

August 1, 2018

# Home Health Agency Provider Refresher Workshop 2018

**Presented by:**

**The Department of Social Services & DXC Technology  
for Billing Providers**



# Training Topics

- Electronic Visit Verification (EVV)
- 2018 Updates
- Provider Re-Enrollment
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# Electronic Visit Verification (EVV)



# Electronic Visit Verification (EVV)

## Overview

Electronic Visit Verification (EVV) is the system that Home Health providers who service ABI, CHC or PCA waiver clients must use to schedule visits, capture visit times and export claims to DXC Technology for adjudication. The EVV system has been specifically configured to support the Department of Social Services (DSS) program requirements.

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

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

# Electronic Visit Verification (EVV)

## Services

### Mandated Home Health EVV Services

- ❑ All Home Health Services for CHC, PCA and ABI Waiver clients are mandated for EVV.

### Non-Medical EVV Services

- ❑ Designated non-medical CHC, PCA and ABI Waiver services are mandated, optional or not applicable for EVV.
- ❑ EVV Mandated and Optional Services can be found on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site, under Important Messages click on the “Electronic Visit Verification Implementation” link.

### Self Directed Services

- ❑ All claims for Community First Choice (CFC) services, regardless of the EVV check-in/check-out election, will continue to be billed by Allied Community Resources, DSS CFC Fiscal Intermediary.
- ❑ The EVV check-in/check-out process is either optional or not required for Waiver services rendered to clients who self direct their own care through the CFC services option.
- ❑ Although CFC services are optional, the client may choose to implement the EVV check-in/check-out process.



# Electronic Visit Verification (EVV) – 2018 Update

## Compliance

### COMPLIANCE:

DSS considers a provider to be compliant if 90% of the visits performed are validated by a check-in and a check-out documented by the caregiver via telephony, Mobile Visit Verification (MVV) or Fixed Visit Verification (FVV) device. Providers must be compliant as of **December 1, 2017**. Providers who fail to reach this 90% threshold may be subject to audit, suspension of referrals or claim recoupments until the provider becomes compliant.

For more information regarding compliance, please see [At Your Fingertip tip sheet #4 – Compliance, “Important EVV Compliance Clarifications” Important Message and Provider Bulletin 18-66 Electronic Visit Verification \(EVV\) Compliance.](#)

# Electronic Visit Verification (EVV) – 2018 Update

## Alternate Claim Solution

Effective April 11, 2018, DSS implemented the alternate claim solution which allows providers to bill or adjust claims for dates of service on or after January 1, 2018 from their own system, via the [www.ctdssmap.com](http://www.ctdssmap.com) secure Web site, from the Santrax system or any combination of these three methods.

Please remember:

- ❑ The alternate claim solution does not remove the requirement that providers use the Santrax system to create schedules, check-in/out or confirm visits.
- ❑ The alternate claim solution does not change the EVV compliance requirement; providers are still expected to achieve a minimum 90% compliance rate in their use of the EVV system.
- ❑ If you choose to export your claims **OUTSIDE** of Santrax, claim export requirements within Santrax will no longer need to be maintained, such as the skilled requirement to capture physician signature, or identify third party liability (TPL) or diagnosis codes.
- ❑ Claims exported outside of Santrax must match a confirmed visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

For more information, see Provider Bulletin 18-17 “[Electronic Visit Verification \(EVV\) Enhancement – Alternate Claim Solution](#)” and [At Your Fingertip tip sheet #14 – Alternate Claim Solution Explanation of Benefits](#).

# Electronic Visit Verification (EVV) – 2018 Update

## Alternate Claim Solution

### Alternate Claim Solution EOB codes

Explanation of Benefit (EOB) code 0630 – “Claim must be submitted via EVV system” will no longer set for claims exported outside of the Santrax system

### Four new EOB codes have been created for use on claims exported outside of Santrax:

- ❑ EOB code **3327** “Confirmed visit not found” - 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)*.

To resolve: the visit must be confirmed in the provider’s Santrax system.

**Confirmed visit data used in claims processing may be up to 24 hours old, therefore, visits must be confirmed at least 24 hours prior to claim submission.**

- ❑ EOB code **3328** “Confirmed visit units are exhausted” - 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 paid claim*.

To resolve: Increase the units on the confirmed visit in Santrax.

# Electronic Visit Verification (EVV) – 2018 Update

## Alternate Claim Solution

### Alternate Claim Solution EOB codes cont'd

- ❑ EOB code **0047** “Confirmed visit units are exceeded” - 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.

To resolve: increase the units on the confirmed visit.

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 in order for the claim to pay the total number of units billed for the day.

- ❑ 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 31 days.

To resolve: reduce the number of days submitted on the claim detail.

# Electronic Visit Verification (EVV) – 2018 Update

## Temporary Client

For a client to be present in your Santrax system, the client must be:

**active on their EVV mandated waiver**

&

**have an approved PA assigned** to your agency on the CMAP website

There may be times when there is delay from when a client is referred to your agency and the client is able to be present in the Santrax system which will result in the client being unable to be scheduled in Santrax and the visit times captured by the caregiver having visit exceptions that need to be resolved prior to claims export.

**The Temporary Client Enhancement** allows office staff to schedule visits and resolve visit exceptions for clients who are not yet present in Santrax via the automatic upload. It also allows the client's caregiver to utilize all the check-in and check-out features available while they wait for the permanent client record to be uploaded to the Santrax system.

For more information about the Temporary Client Enhancement see [Important Messages > Electronic Visit Verification Important Message Important Message > Job Aid > Temporary Client - Merging Process](#)

# Electronic Visit Verification – EVV Common Issues

## Client Eligibility

Client Eligibility must be verified prior to submitting claims to avoid claim denials because of ineligibility

- A client present in the EVV system does not automatically mean they are eligible for the services to be provided.
- Eligibility can change at any time.

### If a client is ineligible:

- A check-in/check-out can still occur.
- Using the temporary client feature the visit can be scheduled and, when completed, confirmed in Santrax
- The care manager at the access agency responsible for the clients care plan should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible.
- The visit **CANNOT** be exported or uploaded to DXC for claim adjudication

# Electronic Visit Verification – EVV Common Issues

## Client Eligibility continued

Providers who identify an eligibility issue that has not been resolved after some time should **first contact the access agency in charge of the clients care plan for assistance**. The provider should check with the care manager to see if the **Medicaid redetermination and required financial verifications** have been submitted. If the redetermination and required documentation have been received and the access agency is unable to render assistance, the provider should send an encrypted email to [HomeAndCommunityBasedServices.dss@ct.gov](mailto:HomeAndCommunityBasedServices.dss@ct.gov).

### The email should include:

- The client's name, client ID and the date service began or is scheduled to begin should be provided.
  
- Place the words "ABI, CHC or PCA Waiver Client Eligibility Issue" in the subject line of the email.

# Electronic Visit Verification – EVV Common Issues

## Prior Authorization

**Access agencies (CHC and PCA Waiver clients) and Case Management agencies (ABI Waiver clients):**

- Are required to upload a care plan to DXC Technology within seven (7) business days from initiating a service order.
- Both new and changed service authorizations uploaded to DXC Technology, will be automatically sent daily to the EVV system, to ensure the EVV system is up to date.

**If a visit occurs prior to the prior authorization being in the DSS portal:**

- Caregiver can still complete the check- in and check- out procedure in Santrax.
- Using the temporary client enhancement a schedule can be created and the visit be confirmed.
- Once the PA has been uploaded to Santrax and the temporary client merged with the client record, the claim can then be submitted to DXC Technology for claims processing

**Note: Prior authorizations must be able to be viewed in the DSS secure site in order to be able be viewed in Santrax. If you cannot view a PA in the DSS secure site the PA has not been uploaded. Please contact the access agency responsible for the clients care plan for assistance.**

# Electronic Visit Verification – EVV Common Issues

## Missing Client/ Prior Authorization

If you are missing a client or prior authorization (PA) in the Santrax system:

- ❑ Confirm the client is eligible on a CHC, PCA or ABI waiver by researching the client's eligibility on the DSS Web portal ([www.ctdssmap.com](http://www.ctdssmap.com))

*and*

- ❑ Confirm the client has an approved PA assigned to your agency by viewing the prior authorization on the DSS Web portal ([www.ctdssmap.com](http://www.ctdssmap.com))

**If, after you confirm the client is eligible on their waiver benefit plan and has a PA assigned to your agency, the client is not present in your Santrax system, please send an email to the EVV mailbox, [ctevv@dxc.com](mailto:ctevv@dxc.com), and provide the PA number (as displayed on the DSS secure site [www.ctdssmap.com](http://www.ctdssmap.com)) and the eligibility verification number.** Someone will research the issue and provide any next steps.

# Electronic Visit Verification – EVV Future Improvements

DSS is continually reviewing and improving EVV based on provider feedback. Below are examples of some of the future enhancements to the EVV program that are being created based on that provider feedback. Providers will be notified when these enhancements are in production. If you have suggestions for ways that EVV could be improved please send your suggestions to [ctevv@dxc.com](mailto:ctevv@dxc.com).

- ❑ **Removal of “Other – Documentation Provided”**- The reason code “Other – Documentation Provided” will be removed from the Santrax system and will not be a valid reason to justify visit changes made after the visit has been performed. More specific reasons for changes to a visit will be incorporated into Santrax, based on provider feedback.
- ❑ **Removal of Middle Call in Back to Back Services** – Providers have communicated that the middle call requirement for back-to-back services is difficult for caregivers to adhere to. As a result, DSS will be removing the middle check-in/check-out call requirement and requiring that all tasks performed for visits be documented in the check-out call.

# Electronic Visit Verification – EVV Contacts

- ❑ If you are **missing a client** from your Santrax system or have clients that you are unfamiliar with, please send a **secure** email to [ctevv@dxc.com](mailto:ctevv@dxc.com).
- ❑ If a **prior authorization** (PA) is present on the DSS secure site but is not present in the Santrax 24-48 hours after upload to the DSS secure site, please send an email to [ctevv@dxc.com](mailto:ctevv@dxc.com).
- ❑ If you are experiencing **issues with the Santrax system** and its functionality please contact Sandata Customer Care. They can be reached at 1-855-399-8050 or by email at [ctcustomer@sandata.com](mailto:ctcustomer@sandata.com).

If you are unsure who to contact for assistance, please send an e-mail to [ctevv@dxc.com](mailto:ctevv@dxc.com). You are also encouraged to send an e-mail the [ctevv@dxc.com](mailto:ctevv@dxc.com) mailbox if you feel you need additional support resolving your issue.

**Important: Do not email client identifying data unless you encrypt your e-mail.**

# 2018 Updates



# 2018 Updates – Enhanced Secure Web Site Features

Effective June 27, 2018, self-service functionality for master users (providers and trading partners) and their clerks have been enabled to allow users to more easily reset their passwords, unlock their accounts when a user has exceeded their password attempts, and reactivate their accounts if they have not been used within the last ninety (90) days. As a result, all Secure Web portal account users have increased site security panels which means that all users must have two (2) updated security questions and answers and an updated email address.

## What can users now do?

- Reset their password by responding to the updated questions and answers supplied through the one time set up process.
- Unlock their account in instances where their account has been locked due to entering an incorrect password more than six (6) times, by responding to their updated security questions and answers supplied through the one time process.
- Reactivate their account in the instance where they have not accessed their account within the last ninety (90) days by responding to the updated security questions and answers supplied through the one time process.

For more information, please see Provider Bulletin 18-34 “Enhanced Secure Web Site Features for Password Resets, Locked Accounts, and Disabled Accounts”.



# 2018 Updates - Face-to-Face Requirements – Katie Beckett Model Medicaid Waiver

Effective for home health services (new or initial orders) ordered on or after July 1, 2017, a face-to-face visit and physician certification is required for home health services that are paid under the Medicaid State Plan for HUSKY Health members (HUSKY A, B, C, and D) **with the exception of those payable under the Federal Waiver Program.**

Procedure code T1016 – Case Management, each 15 minutes, payable under the “Katie Beckett” Model Waiver, does not fall under the federal requirement that a face-to-face encounter must occur no more than 90 days before or 30 days after the start of the initial order.

If the primary reason for Home Health services is other than to provide case management for “Katie Beckett” Model Waiver services, then a face-to-face encounter within the specified period noted above is required.

**For more information, please see the “Attention Home Health Agencies - Follow-up to the Face-to-Face Requirements for Initial Orders of Home Health Services” Important Message.**

**For full documentation on the Face-to-Face requirements please see Provider Bulletin PB17-02 New Face-to-Face Requirements for Initial Orders of Home Health Services.**

# 2018 Updates - Autism Waiver Services

**Effective January 1, 2018** all Home Health services provided to Autism Waiver clients are required to be in a Care Plan approved by the Autism Waiver Case Manager in the Community Options Unit at DSS.

- Home Health Services for clients with an Autism Waiver benefit plan will no longer be authorized by Community Health Network of CT (CHNCT)
- Home Health Services for clients with a behavioral health diagnosis and an Autism Waiver benefit plan **will be authorized by Beacon Health Options**, DSS' Behavioral Health Administrative Services Organization.

***Any clients with an Autism waiver on their benefit plan must have all home health services on the Autism Care Plan. However, the client must also have either a HUSKY A or HUSKY C benefit plan in order for the Home Health Agency to be reimbursed for services provided.***

For more information please see Provider Bulletin 2017-85 “Autism Waiver Program Updates”

# 2018 Updates - PCA Training

**Effective July 1, 2018** DSS requires that all agencies that employ Personal Care Attendants to train all PCA staff using the PCA Training Modules, a standardized comprehensive training designed to build consistent skills in the agency based PCA workforce.

- Existing PCAs should complete the training by July 2019.
- New employees are required to complete the training within 90 days of hire.
- To complete the training employees must pass the test with a score of 70%.
- Allied Community Resources will be checking employee personnel records for evidence of timely completion of the training modules.

To download the PCA Training Modules:

- **Allied Community Resources:** <http://alliedcommunityresources.org/content/provider-information/provider-information>
- **The Department of Social Services Community Options:** <http://portal.ct.gov/DSS/Health-And-Home-Care/Long-Term-Care/Community-Options> in the Documents and Forms tab.
- **CMAP** : Go to [www.ctdssmap.com](http://www.ctdssmap.com). Provider > Provider Services> Scroll down to Provider Training and select “here”. The PCA training modules can be found under “Materials” .

For more information, please see Provider Bulletin 18-37– “Required PCA Training”

# 2018 Updates – Service Codes

Effective for DOS July 1, 2017 the following proc/mod lists was implemented:

<b>Proc Mod/ List</b>	<b>Service Code</b>	<b>Description</b>
36	T1001, T1001TT	Nursing assessment/evaluation - T1001

Effective for DOS January 1, 2018 the following proc/mod lists was implemented:

<b>Proc Mod/ List</b>	<b>Service Code</b>	<b>Description</b>
37	3022Z, 3022ZTT	PCA Agency Overnight
38	1225Z, 1225ZTT	PCA Agency, Per Diem

# 2018 Updates – Service Codes

Effective for DOS January 1, 2018 the following proc/mod lists was implemented:

<b>Proc Mod/ List</b>	<b>Service Code</b>	<b>Description</b>
39	G0162, G0162TT	Nursing Management and Evaluation of the Plan of Care
40	G0162 U2, G0162 U2 TT	Nursing Management and Evaluation of the Plan of Care; One Time Only
41	1021Z U2, 1021Z U2 TT	Personal Care Services: Per 15 Minutes

# 2018 Updates – 3 Week Cycle

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".

2018 Month	Claim Cycle Date	Electronic Claims Received By	Web RA Availability	Check Mail Dates	EFT/835 Availability
Jul					
	6	5	10	11	11
Aug	20	19	24	25	25
	10-b	9	14	15	15
Sep	24	23	28	29	29
	7	6	11	12	12
Oct	21	20	25	26	26
	5	4	10**	11**	11**
Nov	19	18	23	24	24
	9-b	8	14**	15**	15**
Dec	23	22	27	28	28
	7	6	11	12	12
	21	20	26***	27***	27***
<b>b - Denotes 3 week cycle</b> * Denotes a 1 day delay in availability due to Monday Holiday ** Denotes a 1 day delay in availability due to Tuesday Holiday					

# 2018 Updates – Alternate Service Location Addresses

On **April 11, 2018**, DSS implemented functionality that allows billing providers to specifically classify an application for the purpose of adding an alternate service location address(es) using the online Enrollment/Re-enrollment Wizard. An alternate service location address application must be submitted when a provider is expanding their number of practice locations.

## When do I not submit an Alternate Service Location Address application?

- **Change an existing address(es) of a practice.** Changes to an existing address are part of regular maintenance and should be performed on the Demographic Maintenance panel in the [www.ctdssmap.com](http://www.ctdssmap.com) Secure Web portal.
- **Add a practice location to an Automated Voice Response System (AVRS) ID that already exists under another billing AVRS ID registered to your agency.** In these instances, you must submit a letter on the provider's letterhead detailing the request and send that to the Provider Enrollment Unit at DXC Technology to:
  - DXC Technology
  - P.O. Box 5007
  - Hartford, CT 06102-5007

Or, by fax on your organization's letterhead to 1-877-899-5401.

**For more information please see Provider Bulletin 18-19 “Web Portal Enhancement – Alternate Service Location Addresses”.**

# Provider Re-enrollment

# 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).

- A majority 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 DXC Technology Provider Enrollment Unit.
- Re-enrollment Period: Home Health providers are required to **re-enroll every 2 years.**



# Provider Enrollment and Re-enrollment

## Re-enrollment Notification and Process:

- ❑ Home Health providers will receive a reminder letter when they are due for re-enrollment **six (6) months** prior to the end of their current contract (Reference [Provider Bulletin 2014-52](#)).

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

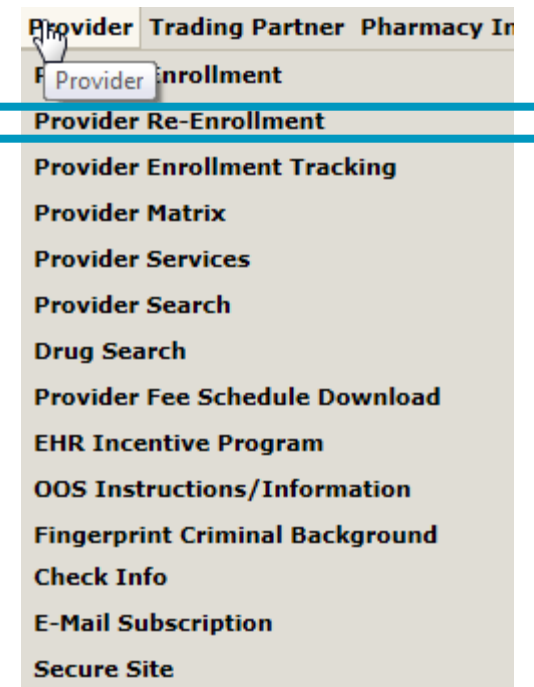
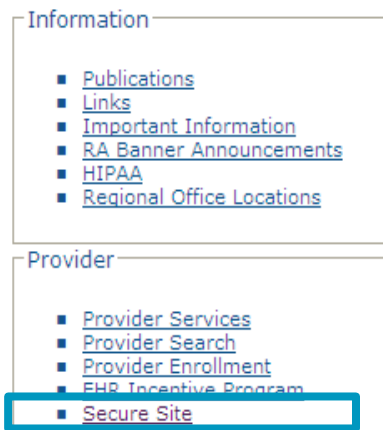
**Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.**

- ❑ Providers who are dis-enrolled *will not be able to bill or receive payment* for services rendered until re-enrollment is completed.
- ❑ Reinstatement of contracts w/out a finalized application violates ACA policies.

# Provider Enrollment and Re-enrollment

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.

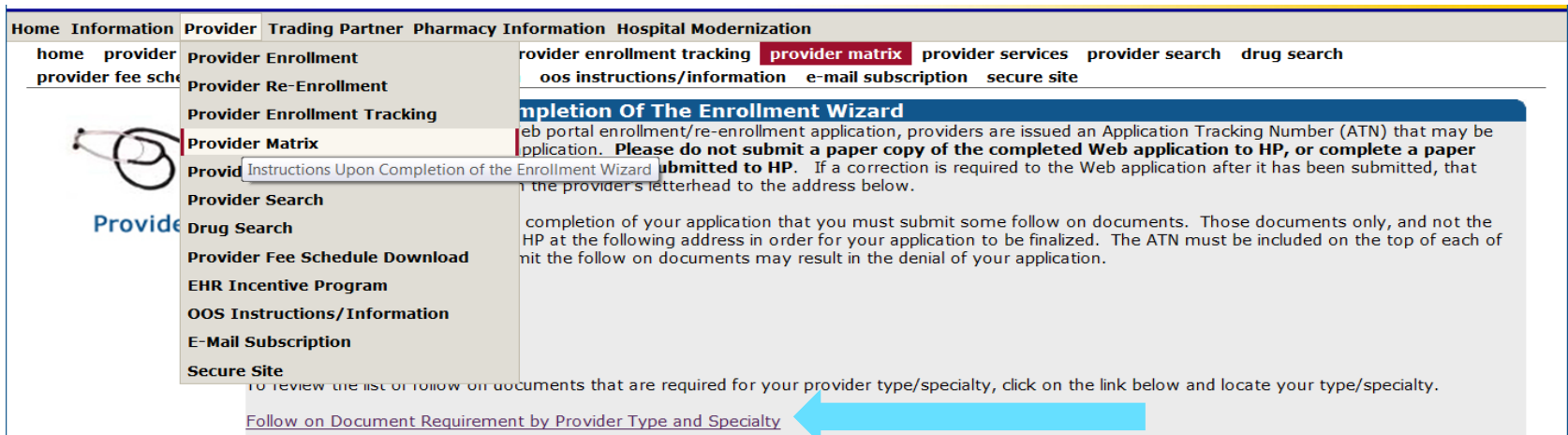
Select *Provider Re-Enrollment* from the *Provider* drop-down menu.



# Provider Enrollment and Re-enrollment

## 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 DXC Technology's Enrollment Unit. The follow-on documents can also be found on the CTDSS map 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.



The screenshot displays the CTDSS map website interface. The navigation menu includes: Home, Information, Provider, Trading Partner, Pharmacy Information, and Hospital Modernization. The 'Provider' dropdown menu is open, listing: Provider Enrollment, Provider Re-Enrollment, Provider Enrollment Tracking, Provider Matrix (highlighted), Provider Instructions Upon Completion of the Enrollment Wizard, Provider Search, Drug Search, Provider Fee Schedule Download, EHR Incentive Program, OOS Instructions/Information, E-Mail Subscription, and Secure Site. The main content area shows a section titled 'Completion Of The Enrollment Wizard' with the following text: 'Web portal enrollment/re-enrollment application, providers are issued an Application Tracking Number (ATN) that may be application. **Please do not submit a paper copy of the completed Web application to HP, or complete a paper application submitted to HP.** If a correction is required to the Web application after it has been submitted, that the provider's letterhead to the address below. completion of your application that you must submit some follow on documents. Those documents only, and not the HP at the following address in order for your application to be finalized. The ATN must be included on the top of each of nit the follow on documents may result in the denial of your application. 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

## Re-enrollment Due Dates:

**Providers with Secure Web portal access can view their re-enrollment due date once logged in.**

- Providers can view their re-enrollment due date on the Home page.
- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

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

home **account home** account maintenance account setup change password clerk maintenance demographic maintenance reset password log out

Welcome, P0042

Provider ID: NPI

Provider AVRS ID:

Reenrollment Due Date: 10/18/2018

Zip Code: 06010 - 5106

# Provider Enrollment and Re-enrollment

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

The screenshot shows a navigation menu with the following items: Home, Information, Provider, Trading Partner, ConnPACE, Pharmacy Information. Below these are links: home, provider enrollment, provider enrollment tracking (highlighted with a red box), and provider matrix. To the right, a dropdown menu is open under 'Provider', showing 'Provider Enrollment' and 'Provider Enrollment Tracking' (highlighted with a blue box).

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

The screenshot shows the 'Enrollment Tracking Search' form with the following fields and buttons:

- ATN\*: 305929
- Business OR Last Name\*: SMITH
- search button
- clear button

❑ In this example DXC Technology is reviewing the application that was submitted on July 13, 2017.

Search Results	
Date Received	Status
07/13/2017	DXC Reviewing Submitted App

# Demographic Maintenance

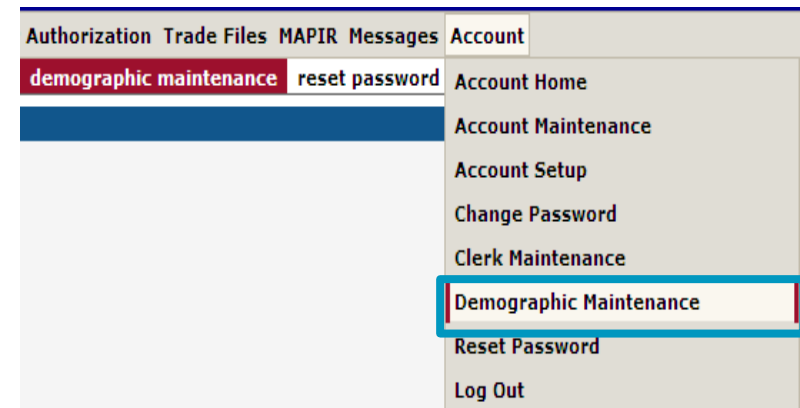
# Demographic Maintenance

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 :

- Mail to, Pay to, Service Location, and Enrollment 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

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 – Ownership
- Service Location – County, Organization Code
- Service Language – Language, Effective Date, End Date

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 – Address Updates

Specify different mailing, payment, service location, and enrollment addresses.

## Location Name Address X

• If a provider is moving its office location, that change in address can be made via this panel. If the provider is a licensed facility (such as a clinic, hospital or pharmacy) moving to a different location but still using the same license, this requires that you submit an updated copy of your license after the address update has been completed. The copy of the license should be mailed to DXC Technology Provider Enrollment, P.O. Box 5007, Hartford, CT 06102-5007, with a note that the address update has been made via the Web portal and the provider is sending a copy of their license to retain with their enrollment/re-enrollment records.

• **Warning - PCMH and Glide Path Providers ONLY**

If you are a PCMH or Glide Path provider, a change to your address information for an existing PCMH/Glide Path site may affect your claim payments. To ensure your practice receives the fee differential payments for primary care services, your primary and/or alternate service location address submitted on claims MUST match exactly to the primary and/or service location address indicated here. Any type of address change made via this Web portal, whether it be as simple as adding a suite number or a total overlay of an address due to the move of an office, must also be communicated back to CHN using CHN's Change Request Form. This form is located at [www.huskyhealthct.org](http://www.huskyhealthct.org), by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the PCMH and Glide Path Change Request Form. If there are claims to be processed for the address you are updating, please do not initiate that address update via this Web portal application. Rather, submit the request to update the address in writing to DXC Technology Provider Enrollment Unit at PO Box 5007, Hartford, CT, 06102-5007. Any updates to address information via the Web portal, when there are still claims to be processed for that address, may cause the fee differential payment not to be applied to those claims.

Usage	Name	Address 1	City	State	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Enrollment Address	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Mail to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Pay to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Service Location	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V

Type changes below.

maintain address

**Apply Changes To:**

Svc Loc

Pay To

Mail To

Enrollment

Name Type  Business Name  Personal Name

Name

Title

Usage

Country

Address 1

Address 2

City

State

Zip

Contact Name

Contact Phone

Fax

Address Indicator

Handicap Accessible?

Email

Confirm Email

save
cancel

# Demographic Maintenance – Location Name Address

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

Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
Enrollment Address		1 BRAD STREET	BRISTOL	CT	06010				
Mail to		1 BRAD STREET	BRISTOL	CT	06010				
Pay to		1 BRAD STREET	BRISTOL	CT	06010				
Service Location		1 BRAD STREET	BRISTOL	CT	06010				

[maintain address](#)

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

**The following messages were generated:**

Message Description	Panel	Field
Save was Successful		

# Demographic Maintenance – EFT Updates

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

- ❑ Click “**add**”; enter the appropriate information; and click “**save**.”

Location Name Address > **EFT Account** > Service Language > Maintain Organization Members

**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
BANK OF AMERICA, N.A.	011900571		Checking		Active

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

Required fields are indicated with an asterisk (\*)

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

Provider Name\*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

**Provider Identifiers\***

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

**\*\*This action will place the provider in a *pre-notification* status\*\***

# Eligibility

# Eligibility - Verification

To check a clients eligibility, log into the DSS secure Web portal.

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services  
oos instructions/information fingerprint criminal background check info e-mail subscription **secure site**

### Login

The Connecticut Department of Social Services Medical Assistance Program secure website is intended for providers, clerks and billing agents.

If you have received your Personal Identification Number letter, click on the setup account button.

[setup account](#)

User ID\*

Password\*

[login](#)

# Eligibility - Verification

Receipt of a service order from the Case Management/ Access Agency confirms the client is eligible on their appropriate waiver. However, the client's eligibility file may not yet reflect the client's current waiver eligibility. To avoid unnecessary claim denials such as:

- EOB code 2003 - The client was not eligible on the date of service
- EOB code 4021 - The service provided was not a covered service under the client's benefit plan

**It is recommended that providers verify client eligibility upon receipt of the initial service order, at the resumption of care, at a change in the plan of care and at regular intervals.**

**Eligibility verification can be performed in the following ways:**

- Internet Web site at [www.ctdssmap.com](http://www.ctdssmap.com).
- Automated Voice Response System (AVRS).
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
- Provider Electronic Solutions (PES) software.

# Eligibility - Verification

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

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

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

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

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 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" value="Doe"/>	From DOS*	<input type="text" value="01/01/2018"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="John"/> <input type="text"/>	To DOS*	<input type="text" value="01/31/2018"/>
Birth Date	<input type="text" value="02/05/1955"/>				
Service Type Code 1	<input type="text" value="30 - Health Benefit Plan Coverage"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

# Eligibility - Verification

Positive eligibility responses provide greater detail.

**Eligibility Verification Request**

Client ID	<input type="text"/>	last name	<input type="text" value="DOE"/>	From DOS*	<input type="text" value="05/01/2018"/>
SSN	<input type="text" value="666-55-4444"/>	First Name, MI	<input type="text" value="JOHN"/> <input type="text"/>	To DOS*	<input type="text" value="05/30/2018"/>
Birth Date	<input type="text"/>				
Service Type Code 1	<input type="text" value="54 - Long Term Care"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

**Eligibility Verification Response**

Verification Number	<input type="text" value="15040039KM"/>
Response Text	<input type="text" value="Client is eligible. Refer to Benefit Plan for specific program coverage."/>

# Eligibility - Verification

What does all this information *mean*?

**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. Provides proof you researched the clients eligibility and verified coverage at the time of service.

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

# Eligibility – Verification

## Benefit Plan

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

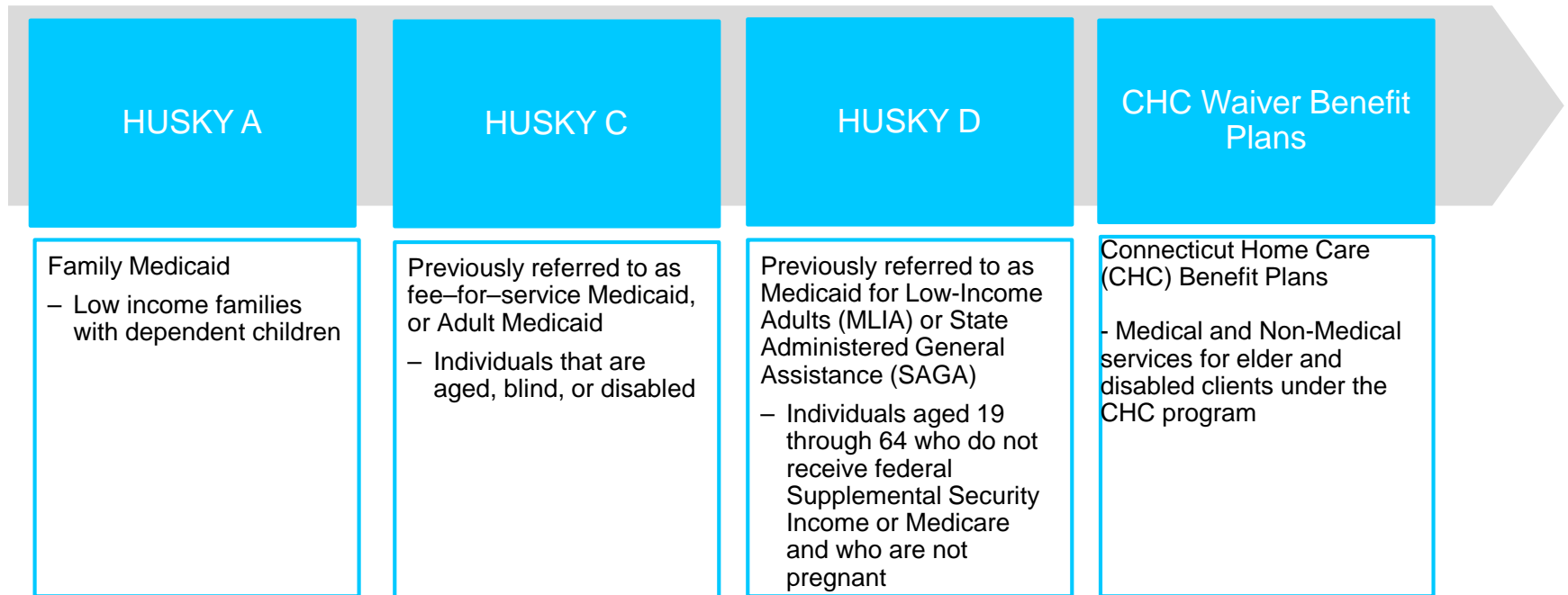
- A client having an ABI I or ABI II Waiver, PCA or CHC benefit plan requires all Home Health services to be in the Care plan in order for the Home Health provider to be reimbursed for services provided.
- The client must also have a HUSKY A, C or D benefit plan for Home Health services to be paid.

Benefit Plan				
Service Information <sup>A</sup>	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

# Eligibility Verification

## Web Account Capabilities

### Benefit Plans payable for Home Health Services



# Prior Authorization

# Prior Authorization

## Care Plan Access – PA Search

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

The screenshot displays the Connecticut Department of Social Services web portal. The header includes the logo and the text "Connecticut Department of Social Services Making a Difference". The date "Tuesday, February 09, 2016" is shown in the top right. The navigation menu contains links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Homecare, MAPIR, Account, and ConnPACE. The "Account" link is highlighted in red. A dropdown menu is open under "Prior Authorization Search", showing options for "Care Plan" and "Pharmacy Prior Authorization". The "Care Plan" option is highlighted in blue. Below the navigation menu, the user is welcomed with the ID "HHA001234567" and notified that "Re-enrollment due 6/1/2018". There are two sections for "Global Messages" and "Secure Mailbox", both showing "\*\*\* No rows found \*\*\*". On the right side, there are "Quick Link" and "Email Subscription" sections. The "Quick Link" section includes links for "Check E-messages", "Claim Status Inquiry", "Client Eligibility Verification", "Prior Authorization Inquiry", "Download Remittance Advices", and "ACA Ordering/Prescribing/Referring Provider List". The "Email Subscription" section includes a link for "Register/Update Email Subscription".

# Prior Authorization

## Prior Authorization Search

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*.

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

# Prior Authorization

## PA Search Results

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.***

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	Prescribing/Ordering Provider ID	Service Code	Service Code Thru	Proc/Mod List	Frequency	Status
0771009324	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial	NPI			SN	36 Per Date Span	Auto Approved for Care Plan
0771009325	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial	NPI	T1004			8 Per Calendar Week	Auto Approved for Care Plan
0771021292	01	04/13/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial	NPI			SN	26 Per Date Span	Auto Approved for Care Plan
0771021334	01	04/12/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial	NPI			SN	13 Per Date Span	Auto Approved for Care Plan
0771022203	01	04/10/2017	04/30/2018	04/21/2017	06:00:11	Home Care Progra	Initial	NPI	T1004			24 Per Calendar Week	Auto Approved for Care Plan
0771022209	02	04/23/2017	04/30/2018	04/26/2017	06:00:11	Home Care Progra	Initial	NPI			SN	27 Per Date Span	Auto Approved for Care Plan
0771022650	01	04/11/2017	04/30/2018	04/24/2017	06:00:10	Home Care Progra	Initial	NPI			SN	26 Per Date Span	Auto Approved for Care Plan

PA Number	Line Item	Authorized Eff. Date	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub
0771009324	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial
0771009325	01	05/01/2017	04/30/2018	04/07/2017	06:00:56	Home Care Progra	Initial
0771021292	01	04/13/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial
0771021334	01	04/12/2017	04/30/2018	04/17/2017	06:00:10	Home Care Progra	Initial
0771022203	01	04/10/2017	04/30/2018	04/21/2017	06:00:11	Home Care Progra	Initial
0771022209	02	04/23/2017	04/30/2018	04/26/2017	06:00:11	Home Care Progra	Initial
0771022650	01	04/11/2017	04/30/2018	04/24/2017	06:00:10	Home Care Progra	Initial



# Prior Authorization

## Viewing and Understanding the Prior Authorization Review

### 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

NOTE: Discrepancies should be reported to the Case/ Access 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 11/1/17** 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	Revenue NDC 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 ] [ Search ]

Procedure Code List [ Search ] [ Search ]

Requested Eff./End Dates\* 11/01/2017 11/01/2017

Requested Units/Dollars\* 12.000 \$0.00

NDC [ Search ]

Status Auto Approved for Care

Authorized Units/Dollars 12.000 \$0.00

Authorized Eff./End Dates 11/1/2017 11/01/2017

Used Units/Dollars 0 \$0.00

Available Units/Dollars 12 \$0.00

Frequency 12 Per Calendar Week

Tooth [ Search ]

Quad [ Search ]

Tooth Surface 1 [ Search ]

Tooth Surface 2 [ Search ]

Tooth Surface 3 [ Search ]

Tooth Surface 4 [ Search ]

Tooth Surface 5 [ Search ]

# Prior Authorization

## PA Details

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

The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

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

Type changes below.

Line Item 01

Service Type Code\* Procedure/Mod List

Procedure Code [ Search ]

Mod 1 [ Search ]

Mod 2 [ Search ]

Mod 3 [ Search ]

Mod 4 [ Search ]

Revenue Code/List [ Search ] [ Search ]

Proc/Mod List SN

Procedure Code List Skilled Nursing

Requested Eff./End Dates\* 12/01/2017 12/31/2017

Requested Units/Dollars\* 15.000 \$0.00

NDC [ Search ]

Status Approved

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 12/01/2017 12/31/2017

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

Notes

\*\*\* No rows found \*\*\*

# 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 ]

# Prior Authorization

## PA Modifiers

**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

**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 care plan/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 Provider Bulletin 17-60

# Claims Processing

# Claims Processing/Submission Information

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/Submission Information

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

**(20)(17)(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 DXC Technology (**17** = 2017)
- 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 DXC Technology 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

## Third Party Liability (TPL) Information

**Commercial / private insurance coverage other than Medicare or Medicaid under which the client is be 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 DXC Technology
- Providers can see other insurance coverage in the eligibility verification process.

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

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

# Claims Processing/Submission Information

## Third Party Liability (TPL) Information

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

**TPL claims submitted to DXC Technology 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 [ctdssmap.com](http://ctdssmap.com) Web site.

# Claims Processing/Submission 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 DXC Technology.
- 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

# Medicare Cost Avoidance

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

## Claim Submission:

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

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

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



# Medicare Cost Avoidance

## 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.



# Medicare Cost Avoidance

## Claim Auditing cont.

- 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

These codes can only be used for Medicare as a third party payer.

These codes 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.

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

[Dental audit protocols](#)

[Homecare audit protocols](#)

[Home health audit protocols](#)

[Medical equipment audit protocols](#)

[Outpatient hospital audit protocols](#)

[Pharmacy audit protocols](#)

[Physicians audit protocols](#)

# Claims Audit Criteria

Home Health audit protocols list the most common reasons why a provider's claims may be audited. You can find the Audit Protocols at [www.ct.gov/dss](http://www.ct.gov/dss) > Divisions Within the Department > Quality Assurance > Please follow the link to view Audit Protocols > Home Health audit protocols.

**DEPARTMENT OF SOCIAL SERVICES  
AUDIT PROTOCOL - HOME HEALTH SERVICES  
UPDATED MAY 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.

<b>Audit Finding</b>	<b>Department Criteria</b>	<b>Regulatory Reference</b>
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)
Billing - Medicare Cost Avoidance	The Department will disallow payment if the provider does not issue dual eligible clients a Home Health Advanced Beneficiary Notice (prior to December 9, 2013) or an Advanced Beneficiary Notice of Non-coverage (as of December 9, 2013) within a year of the dates of service sample.	PB 2010-06
Billing - Medication Administration to Meet Patient Goals	The Department will disallow payment if the provider bills a medication administration code for a nurse to observe and confirm that the member took the medication rather than to actually administer the medication.	Conn. Agencies Regs. §§ 17b-262-725(30); 17b-262-728(b)(6)
Billing - Nursing Provided to Multiple Recipients in Same	When two or more clients in the same household are receiving nursing care services, the Department will adjust any payments made for	Conn. Agencies Regs. §§ 17b-262-725(19); 17b-262-734(b)(2); 17b-262-

# Claim Denial and Corrective Action

# Claim Denial and Corrective Action

Claim Denials, Resolution and Resources

## Claim Denials due to Client Eligibility

### Denial Reasons:

- EOB Code 2003** - Client Ineligible for dates of service
- EOB Code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan.

\*\*If EOB code 4021 is the only EOB that sets on the claim, the client does not have Husky, ABI, CHC or PCA waiver in their benefit plan. If any other EOB is on the claim, take action on the other EOB code and disregard EOB code 4021.\*\*

### Resolution:

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

# Claim Submission

## Claim Denials, Resolution and Resources

### Claim Denials due to Client Eligibility (continued) - Resources:

- ❑ Providers should first verify with the care manager at the Access/Case Management Agency 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 [HomeandCommunityBasedServices.dss@ct.gov](mailto:HomeandCommunityBasedServices.dss@ct.gov).
- ❑ The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC Client Eligibility Issue" in the subject line of the email.
- ❑ Providers who identify an eligibility issue upon claim denial should contact the DSS Community Options Unit as noted above. To avoid further claim denial, check eligibility **before** resubmitting claim.



# Claims Submission

Claim Denials, Resolution and Resources

## Claim Denials Related to Care Plan/PA Issues

### Denial Reasons:

**EOB Code 3015** –Care Plan Required

**Resolution:** A care plan must be created by the Access Agency (CHC or PCA Waiver) or Case Management Agency (ABI Waiver) and uploaded to the DXC Technology system.

**EOB Code 3016** - Service not Covered Under Care Plan

**Resolution:** A service denied for not on care plan must be added by the Access/Case Management Agency to the Care plan.

**Please note: Neither DSS nor DXC can enter or correct care plans or PAs. If a care plan or PA needs to be entered or corrected providers need to contact the Access/Case Management Agency responsible for the clients care plan for assistance.**



# Claims Submission

Claim Denials, Resolution and Resources

## Claim Denials related to Care Plan/PA Issues (continued) - Denial Reasons

- ❑ **EOB Code 5151** - Units exceed frequency units on care plan.

**Resolution:** Units of service must be added to the frequency of an existing PA by the Access/Case Management Agency.

- ❑ **EOB Code 3003** -Prior Authorization is required for payment of the service (units for the service are exhausted)

**Resolution:** Units of service must be added by the Access/Case Management Agency to an existing PA that is currently exhausted.

# Claims Submission

## Claim Denials, Resolution and Resources

### **Claim Denials related to Care Plan/PA Issues (continued) - Resources:**

- Care 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 DXC Technology, in Prior Authorization format, within seven (7) days of issuing the service order.
  
- If the provider **has a service order** and a **PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account** within **seven (7) days** of receipt of the service order, the provider should contact the applicable Access/ Case Management Agency.

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

# Monthly Claims Reprocessing

# Monthly Claims Reprocessing

## ABI, CHC and PCA Waiver Claims

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

- ❑ Access and Case Management Agencies 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 ABI, CHC and PCA 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

## ABI, CHC and PCA Waiver Claims

### Systematic Monthly Reprocessing

- ❑ In the first cycle of each month, DXC Technology will recoup (void) all paid claims impacted by the Access or Case Management Agency PA changes made two months prior. (*A claim that starts with Region code 52 is a voided claim*).
  
- ❑ In the same cycle DXC Technology will reprocess to, deny and/or pay claims posting to the correct PA/PA line detail. (*A claim that starts with Region code 24 is 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 Claim Reprocessing

## ABI, CHC and PCA Waiver Claims

### 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

## ABI, CHC and PCA Waiver Claims

REPORT: CRA-HHAD-R  
 RA#:

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

interChange RHIS  
 MEDICAID MANAGEMENT INFORMATION SYSTEM  
 PROVIDER REMITTANCE SERVICE  
**HOME HEALTH CLAIM ADJUSTMENTS**

Date:   
 PAGE: 312

PAYEE ID NPI  
 ISSUE DATE  
 TAXONOMY 251E00000X  
 P. AVRS ID

FP	--ICH--	ATTEND PROV.	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	PATIENT	PAID
REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	FROM	THRU	AMOUNT	AMOUNT	LIABILITY	AMOUNT
				UNITS	BILLED AMT	ALLOWED AMT	DETAIL	EOPS	

CLIENT NAME: Sally Client  
**2000000000000** NPI  
 7067572782432550263  
**5200000000000** NPI  
 7067572782432550263  
 HEADER EOPS **8236**

CLIENT NO.:	000000000								
073113	073113	(600.00)		(116.83)	(0.00)	(0.00)	(0.00)	<b>(116.83)</b>	
073113	073113	(600.00)		0.00	0.00	0.00	0.00	<b>0.00</b>	



# Monthly Claims Reprocessing

## ABI, CHC and PCA Waiver Claims

### Impact to Provider Remittance Advice (Paper RA)

A new claim will be systematically created. Providers will see the new day claim on their RA

Claim ICN (**Region 24**) in the paid/denied section of the RA.

**EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change.

**NOTE:** If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the paper RA.

# Monthly Claims Reprocessing

## Monthly Claim Reprocessing Due to PA Changes

Claim Reprocessed and appears on RA (paid amount region 24 claim greater than amount recouped – region 52 claim)

REPORT: CRA-HHPD-R  
RA#:

interChange MNIS  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
HOME HEALTH CLAIMS PAID

Date:   
PAGE: 2

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

PAYEE ID  
ISSUE DATE  
TAXONOMY  
P. AVRS ID  
  
NPI  
  
251E00000X

FP	--ICN--	ATTEND PROV.	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	PATIENT	PAID
	--PATIENT NUMBER--		FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	LIABILTY	AMOUNT

PATIENT NAME: Sally Client			CLIENT NO.: 000000000						
	2400000000000	NPI	071517 072217	600.00	396.94	0.00	0.00	0.00	396.94

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED ANT	ALLOWED ANT	DETAIL	EOBS
580	S9124	071517		1.00	175.00	114.74	8238	
570	T1004	071517		6.00	75.00	48.54	8238	
580	S9123	071817		1.00	175.00	116.83	8238	
580	S9123	072217		1.00	175.00	116.83	8238	

# Monthly Claims Reprocessing

## Monthly Claims Reprocessing Due to PA Changes

### 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

## Monthly Claims Reprocessing Due to PA Changes

### Impact to Provider's Secure Web Portal – PA Inquiry

- Region **24 claims** identify a change made to the care plan/PA.
  
- Region **24 claims** with **EOB Code 8238** – “Claim Systematically Reprocessed Due to a PA/Service Order Change” confirms there has been a change which has:
  - Positively** or **negatively** impacted you financially.
  - May **continue to impact** you financially in the future.
  
- Providers should investigate reprocessed claims with a **negative** impact to determine if:
  - Providing appropriate level** of service currently authorized.
  - Current service order matches the PA** on their secure Web account.
  - Report discrepancies** to the Access or Case Management Agency.

# Monthly Claims Reprocessing

## Monthly Claims Reprocessing Due to PA Changes

### 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** and available, 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)



# Remittance Advice

## Financial Transaction:

In a scenario where a claim denies with the Explanation of Benefits (EOB) **code 2003 “Client ineligible for dates of service”** even though you have an eligibility verification response that the client was eligible for the date of service, you can submit an appeal to DXC Technology’s Written Correspondence Unit at the following address:

DXC Technology  
PO Box 2991  
Hartford, CT 06102

The appeal should be on the provider’s letterhead and include the Eligibility Verification Number and a paper claim for the services rendered that were denied.

# Remittance Advice

## Financial Transaction:

DSS will issue a **Financial Payout** for the services rendered in lieu of the claim.

- ❑ You will see the payout information in the **Financial Transactions** section of your Remittance Advice as a “Non-Claim Specific Payout.”
- ❑ The Liability Date refers to the date of service for the claim that was denied due to the client being ineligible.

interChange MMIS  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
**FINANCIAL TRANSACTIONS**

Date: 02/07/2017  
PAGE: 51

-----NON-CLAIM SPECIFIC PAYOUTS-----

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
151250000		<b>394.16</b>	8306	<b>0099999999</b>	<b>BABYC CAREY</b>	<b>11/02/2016</b>
TOTAL PAYOUTS:		394.16				

# Information/ Resources

# Information/ Resources

## Important Messages

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

### Important Messages

Available on the Home page. Also available 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



Information

#### Important Messages

[Electronic Visit Verification \(EVV\) - Understanding Eligibility, Client Benefit Plans and Prior Authorization \(Posted 9/19/17\)](#)

[Attention Home Health Providers- Updated Billing Instructions for the Review of Home Health Therapy Care Plans](#)

[Hospital Monthly Important Message \(Updated 9/13/17\)](#)

[Attention Providers: ICD-10 Diagnosis Codes Not Covered for Date of Service 10/1/17 and Forward](#)

[Hospital Readmissions on the Same Day \(Updated 8/29/17\)](#)

[Birth to Three Implementation Delay Announcement \(Posted 8/22/17\)](#)

[Electronic Visit Verification \(EVV\) - "At Your Fingertips" Tip Sheet \(Posted 8/21/17\)](#)

[Electronic Visit Verification Implementation \(Updated 8/15/17\)](#)

[Electronic Visit Verification \(EVV\) - Creating Claims in the Santrax System \(Posted 8/4/17\)](#)

[Face to Face Requirements for Initial Orders of Home Health, Physician, Physician Assistants, Pharmacies, APRNs and DME](#)

[Attention: Home Health Providers - Electronic Visit Verification \(EVV\) Duration Exceptions](#)

[Revised Provider Manual Chapters \(Updated 7/28/17\)](#)

[Validating the National Drug Code \(NDC\) Submitted in Conjunction with Procedure Codes for Physician Administered Medications \(Posted 7/18/17\)](#)

# Information/ Resources

## RA Banner Announcements

Available by selecting the Information tab or clicking on RA Banner Announcements in the Information box on the left hand 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 regards to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected

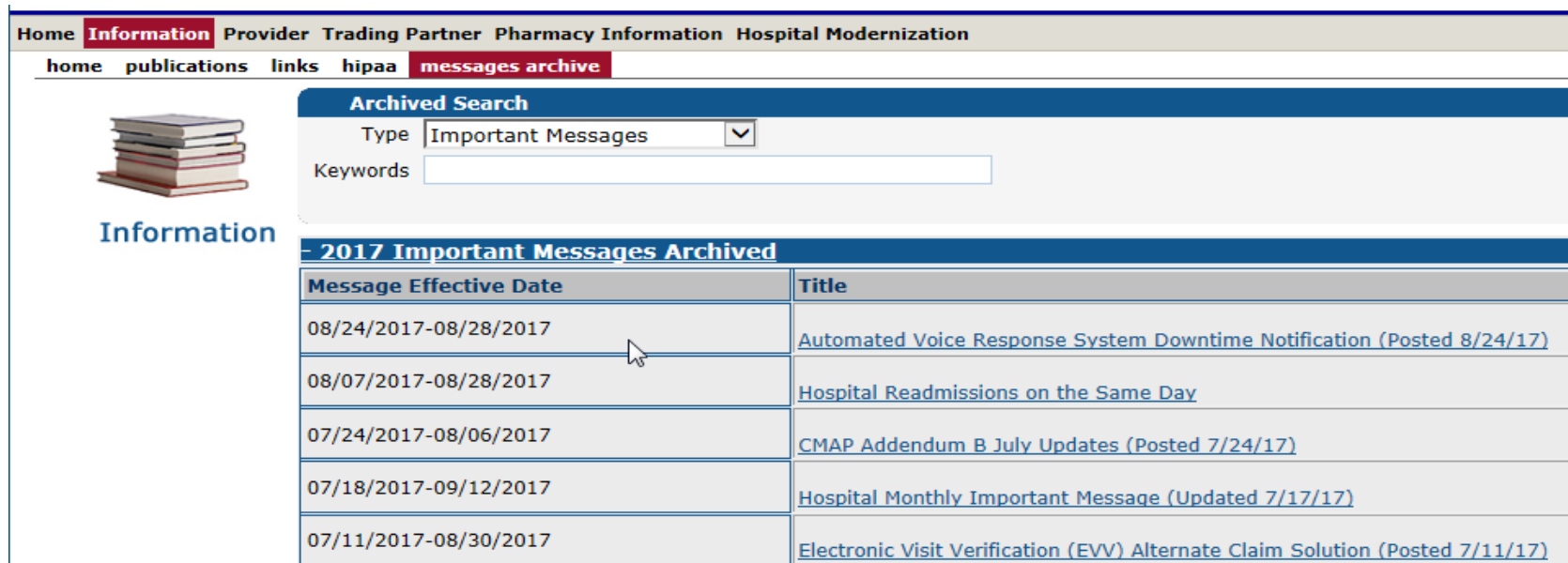
09/22/2017-09/29/2017	Attention Select Providers	Attention Select Providers. PCMH REPROCESS: Providers enrolled in the Person-Centered Medical Home Initiative (PCMH) were enrolled with retroactive effective dates, or were approved for changes in PCMH level or site address with retroactive effective dates. Claims which processed prior to the completion of the provider's PCMH enrollment or level/site address change were not paid with the PCMH differential payment rate and have now been reprocessed to include that amount. For any providers with retroactive site terminations, claims which processed with the PCMH differential payment rate have now been reprocessed without that amount. The impacted claims have been identified and reprocessed and will appear on your September 26, 2017 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55.
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# Information/ Resources

## 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', and 'Hospital Modernization'. The 'Information' menu is expanded to show '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 is an 'Information' icon. The main content area is titled '2017 Important Messages Archived' and contains a table with the following data:

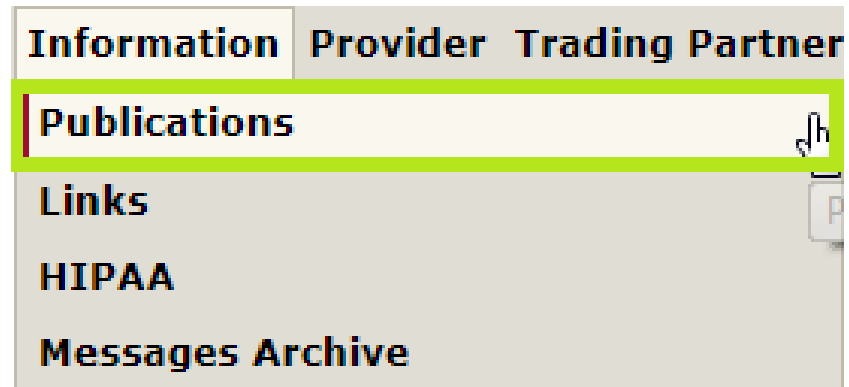
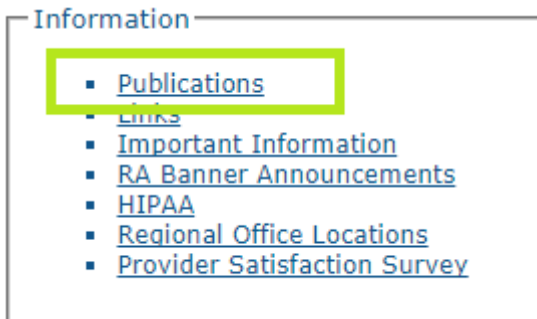
Message Effective Date	Title
08/24/2017-08/28/2017	<a href="#">Automated Voice Response System Downtime Notification (Posted 8/24/17)</a>
08/07/2017-08/28/2017	<a href="#">Hospital Readmissions on the Same Day</a>
07/24/2017-08/06/2017	<a href="#">CMAP Addendum B July Updates (Posted 7/24/17)</a>
07/18/2017-09/12/2017	<a href="#">Hospital Monthly Important Message (Updated 7/17/17)</a>
07/11/2017-08/30/2017	<a href="#">Electronic Visit Verification (EVV) Alternate Claim Solution (Posted 7/11/17)</a>

# Information/ Resources

## 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 hand side of the home page or from the Information drop-down menu.



# Information/ Resources


## 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.

Home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization

home **publications** links hipaa messages archive



**Information**

**Bulletin Search**

Year  Provider Type

Number  Title

Bulletin Search		Search Results
Bulletin Number ▾	Title	Published Date
PB17-66	Electronic Visit Verification (EVV) Compliance	10/06/2017
PB17-60	Increased Rate for Nursing Services for Complex/High Tech Level of Care	09/29/2017
PB17-59	Clarifying Billing Instructions for Therapy Evaluations and Services Performed a...	09/21/2017
PB17-58	Provider Satisfaction Survey	08/31/2017
PB17-52	Clarifying Billing Instructions for Therapy Evaluations and Services Performed a...	08/07/2017
PB17-51	Elimination of Home Health Add-On Fees	07/10/2017
PB17-49	Electronic Claim Attachment Process	06/29/2017
PB17-43	<b>New Explanation of Benefit (EOB) Codes for Manually Priced Claims</b>	<b>06/28/2017</b>
PB17-31	Update to ABN Instructions for the EVV Santrax System	06/01/2017
PB17-30	Important Changes to Evaluation and Assessment Services for Home Health Care Ser...	08/07/2017
PB17-29	Provider Audit Trainings	06/06/2017
PB17-26	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergenci...	05/25/2017
PB17-23	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/10/2017
PB17-20	New Proc/Mod List Code for Oral Medication Administration Direct Observation Ser...	05/04/2017
PB17-02	New Face-to-Face Requirements for Initial Orders of Home Health Services and Lon...	06/08/2017

# Information/ Resources

## E-mail Subscriptions

### 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 PB-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

#### Existing Subscribers

E-Mail

#### Unsubscribe

E-Mail

#### Available Subscriptions

- **Provider**
- ALL Provider Types
- Acquired Brain Injury
- 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
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Clinic EPSDT
- Community First Choice
- Community Services
- DDS Employment and Day Supports
- DDS Specialized Services
- DME/Medical Supply Dealer
- Dental
- Drug and Alcohol Abuse Center
- Early Childhood Autism Waiver
- 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
- Naturognath



# Information/ Resources

## Provider Manual

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

## Provider Manual

### **Chapter 1 – Introduction**

Provides information on the CT Medical Assistance Program, the Department of Social Services' and DXC Technology's responsibilities and resources

### **Chapter 2 – Provider Participation Regulations**

Details the CMAP regulations for provider participation

### **Chapter 3 – Provider Enrollment**

Provides information on provider eligibility in regards to provider enrollment and re-enrollment

### **Chapter 4 – Client Eligibility**

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

### **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

Provider Manual cont'd

## **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

## Provider Newsletters

Quarterly publications to providers on a wide range of topics

### Provider Newsletters

- [June 2018 interChange Newsletter](#)
- [April 2018 interChange Newsletter](#)
- [December 2017 interChange Newsletter](#)
- [September 2017 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](#)
- [ICN Region Code List](#)
- [CT Medical Assistance Program EOB Crosswalk](#)
- [CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy](#)
- [Medically Unlikely Edit \(MUE\) Updates](#)
- [OPR Enrollment FAQ](#)

# Contacts



# Contacts

## **DXC Technology 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@dxc.com](mailto:ctdssmap-ProviderEmail@dxc.com)

This should be your first call resource to answer all enrollment 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.

## **DXC Technology Electronic Data Interchange (EDI) Help Desk**

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

# Contacts

## EVV Email Mailbox

- ❑ [ctevv@dxc.com](mailto:ctevv@dxc.com).

If you are:

- ❑ missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan;
- ❑ have clients that you are unfamiliar with;
- ❑ 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

then contact the EVV email box for assistance.

## Sandata Customer Care

- ❑ 1-855-399-8050 or [ctcustomer care@sandata.com](mailto:ctcustomer care@sandata.com)

If you are experiencing issues with the **Santrax system and 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@dxc.com](mailto:ctevv@dxc.com).

- ❑ You are also encouraged to send an e-mail to the [ctevv@dxc.com](mailto:ctevv@dxc.com) mailbox if you feel you need additional support resolving your issue. Please be sure to include your Sandata ticket number if applicable.

# Contacts

## Access Agencies

### **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 DXC Technology, 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.

### **South Western 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) [chcbilling@aoascc.org](mailto:chcbilling@aoascc.org)**

- Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax.

# Contacts

## Access Agencies continued

**Western Connecticut Area on Aging (WCAA)-** contact WCAA directly at (203)465-1000

- Please have the following information available when contacting WCAA: client name, the client Medicaid ID number, the type of service (SNV, Med admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

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

**Community Option Unit at DSS-** For assistance in correcting a clients eligibility file, please send an email to [HomeandCommunityBasedServices.dss@ct.gov](mailto:HomeandCommunityBasedServices.dss@ct.gov)

**CHNCT (prior authorizations) –**

- 1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)
- [www.ct.gov/husky](http://www.ct.gov/husky)

## Beacon Health Options CT

- 1-877-552-8247



# Contacts

## Access Agencies continued

**CHNCT (prior authorizations)** – For assistance with obtaining PA for clients who are title XIX and exceed the standard benefit.

- 1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)
- [www.ct.gov/husky](http://www.ct.gov/husky)

**Beacon Health Options CT (Behavioral Health prior authorizations)** - For assistance with obtaining PA for clients, with a behavioral health diagnosis, who are title XIX and exceed the standard benefit.

- 1-877-552-8247



# Questions?



# Thank you.

Thank You for attending The Connecticut Medical Assistance Program Home Health Agency 2018 Refresher Workshop!

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey.

Your feedback helps us to improve future workshops!



**Thank you.**