

# Welcome to the Home Health Agency Provider Refresher Workshop - July 11, 2023

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 2023

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

June 2023



gainwell

# Training Topics

- COVID-19 & 2023 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

# 2023 Updates

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# 2023 Updates

Effective March 1, 2023, Beacon Health Options changed their name to Carelon Behavioral Health. This name change did not impact your contract or the quality of service you have come to expect from the Connecticut Behavioral Health Partnership (CT BHP) and its administrative partners. Over time, Carelon Behavioral Health will replace Beacon Health Options materials and logos. Please note, this change will not affect the current CT BHP processes and procedures. Carelon will continue to create value through proven, effective services and data analytics; experienced clinicians, care coordinators, and administrative staff; and a whole-person approach to well-being and recovery.

All existing phone numbers, email addresses, Web sites, and portals will redirect with no reregistration required. Please contact Carelon Behavioral Health at 1-877-552-8247 with any questions.

# 2023 Updates cont.

Effective May 12, 2023, and forward the following standard rules were reinstated For more information, refer the [PB 21-26](#) REVISED Reinstating Prior Authorization Requirements that were Suspended During the Public Health Emergency:

- 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

# 2023 Updates cont.

**Home Health (HH) Services**: Effective May 12, 2023, and forward, all home health services must be rendered in person including nursing care, therapy services, all evaluations (including, start of care (SOC), resumption of care (ROC), and for initial and recertification evaluations for physical therapy (PT), occupational therapy (OT), speech and language pathology (SLP) services), and medication administration services.

Continue to refer to the following provider bulletins (PB) for additional guidance:

- [PB 14-44](#) Implementation of Connecticut General Statute 19a-492 Permitting Registered Nurses to Delegate Administration of Medication to Home Health Aides who have Obtained Certification for Medication Administration.
- [PB 15-07](#) Clarification of Billing Medication Administration Visit Code and Skilled Nursing Visit Code Related to Pre-pouring of Medication
- [PB 15-75](#) Addition of New Medication Administration Prompt Code.
- [PB 15-90](#) Additional Billing Guidance for New Medication Administration Prompt Code for additional guidance.
- [PB 17-59](#) Clarifying Billing Instructions for Therapy Evaluations and Services Performed as Part of the Home Health Care Plans (Revised).
- [PB 19-49](#) Correction to the Guidance for Billing Evaluation and Assessment Services for Home Health Care Services

# 2023 Updates cont.

**HH Face-to-Face Requirements**: Effective for dates of service May 12, 2023, and forward, home health providers must once again comply with the time frame for the Face to face (F2F) encounter requirements as specified by 42 CFR 440.70. Specifically, for the initiation of home health services, the F2F encounter related to the primary reason that the HUSKY Health member requires home health services must occur within 90 days before or within 30 days after the start of services. Compliance with this requirement includes provision of the F2F encounter via telehealth as specified by 42 CFR 440.70(f)(6) and if the service billed complies with the telehealth policies as outlined and specified by DSS. Continue to refer to provider bulletin, [PB 17-02](#) New Face-to-Face Requirement for Initial Orders of Home Health Services for guidance.

**HH Prior Authorization**: There are no changes to prior authorization requirements. Continue to refer to [PB 21-26](#) REVISED Reinstating Prior Authorization Requirements that were Suspended During the Public Health Emergency and [PB 15-38](#) Prior Authorization of Home Health Aide and Extended Nursing Services

# Electronic Visit Verification (EVV) Program Update

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# Electronic Visit Verification (EVV) Program Update

In 2016, Section 12006 of the 21st Century Cures Act established a requirement for all states to use an Electronic Visit Verification (EVV) system. Medicaid home health care services (HHCS) must use EVV by January 1, 2023. The Department of Social Services (DSS) has received approval for a Good Faith Effort (GFE) exemption request from the Centers for Medicare & Medicaid Services (CMS) to delay the EVV implementation timeline for HHCS. All providers are expected to comply with the HHCS mandate prior to January 1, 2024

DSS has approved the use of an Open Vendor EVV model for the HHCS implementation to support both Medicaid waiver and non-waiver members. This will allow home health providers the opportunity to use a third-party (“Alternate”) EVV system or the State’s existing EVV system, i.e., Santrax Agency Management to capture visit data. The changes to accept all home health visit data for HHCS from either an Alternate EVV system or the State’s existing EVV system were implemented on March 23, 2023. **All home health providers are expected to onboard and begin to submit Electronic Visit Verification (EVV) production data for Home Health Care Services (HHCS) either via the State’s EVV system (i.e., Sandata Agency Management) or an Alternate EVV solution no later than September 30, 2023. Moreover, home health claims without a confirmed visit will result in a payment denial for dates of service effective January 1, 2024, and forward**

**For providers who choose to use Santrax Agency Management tasks are optional, no schedules are needed, and prior authorizations (PAs) will not be sent to a providers EVV system. This does not change the current CHN and Carelon PA request and approval process. Provider must continue to request PAs as they do now.**

# Electronic Visit Verification (EVV) Program Update cont.

What changes will I see in my Sandata Agency Management system?

- New modifiers and services that are used for nonwaiver home health services
- Member data will not flow automatically into a providers EVV system for Sandata Agency Management system users; manual input of these members will be necessary by providers using Sandata Agency Management system
- For providers who have 50 or more clients, there will be a one-time process that providers can use to upload initial member data prior to the HHCS implementation.
- There will be some differences in visit capture methods for providers choosing to use Sandata Agency Management system:

**Telephony** – caregivers will need to add the service and modifier to the call

**Sandata Mobile Connect (SMC)** – when a visit is started, providers will see a full list of available services to choose from

**Fixed Visit Verification (FVV)** – no changes noted to the FVV capture method at this time

- If providers choose to remain in Sandata Agency Management system, they will have the option to move to the Alternate EVV solution through September of 2023. During this timeframe DSS will cover Sandata costs associated with onboarding and testing. DSS will not cover provider costs incurred by their vendor. Providers that choose to move to the Alternate EVV solution after September 2023 will be able to do so but may be responsible for additional costs. Details for a later transition are still under development.

# Electronic Visit Verification (EVV) Program Update cont.

For providers choosing to move from Sandata Agency Management system to the Alternate EVV solution for HHCS, the recommendation is that member data for both Medicaid waiver and non-waiver members must be solely maintained in the Alternate EVV solution.

Electronic Visit Verification (EVV) for Connecticut Home Care (CHC), Personal Care Assistance (PCA) Acquired Brain Injury (ABI) and Autism Waivers:

- For dates of service May 12, 2023, and forward, claims for the above-mentioned home health services will require a confirmed EVV visit to be paid, however, claims that may appear with EOB 3327 “Confirmed Visit Not Found” will be in a post and pay status. This will allow providers time to implement EVV for all Home Health Care Services (HHCS). Please note, a post and pay status means that the error is informational and will not affect payment of these claims. The date on which this edit will be enforced for home health claims will be communicated in a future EVV notification. Providers will see home health prior authorizations for CHC, ABI, PCA and Autism members in their Sandata EVV system, as codes in an EVV Temporarily Suspended status due to the COVID-19 Public Health Emergency Period are returned to an EVV mandated status. Home Health agencies will be able to bill these services through Sandata Agency Management, the [www.ctdssmap.com](http://www.ctdssmap.com) Secure Provider Web portal or through their own billing software. Access Agencies or the Autism care manager will continue to provide prior authorizations (PAs) for these services and the PA will be visible via the [www.ctdssmap.com](http://www.ctdssmap.com) Secure provider Web portal. Providers can access their PAs by logging into the secure site, [www.ctdssmap.com](http://www.ctdssmap.com), and selecting Prior Authorization Search.

# Provider Re-enrollment

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# Provider Enrollment and Re-enrollment

The Department of Social Services (DSS) requires providers to enroll / re-enroll on our Web site [www.ctdssmap.com](http://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 e-Delivery when they are due for re-enrollment six (6) months prior to the end of their current contract (Reference [www.ctdssmap.com](http://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](http://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](http://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.



### 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.

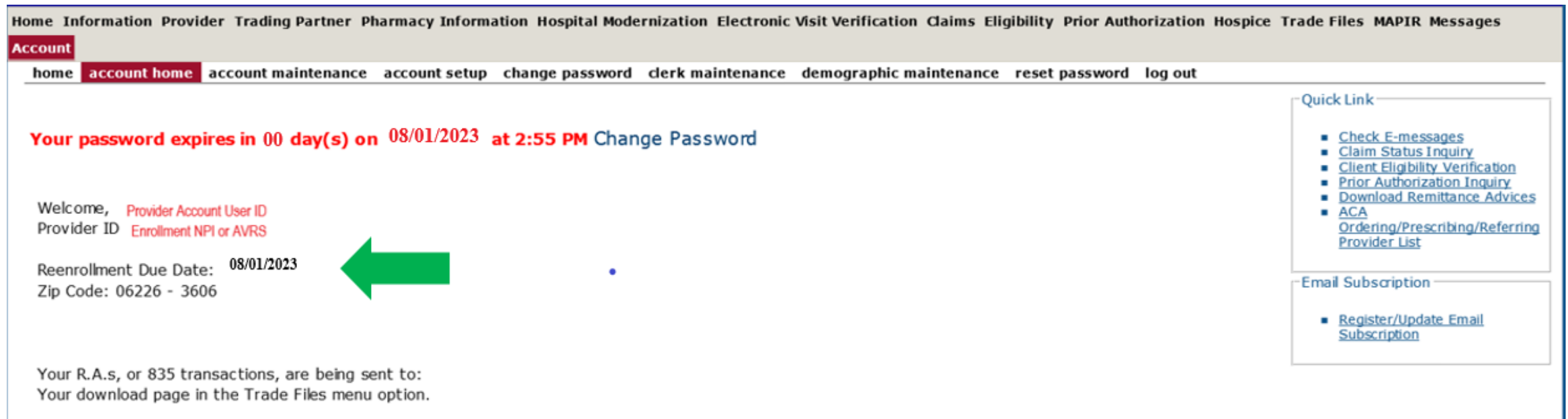
[Follow on Document Requirement by Provider Type and Specialty](#)

# 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.

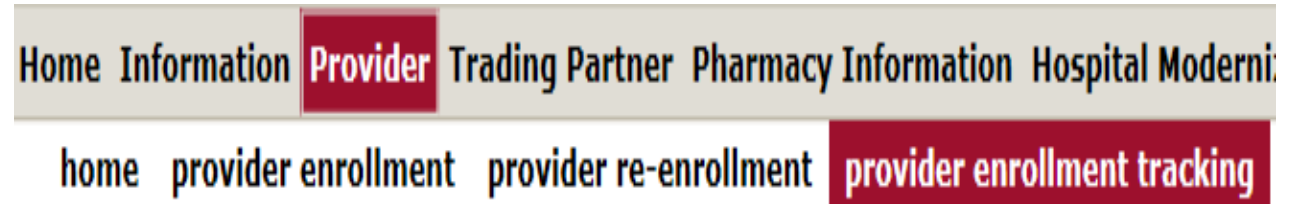
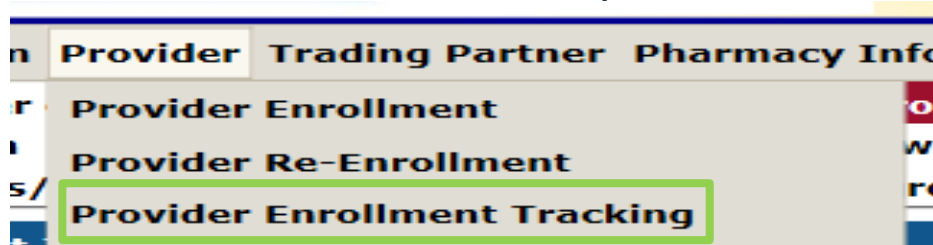
- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.



The screenshot shows a web portal interface for a provider's account. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, and Messages. Below this is a sub-navigation bar with 'Account' highlighted, and further sub-links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The main content area features a red warning message: 'Your password expires in 00 day(s) on 08/01/2023 at 2:55 PM Change Password'. Below this, a welcome message reads: 'Welcome, Provider Account User ID' and 'Provider ID Enrollment NPI or AVRS'. The re-enrollment due date is listed as '08/01/2023', with a green arrow pointing to it. The zip code is '06226 - 3606'. On the right side, there is a 'Quick Link' section with links for 'Check E-messages', 'Claim Status Inquiry', 'Client Eligibility Verification', 'Prior Authorization Inquiry', 'Download Remittance Advices', 'ACA Ordering/Prescribing/Referring Provider List', and an 'Email Subscription' section with a link to 'Register/Update Email Subscription'. At the bottom left, a note states: 'Your R.A.s, or 835 transactions, are being sent to: Your 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. It features two input fields: 'ATN\*' with the value '305929' and 'Business OR Last Name\*' with the value 'SMITH'. To the right of the input fields are two buttons: 'search' and 'clear'.

In this example, the reenrollment application that was received on 1/30/2023 was completed as of 2/9/2023 .

<b>Status</b>	ReEnrollment Completed
<b>Last Status Date</b>	02/09/2023
<b>Application Type</b>	Re-Enrollment
<b>Date Received</b>	01/30/2023

# Demographic Maintenance

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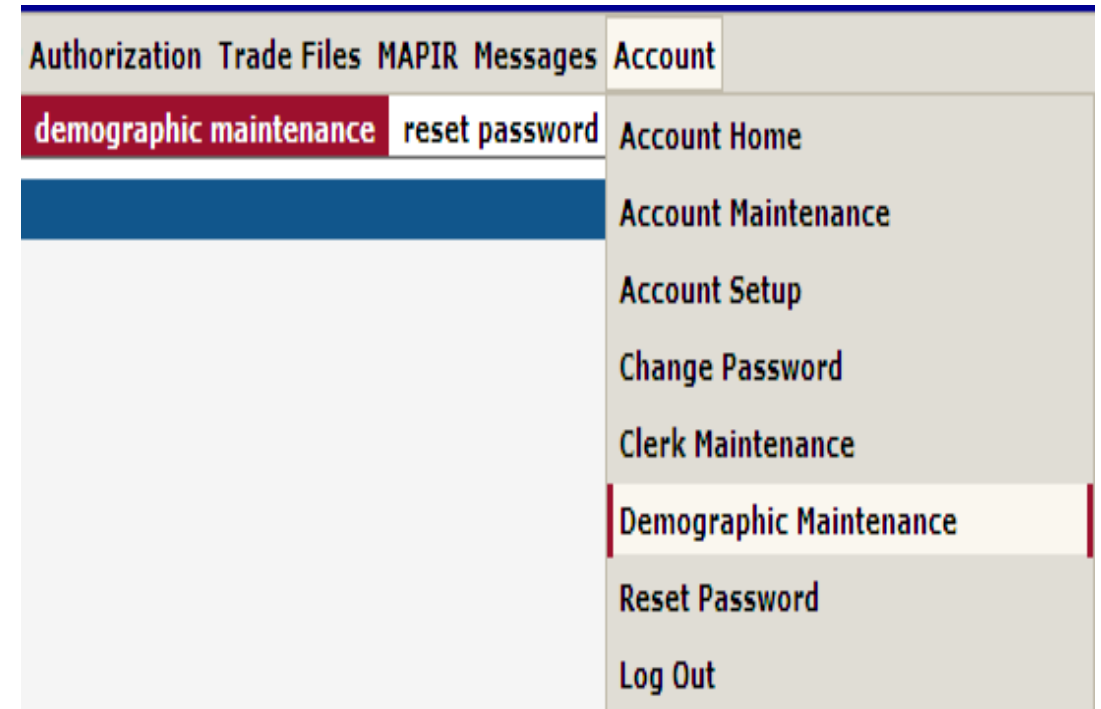
# Demographic Maintenance

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’



**The following messages were generated:**

Message Description	Panel	Field
Save was Successful		

Please note that HHA cannot have alternate service locations. There must be a new enrollment for each service location.

# 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.

**EFT Account**  
Click here to open Provider EFT Enrollment instructions.

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

Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (\*)

**Provider Name\***

**Account Number Linkage to Provider Identifier\***

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

**Provider Identifiers\***

Provider Federal Tax Identification Number (TIN)  
OR Employer Identification Number (EIN)

OR

National Provider Identifier (NPI)

**Other Identifiers**

Assigning Authority

Trading Partner ID

**Financial Institution Information**

Financial Institution Name

**Financial Institution Address**

Street

City

State/Province

ZIP Code/Postal Code

Financial Institution Routing Number

Financial Institution Routing Number(rekey)\*

Type of Account at Financial Institution

Provider's Account Number with Financial Institution

Provider's Account Number with Financial Institution(rekey)\*

Reason for Submission  New Enrollment  Change Enrollment  Cancel Enrollment

Authorized Signature

save cancel

# Demographic Maintenance – Location Name Address cont.

## Please Note:

Any type of change in banking information whether it be the account number, or you change financial institutions, you **MUST** update your EFT Account information on the demographic maintenance panel to prevent deposit discrepancies.

Also, very important to remember when you make any type of change to your EFT Account information this causes the new information entered to go through a prenote period, so your next cycle payment will be in the form of a paper check. Once the prenote process is successful then the payments will be direct deposited into your account. Keep in my that this entire process takes 2 or more weeks depending on if the correct account information was entered.

# Eligibility Verification

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# 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](http://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	DOE	From DOS*	08/01/2020
SSN	<input type="text"/>	First Name, MI	JOHN P	To DOS*	08/23/2020
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					

### Eligibility Verification Response

Verification Number 212350557G

Response Text Cannot validate eligibility for dates older than 1 year

# 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

» Lockin Details					
Status	Active Only	Lockin Plan			
Lockin Plan	Effective Date	End Date	Provider	Provider ID Type	Status Code
HOSPICE-MEDICARE	08/14/2022	01/30/2023		National Provider ID	A - Active

## Medicare

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

Medicare Coverage
Medicare A
Medicare B
Medicare D

## TPL (Third Party Liability)

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

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 – 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](http://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

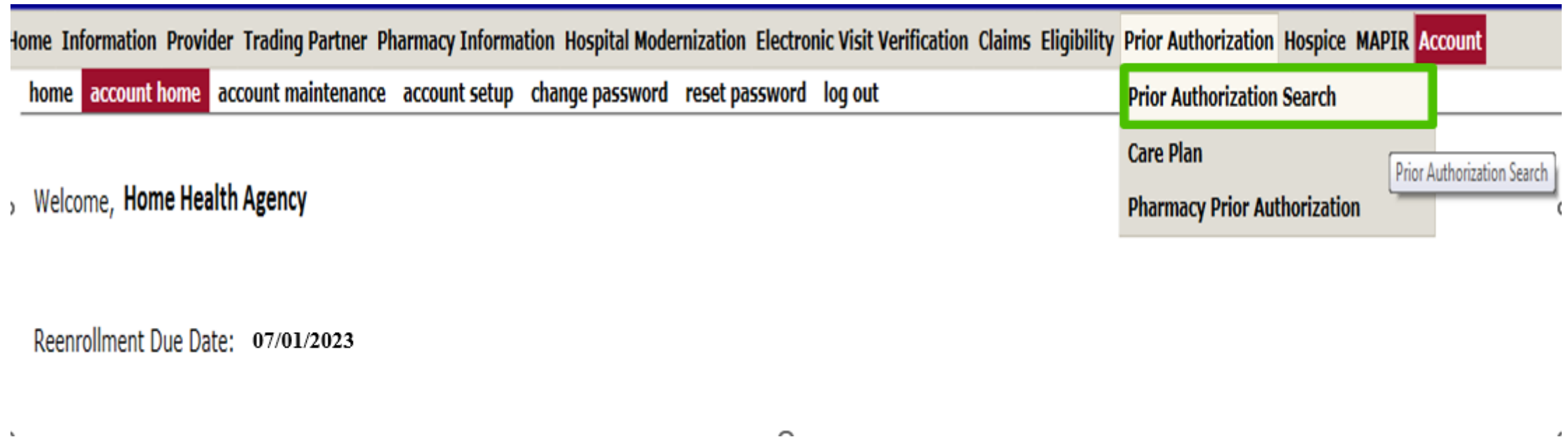
Presented by: The Department of Social Services and Gainwell Technologies for  
Billing Providers

June 2023



# Prior Authorization – PA Search

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



# 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 Code	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	<b>11/1/2021</b>	<b>11/1/2021</b>
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	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

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

Please Note: The Procedure Code/Modifier List is located on each of the Waiver crosswalks

# 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

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 ]

**Please Note: The U2 Modifier is only applicable to waiver members.**

# 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

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 ]

# 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 22-02 [Updating the Reimbursement Rate for Nursing Services for Home Health Pediatric Complex/High Tech Level of Care](#)

# Claims Processing

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

June 2023



# 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](http://www.ctdssmap.com), select Information> Publications> in the title field enter “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule”.

2023 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Mail Dates	835/EFT Dates
<b>Jan</b>	6	5	10	11	11
	20	19	24	25	25
<b>Feb</b>	3	2	8*	9*	9*
	17	16	22*	23*	23*
<b>Mar</b>	10-b	9	14	15	15
	24	23	28	29	29
<b>Apr</b>	6-c	5	11	12	12
	21	20	25	26	26
<b>May</b>	5	4	9	10	10
	19	18	23	24	24
<b>Jun</b>	9-b	8	13	14	14
	23	22	27	28	28

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

**\*THIS SCHEDULE IS SUBJECT TO CHANGE WITHOUT PRIOR NOTICE\***

# Claims Processing/ Submission Information

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

(20)(23)(005)(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 (**23** = 2023)

**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

- Please contact Health Management Systems (HMS) at 1-866-252-0671 to report any discrepancies
- 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](http://www.ctdssmap.com) Web site.

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

If you find that there is a discrepancy in client TPL information, please refer to the following procedure:

Effective May 31, 2023, New HMS Phone number: 1-866-252-0671

A TPL referral should be made directly to HMS to report new client health insurance, or to have a correction made to a client's existing health insurance policy. Here are the methods in which a TPL referral should be made:

- CTDSS Eligibility Staff should send to HMS the W-1685 Medicaid Insurance Information form by FAX: 1-469-320-5117, or by scanning the form into a PDF file and sending it by secure email to:

[CTinsurance@gainwelltechnologies.com](mailto:CTinsurance@gainwelltechnologies.com)

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

An urgent TPL referral should be made to HMS to fix incorrect health insurance information that adversely affects the client's ability to receive a health care good or service, or if a TPL Good Cause situation exists where CTDSS is required to waive TPL requirements and not capture health insurance on a client's ImpaCT record, if it is anticipated that this would result in reprisal against and cause physical or emotional harm to the client or other persons. Urgent TPL referrals should be made to HMS by calling 1-866-252-0671 (8:30AM – 5:30PM), or by secure email:

[CTinsuranceescalation@gainwelltechnologies.com](mailto:CTinsuranceescalation@gainwelltechnologies.com).

- HMS will make needed changes to the client's health insurance coverage and respond back to the sender within 24 hours of receipt of the urgent TPL referral.
- Routine TPL referrals, which are not urgent or TPL Good Cause-related, may be made to HMS by calling: 1-866-252-0671 , or by secure email to: [CTinsurance@gainwelltechnologies.com](mailto:CTinsurance@gainwelltechnologies.com)

Please contact Catherine Leaper in the Office of Quality Assurance if you have any questions regarding these TPL referral procedures ([Catherine.Leaper@ct.gov](mailto:Catherine.Leaper@ct.gov), 860-424-5164).

# 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

June 2023



# 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.

**CMS has made changes to the ABN requirements, DSS is working on defining the changes and will send out a Provider Bulletin with detailed changes in the near future. Until notified of changes, providers must continue to follow the current process.**

## **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

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[Press Releases](#)

[Annual Report](#) 

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[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

June 2023



# 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). This will be seen for services that are provided to non-waiver claims as well.

**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.

**Please Note: the above are only applicable to ABI, CHC, PCA and Aut waiver members.**

- For non-waiver clients Carelon or CHN should be contacted when there are any claim issues, as they are responsible for entering the PA for services.

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](mailto: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 for ABL, CHC, PCA and Autism Waiver Members

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

June 2023



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

CLIENT NAME: Sally Client		CLIENT NO.: 0000000000										
1	22000000000000	080321	081221	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	52000000000000	080321	081221	116.16	0.00	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

June 2023



# 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](http://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](http://www.ctdssmap.com) > Provider>Provider Services> Schedules.

2023 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Mail Dates	835/EFT Dates
Jan	6	5	10	11	11
	20	19	24	25	25
Feb	3	2	8*	9*	9*
	17	16	22*	23*	23*
Mar	10-b	9	14	15	15
	24	23	28	29	29
Apr	6-c	5	11	12	12
	21	20	25	26	26
May	5	4	9	10	10
	19	18	23	24	24
Jun	9-b	8	13	14	14
	23	22	27	28	28

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

**\*THIS SCHEDULE IS SUBJECT TO CHANGE WITHOUT PRIOR NOTICE\***

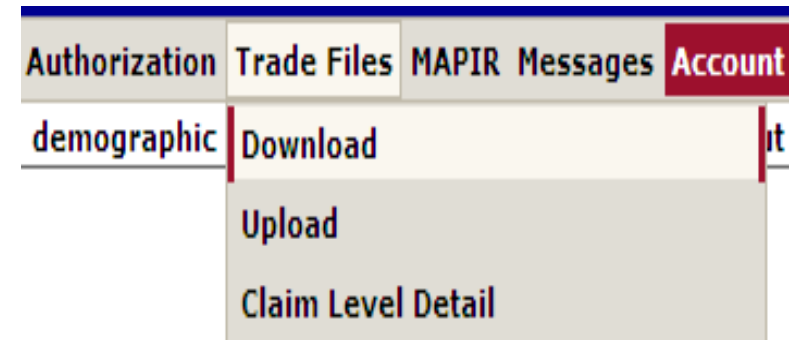
# Remittance Advice cont.

## 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](http://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

**REMINDER: DOI**  
 Web file retention

**TION**  
 e type of file being downloaded.

- Remittance Advice (RA) - PDF; the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgements (997), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment/Inquiry/Request Only (320), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on this web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Remittance Advice (RA) - PDF 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 Remittance Advice (RA) - PDF 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--

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

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

CLIENT NO. :  
UNITS BILLED AMT ALLOWED AMT DETAIL EOB

23.00 6,178.95 6,178.95

## Claim Information (Paid, Long Term Care):

# Remittance Advice cont.

**Claim  
Information  
(Paid, Long  
Terms Care):**

REPORT: CRA-LTPD-R  
RA#: 6800455

interChange MMIS  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE

Date: 08/24/2021  
PAGE: 9

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 AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY	PAID AMOUNT
	--PATIENT NUMBER--		FROM THRU								
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						

REPORT: CRA-EOBM-R  
RA#: 7766400

interChange MMIS  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE

Date: 08/24/2021  
PAGE: 41

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

**EOB Code  
Description:**

# 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-	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

RSN CODE	ACCOUNT RECEIVABLES REASON 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
<b>CLAIMS PAID</b>	2,376	346,187.55	5,557	809,655.63	29,311	4,268,250.86
<b>POS. CLAIMS ADJUSTMENTS</b>	1	14.01	13	118.02	142	222.03
<b>TOTAL CLAIMS PAYMENTS</b>	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		<b>345,471.51</b>		<b>808,167.54</b>		<b>4,259,862.70</b>

# Information/Resources

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

June 2023



# Information/Resources

## Important Messages

[www.ctdssmap.com](http://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
<a href="#">Understanding the Unwinding: Provider Webinar (Posted 5/12/23)</a>
<a href="#">Behavioral Health Clinician Groups and Individual Clinicians in Independent Practice FAQ (Posted 5/11/23)</a>
<a href="#">Updating Dental Code for Billing the Dental Component of the Multi-disciplinary Examinations (Posted 5/11/23)</a>
<a href="#">Hospital Reimbursement Public Notice (Posted 5/9/23)</a>
<a href="#">Hospital Monthly Important Message (Posted 5/8/23)</a>
<a href="#">The Public Health Emergency ending May 11, 2023, pre-pandemic timeliness standards for Preadmission Screening and Resident Review (PASRR) will go into effect May 12, 2023 (Posted 5/4/23)</a>
<a href="#">CMAP Addendum B April 2023 (Posted 4/28/23)</a>
<a href="#">Attention All Inpatient Hospital Providers: DRG Grouper Update (Posted 4/21/23)</a>
<a href="#">Attention Physicians and Outpatient Hospitals: Medical Authorization Portal: Office-Based Procedures and Outpatient Surgeries (Posted 4/17/23)</a>
<a href="#">Attention Home Health Providers: REMINDER: Sandata Agency Management (SAM) Training Dates and Registration Links for Existing &amp; New Users (Posted 4/4/23)</a>
<a href="#">Attention Home Health Providers: Notice of Important Updates (Posted 3/23/23)</a>
<a href="#">Attention Primary Care Providers (PCPs): HUSKY Health Secure Provider Web Portal Sign Up (Posted 3/21/23)</a>
<a href="#">Attention Autism Waiver Service Providers: CMAP COVID-19 Response - Bulletin 12: Waiver of Certain Requirements and Temporary Procedural Changes for Home and Community-Based Waiver Programs - UPDATE (Posted 3/21/23)</a>

# 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.

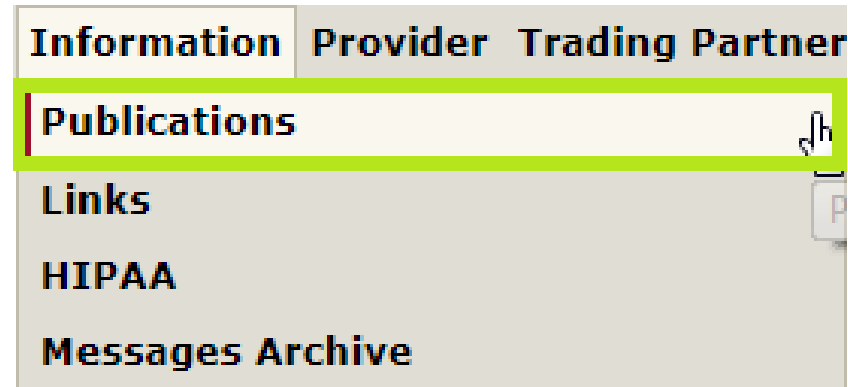
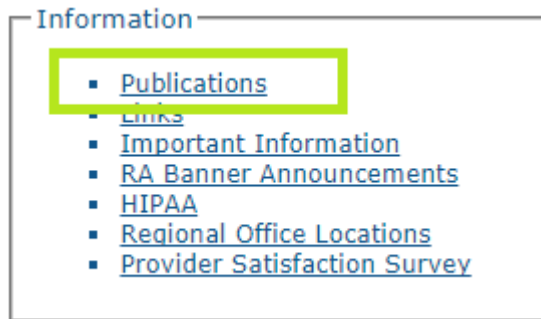
Banner Effective Date	Providers	Banner Page Announcement
05/05/2023-05/12/2023	Attention Select Providers	Attention Select Providers. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed claims which initially processed and paid under a temporary client ID as described in Provider Bulletin 2014-29. The claims were reprocessed to reflect the client's true (permanent) 9-digit Connecticut Medical Assistance Program (CMAP) ID. The claims which processed under a temporary client ID will be recouped and appear on the May 9, 2023 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52 and Explanation of Benefits (EOB) code 8239 "ACA CLIENT TEMP ID REPLACED WITH CMAP ID. NEW CLAIM WILL BE SYSTEMATICALLY GENERATED". The new claims will also appear on the May 9, 2023 RA with an ICN beginning with region code 27.
05/05/2023-05/12/2023	Attention Select Providers	Attention Select Providers. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed crossover claims with dates of service (DOS) 4/1/2021 and forward, which contain at least one detail submitted with Claim Adjustment Reason Code (CARC) 132. The claims were reprocessed to consider CARC CO-132 as the Medicare paid amount. If there is an amount greater than \$0 in the Medicare paid amount field, the Medicare paid amount and CARC CO-132 will be summed. Claims will appear on your May 9, 2023 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.
05/05/2023-05/12/2023	Attention Select Providers	Attention Select Providers. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed crossover claims with dates of service (DOS) 4/1/2021 and forward, which contain at least one detail submitted with Claim Adjustment Reason Code (CARC) 132. The claims were reprocessed to consider CARC CO-132 as the Medicare paid amount. If there is an amount greater than \$0 in the Medicare paid amount field, the Medicare paid amount and CARC CO-132 will be summed. Claims will appear on your May 9, 2023 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](http://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.

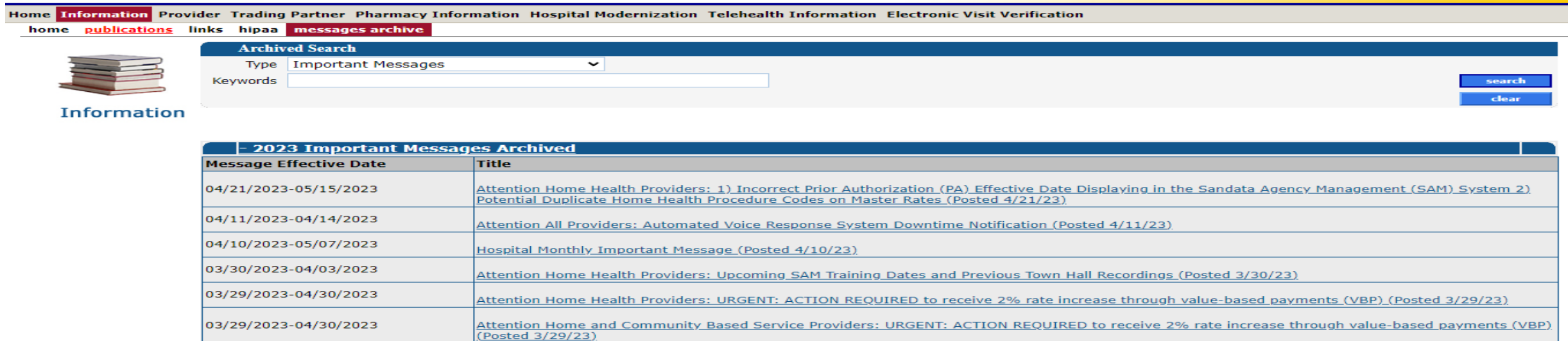
Search Results		
Bulletin Number ▼	Title	Published Date
PB23-39	Electronic Visit Verification (EVV) - Compliance Requirement Update	05/11/2023
PB23-38	REVISED Guidance for Services Rendered via Telehealth	05/11/2023
PB23-34	Public Health Emergency Eligibility Unwinding	04/13/2023
PB23-32	Discontinuation of the Optional COVID-19 Testing Group - Effective May 12, 2023	04/13/2023
PB23-31	Sunsetting Provider Bulletins Issued in Response to the COVID-19 Public Health E...	05/02/2023
PB23-30	COVID-19 Vaccine Administration Guidance	04/13/2023
PB23-29	New Eligibility Group - State Funded Postpartum Care for Non-Citizens	03/28/2023
PB23-24	Updated Guidance - Home Health and Hospice Services - Ending Temporary Flexibili...	04/13/2023
PB23-19	Reinstating Non-Emergency Medical Transportation and Non-Emergency Ambulance Tra...	03/16/2023
PB23-18	New Guidance for Services Rendered via Telehealth under the Connecticut Medical ...	03/27/2023
PB23-10	Electronic Visit Verification (EVV) Town Hall Notification and File Specificatio...	02/14/2023
PB23-07	REVISED Home Health Electronic Visit Verification (EVV) Implementation Update an...	02/01/2023
PB23-03	Provider Satisfaction Survey	01/10/2023

# 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](http://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.



The screenshot shows the 'messages archive' page on the CTDSSMAP website. The navigation bar includes 'Home', 'Information', 'Provider', 'Trading Partner', 'Pharmacy Information', 'Hospital Modernization', 'Telehealth Information', and 'Electronic Visit Verification'. The 'Information' menu is expanded, showing 'home', 'publications', 'links', 'hipaa', and 'messages archive'. Below the navigation is an 'Archived Search' section with a 'Type' dropdown set to 'Important Messages' and a 'Keywords' input field. To the left of the search bar is an icon of a stack of books and the word 'Information'. Below the search bar is a table titled '- 2023 Important Messages Archived' with two columns: 'Message Effective Date' and 'Title'. The table contains six rows of archived messages.

Message Effective Date	Title
04/21/2023-05/15/2023	<a href="#">Attention Home Health Providers: 1) Incorrect Prior Authorization (PA) Effective Date Displaying in the Sandata Agency Management (SAM) System 2) Potential Duplicate Home Health Procedure Codes on Master Rates (Posted 4/21/23)</a>
04/11/2023-04/14/2023	<a href="#">Attention All Providers: Automated Voice Response System Downtime Notification (Posted 4/11/23)</a>
04/10/2023-05/07/2023	<a href="#">Hospital Monthly Important Message (Posted 4/10/23)</a>
03/30/2023-04/03/2023	<a href="#">Attention Home Health Providers: Upcoming SAM Training Dates and Previous Town Hall Recordings (Posted 3/30/23)</a>
03/29/2023-04/30/2023	<a href="#">Attention Home Health Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments (VBP) (Posted 3/29/23)</a>
03/29/2023-04/30/2023	<a href="#">Attention Home and Community Based Service Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments (VBP) (Posted 3/29/23)</a>

# 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](http://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](http://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](http://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

- [March 2023 interChange Newsletter](#)
- [December 2022 interChange Newsletter](#)
- [September 2022 interChange Newsletter](#)
- [June 2022 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

June 2023



# 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](http://www.ctdssmap.com)
- ❑ [ctdssmap-ProviderEmail@gainwelltechnologies.com](mailto: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](mailto: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](http://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](http://www.ctdssmap.com) portal is present in Santrax.**

then contact the EVV email box for assistance.

## Sandata Customer Care

➤ 1-855-399-8050 or [ctcustomer@sandata.com](mailto:ctcustomer@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](mailto:ctevv@gainwelltechnologies.com). You are also encouraged to send an e-mail to the [ctevv@gainwelltechnologies.com](mailto: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](mailto: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](mailto: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) - [providers@aoascc.org](mailto:providers@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)-** Billing inquiries should be sent through secure email [billing@wcaaaa.org](mailto:billing@wcaaaa.org) or faxed to 203-465-1030

- Please include the following information 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.

**Community Option Unit at DSS-** Client eligibility issues related to Medicaid waiver clients should be directed via an encrypted/secure e-mail to the Department of Social Services at the following e-mail address: [Waiver.DSS@ct.gov](mailto:Waiver.DSS@ct.gov).

**Alternate Care Unit-** Eligibility issues regarding State-funded clients with a CT Home Care Community Based Case Managed State Funded Benefit plan, (CBCMS), CT Home Care Community Based Program for Disabled Adults (CBCMD) and CT Home Care Self Directed State Funded (SDIRS) benefit plan should be directed to the following e-mail address: [ACUFinancial.DSS@ct.gov](mailto:ACUFinancial.DSS@ct.gov).

**Autism Waiver-** contact Mike Olsen at [Michael.Olsen@ct.gov](mailto:Michael.Olsen@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](http://www.ct.gov/husky)

### **Carelon Behavioral Health formerly 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](http://www.CTBHP.com)

# Contacts cont.

Effective May 31, 2023, NEW HMS Phone Number: 1-866-252-0671

# Questions?

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

June 2023

