

September 25, 2018

 Connecticut Department
of Social Services
Making a Difference

Connecticut Medical Assistance Program 2018 Long Term Care Refresher Workshop

Presented by
The Department of Social Services & DXC Technology



Training Topics

- 2018 Updates
- Eligibility Verification
- Ascend Overview
- Web Claim Submission Overview
- Remittance Advice Overview
- Provider Electronic Solutions (PES) Software
- Patient Liability
- Hospice
- Hospitalization Bed Reserve Guidelines
- Provider Enrollment/Re-enrollment on the Web
- Additional Information
- Wrap Up & Questions

2018 Updates

2018 Updates – Enhanced Secure Web Site Features

- As of 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, reference provider bulletin, PB 2018-34 “Enhanced Secure Web Site Features for Password Resets, Locked Accounts, and Disabled Accounts”

Eligibility Verification

Eligibility Verification

- DSS recommends that providers verify a client's eligibility on the date of service prior to performing the service as eligibility can change at any time
- *Eligibility verification can be performed in the following ways:*
 - *Provider Secure Web site at www.ctdssmap.com*
 - Automated Voice Response System (AVRS)
 - Provider Electronic Solutions software
 - Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction

Eligibility Verification

Welcome page at www.ctdssmap.com



Help
8/16/2018

[Home](#) [Information](#) [Provider](#) [Trading Partner](#) [Pharmacy Information](#) [Hospital Modernization](#)

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Information

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Provider

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- [Provider Enrollment](#)
- [EHR Incentive Program](#)
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- [Fingerprint Criminal Background Check Info](#)
- [Provider Training](#)
- [Secure Site](#)

Trading Partner

- [Trading Partner Enrollment](#)
- [Trading Partner Documents](#)
- [Provider Electronic Solutions Billing Instructions](#)

Pharmacy

- [Pharmacy Information](#)

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM Web site, PROVIDED BY DXC TECHNOLOGY ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.



Information



Provider



Trading Partner



Pharmacy

Important Messages

[Hospital Monthly Important Message \(Posted 8/15/18\)](#)

[Attention Dental Providers: Restoration Pricing Update \(Updated 8/6/18\)](#)

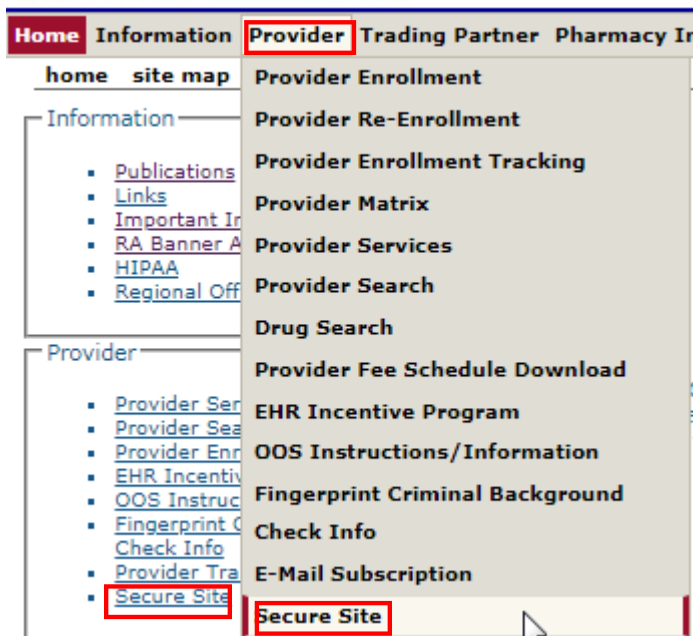
[Clarification of PB18-52 - Electronic Visit Verification \(EVV\) - Consecutive Services Enhancement](#)

[Electronic Visit Verification Important Message \(Updated 8/2/18\)](#)

Eligibility Verification

Accessing your Secure Site Account

Select **Secure Site** from either the Provider panel on the left or the Provider drop-down menu. Enter your **User ID** and **Password** and click **“Login.”**

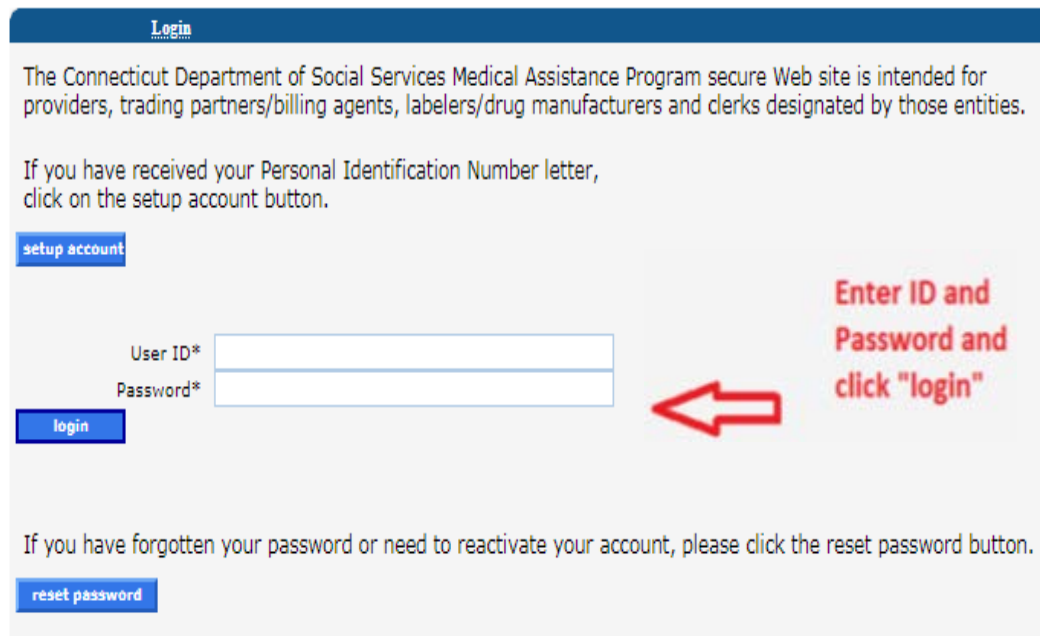


The screenshot shows a navigation menu with the following items:

- Home
- Information
- Provider** (highlighted)
- Trading Partner
- Pharmacy In

Under the **Provider** menu, the following items are listed:

- home
- site map
- Information
 - Publications
 - Links
 - Important In
 - RA Banner A
 - HIPAA
 - Regional Off
- Provider
 - Provider Ser
 - Provider Ser
 - Provider Enr
 - EHR Incentiv
 - OOS Instruc
 - Fingerprint C
 - Check Info
 - Provider Tra
 - Secure Site** (highlighted)
- Provider Enrollment
- Provider Re-Enrollment
- Provider Enrollment Tracking
- Provider Matrix
- Provider Services
- Provider Search
- Drug Search
- Provider Fee Schedule Download
- EHR Incentive Program
- OOS Instructions/Information
- Fingerprint Criminal Background
- Check Info
- E-Mail Subscription
- Secure Site** (highlighted)



The screenshot shows the login page with the following content:

Login

The Connecticut Department of Social Services Medical Assistance Program secure Web site is intended for providers, trading partners/billing agents, labelers/drug manufacturers and clerks designated by those entities.

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

[setup account](#)

User ID*

Password*

[login](#)

If you have forgotten your password or need to reactivate your account, please click the reset password button.

[reset password](#)

Enter ID and Password and click "login" (with a red arrow pointing to the login button)

Eligibility Verification

Access to your Secure Web Account

Alternately, click on the *Provider* icon from the main page then enter User ID and **Password** and click “**Login**” from the *Quick Login* panel on the right side of the screen



WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM Web site, PROVIDED BY DXC TECHNOLOGY ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.



Information



Provider



Trading Partner



Pharmacy

Quick Login

User ID*

Password*

[Logging in for the first time?](#)

[Forgot your password?](#)

Quick Links

- [Provider Services](#)
- [Provider Search](#)
- [Provider Enrollment](#)
- [Eligibility Response Quick Reference Guide](#)
- [Provider Training](#)

Provider Assistance Center

- toll free at 1-800-842-8440
- 1-866-604-3470
(alternate TTY/TDD line)

Email Subscription

- [Register/Update Email Subscription](#)

Eligibility Verification

Service Codes

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

Eligibility Verification

To verify a Connecticut Medical Assistance Program (CMAP) client's eligibility through the secure Web site – click on the [Eligibility tab](#) on the main menu

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

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request			
Client ID	<input type="text"/>	last name	DOE <input type="text"/>
SSN	666-55-4444	First Name, MI	JOHN <input type="text"/>
Birth Date	<input type="text"/>	From DOS*	07/01/2018
Service Type Code 1	54 - Long Term Care	To DOS*	07/31/2018
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"/>		
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

Eligibility Verification Response	
Verification Number	15040039KM
Response Text	Client is eligible. Refer to Benefit Plan for specific program coverage.

- *Eligibility verification can only look back one year, dates of service older than a year must be verified by contacting the Provider Assistance Center (Example on slide 12)*
- *Eligibility verifications can not span months, submitting a request that spans multiple months will result in an error message (Example on slide 13)*

Eligibility Verification

The Eligibility Verification Response window returns a non-favorable search result

- In this specific case – the client’s eligibility cannot be verified for the requested dates (Sept. 1, 2013) – eligibility verification can only look back one year
- Changing the dates of the eligibility request to within the allowable one year window creates a different result

Eligibility Verification Request

Client ID last name From DOS*
SSN First Name, MI To DOS*
Birth Date
Service Type Code 1 Service Type Code 2
Service Type Code 3 Service Type Code 4
Service Type Code 5

Eligibility Verification Response

Verification Number

Response Text

Eligibility Verification

The Eligibility Verification Response window returns an error message


- Eligibility searches cannot span multiple months
 - 5/15/2018 – 6/10/2018 is not valid; 5/15/2018 – 5/31/2018 and 6/1/18 – 6/10/2018 is valid
 - Submitting a request that spans multiple months will result in an error message.

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="DOE"/>	From DOS*	<input type="text" value="05/15/2018"/>
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="06/10/2018"/>
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"/>				

Please correct the following errors:

Eligibility verification requests must not span multiple months.



Eligibility Verification *(Response Possibilities)*

Lockin

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

Lockin				
Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
HOSPICE-MEDICARE	08/16/2017	08/16/2018	HOSPICE AGENCY	(860)555-1234

Medicare

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

Medicare
Coverage [▲]
Medicare A
Medicare B

Benefit Plan

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

Benefit Plan			
Service Information [▲]	Benefit Month Effective Date	Effective Date	End Date
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	04/01/2017	04/01/2017	12/31/2299

Eligibility Verification *(Response Possibilities)*

- ***TPL (Third Party Liability)***

Private insurance plan(s) listed in the client's CMAP profile

TPL	
Carrier Code	Carrier Name
060	BC/BS OF CONNECTICUT

- Due to HIPAA 5010 restrictions CMAP is unable to disclose the eligibility status or covered services with the private insurance plan(s) via the Web portal
- The Automated Voice Response System (AVRS) will continue to return TPL information in the client eligibility verification response
- Providers can access the AVRS by dialing 1-800-842-8440.
 - Press 1 for Self Service Options; enter your *AVRS ID* and *PIN*
 - Press 1 for Eligibility Verification
- Otherwise providers are required to initiate a separate request to the other payer or plan to determine the client's level of coverage

Ascend Overview

Ascend Overview

- After the Department of Social Services (DSS) **Regional Office determines financial eligibility**, DSS then sends the Inter-agency Referral document to the contracted entity ASCEND for level of care determination
- ASCEND reviews the Inter-agency Referral document and sends their determination of approval or denial back to the Regional Office. **If the admission is approved, payment is authorized**
- **IMPORTANT:** Payment will not be made until the level of care has been approved by DSS; payment may be retroactive to the date of authorization

Note: Providers must still complete a Medicare Clearance Form, W-9 for each admission in order for the “Level of Care” (paystart) to be completed

Ascend Overview

Ascend, Tracking and Screening

Tracking and Screening of Nursing Facility Admissions, Transfers, Discharges and Deaths

- Tracking should be entered by the provider:
 - To alert ASCEND to a new admission or to confirm the admission date
 - To notify ASCEND of the individual's discharge from a Nursing Facility
 - To notify ASCEND of the individual's death
 - To notify ASCEND of the individual's transfer to a different facility
 - To inform ASCEND of the receiving facility for an approved screen

For detailed information and instructions, please refer to www.pasrr.com

Note: The Admission Notice, W-352 and Discharge/Transfer Notice, W-353 forms are only used for ICF/IID facilities

Web Claim Submission Overview

Web Claim Submission Overview

- ***As a reminder***, as of October 1, 2016 the Department of Social Services (DSS) no longer accepts paper claims for processing. Providers must submit all claims to DXC Technology electronically, using the HIPAA compliant ASC X12N 837 Health Care Claim, Provider Electronic Solutions (PES) software or through the Provider Secure Web Portal at www.ctdssmap.com
- Providers currently using Provider Electronic Solutions (PES) software, **must** be on version 3.81. Version 3.81 accommodates ICD-10; therefore, if you choose to use PES software you **must** upgrade to this version. Reference provider bulletin, PB 2016-31 under “Long Term Care Providers” for additional information
- The **only exception** for submitting paper claims is for of Out Of State (OOS) providers and/or any claims that are submitted for special handling, such as timely filing overrides

Web Claim Submission Overview

Top 5 reasons to use the Web claim submission tool:

- Easily search, submit, copy and void claims
- Resubmit previously denied claims
- Submit secondary claims containing payments or denials from Other Insurance or Medicare
- Adjust claims on the Web
- Claim results are immediate

Web Claim Submission Overview

When a claim processes through the Connecticut interChange system 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
- Provider must be authorized to bill for this client
- Revenue Center Code submitted must be valid for the Provider Type

Each claim then passes through a series of *audits* that check the validity of claim data and claims in history:

- The claim is compared to previously paid claims
- Is the current claim a duplicate of a paid claim?
- Is the current claim for long term care room/board with the same date of service as a paid inpatient hospital stay claim?

Web Claim Submission Overview

www.ctdssmap.com – *Claim Submission*

- Log onto the secure Web portal
- Select Claims
- Institutional

The screenshot shows 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 navigation bar contains links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, Prior Authorization, Hospice, MAPIR, Account, and ConnPACE. The "Account" link is highlighted. A dropdown menu is open under "Claims", showing options for Claim Inquiry, Professional, Institutional (highlighted), Dental, and Claim History for Specific Services. A red banner at the bottom left states "Your password expires in 3 day(s) on 10/28/2018 at 12:00 AM". A "Quick Link" box on the right contains several links: Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, Download Remittance Advices, ACA Ordering/Prescribing/Referring Provider List. The date "8/16/2018" is visible in the top right corner.

Web Claim Submission Overview

Web Claim Submission - *Submit*

New Claim - Perform the following steps to easily *submit* a new claim:

- Select the appropriate claim type (*Long Term Care Claims*)
- A blank claim will appear
- At a minimum, enter data into all required fields (identified by an asterisk after the field name)

Institutional Claim

Claim Type* L - Long Term Care Claims

ICN 2018123: Facility Number 2843 NPI

Provider ID 109382284 From Date* 04/01/2018

AVRS ID 00000 To Date* 04/30/2018

Type Of Bill* 21: [Search] SN Inpat-Cont Claim

Detail

Item	From DOS	To DOS	Revenue Code	HCPCS/Rates	Units	Charges	Status	Allowed Amount
1	04/01/2018	04/30/2018	100		30.00	\$6,368.70	PAID	\$6,368.70

Diagnosis Cause of Injury Reason For Visit Condition Surgical Procedure Occurrence/Span

Diag-Sequence	Diagnosis	Description
Principal	I6350	Cereb infrc due to unsp occls or stenosis of unsp cereb artery
Admitting	I6350	Cereb infrc due to unsp occls or stenosis of unsp cereb artery

Detail

Item	From DOS	To DOS	Revenue Code	HCPCS/Rates	Units	Charges	Status	Allowed Amount
1	04/01/2018	04/30/2018	100		30.00	\$6,368.70	PAID	\$6,368.70

- To enter additional diagnosis codes, details, or a TPL record, click the **add** button within the panel
- Click the **submit** button at the bottom of the claim page
- Claims process immediately and return a status of ***Paid, Denied*** or ***Suspended***

Web Claim Submission Overview

Once you have successfully logged in, to [search](#) claims on the [ctdssmap.com secure site](#), click on “*Claims*” then “*Claims Inquiry*” on the main menu

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

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

Claim Search 008000011 MCD

ICN	<input type="text"/>	Claim Type	<input type="text"/>
Client ID	<input type="text"/>	Status	<input type="text"/>
TCN	<input type="text"/>	FDate Paid	<input type="text"/>
FDOS	<input type="text"/>	TDate Paid	<input type="text"/>
TDOS	<input type="text"/>	Pending Claims	<input type="checkbox"/>
Prescription No (Pharmacy Only)	<input type="text"/>	Exclude Adjusted Claims	<input type="checkbox"/>
Provider Medicaid ID	<input type="text"/>	Records	20 <input type="text"/>

Web Claim Submission Overview

Web Claim Inquiry



Help
Thursday, August 16, 2018

[Home](#) [Information](#) [Provider](#) [Trading Partner](#) [Pharmacy Information](#) [Hospital Modernization](#) **Claims** [Eligibility](#) [Prior Authorization](#) [Hospice](#) [MAPIR](#) [Account](#)

[Home](#) **claim inquiry** [claim history for specific services](#)

Claim Search 008000011 MCD

ICN	<input type="text"/>	Claim Type	<input type="text"/>
Client ID	00435 <input type="text"/>	Status	<input type="text"/>
TCN	<input type="text"/>	FDate Paid	<input type="text"/>
FDOS	04/01/2018	TDate Paid	<input type="text"/>
TDOS	05/31/2018	Pending Claims	<input type="checkbox"/>
Prescription No (Pharmacy Only)	<input type="text"/>	Exclude Adjusted Claims	<input type="checkbox"/>
Provider Medicaid ID	0000098 <input type="text"/>	Records	20 <input type="text"/>

search

clear

Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2018	<input type="text"/>	JOANNE S <input type="text"/>		05/01/2018	05/31/2018	Long Term Care Claims	Paid	06/12/2018	\$6,613.85	\$5,287.99
4918	00435	JOANNE S		04/01/2018	04/30/2018	Long Term Care Claims	Paid	06/12/2018	\$6,368.70	\$6,368.7
2018	00435	JOANNE S		04/01/2018	04/30/2018	Long Term Care Claims	Adj/Voided	05/08/2018	\$6,368.70	\$6,368.7

Web Claim Submission Overview

What can I do with these claims?

- *Paid* claims allow you to:

- **cancel** Cancel any alterations you have made
- **adjust** Adjust the claim
- **void** Void the claim
- **copy claim** Copy the claim and use it as a template to create a new claim
- **new claim** Create a brand new claim

- *Denied* claims allow you to:

- **re-submit** Resubmit the claim (with or without making changes)
- **cancel** Cancel any alterations you have made
- **new claim** Create a brand new claim

- *Suspended* claims allow you to:

- **new claim** Create a brand new claim

Web Claim Submission Overview

Adjustment - Perform the following steps to easily adjust a *paid* claim:

- Select *Claim Inquiry*
- Enter the paid claim ICN found on your RA in the ICN field
- Click the **search** button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the **adjust** button at the bottom of the claim page

The adjustment will process immediately and return a status of *Paid*, *Denied* or *Suspended*.

Web claim adjustment limitations:

- Timely Filing
 - Claims that are over the *Timely Filing* guidelines cannot be *adjusted*. If a claim outside of timely filing is adjusted, the claim will be fully recouped, unless the adjusted claim payment will be equal to or less than the original claim payment.
- Medicare Crossovers
 - Crossover claims cannot be *adjusted*; they must be *voided*, *copied* and then *submitted* as new claims.
- Special Handled
 - Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by DXC Technology and are, therefore, not able to be adjusted via the **www.ctdssmap.com** Web site.

Web Claim Submission Overview

Void - Perform the following steps to void or completely recoup a *paid* claim:

- Select *Claim Inquiry*
- Enter the paid claim ICN found on your RA in the ICN field
- Click the **search** button
- Once the claim is retrieved, click the **void** button at the bottom of the claim page

The void will process immediately and return a message that the claim has been successfully adjusted/voided with a new ICN.

Web Claim Submission Overview

- Paid claims may be copied and submitted as a new claim
- This feature is helpful for reoccurring services

Copy - Perform the following steps to easily copy a paid claim for submission as a new claim:

- Select Claim Inquiry
- Enter the paid claim ICN found on your remittance advice (RA) in the ICN field
- Click the search button
- Once the claim is retrieved, click the copy button at the bottom of the claim page
- Make the necessary changes to the claim
- Click the submit button at the bottom of the claim page

The new claim will process immediately and return a status of ***Paid, Denied or Suspended***

Web Claim Submission Overview

Web Claim Submission - *Resubmit*

Resubmission - Perform the following steps to easily **resubmit** a denied claim:

- Select *Claim Inquiry*
- Enter the denied claim ICN (found on your RA) in the ICN field
- Click the **search** button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the **re-submit** button at the bottom of the claim page

The claim will process immediately and return a status of ***Paid, Denied or Suspended***

Web Claim Submission Overview

Medicare Coinsurance and/or Deductible Claims Processing

The following information sent to DXC Technology electronically must match the EOMB received from Medicare:

- Patient name
- Dates of service
- Billed amount
- Coinsurance and/or deductible due

Electronic claim submission:

- Providers are encouraged to submit claims on the Medicaid Web secure portal that do not electronically crossover from Medicare
- If a claim needs to be split, i.e. the Explanation of Medicare Benefits (EOMB) dates of service are 1/1 – 1/31; however, Medicare exhausted on 1/15, the provider will need to alter the dates of service, billed amount and coinsurance and/or deductible due if applicable before submitting
- Providers must keep a copy of the EOMB on file for future auditing

Coinsurance claims that aren't split could potentially affect the LTC room/board claim that follows the first non-covered Medicare Day



Remittance Advice Overview

Remittance Advice Overview

All claims processed by DXC Technology are reported to the provider on a bimonthly Remittance Advice (RA)

- RAs are available electronically via the secure Provider Web site at www.ctdssmap.com. RAs are available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper RA version
- The PDF RA via the secure Provider Web site [*will be available to providers on the check date indicated on the financial cycle schedule*](#). The cycle schedule may be downloaded from the Web site portal under Provider > Provider Services. The provider will have access to their last ten (10) RAs
- The ASC X 12N 835 Payment/Advice via the Secure Provider Web site [*will be available the Wednesday following each claims processing cycle*](#). The last ten (10) 835 Payment/Advices will be available
- DXC Technology encourages providers to save a copy of their ASC X12N 835 Payment/Advice and/or their PDF RAs to their local computer system for future access, since **only the last ten (10) RAs are maintained on the DXC Technology Web site**. RAs older than the last ten (10) will **no longer** be available

Remittance Advice Overview

Banner Page

REPORT: CRA-BANN-R
RA#: 6800455

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

Date: 09/26/2017
PAGE: 1

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

RIDGE HEALTH CARE

PAYEE ID
ISSUE DATE 09/26/2017
TAXONOMY 31400000X
P. AVRS ID 000021

Attention All Providers.

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) will be closed on Monday, October 9, 2017 in observance of the Columbus Day holiday. DSS will re-open on Tuesday, October 10, 2017. DXC Technology will be open on Monday, October 9, 2017.

Claim Information (Paid, Long Term)

REPORT: CRA-LTPD-R
RA#: 6800455

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

Date: 09/26/2017
PAGE: 9

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

RIDGE HEALTH CARE

PAYEE ID
ISSUE DATE 09/26/2017
TAXONOMY 31400000X
P. AVRS ID

FP	ICN	PATIENT NUMBER	ATTEND PROV.	SERVICE DATES FROM	THRU	DAYS	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY	PAID AMOUNT
				070317	072617	23	6,178.95	6,178.95	0.00	0.00	0.00	0.00	6,178.95
CLIENT NAME:				CLIENT NO.:									
M 2217262150238	NPI			070317									
051130000FIKR													
REV CD HCPCS/RATE	SRV DATE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL	E OBS							
100	070317	23.00	6,178.95	6,178.95									

Remittance Advice Overview

Claim Adjustments

REPORT: CRA-LTAD-R
RA#: 7024988

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
LONG TERM CARE FACILITY CLAIM ADJUSTMENTS

Date: 08/14/2018
PAGE: 29

GLASTONBURY HEALTH CARE CENTER
1175 HEBRON AVENUE
GLASTONBURY, CT 06033-2478

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID
NPI 10230...
08/14/2018
31400...
00002...

FP	--ICN--	ATTEND PROV.	SERVICE DATES	DAYS	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY	PAID AMOUNT
	--PATIENT NUMBER--		FROM	THRU							
CLIENT NO.:	002355925										
1	5318150002925	NPI 1831110717	122017	123117	12	(2,817.36)	(2,817.36)	(0.00)	(0.00)	(1,110.00)	(1,707.36)
1	5318206004351	NPI 1831110717	122017	123117	12	2,817.36	2,817.36	0.00	0.00	828.10	1,989.26
HEADER EOB5: 8135											

Positive Claim Adjustments The total number of claims and net dollar amount of all positive adjustments finalized for each reporting period. Negative adjustments which result in an AR are reported below in the Accounts Receivable section. Refund adjustments are reported in the Refunds section of the Remittance Advice.

ACCOUNTS RECEIVABLE

A/R NUMBER / ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE/ PGM YEAR
5318206004928	08/10/2018	22.16	22.16	22.16	0.00	8400	0036489	MARY	
5918207005162	08/10/2018	98.00	98.00	98.00	0.00	8400	0040889	OLYMPIA	
-----1099 ADJUSTMENTS-----									

Remittance Advice Overview

Claim Information - Denied

REPORT: CRA-BANN-R RA#: 6800455	interChange MMIS MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER REMITTANCE ADVICE LONG TERM CARE FACILITY CLAIMS DENIED	Date: 09/26/2017 PAGE: 12				
542 DANBURY ROAD RIDGEFIELD, CT 06877-2719	RIDGE HEALTH CARE	PAYEE ID ISSUE DATE TAXONOMY P. AVRS ID				
		NPI 09/26/2017 314000000X				
--ICN-- --PATIENT NUMBER--	ATTEND PROV. SERVICE DATES FROM THRU DAYS	BILLED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY
CLIENT NAME: 2014183151898 NPI 0607400001TUX HEADER EOB#: 2003	CLIENT NO.: 060114 063014 30	6,876.00	0.00	0.00	0.00	0.00
REV CD HCPCS/RATE SRV DATE	UNITS	BILLED AMT	DETAIL EOB#			
100 060114	30.00	6,876.00				

EOB Code Descriptions

REPORT: CRA-BANN-R RA#: 6800455	interChange MMIS MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER REMITTANCE ADVICE EOB CODE DESCRIPTIONS	Date: 09/26/2017 PAGE: 12
542 DANBURY ROAD RIDGEFIELD, CT 06877-2719	RIDGE HEALTH CARE	PAYEE ID ISSUE DATE TAXONOMY P. AVRS ID
		NP 09/26/2017 314000000X
EOB CODE	EOB CODE DESCRIPTION	
0704	BCC NOT ALLOWED FOR HOSPICE CLIENT	
0870	CLAIM/DETAIL PAID FULL CO-INSURANCE BILLED.	
1024	PROVIDER IS NOT AUTHORIZED TO BILL FOR THIS CLIENT.	
2002	CLIENT INELIGIBLE FOR DATES OF SERVICE.	
2003	CLIENT INELIGIBLE FOR DATES OF SERVICE.	
2504	BILL PRIVATE CARRIER FIRST.	
4030	THE DIAGNOSIS IS NOT CONSISTENT WITH THE CLIENT'S AGE.	
8135	CLAIM ADJUSTED DUE TO PATIENT LIABILITY CHANGE.	
8188	PROVIDER RECOVERED CLAIM	
9919	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED.	
9922	PATIENT LIABILITY, APPLIED INCOME OR SPENDDOWN AMOUNT APPLIED.	
FINANCIAL TRANSACTIONS REASON CODES		
ACCOUNT RECEIVABLES REASON CODES		
RSN CODE	REASON CODE DESCRIPTION	
8400	Result of claim adjustment	

Remittance Advice Overview

Financial Transaction

REPORT: CRA-BANN-R
RA#: 6800455

interChange RHIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

Date: 09/26/2017
PAGE: 12

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

RIDGE HEALTH CARE

PAYEE ID NPI
ISSUE 09/26/2017 09/25/2014
TAXON 314000000X 314000000X
P. AV-- --

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

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
100098508		716.38	8382			10/01/2013
TOTAL PAYOUTS:		716.38				

Financial Transaction Reason Codes

FINANCIAL TRANSACTIONS REASON CODES

RSN CODE	EXPENDITURES REASON CODES
RSN CODE	REASON CODE DESCRIPTION
8382	HMS Special Project Transaction

Remittance Advice Overview

Summary

---NEW DAY CLAIMS---		---CURRENT CYCLE TOTALS BY FUND PAYER---			
NUMBER	PAID AMOUNT	---POSITIVE ADJUSTMENTS---		---TOTAL ALL CLAIMS---	
NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT
Medicaid	7,334.16	0	0.00	4	7,334.16
MUSKY B-3	0.00	0	0.00	0	0.00
MUSKY B 1 and 2	0.00	0	0.00	0	0.00
CADAP	0.00	0	0.00	0	0.00
CommPACE	0.00	0	0.00	0	0.00
SAGA	0.00	0	0.00	0	0.00
Charter Oak	0.00	0	0.00	0	0.00
MLIA	0.00	0	0.00	0	0.00
Tuberculosis	0.00	0	0.00	0	0.00
Family Planning	0.00	0	0.00	0	0.00

---CLAIMS DATA---						
CLAIMS PAID	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	4	7,334.16	85	364,340.27	250	1,102,851.68
POS. CLAIMS ADJUSTMENTS	0	0.00	2	2,020.83	5	3,117.85
TOTAL CLAIMS PAYMENTS	4	7,334.16	87	366,361.10	255	1,105,969.53
CLAIMS DENIED	5		25		58	
CLAIMS IN PROCESS	0		0		0	

---EARNINGS DATA---			
	CURRENT	MONTH-TO-DATE	YEAR-TO-DATE
PAYMENTS:			
CLAIMS PAYMENTS	7,334.16	366,361.10	1,105,969.53
PAYOUTS	716.38	716.38	716.38
ACCOUNTS RECEIVABLE:			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(326.49)	(685.18)
NON-CLAIM SPECIFIC	(0.00)	(0.00)	(1,389.88)
NET PAYMENT	8,050.54	366,750.79	1,104,710.85
1099 ADJUSTMENTS	0.00	0.00	0.00
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS	0.00	0.00	
CHECK VOIDS	(0.00)	(0.00)	
NET EARNINGS	8,050.54	366,750.79	1,104,710.85

Remittance Advice Overview

Summary

	---NEW DAY CLAIMS---		---CURRENT CYCLE TOTALS BY FUND PAYER---		---TOTAL ALL CLAIMS---	
	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT
Medicaid	2,022	294,967.21	1	14.01	2,023	294,981.22
HUSKY B-3	3	379.63	0	0.00	3	379.63
HUSKY B 1 and 2	41	5,577.61	0	0.00	41	5,577.61
CADAP	0	0.00	0	0.00	0	0.00
ConnPACE	0	0.00	0	0.00	0	0.00
SAGA	0	0.00	0	0.00	0	0.00
Charter Oak	0	0.00	0	0.00	0	0.00
MLIA	310	45,263.10	0	0.00	310	45,263.10

	CURRENT		MONTH-TO-DATE		YEAR-TO-DATE	
	NUMBER	AMOUNT	NUMBER	AMOUNT	NUMBER	AMOUNT
CLAIMS PAID	2,376	346,187.55	5,557	809,655.63	29,311	4,268,250.86
POS. CLAIMS ADJUSTMENTS	1	14.01	13	118.02	142	222.03
TOTAL CLAIMS PAYMENTS	2,377	346,201.56	5,570	809,773.65	29,453	4,268,472.89
CLAIMS DENIED	301		750		6,745	
CLAIMS IN PROCESS	0		0		0	

	CURRENT		MONTH-TO-DATE		YEAR-TO-DATE	
	NUMBER	AMOUNT	NUMBER	AMOUNT	NUMBER	AMOUNT
PAYMENTS:						
CLAIMS PAYMENTS		346,201.56		809,773.65		4,268,472.89
PAYOUTS		0.00		0.00		0.00
ACCOUNTS RECEIVABLE:						
CLAIM SPECIFIC:						
CURRENT CYCLE		(730.05)		(730.05)		(730.05)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(876.06)		(7,880.14)
NON-CLAIM SPECIFIC		(0.00)		(0.00)		(0.00)
NET PAYMENT		345,471.51		808,167.54		4,259,862.70
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		(0.00)
NON-CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		(0.00)
OTHER FINANCIAL:						
MANUAL PAYOUTS		0.00		0.00		0.00
CHECK VOIDS		(0.00)		(0.00)		(0.00)
NET EARNINGS		345,471.51		808,167.54		4,259,862.70

Note: For additional information about the ASC X12N 835 Payment/Advice, refer to Chapter 6, section 6.4 “Electronic Remittance Advice”. For additional information about PDF RAs, refer to Chapter 5, section 5.9 “Provider Remittance Advice and Electronic Funds Transfer (EFT)”



Provider Electronic Solutions (PES) Software

Provider Electronic Solutions (PES) Software

PES version 3.81 Electronic Claims Submission Option:

- As a reminder, in addition to the Web claim submission tool, Long Term Care providers also have the option to use the free Provider Electronic Solutions (PES) software to transmit their claims
- Providers who are currently using PES software **must** be on version 3.81
- In order to upgrade to version 3.81, you must have sequentially installed all previous versions and currently have version 3.80 installed
- To verify the current version you are running click the “Help” icon in the software menu and click on “About”
- Complete instructions regarding how to upgrade PES are available on our Web site at www.ctdssmap.com. From the Home page, go to Trading Partner, EDI, look under Provider Electronic Solutions Upgrade, click on “Upgrade instructions via the Web” or “Upgrade Instructions via Provider Electronic Solutions”, and then click on the “Provider Electronic Solutions 3.81 Upgrade” link

Reference provider bulletin(s), PB14-50 and/or PB 16-31 for additional information

Patient Liability

Patient Liability

- *Patient Liability* (Applied Income) represents the amount a client is responsible to contribute toward their care each month, starting with the month in which the 30th day of consecutive institutionalized care occurs.
- Patient liability amounts are calculated and determined by the Department of Social Services (DSS) Regional offices based on the client's income (pension, SS, etc.) and healthcare expenses
- If a claim is submitted and the patient liability exceeds the Medicaid allowed amount an accounts receivable (A/R) is created for the difference

Patient Liability

When a claim is recouped the system will take the patient liability by way of a recoupment

- If the claim is **resubmitted**, the system will pay the claim and include the patient liability in the claim payment
- If the provider **does not resubmit** the claim and is seeking reimbursement for the patient liability by way of a payout, the DSS Convalescent Unit must be contacted
- Proof (general ledger, patient account ledger) must be provided illustrating that the money is owed to the provider, and not the client

Patient Liability

Mass adjustments due to patient liability changes within clients' profiles will occur as those amounts are often retroactively changed by DSS

- Providers **should not** perform claim adjustments for retroactive changes made to a client's profile
 - Providers that submit their own claim adjustments for retroactive changes made to a client's profile, negate the systematic mass adjustment process from properly functioning, resulting in increased provider calls and manual payouts when decreases to the patient liability has occurred
- **Patient liability Mass adjustments are processed the first cycle of every month** for changes that occurred to the client's profile in the previous month; adjustments will appear on RA with an ICN region code 53
- Claims will be automatically adjusted by DXC Technology and the necessary A/Rs, payouts and reimbursements will be generated

Hospice

Hospice

Hospice services are a covered service for all HUSKY Health Program (HUSKY A, HUSKY B, HUSKY C and HUSKY D) clients. The hospice benefit for all CT Medical Assistance Program Medicaid clients has been available since January 1, 2010

This benefit provides compassionate end-of-life care that includes medical and supportive services intended to provide comfort to an individual whose physician certifies that they are terminally ill (i.e. having a life expectancy of six months or less if the illness runs its normal course).

Hospice

When is a client eligible to receive the hospice benefit?

- A client in a Nursing Facility or ICF/IID may elect the hospice benefit
- Hospice Services are a covered service for all HUSKY A, HUSKY B, HUSKY C & HUSKY D clients

To secure accurate reimbursement:

- Hospice clients may only be admitted to those facilities with which the hospice agency has a written agreement.
- A client who resides in a Nursing Facility or ICF/IID that has elected their hospice benefit, must have a “*Lock-In*” on their eligibility file for the Hospice agency that will be submitting to DXC Technology
- A client who resides in a Nursing Facility or ICF/IID must be authorized with a “*Level of Care*” also known as *pay start* of the institution in which they reside
- The Hospice agency submits the Nursing Facility or ICF/IID per diem rate charges directly to DXC Technology for hospice clients
- Long term care providers may bill the Department of Social Services for hospital and home leave days for a hospice client (RCCs 183, 185)

Room and board charges are billed by and payable to the hospice agency only:

- Facility charges are [paid to the hospice agency at 95% of the nursing facility’s rate on file](#), who in turn reimburses the facility at the rate agreed to in the written agreement between the hospice and Nursing Facility or ICF/IID
- If a long term care provider bills a revenue center code (RCC) 100 for a hospice client the claim will deny with an Explanation of Benefit (EOB) code **0704** “*Service not covered for hospice client*”

Hospice

Patient liability is deducted from the first claim processed for the month in which patient liability is due

If a client elects the Hospice benefit:

- Hospice agency submits claims for the client's care
- Nursing Facility or ICF/IID submits a claim for client's care after the client has discharged from Hospice within the same month
- Patient liability is deducted from the first claim that processes; at the header of the claim, not the detail

Hospice agency and Nursing Facility or ICF/IID providers need to make arrangements to reconcile patient liability



Hospitalization Bed Reserve Guidelines

Hospitalization Bed Reserve Guidelines

As described in section 19a-537 of the Connecticut General Statutes, a nursing facility may bill up to **15 days** for bed reserve for a patient who is discharged from the facility due to hospitalization, unless the nursing facility documents that it has objective information from the hospital confirming that the resident will not return to the nursing home within fifteen days of the hospital admission (including the day of hospitalization)

Hospitalization Bed Reserve Guidelines

Days 1 – 7:

The Department of Social Services (DSS) will reimburse the nursing facility for reserving the bed of a resident who is hospitalized for a maximum of seven (7) days, including the admission date of hospitalization, if the nursing facility documents that on such date and the following criteria are met:

(A) There is a vacancy rate of not more than three (3) beds or three (3) percent of licensed capacity, whichever is greater; **and** (B) contact has been made to the hospital and the hospital failed to provide objective information confirming that the person would be unable to return to the nursing facility within fifteen days of the date of hospitalization

Days 8 – 15:

DSS will reimburse the nursing facility for a maximum of eight (8) additional days if the following criteria are met: (A) On the seventh day of the person's hospital stay, the nursing facility has a vacancy rate that is not more than three (3) beds or three (3) percent of licensed capacity, whichever is greater; **and** (B) contact has been made to the hospital for an update on the person's status and the nursing facility documents such contact in the person's file and the information obtained through the contact does not indicate that the person will be unable to return to the nursing facility within fifteen days of hospitalization

Hospitalization Bed Reserve Guidelines

- Nursing Facilities **only** have two (2) opportunities to determine whether or not a bed reserve is billable; nursing facilities must check on day one (1) for days **1 – 7** and day seven (7) for days **8 – 15**. When calculating the number of vacancies, nursing facilities should not round up. Nursing facilities are strongly encouraged to follow these policy guidelines so that monies aren't recovered during future audits
- When billing for billable/covered bed reserve days, providers must use revenue center code (RCC) 185 - "Inpatient Hospital Reserve" along with occurrence code 42 and "Date of Discharge". When billing for non-billable/non-covered bed reserve days, providers must use RCC 189 – "Non-covered reserve"



Provider Enrollment/Re-enrollment on the Web

Provider Enrollment/Re-enrollment on the Web

- *As a reminder*, in order to receive reimbursement for services rendered to clients, providers must be enrolled in the Connecticut Medical Assistance Program (CMAP). After initial enrollment, Nursing Home and ICF/IID providers will be required to re-enroll every five (5) years
- Nursing Home and ICF/IID providers will receive a reminder letter when they are due to re-enroll eight (8) months prior to their re-enrollment due date
- DSS offers an online enrollment/re-enrollment application tool called the *Enrollment Wizard*
 - Providers are required to use the Wizard to submit their enrollment/re-enrollment applications for CMAP on the public Web site
- Providers can access the Wizard's enrollment/re-enrollment tracking self-service features from the Web Portal at www.ctdssmap.com
 - Access to this application does not require a log in: any user with internet access can utilize this application. *An Application Tracking Number (ATN) (which is mailed to providers) and provider ID will be required to complete re-enrollment applications via the Web portal*
- Provider enrollment/re-enrollment applications must be completed in their entirety
 - *Partially completed applications cannot be saved for future completion (exiting the Wizard before completing the application will require you to restart from the beginning)*
 - *Completed applications may not be modified through the Web site. Required alterations must be mailed to the DXC Technology Provider Enrollment Unit*

Provider Enrollment/Re-enrollment on the Web

Getting Started

- Enrolling and re-enrolling providers are **required** to use the on-line Wizard to enroll or re-enroll; this Wizard will collect all data necessary from Nursing Facilities and ICF/IID providers to enroll/re-enroll
- A majority of the required information is automatically populated for you when completing the re-enrollment application, drastically reducing the amount of time the process takes to complete the re-enrollment application

The screenshot displays the Connecticut Department of Social Services website. At the top left is the logo with the text "Connecticut Department of Social Services" and "Making a Difference". At the top right is the date "Thursday, August 16, 2018" and a "Help" link. A navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, MAPIR, and Account. A dropdown menu for "Provider" is open, listing options such as "Provider Enrollment", "Provider Re-enrollment", "Provider Enrollment Tracking", "Provider Matrix", "Provider Services", "Provider Search", "Drug Search", "Provider Fee Schedule Download", "EHR Incentive Program", "OOS Instructions/Information", "Fingerprint Criminal Background", "Check Info", "E-Mail Subscription", and "Secure Site". The main content area features a large "WELCOME" banner and the text "TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM". Below this is a paragraph of text: "CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY DXC TECHNOLOGY ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM." At the bottom, there are four icons representing different user types: a stack of books for "Information", a stethoscope for "Provider", a key for "Trading Partner", and a pill bottle for "Pharmacy".

For **step by step instructions** on completing your re-enrollment application, reference the **“Nursing Home and Intermediate Care Facilities Enrollment/Re-enrollment Workshop”** on the www.ctdssmap.com Web site. From the home page click on “Provider”, “Provider Services”, scroll down to “Provider Training” and click “here”. Here you can access a copy of the presentation under “Materials” and can view, save and/or print the presentation for later reference

Provider Enrollment/Re-enrollment on the Web

Application Submitted

- Provides an address to mail any corrections needing to be made to the application and/or submission of “Follow on Documents”

DXC Technology
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06102-5007

- Once the application has been submitted, providers will receive an Application Tracking Number (ATN), please save this number as it will be required for you to check the status of your application through the Web site

- Application Tracking Number (ATN)
 - Your tracking number is 305929

- Provides a link you can use to save a copy of the application for your records only

Save a copy of the application for your records only.

- Alternatively, if you are having problems opening the PDF file, you can download and/or print the application directly

** If you are having problems opening PDF file. Please [click here](#) to download the file directly.*

- Please do not submit a hard copy of the application to DXC Technology

Important! Once you leave the application, you cannot go back and re-print

Provider Enrollment/Re-enrollment on the Web

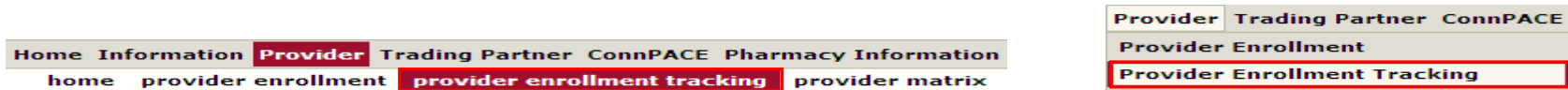
What's Next?

- DXC Technology will coordinate monthly verifications with the Department of Public Health (DPH) between provider's re-enrollment periods to ensure license compliance
 - **IMPORTANT:** Since DPH doesn't license ICF/IID facilities, these providers will need to submit "**follow on documents**" to DXC Technology as part of their enrollment/re-enrollment application which includes a copy of their current license
- The information on your submitted application will then be reviewed by DXC Technology
- If any information is missing, invalid, or if DXC Technology is unable to process the application, you will receive a letter that informs you what is required for correction or completion of your application
- **Reminder:** Providers will not be able to correct or modify submitted applications using the *Wizard* but will need to submit paper corrections to the following address:
 - DXC Technology
 - Provider Enrollment Unit
 - P.O. Box 5007
 - Hartford, CT 06102-5007
- **All additional information sent to DXC Technology will need the ATN entered on the upper right hand corner**

Provider Enrollment/Re-enrollment on the Web

Application Tracking

- To check the status of an enrollment/re-enrollment application, select “**Provider**” then “**provider enrollment tracking**” from either the *Provider* submenu or the *Provider* drop-down menu



- Enter your *ATN* and *Business Name* and click **search**

Enrollment Tracking Search

ATN*

Business OR Last Name*

- In this example, DXC Technology is waiting for additional information from the provider

Search Results				
ATN	Name	Date Received	Status	
309002	SUE'S NURSING HOME	04/30/2018	Waiting Appl or Info from Prov	

Provider Enrollment/Re-enrollment on the Web

Notification of Enrollment/Re-enrollment Decision:

- If all information has been provided and is correct, the completed application is submitted to the DSS Quality Assurance Unit for review. The entire process typically takes several weeks to complete
 - If an **approval** is received from DSS, the DXC Technology Provider Enrollment Unit completes the enrollment or re-enrollment process in the interChange system and sends a *Provider Enrollment or Re-enrollment Approval Notice* to the provider
 - If a **denial** is received from DSS, the DXC Technology Provider Enrollment Unit sends a *Provider Enrollment/Re-enrollment Rejection Notice* to the provider. This letter outlines the reason(s) the application was denied
 - **A provider receiving a denial from DSS' Quality Assurance Unit must follow the instructions for responding to the denial as outlined in the *Rejection Notice*. In order to reapply to the Connecticut Medical Assistance Program, the provider must once again submit an application via the online *Enrollment Wizard***

Provider Enrollment/Re-enrollment on the Web

Upon Approval

- If the re-enrollment application is approved, providers **re-enrolling** will have already established an effective date that will be pre-populated in the “*Identifying Information*” panel

Identifying Information

- The name entered on this line must match exactly the provider name submitted to the Internal Revenue Service and what is submitted on all other information supplied to the Connecticut Medical Assistance Program.
- Indicate the date the provider wishes to become effective. This date cannot be further back than six months.
- Indicate the language(s) spoken by organization staff that is available to interpret for clients.

Required fields are indicated with an asterisk (*)

Name - Organization* | Sue's Nursing Home

Provider Effective Date* | 02/01/2015

- Providers re-enrolling should already be established on the secure Web portal. If you have questions regarding Web access, you are encouraged to contact your main account administrator and/or the Provider Assistance Center

Reference provider bulletin, PB 2015-42 for additional information

Additional Information

Additional Information

- Connecticut Medical Assistance Program Web site – www.ctdssmap.com

Information > Publications > Bulletins

Bulletin Search

Year Provider Type

Number Title

Search Results

Bulletin Number	Title	Published Date
PB18-45	Proof of Delivery Receipts for Covered Medical Equipment, Devices and Supplies (...)	07/19/2018
PB18-44	Prescription/Written Orders for all Services Covered under the Connecticut Medic...	07/19/2018

Information > Publications > Provider Manuals

Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information Additional Chapter 5 Information <ul style="list-style-type: none"> • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation <input type="text" value="Nursing Facilities and ICF/IID"/> <input type="button" value="View Chapter 7"/>
8	Provider Specific Claims Submission Instructions <input type="text" value="Nursing Facilities, ICF/IID and Chronic Disease Hospi..."/> <input type="button" value="View Chapter 8"/>
9	Prior Authorization
10	Web Portal/AVRS
11	Other Insurance and Medicare Billing Guides <input type="text" value="Select a claim type"/> <input type="button" value="View Chapter 11"/>
12	Claim Resolution Guide

Additional Information

Home > Important Messages

Important Messages

[Hospital Monthly Important Message \(Posted 8/15/18\)](#)

[Attention Dental Providers: Restoration Pricing Update \(Updated 8/6/18\)](#)

[Clarification of PB18-52 - Electronic Visit Verification \(EVV\) - Consecutive Services Enhancement](#)

[Electronic Visit Verification Important Message \(Updated 8/2/18\)](#)

Information > Publications > 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](#)

Information > Publications > Claims Processing

Claims Processing Information

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

Information > Publications > Claim Resolution Guide, chapter 12 (EOB Reference)

12

[Claim Resolution Guide](#)

EOB Code information on slides 70 – 74 can be found in chapter 12

Additional Information

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, and other related transactions. This manual contains detailed instructions regarding the Medicaid Program, and should be your first source of information pertaining to policy and procedural questions.
- Provider Manuals can be accessed by going to www.ctdssmap.com. From the home page click on “Publications”, scroll down to “Provider Manuals” then select the appropriate provider manual and/or select the appropriate provider specific or claim specific manual from the drop down menu and click on “View Chapter”.
- The Provider Manual is divided into twelve (12) chapters:
 - Chapters 7 and 8 are provider specific – select “Nursing Facilities and ICF/IID” from the drop-down menu and click **View Chapter** to access the chapter
 - Chapter 10 is the *Web Portal/Automated Voice Response System (AVRS) information*
 - Chapter 11 is claim-type specific

A complete reference of chapters 1 through 12 can be found on slides 67 and 68

Additional Information

Provider Manual

- *Chapter 1 – Introduction*
 - Provides information on the CT Medical Assistance Program, the Department of Social Services' and DXC Technology 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

Additional Information

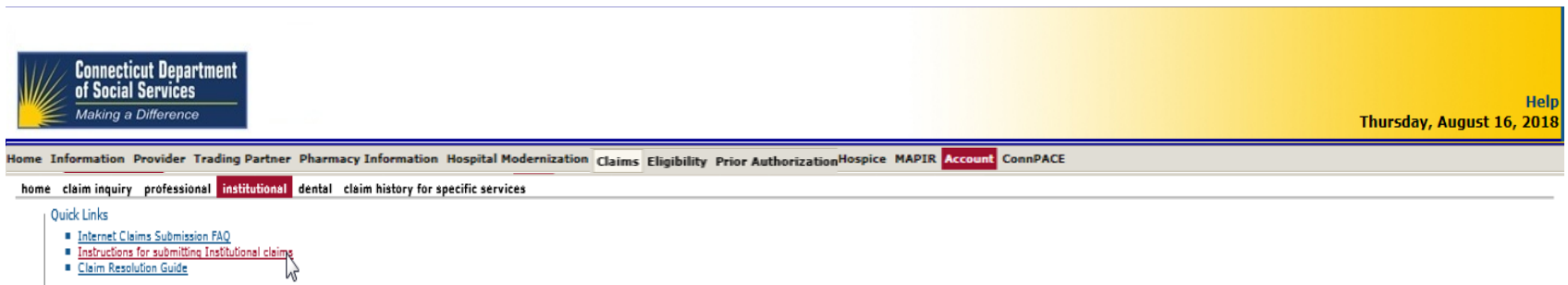
Provider Manual

- *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 of interChange
- *Chapter 11 – Other Insurance/Medicare Billing Guides*
 - Provides claim-type specific information on other insurance and Medicare billing.
- *Chapter 12 – Claim Resolution Guide*
 - Provides descriptions of common EOB codes and, if applicable, information to resolve the errors

Additional Information

Where to go for more information www.ctdssmap.com

- If you have any questions regarding Web claim submission,
 - Reference the Instructions for Submitting Institutional Claims which can be found after logging into the Web portal then selecting “Claims” then “Institutional”.



The screenshot shows the Connecticut Department of Social Services website. The header includes the logo and the text "Making a Difference". The date "Thursday, August 16, 2018" is displayed in the top right. The navigation menu includes: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, Prior Authorization, Hospice, MAPIR, Account, and ConnPACE. Below the navigation menu, there are links for "home", "claim inquiry", "professional", "institutional", "dental", and "claim history for specific services". A "Quick Links" section is visible, containing three links: "Internet Claims Submission FAQ", "Instructions for submitting Institutional claims", and "Claim Resolution Guide".

- **DXC Technology Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- **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

Additional Information

LTC Claim Denials and Resolution

EOB Code Description:

0572 Quantity disagrees with days elapsed

Cause

For Nursing Home claims, the sum of the detail units billed for the accommodation revenue center codes does not equal the header covered days.

Accommodation revenue center code list:

100

183

185

189

Resolution

Correct either the header covered days or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Additional Information

LTC Claim Denials and Resolution

EOB Code Description:

1024 Provider is not authorized to bill for this client

Cause

For Nursing Home claims, the pay start has not been established for this client. DSS has not yet updated the Eligibility Management System (EMS) with authorization for this client to reside in the billing provider's facility.

Resolution

The claim is not payable until EMS is updated with the client's pay start/authorization to be in the billing provider's Nursing Home. Resubmit the claim when the pay start has been established.

Additional Information

LTC Claim Denials and Resolution

EOB Code Description:

0704 Revenue center code not allowed for hospice client

Cause

A long term care claim with revenue center code 100 was submitted for a client with an active hospice lock-in on the date(s) of service in question.

Resolution

Room and board claims for hospice clients must be submitted by the hospice agency with which the client is currently locked-in; they cannot be submitted by the nursing facility. This claim will not pay unless submitted by the hospice provider.

Additional Information

LTC Claim Denials and Resolution

EOB Code Description:

0518 Total accommodation days billed are not equal to the elapsed days

Cause

Nursing Home claims:

The header span dates are calculated by determining the elapsed days. If the patient status does not equal one of the following values, the system will automatically subtract one day:

20 Expired

30 Still a Patient

40 Expired at Home

41 Expired in a medical facility

42 Expired – place unknown

For example, if the statement covers period is January 1, 2010 through January 31, 2010 and the patient discharge status equals 20, the header span is 31 days. If the patient discharge status is 01 (Discharged to home or self-care), the header span is 30 days.

The detail span dates are calculated by summing the days billed on all covered and non-covered days. The sum of the days billed must equal the header span.

Resolution

Review the header from and through dates of service, patient discharge status, detail dates of service and detail days billed to determine which field is in error, correct and resubmit the claim.

Additional Information

LTC Claim Denials and Resolution

EOB Code Description:

0570 Header total days less than covered days

Cause

For Nursing Home claims with a patient status of 20 (Expired), 30 (Still Patient), 40 (Expired at Home), 41 (Expired in a Medical Facility) or 42 (Expired – Place Unknown), the number of days in the header date span do not equal the sum of the detail units billed for the accommodation revenue center codes.

Accommodation revenue center code list:

100

183

185

189

Resolution

Correct either the header covered days, the patient status or the detail units billed for the accommodation revenue center codes and resubmit the claim.

Time for Questions

