2013. Chore services are reimbursed ¼ hour per unit and are being requested for 8 hours 1 x per month. This should equal a frequency number of 32 units per month x 6 months with a total of 192 units authorized. In this case services are restricted to 32 units per month. Services billed in excess of 32 units per month will be cut back to 32 and deny with EOB 5151, "Units exceed frequency units on care plan."

Example: Monthly Frequency with Onetime Only Service

To further illustrate, in September a onetime only of an additional 8 hours x 4 units per hour or a total of 32 units is needed. In this case the existing service order should be end dated 8/31/2013. A second line detail 9/1-9/30/2013 should be added for 64 units to accommodate the monthly service of 8 hours and the one time only for an additional 8 hours per month. A third detail 10/1-12/31/2013 will resume the service for 32 units per month through the end date of the service order.

31 Q. How long will a Prior Authorization be spanned?

A. The average Care Plan is six months to a year, however it is defined based on the service needs of the client, which can be as little as a day to as long as a year or more.

31.1 Q. When there is a discrepancy on a client's care plan who do I contact?

A. Discrepancies in care plans should be directed to the appropriate Access Agency.

31.2 Q. Who do I contact if it has been more than seven days since I have received a service order(s) from the Access Agency and there is no care plan for the service(s) on the web portal?

A. Contact the Access Agency that provided you with the service order.

Client Eligibility

32 Q. Why must I check client eligibility?

A. You are not required to check client Eligibility, however, doing so will prevent unnecessary claim denials. You may also want to check client eligibility effective July 1, 2013 for those clients you currently service to determine if a client currently has a CHC benefit on their eligibility file for the payment of non-medical services and a CHC benefit and/or HUSKY A or HUSKY C for the payment of medical services. This may be important as you may currently be receiving payment for claims submitted to an Access Agency that are being denied to them due to client ineligible, however your contract with the Access Agency requires you to be paid within a certain period of time.

33 Q. When checking client eligibility, how do I know if the client has coverage for the services I am providing?

A. A client must have one of the following CHC Benefit Plans in order for you to receive payment of 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

For the payment of medical services, if a client does not have one of the above CHC benefit plans, they must be covered under HUSKY A or HUSKY C.

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34 Q. I received a service order from an Access Agency, doesn't that mean the client is eligible for CHC Services?

A. Most likely, however, the client may be newly assessed and the eligibility information has not yet been updated on the client's file or the client/family have not been timely in their follow-through of information requested for the clients initial or redetermination of program eligibility. In either event their eligibility has not yet been updated to cover the services requested. This may take some time depending on the circumstances. In the interim, claims submitted will deny.

35 Q. If the client does not have eligibility on file to cover CHC services, how long will I have to wait before I can submit a claim that will not deny for client ineligible?

A. It depends on the circumstances of each client. However, to ensure as timely an outcome as possible, the Alternate Care Unit has established an e-mail address for providers to submit a notification of ineligibility for a client they service. Providers who check eligibility upon receipt of a service order can communicate an ineligibility response to DSS via the following e-mail address: AlternateCare.dss@ct.gov.

36 Q. How often should I check client Eligibility?

A. DSS suggests providers check client Eligibility prior to service. This may be difficult for some providers who render daily services to a large volume of clients or for those providers who do not have the staff to support daily eligibility verification. These providers may choose to use a batch eligibility verification offered through a vendor or Provider Electronic Solutions Software until October 2014 when a Web based batch functionality via the Web will become available. Providers may also choose to check eligibility when the client comes on to their service and then periodically thereafter.

37 Q. How important is it to check client eligibility?

A. Identifying ineligibility early can prevent claim denials and alert DSS of an ineligibility issue which may be able to be resolved prior to claim submission. It should be noted that ineligibility at the time of verification does not mean the provider will not be paid for the service. It does mean that there potentially could be an eligibility issue which may take some time to resolve. Checking client eligibility regularly identifies possible cash flow issues resulting from clients whose eligibility may be pending.

38 Q. How can I check eligibility on a large volume of clients on a regular basis?

A. Providers wishing to check eligibility on a large volume of clients on a regular basis may:

- Contract with a software vendor in order to send a HIPAA compliant 270 eligibility transaction and receive a 271 eligibility response from HP.

- Submit a 270 transaction via free Provider Electronic Solutions Software offered by DSS via HP. This software is HIPPA compliant, however, will only be available for provider use until October 2014 at such time it will be replaced with a Web based batch tool for client eligibility only.

Both methods of eligibility verification require the provider to become a Trading Partner with HP.

39 Q. Where can I obtain the 270/271 transaction specifications?

A. Refer to the Electronic Transaction Specifications/Information section of this FAQ document.

Claim Submission

40 Q. When can I begin submitting claims to HP?

A. Claims can be submitted once you are an enrolled CHC Service Provider, received your enrollment approval notice with your initial Web ID and Web Pin under separate cover and set up your secure Web account.

41 Q. Do we submit claims using the client's Medicaid ID number or the number assigned by the Access Agency?

A. The client's nine digit Medicaid ID/EMS number must be submitted on all claims.

42 Q. If we are billing services for clients that are case managed through SWCAA and others that are case managed through CCCI, do we need to submit the claims under separate batches? Do we need to indicate the name of the Access Agency on the claim?

A. There is no need to submit claims from each agency in a separate batch as long as you are submitting the same claim type (Professional vs. Institutional). The Agency name on the claim is not required.

43 Q. I did not attend the CHC Claim Submission Workshop, how can I submit claims to HP?

A. Please refer to the Training/On-Going Provider Communications section of this FAQ document for the location of the Workshop Presentations on the www.ctdssmap.com Web site. Claims can be submitted to HP via:

- Vendor Software
- Web
- Provider Electronic Solutions (available only until October 2014.)
- Paper

You can also use the services of a clearing house or billing service.

44 Q. Will the CHC Service rates be increasing now that we are the billing Provider?

A. Rate increases are determined by DSS based on legislative fiscal decisions. It is unknown if the CHC Service rates will increase in the future.

45 Q. I currently submit my services to CCCI via a paper format they provided to me. Can I submit my services to HP via this form?

A. No, the CCCI form given to providers is not in the CMS 1500 format, although it does contain all information needed to submit claims to HP. If you must submit on paper, you must submit your claims via an original red CMS 1500 claim form. Copies of paper CMS 1500 claims are not acceptable. Paper claims, however, are cumbersome in their processing time and potential for claim denials due to information crossing over into other fields if hand written or the printer is misaligned. Providers who currently submit paper claims should seriously consider an alternate method of claim submission such as using the web or the services of a vendor for extremely high volume claim submissions.

46 Q. We previously submitted paper claims to the Access Agency. Our vendor built a bridge from our printed claims to CCCIs system. Can we do this with HP?

A. Only if the bridge allows you to submit in the ASC 837 5010 Professional format.

47 Q. Where do I get the CMS 1500 Claim Form?

A. The red CMS claim form must be obtained from private printing vendors.

48 Q. What information is required to submit CHC non-medical claims to HP? Are there general service submission guidelines that I should follow when creating my claims?

A. Please refer to the CHC claim submission instructions in Chapter 8 of the CHC provider manual. To access these instructions go to the www.ctdssmap.com home page and click Publications. Under Provider manuals scroll to chapter 8, click the drop-down arrow and select Connecticut Home Care, click view chapter 8 and scroll to the claim submission instructions. As a general rule, service details should be created as follows:

- First determine the procedure code you will be billing. The procedure code can be determined by accessing the fee schedule on the www.ctdssmap.com Web site or the service/frequency crosswalk.

- Next, determine the unit increment for the procedure code you will be billing, noted in its description. You will need to know the unit increment to determine the number of units to bill per day based on the amount of time you serviced the client.
    - Procedure codes with a unit increment of 1 or more per day performed on consecutive dates of service can be billed with spanned from and through dates of service related to the consecutive dates the service was provided. Refer to the service/frequency crosswalk to determine if the procedure code can be spanned when performed on consecutive dates of service.
    - When spanning dates of service please note the following:
        - *Dates of service can only be spanned for non-medical services submitted in the professional claim format when service is provided on consecutive dates which span the from and through dates of service on the claim detail.
        - Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan.
            - For example, if 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.

49 Q. Can you illustrate how I would submit companion services, 3x per week (M,W,F)x 2 hours per visit beginning July 1, 2013 based on the service guidelines above?

A. Companion services have a unit increment of ¼ hr. As this service was not performed on consecutive dates, it cannot be spanned.

Detail 1	7/1/2013	1210z	8 units	$32.00 (@ $4 per unit x8 units 4/hrx2)
Detail 2	7/3/2013	1210z	8 units	$32.00
Detail 3	7/5/2013	1210z	8 units	$32.00

If the same service was performed M-F for 2 hours per day of the week noted above, the services can be spanned as noted below:

Detail 1	7/1/13-7/5/13	1210z	40 units	$160.00 (@$4 per unit x 40 units)

50 Q. We currently have clients that are receiving live-in companion services, however, there is no code on the fee schedule for these services how will we submit these claims.

A. Services for live-in companion will be submitted using procedure code 1210z billed at the rate negotiated with the Access Agency. This also applies to multiple clients in the home.

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51 Q. Can you illustrate how meals on wheels 5 x per week M-F beginning 7/1/2013 would be billed based on the above guidelines?

A. Meals, regardless of 1 (1218z) or 2 (1220z) per day are billed at a 1 per day increment. Meals provided on consecutive days of service can be spanned. However, multiple months cannot be spanned on the same detail or claim.

Detail 1	7/1/2013 (From DOS)	7/5/2013 (To DOS)	1220z	5 units	$45.00/ (5 x$9)
Detail 2	7/8/2013	7/12/2013	1220z	5	$45.00
Detail 3	7/15/2013	7/19/2013	1220z	5	$45.00
Detail 4	7/22/2013	7/26/2013	1220z	5	$45.00
Detail 5	7/29/2013	7/31/2013	1220z	3	$27.00

52 Q. We currently bill single or double meals, do we need to indicate hot or cold with different service codes.

A. Refer to your CHC fee schedule or service/frequency spreadsheet for meal service descriptions. There are no codes specifically for hot or cold meals. Meal services are:

- 1218z Single Meal hot/cold
- 1220z Double Meal 1 hot/1 cold
- 1221z Kosher meal double

53 Q. Are PCA services medical or non-medical? What is the procedure code for PCA per diem prorated Agency?

A. CHC PCA Service Provider codes are **non-medical** services and include the following:

- **1021z** per 15 minutes for less than 24 hr., overnight or multiple providers.
- **1022z** Overnight service- includes midnight up to 12 hrs.
- **3022z** Overnight service-cannot be completed prorated hourly*****
- **1023z** Per Diem Live-In Single Provider
- **1025z** Per Diem cannot be completed prorated hourly*****

These PCA codes and updated descriptions can be found in the latest version of the Service/Frequency crosswalk.

Note: If a shift cannot be completed the provider must contact the Access Agency to add the appropriate prorated service code for the date the normal shift could not be completed. Failure to do so will result in a claim denial for the prorated service billed.

54 Q. When I submit my PCA services do I submit CCCI's code for the service?

A. No, CCCI developed a number of internal codes to accommodate varying services and contracted rates. Providers must bill services provided based on the procedure codes on the fee schedule or the procedure/frequency crosswalk. This document has been updated with more specific descriptions relating to PCA services. Providers should, however, submit their services with the same rates as submitted to the Access Agencies.

55 Q. If we bill hospice claims and also provide meals, do we need to put the GW modifier on the meals claim?

A. No, DSS has lifted the GW modifier requirement for non-medical claims. You are no longer required to put the GW modifier on a non-medical claim.

56 Q. If we are providing Home Health Services to a Hospice client do we bill with the GW modifier?

A. No, the GW Modifier will not appear on the care plan and therefore would not be required on your claim.

57 Q. What is the difference between the Usual and Customary billing rate as opposed to the agreed upon billing rate with the Access Agency?

A. A provider's Usual and Customary Rate is the Rate charged to all consumers/payers. Under the CHC program, agreements with Access Agencies have been made to offer "competitive" rates in order to maintain cost caps while maximizing consumer services.

It would be expected that the same rates would continue to be billed by the service provider, to HP, if the provider continues to service the client. Should the service provider choose to no longer offer the "competitive" rate, it would be expected that the Access Agency would seek service assistance from another provider offering a more competitive rate.

58 Q. Are the claim submission due dates the same as the Access Agencies, for example June claims are due by July 10, 2013?

A. No, you can submit your claims to HP as often as you wish, however, HP processes claims twice per month. If you wish claims to process in a certain claim cycle, you must submit you claims no later than 7:00 p.m. on the Thursday prior to the claim cycle. DSS via HP publishes a six month claims processing schedule, effective January 1 through June 30 and July 1 through December 31. The cycle schedule July 1 through December 31, 2013 is available on the www.ctdssmap.com Web site under Publications > Bulletins > enter 13 for year and 28 for bulletin number and click search. The cycle schedule also provides EFT and RA availability dates.

The only other claim submission criteria, is that of timely filing. Your claim must be received within one year (noted by the Julian date on the ICN) of the through date of service on the claim. Failure to do so will cause your claim to deny for timely filing, EOB 512. Providers should refer to the CHC billing presentation; see Training/ On-Going Communication for exact location on the Web. Providers can also access Chapter 5 of the Provider Manual on the Web for further details regarding timely filing.

59 Q. How would we bill a monthly PERS service for a client with a mid-month installation?

A. You would bill HP with the 1223Z procedure code for the same rate as you billed the Access Agency.

60 Q. DSS does not currently pay for the services of an MSW, however, the Access Agency does pay for this service. Now that we will be billing direct to HP, will we be paid for MSW services.

A. Under the CHC program, the services of an MSW are paid under 1247Z, Mental Health Counseling Individual in Home and 1256Z, Mental Health Counseling Individual out of Home. If the services you are providing fit into the description of one of these two services, you will be reimbursed for your MSW services. You must enroll as a CHC service provider and submit your claims for dates of service July 1, 2013 directly to HP using the Professional claim format. MSW services for clients dually eligible need not be billed to Medicare first, HP will not cost avoid, deny your claim under the CHC program. MSW services are not covered under the HUSKY benefit Plans.

61 Q. Please clarify if we send our current MOWS (Meals on Wheels) claims to HP?

A. Effective July 1, 2013 you will be submitting your MOWS claims to HP in the 5010 Professional claim format using your new CHC Service Provider ID. MOW claims for dates of service prior to July 1, 2013 will continue to be billed to the Access Agencies.

62 Q. How do I submit claims via the Web?

A. First set up your secure Web account. From your secure Web account Home Page click on claims, select the Professional Claim format to submit non-medical claims and the Institutional claim format to submit medical claims. For further information, review chapter 10, section 9 for secure web account set up and section 10 Web claim submission. Also review the Web Claim Submission Presentation, located on the www.ctdssmap.com Web site, see training section for exact location.

63 Q. Can I correct claims on the web that I submitted using vendor software or paper?

A. Yes, all methods of claim submission which can be viewed on the web can be corrected on the web except region 12 and region 13 claims.

CONNECTICUT HOME CARE PROGRAM CHANGES
FREQUENTLY ASKED QUESTIONS

64 Q. What do you mean by the region of the claim and what are region 12 & 13 claims?

A. Claim region refers to the manner in which a claim is submitted. An internal control number is the claim tracking number assigned by HP when a claim is received. The first two digits of the Internal Control Number (ICN) denote the manner in which the claim was submitted to HP. For example a region 20 indicates the claim was submitted electronically with no attachments. A region 10 would indicate the claim was submitted via a paper claim form. A region 12 & region 13 would indicate these claims were special handled in order to override designated edits or audits. You would not want to make a correction to these types of claims and undo any special overrides that may have occurred during their processing. Should the claim(s) need to be corrected, you will need to contact the provider assistance center regarding these corrections.

65 Q. Is there a list of these claim regions for reference?

A. Yes, the ICN Region Code list is available on the ctdssmap.com Web site. From the Home Page; click >Information > Publications > Claims Processing Information > ICN Region Code List.

66 Q. Is there logic in the remaining digits of the Internal Control Number (ICN)?

A. Yes, the next two digits are the year the claim was submitted to HP, the next three indicate the Julian date the claim was received with 001 indicating January 1 and 365 indicating December 31, in a non - leap year. Please refer to the CHC Claim Presentation slide #65 for a complete illustrative example of ICN logic.

67 Q. How can I query claims submitted electronically using vendor software?

A. First I would suggest you review the Web claim submission Presentation available on the www.ctdssmap.com Web site. Please refer to the Training/On-Going Provider Communications section of this document for the exact location of the Web Claim Submission Training on the Web site.

Once you submit claims via vendor software, they should be viewable in just a couple of hours depending on the day of the week they are submitted. Traditionally the Wednesday and Thursday prior to a claim cycle are the busiest days, when the processing of claim files may take several hours. Claims submitted via vendor software can be viewed from the provider's secure web account by clicking on claims > claims inquiry.

Query all claims submitted since the last claims processing cycle by clicking the "Pending Claims" box. Narrow your search by clicking the dropdown arrow in the status box for the status of the claims you wish to view. Paid will display all claims in an approved to pay status since the last claims processing cycle Denied will display all claims denied since the last claims processing cycle. To further narrow your search, enter more criteria.

If you submit a number of claim batches on different days in a cycle, you can view just the claims in a specific batch if you know the dates your claim batches were submitted. To define this type of search, check the pending claims box and enter the region code, year and Julian date of submission in the ICN field.

68 Q. Are Home Health Agencies required having an Advance Beneficiary Notice on file for CHC only clients and those with HUSKY A or C?

A. Yes, to clarify, an Advanced Beneficiary Notification is a Medicare requirement. If the client has a Medicare benefit, however, the services provided do not meet Medicare's level of care, the Provider must issue an ABN to the client per Medicare guidelines. Home Health Agency Providers are now required, effective July 1, 2013 to follow ABN requirements when the client has CHC only. As a result home health claims for clients that are CHC only must be submitted with an adjustment reason code of 150, 151 or 152 and the date the ABN was issued to the client. Home Health Agencies have always had to follow Medicare ABN guidelines and Medicaid ABN requirements when the CHC client also had a HUSKY A or HUSKY C benefit plan.

69 Q. Can I submit all CHC claims in the same batch?

A. Professional CHC claims for CHC non-medical services must be submitted in a separate batch from Institutional CHC Medical claims.

69.1 Q. Are Home Health Agencies required to submit claims to other insurance carriers for CHC only clients and those with HUSKY A or C?

A. Yes, to clarify, Home Health Agencies are required to submit their claims for medical services to other payers prior to submitting to HP, as the CT Medical Assistance Program is the payer of last resort.

69.2 Q. My medical claims are denying for EOB 574 "Dates of Service Cannot Span Calendar Months", will this be corrected in the HP system?

A. HP is making changes to the way medical claims for a client with a CHC benefit process when spanning calendar months. A new edit, 580, "Detail Dates Are Not In The Same Month-Header Or Detail" will set on a Home Health claim when a client is CT Home Care eligible with or without HUSKY C (Medicaid) coverage and applied income and/or cost share is calculated on the claim. This edit has been revised to allow spanning calendar months for HUSKY C only clients and CT Home Care clients with or without HUSKY C when applied income or cost share does not apply to the claim.

69.3 Q. Will my non-medical claims deny if they span calendar months?

A. Yes, non-medical CHC claims have always set edit 574 "Dates of Service Cannot Span Calendar Months" and will continue to do so for dates of service on or after July 1, 2013.

Electronic Transaction Specifications/Information

70 Q. What do I have to do to submit electronic claims to HP using Vendor software?

A. Speak to your vendor or contract with a vendor who currently supports the ASC X12 837 Professional 5010 format. Vendors who currently do not support the 837 transaction can obtain the **Implementation guide**, which contains the CMS HIPAA Transaction Specifications. As these specifications are not proprietary to HP, vendors who wish to obtain these electronic specifications must purchase them and can do so by accessing the www.ctdssmap.com Web site. From the Home Page, under Trading Partner, click on EDI, scroll down to EDI documents. Under Implementation Guides click on the "ASC X12N" link to the WPC Washington Publishing Company Web site.

The **HP Companion Guide**, provides useful Connecticut Medical Assistance Program information and should be used in conjunction with the Implementation guide to submit successful HIPAA transactions. As noted by the path above, under EDI Documents, under Companion Guide, click the Companion Guide Link.

The **Vendor Interface Specifications** assist software vendors in developing applications to interact with the Connecticut Medical Assistance Program system and upload and download HIPAA compliant transactions. To obtain these specifications as noted by the path above, under EDI Documents, under Vendor Specifications, click the download link. You must also become a Trading Partner with HP to submit electronic transactions.

71 Q. How do I become a Trading Partner?

A. From the www.ctdssmap.com Web site, click Trading Partner, Trading Partner Enrollment. Read the Instructions, click next and complete the Trading Partner Agreement online. You may also submit a paper Trading Partner Agreement by clicking on Trading Partner, EDI, and scroll down to EDI Documents and click on Trading Partner Agreement.

72 Q. Where can I find the electronic specifications for submitting/receiving electronic 270/271 transactions to/from HP?

A. The 270/271 5010 specifications are not proprietary to HP and must be purchased. Vendors can do so from the www.ctdssmap.com Home Page, under Trading Partner click EDI and scroll down to **"EDI Documents**". Under Implementation Guides click on the "ASC X12N" link to the WPC Washington Publishing Company Web site. Providers submitting 270 Transactions and receiving 271 Transactions must be an enrolled Trading Partner.

73 Q. Where can I get information on testing my 270/271 and 837 transactions?

A. From the www.ctdssmap.com Home Page, under Trading Partner click Trading Partner Documents. Scroll down to "**Required HIPAA EDI Testing**".

74 Q. Where can I get information regarding Provider Electronic Solutions Software for the submission of batch eligibility verifications and claims?

A. First, as a reminder, Provider Electronic Solutions will no longer be available to providers effective October 2014. The software should only be used as an interim solution while preparing to submit 837 claim submission transactions using vendor software. HP, however, will be replacing the Provider Electronic Solutions eligibility verification functionality with a web based batch tool.

Providers interested in this software as an interim solution to submitting 270 eligibility and 837 claim submission transactions can obtain the download instructions and software from the www.ctdssmap.com Web site. From the Home Page click Trading Partner > EDI. Providers who previously never used the software must download the full updated 3.80 version of the software or upgrade their existing version to the 3.80 version in sequence.

Training/On-Going Provider Communications.

75 Q. I did not attend all of the training workshops offered. How can I get the information that was presented?

A. All of the Workshop Presentations are located on the www.ctdssmap.com Website. From the home page under "Provider", click on provider services, scroll to bottom of the page to "Provider Training", click on the "here" link at the end of the paragraph. Under "Materials", click CHC Workshops. Under Training Materials, click on the "Presentation" link of the Workshop you wish to view. The presentation can also be printed or saved to your computer.

76 Q. Where can I find the latest communications regarding the CHC implementation?

A. HP will be communicating updates to the CHC implementation on the www.ctdssmap.com Home Page under Important Messages via the "Welcome to the CT Home Care Program Implementation" link. The date after the link is the last time the IM was updated.

77 Q. Will there be more training sessions added regarding this implementation?

A. Providers can review the workshop schedule at any time on the www.ctdssmap.com Web site. From the Home Page click Provider Services, scroll to Provider Training, click the "here" link. All workshops currently offered will be listed under "Workshops". Click the workshop you wish to view for date, time

and location offerings. Click the "Registration Form/Directions" link associated to the workshop you wish to attend in order to register for the workshop.

The Enrollment, CHC Billing and Web Claim Submission Presentations are available on the Web site as noted above. In addition, this FAQ should give providers additional information that may not have been known at the time the workshops were presented. This document in combination with the online workshop presentations, updated service/limitations spreadsheet and revised provider manual should give providers the information they need to become a successful billing provider.

Providers should look for CHC Implementation IM updates regarding additional training offerings in the future.

78 Q. I have general questions regarding CHC services and claim submission who do I contact?

A. Contact the Provider Assistance Center (PAC) Monday through Friday, 8 a.m. to 5.p.m. (EST), excluding holidays at 1-800-842-8440 (toll free).

79 Q. I have questions regarding electronic claim submission and testing, who do I contact?

A. Contact the EDI Help Desk Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays at 1-800-688-0503 (toll free)