

Welcome to the Home Health Agency Provider Billing and Web Claims Submission Workshop – December 2, 2021

Once you have joined the Teams meeting, please follow these Communication rules:

- ❖ Please ensure your camera is off.
- ❖ Use the mute button when you are not speaking.
- ❖ Be sure to select Show conversation as documents or links used during the meeting will be posted to the Meeting chat. You may also use this Meeting chat to ask the speaker a question or to comment.
- ❖ Alternatively, you can use the Raise hand icon or (Ctrl+Shift+K) to ask the speaker a question or to comment.

Thank you for your participation!

Home Health Agency Provider Refresher Workshop 2021

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



gainwell

Training Topics

- COVID-19 & 2020 Update
- Electronic Visit Verification (EVV) Program Update
- Provider Re-Enrollment
- Demographic Maintenance
- Eligibility
 - Prior Authorization
 - Claims Processing
- Medicare Cost Avoidance and Home Health Audit
- Claim Denial and Corrective Action
- Monthly Claims Reprocessing
- Remittance Advice (RA)
- Information/ Resources
- Contacts
- Questions/Comments

COVID-19 and 2021 Updates

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COVID-19 and 2021 Updates

Effective May 21, 2021, and forward the following standard rules were reinstated:

- CMAP's medical administration services organization (ASO) (Community Health Options and behavioral health ASO (Beacon Health Options) will not grant any additional automatic home health extensions for prior authorizations (PAs) for dates of service beyond May 31, 2021. Home Health agencies must request reauthorizations for dates of service on and after June 1, 2021, in accordance with all standard procedures and requirements.
- PA thresholds that were temporarily increased during the Public Health Emergency (PHE) declaration returned to threshold standards, as required by section 17b-262-732 of the Regulations of Connecticut State Agencies.
- Nursing Services – PA will be required for skilled nursing in excess of the initial evaluation and **two (2)** visits per week
- Pregnancy-related preventative prenatal nursing care services in excess of **two (2)** visits during the prenatal period

COVID-19 and 2021 Updates cont.

- Pregnancy-related preventative postpartum nursing care services in excess of **two (2)** visits during the postpartum period
- Physical therapy services in excess of the initial evaluation and **two (2)** visits per week
- Speech therapy services in excess of the initial evaluation and **two (2)** visits per week
- Occupational therapy in excess of the initial evaluation and **one (1)** visits per week.

Please refer to provider bulletin 21- 26 **REVISED Reinstating Prior Authorization Requirements that were Suspended During the Public Health Emergency**

COVID-19 and 2021 Updates cont.

For dates of service July 1, 2021 and forward, there was a 1.7% rate increase in the reimbursement of pediatric (ages 0-18 years) complex care skilled nursing provided by home health agencies. The fee schedules have been updated with the new rates listed below.

HCPCS Codes	Modifier	Pre 7/1/21 Rates	Rates Effective 7/1/21
S9123	TG	\$44.93	\$45.69
S9123	TG/TT	\$22.47	\$22.85
S9124	TG/TE	\$38.01	\$38.66
S9124	TG/TT/TE	\$19.01	\$19.33

To access the updated fee schedule, go the CMAP Web site: www.ctdssmap.com. From the Web page, go to “Provider”, then to Provider Fee Schedule Download, scroll to the bottom of the page click on “I Accept”, then select the applicable fee schedule.

Home Health agencies must continue to request PA from the ASO, Community Health Network of Connecticut, Inc. (CHNCT) for greater than 2 hours of nursing care per day.

Please refer to provider bulletin 21- 54 [Increased Rate for Nursing Services for Home Health Pediatric Complex/High Tech Level of Care](#)

COVID-19 and 2021 Updates cont.

On July 7, 2021, temporary authority was granted under the CARES Act to advanced practice registered nurses (APRN) and physician assistants (PA) to order home health services, was made permanent under recently enacted state law. In accordance with state law, as amended by sections 1 and 2 of Public Act 21-133, APRNs and PAs, for the purposes of scope of practice, are authorized to issue orders for home health services under the Connecticut Medical Assistance Program (CMAP).

For reference, please see PB 2021-81 [**Advanced Practice Registered Nurses and Physician Assistants Authorized to Order Home Health Services**](#)

Please continue to refer to provider bulletin, [**PB 17-02**](#) New Face-to-Face Requirement for Initial Orders of Home Health Services, [**PB 17-30**](#) Important Changes to Evaluation or Assessment Services for Home Health Care Services-Addition of Review of Care Plan Code-G0162 (Revised) and [**PB 17-59**](#) Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised) for additional guidance.

Electronic Visit Verification (EVV) Program Update

Presented by: The Department of Social Services and Gainwell Technologies for
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Electronic Visit Verification (EVV) Program Update

Electronic Visit Verification (EVV) is the system that Home Health providers who service Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) or Personal Care Assistance (PCA) waiver clients must use to schedule visits, capture visit times and maintain visit data used to verify claims data submitted to Gainwell Technologies for adjudication. The EVV system has been specifically configured to support the Department of Social Services (DSS) program requirements.

EVV was implemented for Home Health providers effective April 3, 2017. EVV is federally mandated for Home Health providers effective January 1, 2023.

Providers who choose not to use EVV as directed will experience claim denials for services that are mandated for EVV use.

Electronic Visit Verification (EVV) Program Update cont.

On August 3, 2020, the EVV Mobile Visit Verification (MVV) app was upgraded to the Sandata Mobile Connect (SMC) app and effective March 31, 2021, the MVV version of the app was deactivate.

Effective October 6, 2021, Sandata added additional language options to the toll-free phone numbers used for calling in and out of visits and for the Sandata Mobile Connect (SMC) phone application for the Electronic Visit Verification (EVV) program. The languages that will be available via telephony will be as follows: English, please press one (1), Spanish, please press two (2), Russian, please press three (3), Somali, please press four (4), Chinese Simplified, please press five (5), Egyptian Arabic, please press six (6) and Polish, please press seven (7). All call languages are heard in the selected languages.

Electronic Visit Verification (EVV) Program Update cont.

Also, effective October 6, 2021, SMC users now have the option to change the language in which they view the app. If a user is accessing the SMC app for the first time, they will have the option to choose their desired language from a dropdown menu during the initial setup. If a current SMC user would like to change the preferred language, they will need to first log in to the app, then click on the menu icon (depicted as three lines in the top left corner of the app). The user will then click on 'Settings' and then 'Language'. From there, they will see the selection to change the language from English to one of the new language options.

For reference, please see PB 2021- 58 [Electronic Visit Verification Additional Languages](#)

Provider Re-enrollment

Presented by: The Department of Social Services and Gainwell Technologies for
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December 2021



Provider Enrollment and Re-enrollment

The Department of Social Services (DSS) requires providers to enroll / re-enroll on our Web site www.ctdssmap.com.

- Most of the required information on a re-enrollment application is automatically populated based on the provider's previous contract information.
- Online re-enrollment cannot be initialized until an Application Tracking Number (ATN) is received from the Gainwell Technologies Provider Enrollment Unit.
- Re-enrollment Period: Home Health providers are required to re-enroll every two (2) years.

Provider Enrollment and Re-enrollment cont.

Re-enrollment Notification and Process:

- Home Health providers will receive a reminder letter via eDelivery when they are due for re-enrollment six (6) months prior to the end of their current contract (Reference www.ctdssmap.com > Information > Publications > Provider Newsletters > August 2020 > Important Re-Enrollment Information)

It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.

Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.

Providers who are dis-enrolled will not be able to do the following until re-enrollment is completed:

- Get new referrals to services
- Receive Prior Authorization
- Bill or receive payment for services rendered.

Reinstatement of contracts w/out a finalized application violates ACA policies

Provider Enrollment and Re-enrollment cont.

Re-enrollment via the Enrollment/Re-enrollment Wizard on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com, is required.

Select Provider Re-Enrollment from the Provider drop-down menu.

Information

- [Publications](#)
- [Links](#)
- [Important Information](#)
- [RA Banner Announcements](#)
- [HIPAA](#)
- [Regional Office Locations](#)

Provider

- [Provider Services](#)
- [Provider Search](#)
- [Provider Enrollment](#)
- [EHR Incentive Program](#)
- [Secure Site](#)

Provider Trading Partner Pharmacy Info

Provider Enrollment

Provider Re-Enrollment

Provider Enrollment Tracking

Provider Matrix

Provider Services

Provider Search

Drug Search

Provider Fee Schedule Download

Promoting Interoperability Program

OOS Instructions/Information

Fingerprint Criminal Background

Check Info

E-Mail Subscription

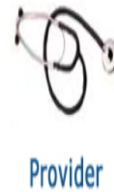
Secure Site

Provider Enrollment and Re-enrollment cont.

Follow on Documents:

- Once the enrollment/re-enrollment application is submitted, providers are notified of any follow-on documents that need to be mailed to Gainwell Technologies Enrollment Unit. The follow-on documents can also be found on the Web site (www.ctdssmap.com) by selecting Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty.
- The document requirements vary by provider type. The enrollment/re-enrollment application is not considered complete until *all* the required documents have been received.

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification
home provider enrollment provider re-enrollment provider enrollment tracking **provider matrix** provider services provider search drug search provider fee schedule download
promoting interoperability program oos instructions/information fingerprint criminal background check info e-mail subscription secure site



Instructions Upon Completion Of The Enrollment Wizard

Upon completion of the on-line Web portal enrollment/re-enrollment application, providers are issued an Application Tracking Number (ATN) that may be used to track the status of their application. **Please do not submit a paper copy of the completed Web application to Gainwell Technologies, or complete a paper application after a Web application has been submitted to Gainwell Technologies.** If a correction is required to the Web application after it has been submitted, that correction should be submitted on the provider's letterhead to the address below.

You may have been notified upon completion of your application that you must submit some follow on documents. Those documents only, and not the application itself, must be sent to Gainwell Technologies at the following address in order for your application to be finalized. The ATN must be included on the top of each of these documents. Failure to submit the follow on documents may result in the denial of your application.

Gainwell Technologies
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06102-5007

To review the list of follow on documents that are required for your provider type/specialty, click on the link below and locate your type/specialty.

[Follow on Document Requirement by Provider Type and Specialty](#)

Provider Enrollment and Re-enrollment cont.

Re-enrollment Due Dates:

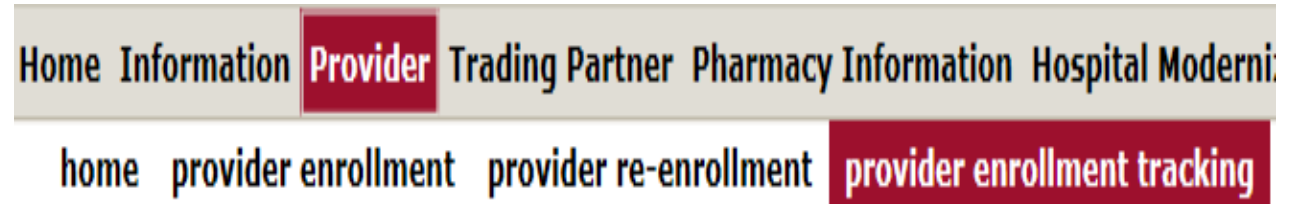
Providers with Secure Web portal access can view their re-enrollment due date once logged in as it is displayed on the Home page.

- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

The screenshot displays the 'Account' section of a provider's web portal. At the top, a navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, and Messages. Below this, a sub-menu for 'Account' contains links for home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. A prominent red warning message states: 'Your password expires in 52 day(s) on 11/21/2021 at 2:55 PM Change Password'. The main content area shows a welcome message for 'Provider Account User ID' and 'Provider ID Enrollment NPI or AVRS'. The 'Reenrollment Due Date' is listed as '09/01/2022', with a large green arrow pointing to it. Below this, the 'Zip Code' is '06226 - 3606'. A 'Quick Link' sidebar on the right offers options like 'Check E-messages', 'Claim Status Inquiry', 'Client Eligibility Verification', 'Prior Authorization Inquiry', 'Download Remittance Advices', 'ACA', and 'Ordering/Prescribing/Referring Provider List'. An 'Email Subscription' section at the bottom right includes a link to 'Register/Update Email Subscription'. A footer note mentions that 835 transactions are being sent to the download page in the Trade Files menu option.

Provider Enrollment and Re-enrollment cont.

To check the status of a re-enrollment application, select *Provider Enrollment Tracking* from either the *Provider* submenu or the *Provider* drop-down menu.



Enter your *ATN* and *Business OR Last Name as enrolled* and click *search*

A screenshot of the 'Enrollment Tracking Search' form. The form has two input fields: 'ATN*' with the value '305929' and 'Business OR Last Name*' with the value 'SMITH'. There are two buttons: 'search' and 'clear'.

In this example, DSS is reviewing the application that was submitted on 09/29/2021.

Status	DSS Conducting Initial Review
Last Status Date	10/26/2021
Application Type	Re-Enrollment
Date Received	09/29/2021

Demographic Maintenance

Presented by: The Department of Social Services and Gainwell Technologies for
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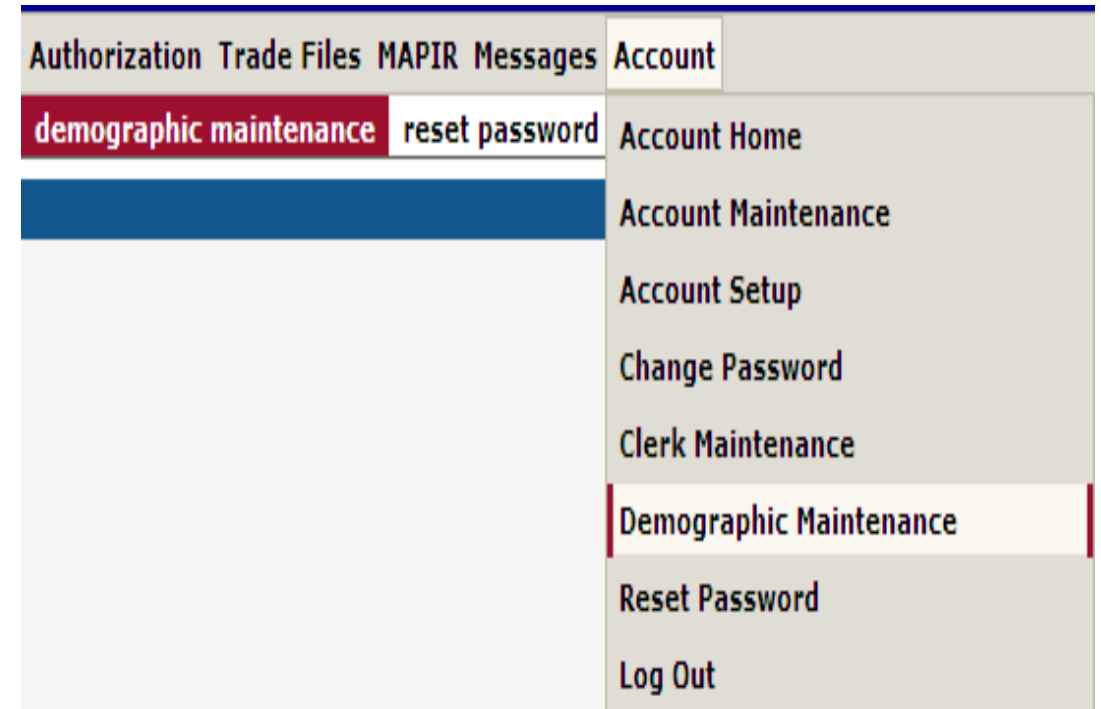
Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes **provider addresses, languages known by staff, Electronic Funds Transfer (EFT) and member of organization maintenance.** Failure to update demographic information could result in the delay of receipt of time sensitive information, information being sent to the wrong address, or delay of payments.

You can alter and update demographic information in the Demographic Maintenance section of the Secure Site :

- All address types including Mail to, Pay to, Service Location, Enrollment and Home Office addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Maintain Organization Members

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



Demographic Maintenance cont.

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

- Clicking the submenu options will open a panel with related information:
 - Base Information Service Location
 - Location Name Address
 - EFT Account
 - Service Language
 - Maintain Organization Members
 - Add/Update Vehicle Registration Information

Provider Information			
Provider ID	1234567890	Address	15 Main Street
Organization	Sole Proprietor		Suite 2A
Usage	Service Location	City	Willimantic
Provider Type	27 - Dentist	County	Fairfield
Ownership	Yes	State/Zip	CT 06614-4008
Phone	203-555-5555		

[Base Information](#) > [Service Location](#) > [Location Name Address](#) > [EFT Account](#) > [Service Language](#) > [Maintain Organization Members](#)

Demographic Maintenance – Location Name Address

Specify different mailing, payment, service location, home office and enrollment addresses

Usage	Name	Address 1	City	State	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Enrollment Address	AUTISM FISCAL INTERMEDIARY	201 SOUTH PARK DR	BRIDGEPORT	CT	06047	4154	(860)746-5765		N	V
Home Office	AUTISM FISCAL INTERMEDIARY	201 SOUTH PARK DR	BRIDGEPORT	CT	06047	4154	(860)746-5765		N	V
Mail to	AUTISM FISCAL INTERMEDIARY	201 SOUTH PARK DR	BRIDGEPORT	CT	06047	4154	(860)746-5765		N	V
Pay to	AUTISM FISCAL INTERMEDIARY	201 SOUTH PARK DR	BRIDGEPORT	CT	06047	4154	(860)746-5765		N	V
Service Location	AUTISM FISCAL INTERMEDIARY	191 NORTH WEST ST	SALEM	CT	06065	6065	(860)746-5765		N	V

Select row above to update.

Apply Changes To:

- Svc Loc
- Pay To
- Mail To
- Home Office
- Enrollment

Name Type Business Name Personal Name

Name

Title

Usage

Country

Address 1

Address 2

City

State

Zip

Contact Name

Contact Phone

Fax

Patient Use Phone

TDD\TTY

E-Mail

Confirm E-Mail

Mobile Number

Pager Number

Address Indicator

Handicap Accessible?

Demographic Maintenance – Location Name Address cont.

To update address information, simply select the applicable row from the provided list (Alternate Service Location, Enrollment Address, Home Office, Mail to, Pay to, or Service Location); then click ‘maintain address’

Provider Location Name Address											
Usage	Name	Street	City	State	Country	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Alt Service Location	HARPER, KATHLEEN	1275 POST ROAD	FAIRFIELD	CT		06824	6015			N	V
Alt Service Location	HARPER, KATHLEEN	1020 MEMORY LN	HARTFORD	CT	US	06066	6066	(860)741-2333		N	V
Alt Service Location	HARPER, KATHLEEN	1020 MEMORY LN	HARTFORD	CT	US	06066	6066	(860)741-2333		N	V
Enrollment Address	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT	US	06824	5166	(203)254-2452		N	V
Home Office	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Mail to	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Pay to	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V
Service Location	HARPER, KATHLEEN	134 ROUND HILL ROAD	FAIRFIELD	CT		06824	5166	(203)254-2452		N	V

Select/fill in the appropriate information (address, phone number, etc.); click ‘save’

maintain address

The following messages were generated:

Message Description	Panel	Field
Save was Successful		

Demographic Maintenance – EFT Account Information

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited.

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited.

The screenshot shows a web browser window titled "EFT Account" with a close button in the top right corner. Below the title bar is a blue header with the text "Click here to open Provider EFT Enrollment instructions." Below this is a table with the following data:

Financial Institution Name	Financial Institution Routing Number	Provider's Account Number with Financial Institution	Type of Account at Financial Institution	Last Change Date	EFT Status
TD BANK NA	011100111	4242042420	Checking		Active

Below the table is the text "Select row above to update -or- click Add button below." The main form area contains several sections:

- Required fields are indicated with an asterisk (*)**
- Provider Name*** (text input)
- Account Number Linkage to Provider Identifier*** (text input)
- Provider Tax Identification Number (TIN)** (text input)
- OR**
- National Provider Identifier (NPI)** (text input)
- Provider Identifiers***
 - Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN)** (text input)
 - OR**
 - National Provider Identifier (NPI)** (text input)
- Other Identifiers**
 - Assigning Authority** (text input)
 - Trading Partner ID** (text input)
- Financial Institution Information**
 - Financial Institution Name** (text input)
- Financial Institution Address**
 - Street** (text input)
 - City** (text input)
 - State/Province** (text input)
 - ZIP Code/Postal Code** (text input)
 - Financial Institution Routing Number** (text input)
 - Financial Institution Routing Number(rekey)*** (text input)
 - Type of Account at Financial Institution** (dropdown menu)
 - Provider's Account Number with Financial Institution** (text input)
 - Provider's Account Number with Financial Institution(rekey)*** (text input)
- Reason for Submission** (radio buttons): New Enrollment, Change Enrollment, Cancel Enrollment
- Authorized Signature** (text input)

At the bottom right of the form are "save" and "cancel" buttons.

**** If you change bank accounts, your EFT Account information should be updated to prevent deposit discrepancies.****

Eligibility Verification

Presented by: The Department of Social Services and Gainwell Technologies for
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December 2021



Eligibility Verification

DSS recommends that providers verify a client's eligibility on the date of service prior to performing the said service and at regular intervals

- Eligibility can change at any time

Verifying a client's eligibility:

- Secure Web portal account at www.ctdssmap.com
- Automated Voice Response System (AVRS)
- Provider Electronic Solutions (PES) software
- Point of Sale (POS) Device
 - Providers interested in using a POS device must contact a third-party vendor to obtain the device
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
- Via e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

Eligibility Verification cont.

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

You must satisfy one of the search combinations prior to selecting submit.

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

Valid Search Combinations

- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date



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

When entering a full name as part of your search criteria, a middle initial is required if one is present in the client's CMAP profile.

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text"/>	From DOS*	<input type="text" value="11/21/2019"/>
SSN	<input type="text"/>	First Name, MI	<input type="text"/>	To DOS*	<input type="text" value="11/21/2019"/>
Birth Date	<input type="text"/>				
Service Type Code 1	30 - Health Benefit Plan Coverage	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"/>				



submit

Eligibility Verification cont.

1 – Medical	54 – Long Term Care	AD – Occupational Therapy
4 – Diagnostic X-Ray	56 – Medical Related Transportation	AF – Speech Therapy
5 – Diagnostic Lab	75 – Prosthetic Device	AL – Vision (Optometry)
33 – Chiropractic	82 – Family Planning	DM – Durable Medical Equipment
35 – Dental	86 – Emergency Services	MH – Mental Health
42 – Home Health Care	88 – Pharmacy	PT – Physical Therapy
45 – Hospice	93 – Podiatry	RT – Residential Physical Treatment
47 – Hospital	98 – Professional (Physician) Office Visit	UC – Urgent Care

Eligibility Verification cont.

The Eligibility Verification Response window provides the search results

- In this example— the client’s eligibility cannot be verified for the requested dates (Aug. 1 – Aug. 23, 2020) – **eligibility verification can only look back one year**
- Changing the dates of the eligibility request to within the allowable one-year window creates a different result.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims **Eligibility** Prior Authorization Hospice MAPIR Account

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	<input type="text" value="DOE"/>	From DOS*	<input type="text" value="08/01/2020"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="JOHN"/> <input type="text" value="P"/>	To DOS*	<input type="text" value="08/23/2020"/>
Birth Date	<input type="text"/>				
Service Type Code 1	<input type="text" value="30 - Health Benefit Plan Coverage"/>	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"/>				

Eligibility Verification Response

Verification Number

Response Text

Eligibility Verification cont.

Eligibility searches cannot span multiple months

- 2/01/20- 03/05/20 is **not** valid.
- 02/01/20- 02/29/20 and 3/1/20- 3/5/20 is valid
- Submitting a request that spans multiple months will result in an error message.

Eligibility Verification Request

Client ID	<input type="text"/>	last name	DOE	From DOS*	02/01/2020
SSN	989-44-5555	First Name, MI	JOHN	To DOS*	03/05/2020
Birth Date	<input type="text"/>				
Service Type Code 1	30 - Health Benefit Plan Coverage	Service Type Code 2			
Service Type Code 3		Service Type Code 4			
Service Type Code 5					

From DOS* 02/01/2020
To DOS* 03/05/2020



Please correct the following errors:
Eligibility verification requests must not span multiple months.

Eligibility Verification cont.

Positive eligibility responses provide detailed information.

Eligibility Verification Response

- Provides a verification number that should be kept on record in case the client's coverage is retroactively changed at a later date
- Reports client's eligibility status for the requested date(s) of service

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

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

Eligibility Verification cont.

Eligibility Verification Response	
Verification Number	160480000Z
Response Text	Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information			
Client ID	009999999	Last Name	CAREY
SSN	111-99-9999	First Name, MI	BABYC
Birth Date	01/20/2007	Street	1 MAIN ST

Benefit Plan				
Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Husky D. For Behavioral Health Services, call BHP at 877-552-8247.	04/01/2019	04/01/2019	04/30/2019	

Deductible Information				
Service Information	Effective Date	End Date	Base Deductible Amount	Remaining Amount
Husky D			\$0.00	

Out of Pocket Information - Includes Deductible and Coinsurance

*** No rows found ***

Service Type Codes - Medicaid Services			
Service Type Code ▲	Service Type Information	Copay	Coinsurance
1	Medical Care		
33	Chiropractic	\$0.00	0%
35	Dental Care		
4	Diagnostic X-Ray	\$0.00	0%
40	Oral Surgery	\$0.00	0%
42	Home Health Care	\$0.00	0%
45	Hospice	\$0.00	0%
47	Hospital	\$0.00	0%
48	Hospital - Inpatient	\$0.00	0%
5	Diagnostic Lab	\$0.00	0%

1 2 3 Next >

Eligibility Verification cont.

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

1 2 3 Next >

Service Type Codes - MCO Services
*** No rows found ***

Service Type Codes - Not Covered
*** No rows found ***

Limit Information
*** No rows found ***

TPL	
Carrier Code ▲	Carrier Name
788	CONNECTICARE INC
A12	EXPRESS SCRIPT

Provider should initiate a separate request to the other payer or plan to determine level of coverage

Managed Care Provider
*** No rows found ***

Lockin
*** No rows found ***

Medicare
Coverage ▲
Medicare A
Medicare B

Eligibility Verification cont.

Benefit Plan

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

Benefit Plan					
Service Information	Benefit Month Effective Date	Effective Date	End Date	Message 1	Message 2
Husky D. For Behavioral Health Services, call BHP at 877-552-8247.	08/01/2021	08/01/2021	08/23/2021		

Service Type Codes – Gainwell Technologies

- A list of services for which the client was eligible that would be submitted for payment to Gainwell Technologies
- The Service type code field will also provide copay amounts for HUSKY B clients

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

1 2 3 Next >

Eligibility Verification cont.

Lockin

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

Medicare

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

TPL (Third Party Liability)

- Commercial / private insurance coverage other than Medicare or Medicaid under which the client may be covered

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

Medicare
Coverage ▲
Medicare A
Medicare B
Medicare D

TPL	
Carrier Code	Carrier Name
813	AARP HEALTH CARE OPTIONS

Eligibility Verification – Eligibility Issues

Medicare Covered Services

If **Medicare Covered Services** or **Qualified Medicare Beneficiary (QMB)** is present on the benefit plan and are the *only* coverage(s) on the benefit plan, the client *does not* have active Medicaid for the eligibility period being researched.

Benefits are limited to the payment of Medicare coinsurance and deductible amounts assuming the Medicare paid amount is less than the Medicaid allowed amount. Charges that are denied or are not covered by Medicare will not be considered for payment under the QMB program.

Benefit Plan					
Service Information	Benefit Month			Message 1	Message 2
	Effective Date	Effective Date	End Date		
Medicare Covered Services	08/01/2021	08/01/2021	08/23/2021		

Deductible Information				
Service Information	Effective Date	End Date	Base Deductible Amount	Remaining Amount
Qualified Medicare Beneficiary				\$0.00

Eligibility Verification – Eligibility Issues cont.

Spend Down

For clients who have a spend down, the eligibility date in a spenddown must be determined as well as meeting the spenddown amount before claims can be submitted to and paid by Medicaid.

A spend down *may* be indicated on the eligibility verification response. To verify if a client has a spenddown or to verify the status of the receipt of medical bills applied toward a spend down, please call the HUSKY Spenddown Unit at 1-877-858-7012.

Eligibility Verification – Benefit Plans

HUSKY A

- Coverage group for eligible children, parents, relative caregivers; pregnant women

HUSKY B

- Non-Medicaid Children's Health Insurance Program (CHIP)
- Free or low-cost health insurance for children and youth up to age 19 & for families who are not income eligible for HUSKY A with income between 201% and 323% of the federal poverty level qualify under either band 1 or band 2.

HUSKY C

- Previously referred to as fee-for-service Medicaid, or Adult Medicaid
- Individuals that are aged, blind, or disabled

HUSKY D

- Previously referred to as Medicaid for Low-Income Adults (MLIA) or State Administered General Assistance (SAGA)
- Individuals aged 19 through 64 who do not receive federal Supplemental Security Income or Medicare and who are not eligible for another coverage group.

Eligibility Verification – Benefit Plans cont.

Tuberculosis

- Individuals not eligible for full Medicaid coverage who have active or latent TB; covers medical and pharmacy services relevant to the treatment of TB

Family Planning

- Individuals of childbearing age (including minors) who are not otherwise eligible for full Medicaid coverage; provides coverage for family planning and family planning-related medical and pharmacy services

Limited Behavioral Health Services

- Intensive in-home child and adolescent psychiatric services only

CHC Waiver Benefit Plans

Connecticut Home Care (CHC) Benefit Plans

- Medical and Non-Medical services for elder and disabled clients under the CHC program

Please Note: There are other waivers that provide non-medical services to HUSKY clients at risk of institutionalization, thereby enabling them to continue to live in a home and community-based setting at a cost less than that of an institution, such as Personal Care Attendant and Acquired Brain Injury Waivers.

Providers will be able to find additional information about eligibility responses on our Web site. Or from our Web site, www.ctdssmap.com > Information > Publications, then scrolling down to the second to last panel, “Claims Processing Information” then clicking on Eligibility Response Quick Reference Guide

Prior Authorization

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Prior Authorization – PA Search

Once on the secure site, click [Prior Authorization](#) > [Prior Authorization Search](#).

The screenshot shows a web application navigation menu. The top navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, MAPIR, and Account. The 'Account' link is highlighted in red. Below this, a secondary navigation bar contains links for home, account home (highlighted in red), account maintenance, account setup, change password, reset password, and log out. A dropdown menu is open under 'Prior Authorization', with 'Prior Authorization Search' highlighted in green. Other items in the dropdown include Care Plan and Pharmacy Prior Authorization. A tooltip for 'Prior Authorization Search' is visible. Below the navigation, the text 'Welcome, Home Health Agency' is displayed, followed by 'Reenrollment Due Date: 10/29/2020'.

Prior Authorization – PA Search cont.

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

home **prior authorization search** care plan pharmacy prior authorization

Quick Link

- Web Guide - Prior Authorization Search

Provider 001234567 MCD

Prior Authorization Search

Client ID

Client Name

Search Pharmacy PAs only

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assign - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Procedure Code List [Search]

Records

It is easier to search by Client ID or PA Number, however you can search by any combination of the fields below, such as by date, procedure or list code.

Prior Authorization – PA Search cont.

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

Search results can include PAs authorized by procedure code, procedure code with modifier, procedure code lists and proc/mod lists.

Search Results														
PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub	Billing Provider ID	Prescribing/Ordering Provider ID	Service Code	Code Thru	Proc/Mod List	Frequency	Status
0771587512	02	10/28/2021	11/05/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI	424			1 Per Date Span	Auto Approved for Care Plan
0771587512	04	11/01/2021	12/31/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI			SN	9 Per Date Span	Auto Approved for Care Plan
0771587512	03	11/01/2021	12/31/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI	G0162			6 Per Date Span	Auto Approved for Care Plan
0771587512	01	10/27/2021	10/27/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI			36	1 Per Date Span	Auto Approved for Care Plan

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														
PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub	Billing Provider ID	Prescribing/Ordering Provider ID	Service Code	Code Thru	Proc/Mod List	Frequency	Status
0771587512	02	10/28/2021	11/05/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI	424			1 Per Date Span	Auto Approved for Care Plan
0771587512	04	11/01/2021	12/31/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI			SN	9 Per Date Span	Auto Approved for Care Plan
0771587512	01	10/27/2021	10/27/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI			36	1 Per Date Span	Auto Approved for Care Plan
0771587512	03	11/01/2021	12/31/2021	10/29/2021	20:06:31	Home Care Progra	Initial		NPI	G0162			6 Per Date Span	Auto Approved for Care Plan

Prior Authorization - Viewing and Understanding the PA

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

36	Nursing assessment/evaluation - T1001 T1001 T1001 TT
----	--

39	Skilled Services by Registered Nurse (RN) for Management and Evaluation of Plan of Care G1062 G1062 95 G1062 95 TT G0162 GT G1062 GT TT G1062 TT
----	--

NOTE: Discrepancies should be reported to the Access/ case Management Agency

Prior Authorization – PA Details

Authorized services are for a Nursing Aide Service one time only service to a subsequent client with billing codes **T1004 U2 TT** for **12 units = 3 hours** of authorized service with an **effective/end date of 11/1/21** and **frequency of 12 units per calendar week**.

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	12.000	\$0.00	12.000	\$0.00	Auto Approved for Care Plan	T1004	U2	TT								

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code **T1004** [Search] Nsg aide service up to 15min

Mod 1 **U2** [Search]

Mod 2 **TT** [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List [Search]

Requested Eff./End Dates* **11/1/2021** **11/1/2021**

Requested Units/Dollars* 12.000 \$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]

NDC [Search]

Status Auto Approved for Care

Authorized Units/Dollars	12.000	\$0.00
Authorized Eff./End Dates	11/1/2021	11/1/2021
Used Units/Dollars	0	\$0.00
Available Units/Dollars	12	\$0.00
Frequency	12 Per Calendar Week	

Prior Authorization – PA Details cont.

This PA for Skilled Nursing services is authorized with a **Procedure Code/Modifier list SN.**

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	NDC	Revenue Code	Revenue Code List	
01	15.000	\$0.00	15.000	\$0.00	Approved							SN				

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 SN **Skilled Nursing**

Procedure Code List

Requested Eff./End Dates* **11/1/2021** **11/11/2021**

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]

NDC [Search]

Status **Approved**

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates **11/1/2021** **11/11/2021**

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

Prior Authorization – PA Modifiers

Modifiers include:

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 screenshot shows a software interface for a medical procedure. At the top, 'Line Item 01' is displayed. Below it, there are two dropdown menus: 'Service Type Code*' and 'Procedure Code'. The 'Procedure Code' dropdown is open, showing 'T1004' selected and highlighted with a green box. To the right of 'T1004' is a '[Search]' button. Below the 'Procedure Code' dropdown, there are two more dropdown menus: 'Mod 1' and 'Mod 2'. 'Mod 1' is set to 'U2' and 'Mod 2' is set to 'TT', both highlighted with green boxes. To the right of each modifier dropdown is a '[Search]' button. On the far right, a text box contains the description 'Nsg aide service up to 15min'.

Prior Authorization – PA Modifiers cont.

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

The screenshot displays a form with the following fields and values:

Line Item	01
Service Type Code*	Procedure Code
Procedure Code	T1004 [Search]
Mod 1	U2 [Search]
Mod 2	TT [Search]

A search box on the right contains the text: Nsg aide service up to 15min

Prior Authorization – PA Modifiers cont.

TG – Complex Visit can be used to authorize:

- Complex nursing care greater than two (2) hours of nursing care per day
- Is billed in conjunction with PA from CHNCT
- Billed for services S9123 – Nursing care in home by Registered Nurse, per hour and S9124 - Nursing care in home by licensed practical nurse, per hour

If authorized:

- The **TG** modifier must be associated to the procedure code on the PA
- If used when billing S9124, must also bill with modifier **TE** - LPN/ LVN for complex/high tech level of care services rendered by a licensed practical nurse

For more information see PB 17-60 [Increased Rate for Nursing Services for Complex/High Tech Level of Care](#)

Claims Processing

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Claims Processing

- Providers should remember that because payment for services rendered are made twice per month there are several times per year when providers encounter a 3-week cycle. Providers are strongly encouraged to submit enough claims prior to the 3-week cycle to meet their organizations/ agency’s operational needs.
- A 3-week cycle is indicated on the “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule” with the following identifier “-b” under Claim Cycle Date.
- To download the Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule navigate to www.ctdssmap.com, select Information> Publications> in the title field enter “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule”.

2021 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Dates
Jul					
	9-b	8	13	14	14
	23	22	27	28	28
Aug					
	6	5	10	11	11
	20	19	24	25	25
Sep					
	10-b	9	14	15	15
	24	23	28	29	29
Oct					
	8	7	13*	14*	14*
	22	21	26	27	27
Nov					
	5	4	9	10	10
	19	18	23	24	24
Dec					
	3	2	7	8	8
	17	16	21	22	22

b - Denotes 3 week cycle
c - Denotes Thursday cycle

* Denotes a 1 day delay in availability due to Monday Holiday
 ** Denotes a 1 day delay in availability due to Tuesday Holiday
 *** Denotes a 1 day delay in availability due to Wednesday Holiday

Claims Processing/ Submission Information

Claims Submitted to Gainwell Technologies are assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research

(20)(21)(05)(123)(456)

1 2 3 4 5

1 Claim Region – Identifies the manner in which the claim was submitted (**20** = *Electronic Claims with No Attachments*. The ICN Region Code List can be found on our Web site under *Information> Publications> Claims Processing Information*.)

2 Year of Receipt – Indicates the year in which the claim was received by Gainwell Technologies (**21**= 2021)

3 Julian Date of Receipt – The Julian calendar date of receipt (**005** = *the fifth day of the year; January 5*)

4 Batch Number – An internal number assigned by Gainwell Technologies to uniquely identify a batch (**123**)

5 Claim Number – A sequential number assigned to uniquely identify claims within a batch (**456**)

Claims Processing/ Submission Information cont.

When a claim processes through CMAP, it is subject to a series of edits that check the validity of claim data such as:

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

Each claim then passes through a series of audits.

- The claim is compared to **previously paid claims**.
- Is the current claim a duplicate of a paid claim?
- Does the billed procedure code require PA?
- Does the billed procedure code have PA?

Claims Processing – Third Party Liability (TPL) Information

Commercial / private insurance coverage other than Medicare or Medicaid under which the client is covered must be on the billed claim.

Medicaid is the payer of last resort

- Because of this providers must investigate the possibility of clients having other insurance coverage and pursue payment prior to submitting their claim to Gainwell Technologies
- Providers can see other insurance coverage in the eligibility verification process.

Claims can potentially deny when a discrepancy in TPL data exists on the client's state profile

- A Third-Party Liability Information Form should be sent to Health Management Systems (HMS)
- This form is available on the Information > Publications page of www.ctdssmap.com
- HMS will contact the insurance carrier and notify DSS of any discrepancy to avoid having CMAP claims unnecessarily denied for health insurance or Medicare reasons.
- Client eligibility will be updated

Claims Processing – Third Party Liability (TPL) Information cont.

Any TPL payers must be billed prior to submitting claims to Medicaid.

TPL claims submitted to Gainwell Technologies with other insurance payment or denial must include:

- Carrier's unique three-digit carrier code
- Available through eligibility verification (Web, phone, X12N 270/271 Eligibility Benefit Inquiry / Response Transaction) and in Chapter 5 of the CMAP Provider Manual
- The Amount Paid (on a paid claim) or "0.00" for a TPL denial
- The date of payment or denial from the TPL Explanation of Benefits (EOB)
- The physical TPL EOB should not be submitted with paper claims; the provider must retain this for audit purposes
- The Subrogation Process – Available to providers who do not receive timely responses from insurance carriers to get their claim paid.

For more information on this please see Chapter 5 of the Provider Manual on the www.ctdssmap.com Web site.

Claims Processing – Coinsurance/Deductible Information

Medicare Coinsurance and / or Deductible Claim Submission:

- Claims for clients covered under Medicare must first be billed to Medicare.
- Crossover claims are claims that Medicare has considered and made payment on.
- Crossover claims from Medicare will be denied if TPL information is on the client's eligibility file.
- Only claims paid by Medicare will be electronically submitted to Medicaid.
- Claims that do not cross over from Medicare or are denied by Medicare can be submitted by the provider to Gainwell Technologies.
- Claims submitted do not need the Explanation of Medicare Benefits (EOMB) attached if Medicare denied the service. Enter Medicare N/A or Medicare HMO N/A and the date of Medicare's denial.
- TPL or Medicare Coinsurance and / or Deductible Reimbursement
- Medicaid **will pay** up to the Medicaid Allowed Amount minus any Medicare or TPL payment.
- Medicaid **will not pay** if the Medicare or TPL payment is equal to or exceeds the Medicaid Allowed Amount.

A provider may not balance-bill the client, financially responsible relative, or representative of the client.

Medicare Cost Avoidance and Home Health Audit

Presented by: The Department of Social Services and Gainwell Technologies for Billing Providers

December 2021



Medicare Cost Avoidance

Home Health Agencies are required to submit claims for dually eligible clients to Gainwell Technologies indicating the reason an Advanced Beneficiary Notification (ABN), Form CMS-R-131 was issued to the client.

Claim Submission:

Claims for dually eligible clients who are traditional or Medicare Managed Care (A, B or A&B benefit eligible) and HUSKY eligible, must contain:

- At least one HIPAA Adjustment Reason Code (**150, 151, or 152**)
- Date the associated ABN or MCO Notice of Medicare Non-Coverage (NOMNC) was issued.
- The **issue date** of the ABN must be within **one year of the date of service**.

Note: This is not applicable to Medicare clients who are State Funded CT Home Care eligible.

Medicare Cost Avoidance cont.

Claim Denial:

If a client's care does not meet Medicare's coverage criteria and the claim does not contain one of the indicated Adjustment Reason Codes and corresponding ABN issue date, the claim will deny **Explanation of Benefit Code (EOB) code 2522 - "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of ABN or NOMNC"**.

Claim Auditing:

- Claims submitted with a HIPAA Adjustment Reason Code 150, 151, or 152 will be included in an Other Insurance Audit based upon a random sample of claims that contain one of the three Adjustment Reason Codes.
- Audited Home Health providers will be required to submit a copy of the original signed and dated ABN associated with the selected claim under review.
- Failure to provide the appropriate ABN issued contemporaneously with the date of the selected claim will result in the claim being recouped.
- Providing an ABN with a different signature date than the ABN date of issue indicated on the claim will also result in recoupment of the claim.

Medicare Cost Avoidance cont.

These codes can only be used for Medicare as a third-party payer. They are not valid for any other third-party payer.

Home Health Agency Reasons to Issue Advanced Beneficiary Notice	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Code Description
Client determined to be not homebound; either at the start of care or after Medicare-covered services has been provided.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week.	151	Payment adjusted because the payer deems the information submitted does not support this many services.
Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care.	150	Payment adjusted because the payer deems the information submitted does not support this level of service.
Client's continued care determined to not be Medicare-coverable. CMS required Annual HHABN issued.	152	Payment adjusted because the payer deems the information submitted does not support this length of service.

Claims Audit Criteria

In accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, audit protocols have been published on the Department of Social Services' Web site. An introduction to audit protocols and an overview of the audit process can be found at: <http://www.ct.gov/dss/auditprotocols>.

Additional resources can be found in provider bulletin 17-29.

Links to audit protocols organized by provider type are located on the lower section of this Web page.

The Office of Quality Assurance

[Overview](#)

[Related Resources](#)

Provided by:

[Department of Social Services](#)

Related Resources

[Press Releases](#)

[Annual Report](#) 

[Audit Protocols](#)

[Long Term Care Audit Process](#) 

[Administrative Actions List](#)

[OIG Exclusion File](#)

[Report Fraud](#)

[Alcohol and drug abuse centers audit protocols](#) 

[Birth to Three Audit Protocol](#) 

[Dental audit protocols](#) 

[Department of Developmental Services Waiver audit protocols](#) 

[Homecare audit protocols](#) 

[Home health audit protocols](#) 

[Medical equipment audit protocols](#) 

[Outpatient hospital audit protocols](#) 

[Pharmacy audit protocols](#) 

[Physicians audit protocols](#) 

[Transportation audit protocols](#) 

[Long Term Care Audit Process](#) 

Claims Audit Criteria cont.

The Home Health audit protocols list the most common reasons why a provider's claims may be audited. You can find the Audit Protocols at <https://www.ct.gov/dss/auditprotocols> > Home Health audit protocols.

DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - HOME HEALTH SERVICES
UPDATED MAY 1, 2017

Listed are the most common audit findings for Medicaid home health services, and clarification of the criteria the Connecticut Department of Social Services (the "Department") uses when it makes those findings. Disallowances for home health services under the Medicaid program are governed by policies included in the Connecticut Medical Assistance Program Provider Manual (PM), the Medicaid Provider Enrollment Agreement (PA), Provider Bulletins (PB), the Regulations of Connecticut State Agencies (Conn. Agencies Regs.), the Connecticut General Statutes (Conn. Gen. Stat.) and the Code of Federal Regulations (C.F.R.). This protocol is for services performed prior to the implementation of the Electronic Visit Verification system. Please see the protocol for homecare services for additional requirements that may apply to home health services.

Title	Audit Criteria	Regulatory Reference
Billing - Failure to Utilize Third Party Liability.	The Department will disallow payment for services if there is a private insurance/third-party payor that the provider failed to bill first or did not receive a denial of payment by the third party.	Conn. Agencies Regs. § 17b-262-526(3)
Billing - Home Health Aide Services Provided to Multiple Clients in Same Household	If timesheets show that hands-on care services were provided to more than one client by the same home health aide during the same time period, the Department will disallow payment for the overlapping hours of home health aide services.	Conn. Agencies Regs. § 17b-262-734(b)(4)
Billing - Hours Paid In Excess of the Number of Hours on Timesheets	The Department will disallow payment for service if the number of hours paid exceeds the number of hours documented on the timesheet. The financial disallowance is the difference between the number of hours paid and the number of hours documented.	Conn. Agencies Regs. § 17b-262-735(c)(8)

Claim Denials and Resolution

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Claim Denials and Resolution

Denial Reasons Due to Eligibility:

- **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 a Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021).

Please Note: The system attempts to process under the HUSKY benefit plan first, if not a covered service it will set 4021 for the HUSKY benefit plan. The system will then attempt to process under the Waiver benefit plan. If the claim denies, the system will attempt to process under any other benefit plan the client may have, which too will set 4021. It is the other EOB that should be acted upon. Disregard the 4021 EOB codes

Resolution:

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

Claim Denials and Resolution cont.

- **Denial Reasons due to Care Plan not on File :**
 - **EOB Code 3015 – Care Plan Required**

Resolution:

A care plan must be created by the Access Agency or DSS Autism Case Manager via batch upload or interactively online via the secure Web portal. **Contact the appropriate case manager who must add a Care Plan for the client.**

Claim Denials and Resolution cont.

- **Denial Reason due to Service not Authorized on the care Plan:**

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

Resolution 1: A service denied for not on care plan must be added by the Access Agency or DSS Autism Case Manager to the Care Plan.

Resolution 2: Incorrect Procedure code billed by provider. Provider must correct the claim and resubmit.

Claim Denials and Resolution cont.

- **Denial Reason due to Units Billed Exceeding Frequency :**

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

Resolution 1: Units of service must be added to the frequency of an existing PA by Access Agency or DSS Autism Case Manager.

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

Claim Denials and Resolution cont.

- **Claim Denial Reason due to PA Exhausted:**
 - **EOB Code 3003** – Prior Authorization is required for payment of the service (units for the service are exhausted).

Resolution 1: Units of service must be added by Access Agency or DSS Autism Case Manager to an existing PA that is currently exhausted.

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

Claim Denials and Resolution cont.

- **Denial Reason Due to Modifier U2 Not Allowed:**

- **EOB Code 749 - Modifier U2 not allowed**

Cause:

Prior Authorization does not contain a U2 Modifier

Resolution:

Remove U2 modifier and resubmit the claim

If one-time only service, contact Access Agency or DSS Autism Case Manager who must enter a PA for service with a U2 modifier

Cause:

Claim is submitted with a U2 modifier for a service that is not a valid service on the Waiver Fee schedule

Resolution:

Claim must be resubmitted with the correct procedure code and the U2 modifier and must be on the Care Plan.

Claim Denials and Resolution cont.

- **Claim Denials related to EVV mandated claims submitted outside of the Santrax system:**

- **EOB Code 3327** - Confirmed visit not found

This EOB posts to a claim containing an EVV mandated service if there is no confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s).

Resolution: the visit must be confirmed in the provider's Santrax system.

NOTE: Confirmed visit data used in claims processing may take up to 24 hours for access to systematic confirmation therefore, visits must be confirmed at least 24 hours prior to claim submission.

- **EOB Code 3328** - Confirmed visit units are exhausted

This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units have been exhausted due to a previously submitted and paid claim.

Resolution: Increase the units on the confirmed visit in Santrax.

Claim Denials and Resolution cont.

- **Claim Denials related to EVV mandated claims submitted outside of the Santrax system cont'd:**

- **EOB Code 0047** - Confirmed visit units are exceeded

This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units on the confirmed visit are less than the units billed on the claim. This claim will pay, but it will cut back to the number of units on the confirmed visit.

Resolution: increase the units on the confirmed visit.

Please Note: EOB code 0047 may also occur if there are two visits for the same client and service on the same day and only one visit is confirmed. The second visit must be confirmed for the claim to pay the total number of units billed for the day.

Claim Denials and Resolution cont.

➤ **EOB Code 3329** - Details cannot exceed 31 days

Claims submitted from Santrax are limited to one date of service per claim detail. Claims submitted outside of Santrax may be submitted using spanned dates. These spanned dates cannot exceed the lessor of 31 days or a single month of service.

Resolution: reduce the number of days submitted on the claim detail.

Claim Denials and Resolution - Resources

- Case Managers create service orders and enter them in the Access/Case Management Agencies Care Management System.
- The Access/Case Management Agency is responsible for uploading initial care plans and changes to care plans to Gainwell Technologies, in Prior Authorization format, within seven (7) days of issuing the service order. DSS Autism Case Managers enter care plans and changes via a secure Web account directly into the PA subsystem for claims processing.
- If the provider has a PA for the services but 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/ Case Management Agency or DSS Autism Case Manager.

For assistance in resolving claim denials, please refer to Provider Manual chapter 12 – Claim Resolution Guide.

Claim Denials and Resolution - Resources

- Providers should first verify with the care manager at the Access/Case Management Agency or DSS Autism Case Manager responsible for the client's care plan that the client's Medicaid redetermination and financial verifications have been submitted to DSS for processing.
- If the clients Medicaid redetermination and financial verifications have been submitted to DSS and the access agency cannot be of further support, the Community Options Unit, formerly the Alternate Care Unit, at DSS should be notified of the eligibility issue. Providers should send an encrypted email to Waiver.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 "<Waiver> Client Eligibility Issue" in the subject line of the email

To avoid claim denials due to eligibility, providers should verify client eligibility prior to performing a service.

Monthly Claims Reprocessing

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Monthly Claims Reprocessing

The Access or Case Management Agencies can make **retroactive** changes to Care Plans when claims are paid against the Prior Authorization (PA) for a CHC, PCA, Autism, MHW or ABI Waiver client.

Access Agencies, Case Management Agencies and Autism Case Managers can make changes to individual care plans **without** requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.

A Systematic Monthly Claims Reprocessing for all CHC, PCA, Autism or ABI Waiver claims occurs in the **first financial cycle of each month** to sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Access or Case Management Agencies.

Monthly Claims Reprocessing cont.

Systematic Monthly Reprocessing

- In the first cycle of each month, Gainwell Technologies will recoup (void) all paid claims impacted by the Access or Case Management Agency PA changes made two months prior. (*Region code 52 claims = a voided claim*).
- In the same cycle Gainwell Technologies will reprocess to, deny and/or pay claims posting to the correct PA/PA line detail. (*Region 24 claims = a new day claim*).
- There is a two-month delay between the PA change and reprocessing of the claim impacted by the change.
- For example: In the first cycle of June claims impacted by changes made in April will be reprocessed.

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

Monthly Claims Reprocessing cont.

Impact to Provider Remittance Advice (RA)

If there is a financial impact (change in reimbursement amount up or down) between the voided claim (**region 52**) and the reprocessed claim (**region 24**):

Providers will see in the adjustment section of their RA:

- The previously paid claim ICN (**Region 20, 22, 59, 10** etc.)
- Recouped/Voided claim ICN (**Region 52**)
- **EOB Code 8236** – Claim was recouped due to PA change

Monthly Claims Reprocessing cont.

REPORT: CRA-PHAD-R

interChange MMIS

Date: 10/26/2021

RA#:

MEDICAID MANAGEMENT INFORMATION SYSTEM

PAGE: 33

PROVIDER REMITTANCE ADVICE

CMS 1500 CLAIM ADJUSTMENTS

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

PAYEE ID
ISSUE DATE 10/26/2021
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	INCOME	AMOUNT	CONTR.	
		SERVICE DATES RENDERING				BILLED	ALLOWED					
PL	SERV	PROC	CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	AMOUNT	AMOUNT	DETAIL	EOBS

CLIENT NAME: Sally Client		CLIENT NO.: 0000000000									
1	2200000000000	080321	081221	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	080321	081221	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HEADER EOBS:		8236									

Monthly Claims Reprocessing cont.

Impact to Provider Remittance Advice (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 paper RA.

Monthly Claims Reprocessing – Claims Reprocessed

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.
REPORT: CRA-PHPD-R RA#:											
interChange MHIS MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER REMITTANCE ADVICE CMS 1500 CLAIMS PAID											
Home Care Agency 555 Any ST Somewhere, CT00000-0000											
										PAYEE ID	MCD
										ISSUE DATE	10/26/2021
										TAXONOMY	-----
										P. AVRS ID	
CLIENT NAME: Sally Client CLIENT NO.:											
2400000000000 080221 081221 116.16 75.00 0.00 0.00 0.00 0.00 0.00 75.00 0											
HEADER EOB 8238											
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL	EOBS		
12	1542P		20	080221 081221	MCD	116.16	75.00				

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 when performing a claim inquiry.

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 only** with:

EOB code 8237 – Claim Systematically Reprocessed Due to Retro Change-Information Only.

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

Monthly Claims Reprocessing cont.

Impact to PA Inquiry in Provider's Secure Web Portal

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 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/Case Management Agency or DSS Autism Case Manager.

Monthly Claims Reprocessing cont.

Impact to Provider's Secure Web Portal – PA Inquiry (continued)

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 4 units per week for 4 weeks = 16 units authorized and available.
- Claims are paid against the PA = 16 units used
- Access Agency changes the PA to 4 units a week for 3 weeks = 12 units authorized due to hospitalization after the third week

Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Remittance Advice (RA)

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Remittance Advice

Claim Cycle Schedule

The Claim Cycle Schedule is published twice per year to tell providers when their Medicaid claims must be submitted to Medicaid for processing and when they can expect payment and the ability to download the Remittance Advice.

To download the Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule navigate to www.ctdssmap.com, select Information> Publications> in the title field enter “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule”.

The Claim Cycle Schedule can also be located by navigating to www.ctdssmap.com > Provider>Provider Services> Schedules.

2021 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Dates
Jul					
	9-b	8	13	14	14
	23	22	27	28	28
Aug					
	6	5	10	11	11
	20	19	24	25	25
Sep					
	10-b	9	14	15	15
	24	23	28	29	29
Oct					
	8	7	13*	14*	14*
	22	21	26	27	27
Nov					
	5	4	9	10	10
	19	18	23	24	24
Dec					
	3	2	7	8	8
	17	16	21	22	22

b - Denotes 3 week cycle
c - Denotes Thursday cycle

* Denotes a 1 day delay in availability due to Monday Holiday
 ** Denotes a 1 day delay in availability due to Tuesday Holiday
 *** Denotes a 1 day delay in availability due to Wednesday Holiday

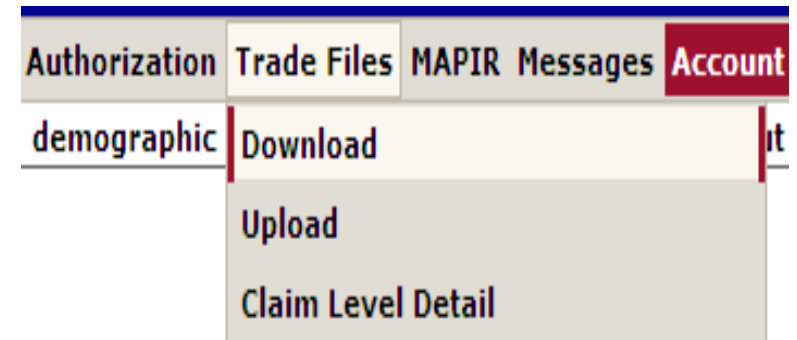
Remittance Advice cont.

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

- RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider's claim activity
- Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com
- Available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper version of the RA
- Only the last 10 RAs are maintained on the Gainwell Technologies' Web site. It is recommended that providers save a copy of their RAs to their local computer system for future access
- Click Download Remittance Advice from the Quick Link box on the account home screen or select Download from the Trade Files drop-down menu

Quick Link

- [Check E-messages](#)
- [Claim Status Inquiry](#)
- [Client Eligibility Verification](#)
- [Prior Authorization Inquiry](#)
- [Download Remittance Advices](#)



Remittance Advice cont.

Select Remit. Advice (RA) – PDF from the Transaction Type menu; click Search

NOTE: 1099s are available to download as well.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims Eligibility
 Prior Authorization Hospice **Trade Files** MAPIR Messages Account
 home **download** upload claim level detail

File Download Search

Transaction Type

- Billing/Reversal
- CSV
- Claim Payment/Advice
- Claim Status Response
- Drug Rebate File Transfer
- E-Delivery
- Eligibility Response
- Enrollment/Maintenance
- Functional Ack
- Interchange Ack
- PA Revers/Inq/Req Only
- PCCM Reports
- PDP/MAPD Reports
- Premium Payments
- Prior Authorization
- Remit. Advice (RA) - PDF**
- Transportation PA Files

REMINDER: DOI
Web file retention

TION
type of file being downloaded.

- Remittance Advice (RA) files, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgements (999), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment/Response (279), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical files will no longer be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery files will no longer be available to authorized users for a period of approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

It is recommended all electronic files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by such data as client ID, ICN or Explanation of Benefits (EOB) Codes.

All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.

Remittance Advice cont.

Banner Page

- Important messages from DSS or Gainwell Technologies

Claims Information (Paid, Denied, and Adjustments)

- Sorted by claim type and status; reports up to 20 EOB codes per claim

TPL Information

- The primary insurance that is on file for clients whose services appear on the RA

Financial Transactions Processed

- Payouts, Refunds, Account Receivables

RA Summary

- Month-to-day and year-to-day summaries of financial activities, account receivables

EOB Code Descriptions

- Descriptions of the EOB codes that posted to claims on the RA

Claims in Process

- Lists claims that were in suspense when the financial cycle was run

Remittance Advice cont.

Banner Page

REPORT: CRA-BANN-R
RA#: 7766400

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
PROVIDER BANNER MESSAGES

Date: 08/24/2021
PAGE: 1

123 Home Care
This Rd
EAST HARTFORD, CT 06118-4001

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI 1234567890
08/24/2021
251E00000X
123456789

Attention All Providers.

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and Gainwell Technologies will be closed on Monday, September 6, 2021 in observance of the Labor Day holiday. Both the DSS and Gainwell Technologies offices will re-open on Tuesday, September 7, 2021.

REPORT: CRA-LTPD-R
RA#: 6800455

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
LONG TERM CARE FACILITY CLAIMS PAID

Date: 08/24/2021
PAGE: 9

642 DANBURY ROAD
RIDGE HEALTH CARE
RIDGEFIELD, CT 06877-2719

RIDGE HEALTH CARE

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI 09/26/2017
314000000X

FP --ICN-- ATTEND PROV.
--PATIENT NUMBER--

CLIENT NAME:
M 2217262150238 NPI
051130000FIKR
REV CD HCPCS/RATE SRV DATE
100 07032021

CLIENT NO. :	SERVICE DATES FROM	THRU	DAYS	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY	PAID AMOUNT
07032021 07262021			23	6,178.95	6,178.95	0.00	0.00	0.00	0.00	6,178.95
	UNITS	BILLED AMT	ALLOWED AMT	DETAIL	EOBS					
	23.00	6,178.95	6,178.95							

Claim Information (Paid, Long Term Care):

Remittance Advice cont.

Claim Information (Denied, Long Terms Care):

REPORT: CRA-LTPD-R	interChange MMIS										Date: 08/24/2021
RA#: 6800455	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 9
PROVIDER REMITTANCE ADVICE											
LONG TERM CARE FACILITY CLAIMS PAID											
RIDGE HEALTH CARE											
642 DANBURY ROAD											
RIDGE HEALTH CARE											
RIDGEFIELD, CT 06877-2719											
PAYEE ID											
ISSUE DATE											
TAXONOMY											
P. AVRS ID											
NPI											
09/26/2017											
314000000X											
FP --ICN--	ATTEND PROV.	SERVICE DATES	DAYS	BILLED	ALLOWED	DEDUCT	CO-INS	TPL	PATIENT	PAID AMOUNT	
--PATIENT NUMBER--		FROM THRU		AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	LIABILITY		
CLIENT NAME:		CLIENT NO.:									
M 2217262150238	NPI	07032021	07262021	23	6,178.95	6,178.95	0.00	0.00	0.00	6,178.95	
051130000FIKR											
REV CD HCPCS/RATE	SRV DATE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL	EOBS					
100	07032021	23.00	6,178.95	6,178.95							

EOB Code Description:

REPORT: CRA-EOBM-R	interChange MMIS										Date: 08/24/2021
RA#: 7766400	MEDICAID MANAGEMENT INFORMATION SYSTEM										PAGE: 41
PROVIDER REMITTANCE ADVICE											
EOB CODE DESCRIPTIONS											
123 Home Care											
This Rd											
EAST HARTFORD, CT 06118-4001											
PAYEE ID											
ISSUE DATE											
TAXONOMY											
P. AVRS ID											
NPI											
08/24/2021											
251E00000X											
EOB CODE	EOB CODE DESCRIPTION										
0047	CONFIRMED VISIT UNITS ARE EXCEEDED										
1042	RESIDENT NOT ALLOWED AS ATTENDING PROVIDER										
2504	BILL PRIVATE CARRIER FIRST OR INVALID ADJUSTMENT REASON CODE BILLED.										
2522	BILL MEDICARE FIRST OR PROVIDE APPROPRIATE ADJUSTMENT REASON CODE AND DATE OF ABN OR NOMNC										
3003	Prior authorization is required for payment of this service.										
3016	SERVICE NOT COVERED UNDER CARE PLAN										
3327	CONFIRMED VISIT NOT FOUND										
4021	The procedure billed is not a covered service under the client's benefit plan.										
4227	The RCC billed is not a covered service under the client's benefit plan.										
4980	The procedure billed is restricted under the client's benefit plan.										
6230	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK										
6237	PLAN OF CARE EXCEEDED OR PA REQUIRED > 5 NURSE VISITS PER WEEK										
6420	PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK										
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED										
9977	PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED										

Remittance Advice cont.

Financial Transaction

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE			
-----NON-CLAIM SPECIFIC PAYOUTS-----									
NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDER									
-----REFUNDS/CASH RECEIPTS FROM PROVIDER-----									
--CCN--	REFUNDS/CASH RECEIPTS --AMOUNT--	REASON CODE							
NO REFUNDS FROM PROVIDER									
-----ACCOUNTS RECEIVABLE-----									
A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE PGM YEAR
5921230012713	08/20/2021	155.88	155.88	155.88	0.00	8400	001141231	WILLIAM NARGI	
-----1099 ADJUSTMENTS-----									
TRANSACTION NUMBER	SETUP DATE	ADJUSTMENT AMOUNT	REASON CODE						
NO 1099 ADJUSTMENTS									

Financial Transaction Reason Codes

FINANCIAL TRANSACTIONS REASON CODES	
RSN CODE	REASON CODE DESCRIPTION
8400	Result of claim adjustment

Remittance Advice - Summary

-----CURRENT CYCLE TOTALS BY FUND PAYER-----						
	---NEW DAY CLAIMS---		---POSITIVE ADJUSTMENTS---		---TOTAL ALL CLAIMS---	
	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT
Medicaid	2,022	294,967.21	1	14.01	2,023	294,981.22
HUSKY B-3	3	379.63	0	0.00	3	379.63
HUSKY B 1 and 2	41	5,577.61	0	0.00	41	5,577.61
CADAP	0	0.00	0	0.00	0	0.00
ConnPACE	0	0.00	0	0.00	0	0.00
SAGA	0	0.00	0	0.00	0	0.00
Charter Oak	0	0.00	0	0.00	0	0.00
MLIA	310	45,263.10	0	0.00	310	45,263.10
-----CLAIMS DATA-----						
	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	2,376	346,187.55	5,557	809,655.63	29,311	4,268,250.86
POS. CLAIMS ADJUSTMENTS	1	14.01	13	118.02	142	222.03
TOTAL CLAIMS PAYMENTS	2,377	346,201.56	5,570	809,773.65	29,453	4,268,472.89
CLAIMS DENIED	301		750		6,745	
CLAIMS IN PROCESS	0		0		0	
-----EARNINGS DATA-----						
PAYMENTS:						
CLAIMS PAYMENTS		346,201.56		809,773.65		4,268,472.89
PAYOUTS		0.00		0.00		0.00
ACCOUNTS RECEIVABLE:						
CLAIM SPECIFIC:						
CURRENT CYCLE		(730.05)		(730.05)		(730.05)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(876.06)		(7,880.14)
NON-CLAIM SPECIFIC		(0.00)		(0.00)		(0.00)
NET PAYMENT		345,471.51		808,167.54		4,259,862.70
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		(0.00)
NON-CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		(0.00)
OTHER FINANCIAL:						
MANUAL PAYOUTS		0.00		0.00		0.00
CHECK VOIDS		(0.00)		(0.00)		(0.00)
NET EARNINGS		345,471.51		808,167.54		4,259,862.70

Information/Resources

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Information/Resources

Important Messages

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

Important Messages

Available on the Home page and on the Information page

Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes. Reference the COVID-19 IM for FAQs, Bulletins and IMs with important DSS communications during the Emergency period



Information

Important Messages

[COVID-19 Information and FAQs \(Updated 11/19/21\)](#)

[Attention Outpatient Hospitals: Ambulatory Payment Classification \(APC\) Weight Corrections \(Posted 11/10/21\)](#)

[Hospital Monthly Important Message \(Posted 11/8/21\)](#)

[Postponed: Task to Service Enhancement for Sandata Agency Management \(SAM\) - Electronic Visit Verification \(EVV\) \(Posted 11/2/21\)](#)

[Attention Pharmacy and Durable Medical Equipment Providers: Pharmacy Coverage of V-Go Products \(Posted 10/28/21\)](#)

[Attention Inpatient Hospitals: Annual 3M Grouper Updates \(Updated 10/26/21\)](#)

[CMAP Addendum B October 2021 \(Updated 10/26/21\)](#)

[New Face-to-Face Requirements for Initial Orders of Home Health Services and Certain Durable Medical Equipment \(DME\) Updated as of 10/19/21](#)

[Attention All Providers: CDC Health Update: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results \(Posted 10/14/21\)](#)

Information/Resources cont.

RA Banner Announcements

- Available by selecting Information >Messages Archive or clicking on RA Banner Announcements in the Information box on the left side of the home page.
- Messages originally published for providers on the first page of their remittance advice. Some banner announcements are provider specific and therefore are only sent to the relevant provider types/specialties.
- Often published in reference to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected.

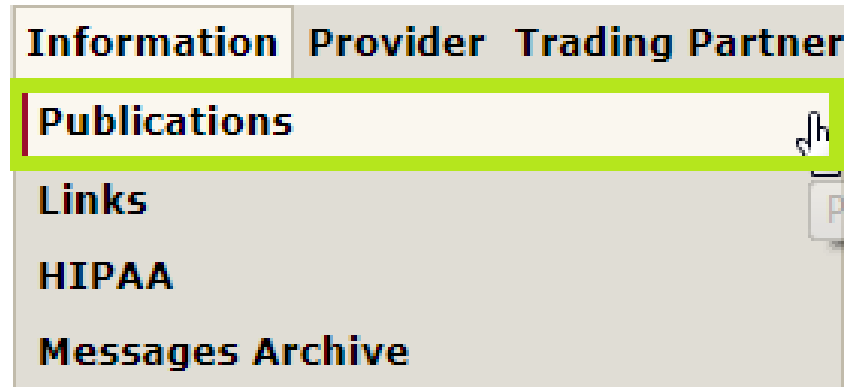
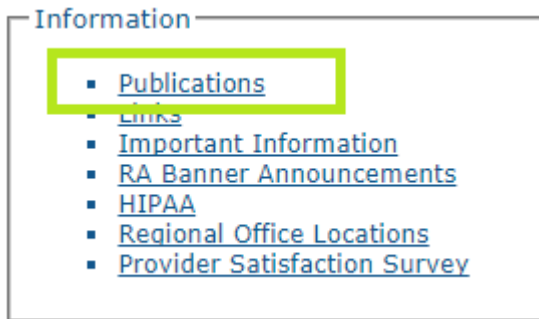
RA Banner Announcements		
Banner Effective Date	Providers	Banner Page Announcement
11/19/2021-11/26/2021	Attention All Providers	Attention All Providers. HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and Gainwell Technologies will be closed on Thursday, November 25, 2021 in observance of the Thanksgiving holiday. DSS offices will re-open on Friday, November 26, 2021. Gainwell Technologies will re-open on Monday, November 29, 2021.
11/19/2021-11/26/2021	Attention Select Outpatient Hospital Providers	Attention Select Outpatient Hospital Providers. REPROCESSED THIS CYCLE: As a follow up to PB 2020-48, REVISED CMAP COVID-19 Response - Bulletin 32: Services Covered under the Optional Medicaid Coverage Group "COVID-19 Testing Group" for Uninsured Connecticut Residents, DSS has retroactively added procedure codes G0380 - G0384 as payable procedure codes for clients enrolled in the Limited COVID-19 Coverage Group, retroactive to March 18, 2020. Gainwell Technologies has identified and re-processed claims with dates of service March 12, 2020 through October 19, 2020 for claims that meet the above criteria. The impacted claims will appear on your November 23, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

Information/Resources cont.

Publications

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

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



Information/Resources cont.

Provider Bulletins

Publications posted to relevant provider types / specialties documenting changes or updates to the CT Medical Assistance Program

Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.

The screenshot displays the 'Bulletin Search' interface. At the top, there is a search bar with the following fields: 'Year' (set to 21), 'Provider Type' (set to Home Health Agency), 'Number' (empty), and 'Title' (empty). There are 'search' and 'clear' buttons to the right. Below the search bar is a table titled 'Search Results' with three columns: 'Bulletin Number', 'Title', and 'Published Date'. The table contains 20 rows of search results, with the row for Bulletin PB21-89 highlighted in red.

Bulletin Number	Title	Published Date
PB21-94	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/19/2021
PB21-91	CMAP COVID-19 Response Bulletin 57: Authorization of Pfizer-BioNTech COVID-19 Va...	11/17/2021
PB21-89	CMAP COVID-19 Response Bulletin 56: Booster Doses COVID-19 Vaccine Administratio...	11/08/2021
PB21-88	Outpatient Crossover Claim Pricing Changes	11/04/2021
PB21-81	Advanced Practice Registered Nurses and Physician Assistants Authorized to Order...	10/18/2021
PB21-73	Other Insurance/Medicare Claim Submission Instruction Reminders	09/20/2021
PB21-63	CMAP COVID-19 Response Bulletin 55: ADDITIONAL DOSE COVID-19 Vaccine Administrat...	09/02/2021
PB21-62	Emergency Medicaid Coverage of Dialysis for End Stage Renal Disease	08/18/2021
PB21-58	Electronic Visit Verification Additional Languages	08/10/2021
PB21-54	Increased Rate for Nursing Services for Home Health Pediatric Complex/High Tech ...	08/27/2021
PB21-38	Use of ICD-10-CM "Z" Codes for Social Determinants of Health	06/11/2021
PB21-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/17/2021
PB21-34	CMAP COVID-19 Response - Bulletin 54: ADDITIONAL Services Covered under the "COV...	05/17/2021
PB21-32	Reinstatement of Copayments for Medical Services Rendered to HUSKY B Members	05/12/2021
PB21-27	Policy Updates and Changes to Clinical Review Criteria: Breyanzi, Cyanoacrylate ...	04/09/2021
PB21-26	REVISED Reinstating Prior Authorization Requirements that were Suspended During ...	04/16/2021
PB21-23	CMAP COVID-19 Response Bulletin 51: Updated Guidance - COVID-19 Vaccine Administ...	03/31/2021
PB21-18	Electronic Visit Verification (EVV) - End Date for Mobile Visit Verification (MV...	03/18/2021

Information/Resources cont.


Archive Important Messages and Banner Announcements

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

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

Home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification

home publications links hipaa **messages archive**



Information

Archived Search

Type:

Keywords:

2021 Important Messages Archived

Message Effective Date	Title
11/09/2021-11/18/2021	COVID-19 Information and FAQs (Updated 11/9/21)
10/25/2021-10/25/2021	CMAP Addendum B October 2021 (Posted 10/25/21)
10/25/2021-10/25/2021	Attention Inpatient Hospitals: Annual 3M Grouper Updates (Posted 10/25/21)
10/25/2021-11/08/2021	COVID-19 Information and FAQs (Updated 10/25/21)
10/22/2021-10/24/2021	COVID-19 Information and FAQs (Updated 10/22/21)

Information/Resources cont.

Register for E-mail Subscriptions

- Providers **MUST** register to receive information electronically for new provider publications and notifications through the email subscription function on the CMAP Web site at www.ctdssmap.com.

Communications are no longer mailed to providers and must be downloaded from the DSS Web site.

- *For complete E-mail subscription information, please see Provider Bulletin PB15-23 on the CMAP Web site

E-Mail Subscriptions

Do you want to get the latest information from the Connecticut Medical Assistance Program (CMAP)? Registration is a very quick and simple process! You can register now to receive on-line publications such as provider bulletins, workshop invitations, newsletters, and important messages via email by entering your email address below under "New Subscriber". Once you have entered your email address and confirmed that address, you will be asked to select the type of information you wish to receive (reference list of provider types, trading partner, and topics on the right side of the screen). Once registered, you will receive a confirmation email.

There is no limit on the number of e-mail subscriptions per office! Each provider, member of your office staff, enrollment support staff, etc. can subscribe to receive information via email.

It is important to note that, as of June 30, 2015, the Department of Social Services will no longer send provider bulletins and workshop invitations via the postal service. To ensure that you receive the latest information from CMAP, you must either subscribe to receive this information or review the information posted to www.ctdssmap.com daily to obtain newly published information.

Once you have subscribed, you can modify the type of information you receive at any time by entering your email in the Existing Subscribers box below. You may also unsubscribe at any point in time by entering your email in the Unsubscribe box below.

Click [here](#) to receive detailed instructions on how to newly subscribe, modify an existing subscription, or unsubscribe.

New Subscriber

E-Mail

Confirm E-Mail

Register

Available Subscriptions

- **Provider**
- ALL Provider Types
- Acquired Brain Injury
- Acupuncturist
- Advance Practice Nurse
- Autism Spectrum Disorder/Behavior Analysts
- Autism Waiver
- BHH/TCM/Waiver Provider
- Behavioral Health Clinician
- Birth to Three
- CHC Access Agency
- CHC Assisted Living
- CHC PCA Fiduciary
- CHC Service Providers
- CT Housing Engagement and Support Services
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Community First Choice
- Community Services
- DDS Employment and Day Supports
- DDS Specialized Services
- DME/Medical Supply Dealer
- Dental
- Drug and Alcohol Abuse Center
- Extended Care Facility/Long Term Care
- FQHC - Behavioral Health
- FQHC - Dental
- FQHC - Medical & Tribal Svs Medical
- Home Health Agency
- Hospice Agency
- Hospital
- Laboratory
- Local Health Department
- Mental Health Group Home
- Mental Health Waiver

Information/Resources cont.

Access via the www.ctdssmap.com Web site Home page >Information > Resources > 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, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions

The Provider Manual is divided into twelve (12) chapters

Click on the chapter title to open the document (*disable* pop-up blockers)

Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter

Chapter 11 is claim-type specific

Information/Resources cont.

Provider Manual

Chapter 1 – Introduction

Provides information on the CT Medical Assistance Program, the Department of Social Services' and Gainwell Technologies' 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 reference to provider enrollment and re-enrollment

Chapter 4 – Client Eligibility

Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability

Chapter 5 – Claim Submission Information

Provides information on general claims processing and billing requirements

Chapter 6 – EDI Options

Provides information on electronic claim submission and electronic RAs

Information/Resources cont.

Provider Manual cont.

Chapter 7 – Regulations/Program Policy

This section contains the Medical Services Policy sections that pertain to the chosen provider type

Chapter 8 – Billing Instructions

Provides information on provider specific billing requirements and instructions

Chapter 9 – Prior Authorization

Provides information on how to obtain Prior Authorization for designated services

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

Provides information on both the AVRS and the Web Portal functions

Chapter 11 – Other Insurance/Medicare Billing Guides

Provides claim-type specific information on other insurance and Medicare billing

Chapter 12 – Claim Resolution Guide

Provides descriptions of common EOBs and, if applicable, information to resolve the errors

Information/Resources cont.

Provider Newsletters

Quarterly publications to providers on a wide range of topics

Provider Newsletters

- [October 2021 interChange Newsletter](#)
- [June 2021 interChange Newsletter](#)
- [March 2021 interChange Newsletter](#)
- [December 2020 interChange Newsletter](#)
- [Provider Newsletter Archives](#)

Claims Processing Information

Guides and FAQs to assist with billing/claims processing

Claims Processing Information

- [Eligibility Response Quick Reference Guide](#)
- [Internet Claims Submission FAQ](#)
- [Hospice Procedure Code Exception List](#)
- [ICD-10 Diagnosis Codes Not Allowed as Primary Diagnosis](#)
- [ICN Region Code List](#)
- [CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy](#)
- [Medically Unlikely Edit \(MUE\) Updates](#)
- [OPR Enrollment FAQ](#)

Contacts

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Contacts

Gainwell Technologies Provider Assistance Center (PAC)

- ❑ 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- ❑ www.ctdssmap.com
- ❑ ctdssmap-ProviderEmail@gainwelltechnologies.com

This should be your first call resource to answer all **enrollment, eligibility** and **billing** related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number for future call reference.

Gainwell Technologies Electronic Data Interchange (EDI) Help Desk

- ❑ 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

Contacts cont.

EVV Email Mailbox

➤ ctevv@gainwelltechnologies.com.

If you are:

- missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan and has a valid PA;
- or if a prior authorization (PA) is present on the www.ctdssmap.com portal but is not present in the Santrax system. **NOTE: it can take up to 48 hours before a PA that is present on the www.ctdssmap.com portal is present in Santrax.**

then contact the EVV email box for assistance.

Sandata Customer Care

➤ 1-855-399-8050 or ctcustomercare@sandata.com

- If you are experiencing issues with the Santrax system or its functionality, please contact Sandata Customer Care for assistance.
- If you are unsure who to contact for assistance, please send an e-mail to ctevv@gainwelltechnologies.com. You are also encouraged to send an e-mail to the ctevv@gainwelltechnologies.com mailbox if you feel you need additional support resolving your issue. Please be sure to include your Sandata ticket number if applicable.

Contacts cont.

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 Medicaid ID number, CCCI number, EOB code on rejecting claim at Gainwell Technologies, from and to dates of service, the type of service (SNV, Med Admin, 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.

Southwestern Connecticut Area on Aging (SWCAA) - SWCAABillings@swcaa.org

- Please have the following information available when contacting SWCAA:
Client name, the client Medicaid ID number, the type of service (SNV, Med Admin, 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 (AOASCC) - chcbilling@aoascc.org

- Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. All other provider information may be faxed to (203)752-3064. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax. Service Order inquiries must include, on an Excel spreadsheet, the applicable following information when contacting AASCC: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

Contacts cont.

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 Medicaid ID number, the type of service (SNV, Med admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Department of Social Services (DSS) – For Self Directed clients on the CHCPE Program, please contact Melva Cooper, RN directly via e-mail at melva.cooper@ct.gov or by phone at (860)424-5863.

Community Option Unit at DSS- For assistance in correcting a waiver client's eligibility file, please send an email to Waiver.DSS@ct.gov

Contacts cont.

Administrative Service Organizations (ASOs)

Community Health Network of CT CHNCT (PAs for non-waiver clients)

1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)

www.ct.gov/husky

Beacon Health Options CT (PAs for clients with behavioral health primary diagnosis)

1-877-552-8247 – Monday through Friday, 9 a.m. to 5 p.m. (EST)

www.CTBHP.com

Questions?

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

December 2021



Thank you

Thank You for attending the Connecticut Medical Assistance Program Home Health Agency 2021 Refresher Workshop!

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey.

Your feedback helps us to improve future workshops!

Contact

brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies

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McLean, VA 22102