Connecticut Medical Assistance Program 2023 Long Term Care Refresher Provider Workshop

Presented by
The Department of Social Services & Gainwell Technologies
October 25, 2023

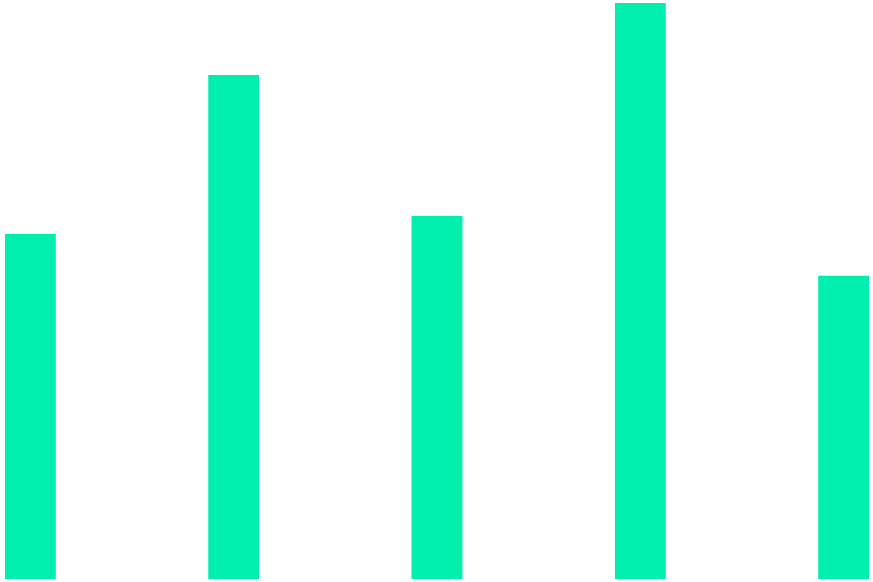
Connecticut Department of Social Services
Making a Difference

gainwell

Training Topics

- Updates
- Eligibility Verification
- Assessment Pro 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
- eDelivery
- Web Site Information
- Common Billing Denials and Resolutions
- Contacts
- Wrap Up & Questions

Updates



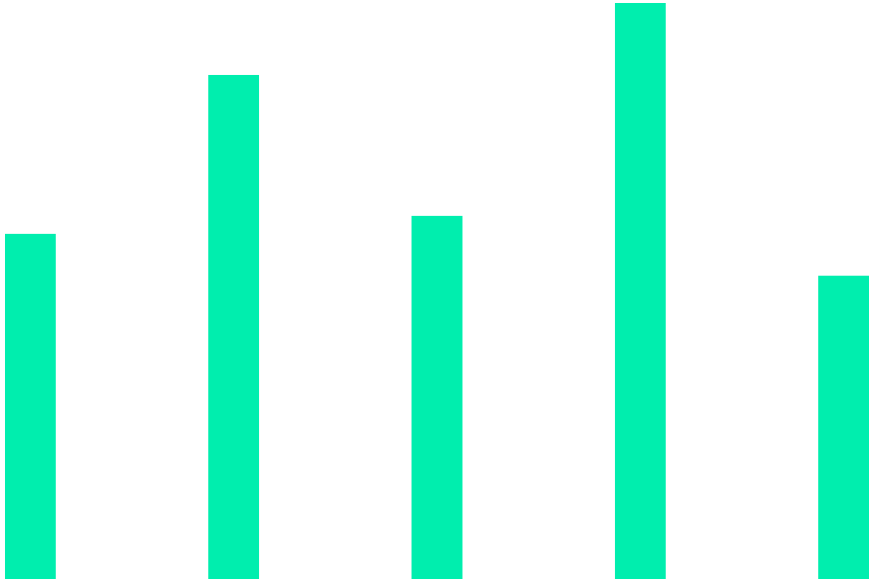
2023 Updates

LTC Bulletins since 2021

- PB21-29 Intermediate Care Facilities for Individuals with Intellectual Disabilities Leave Day
- PB21-88 Outpatient Crossover Claim Pricing Changes
- PB21-95 Outpatient Crossover Electronic 837I Claim Submission and Pricing Changes
- PB22-35 Updated Guidance Regarding Shared/Split Medical Visits
- PB22-87 Outpatient Crossover Claims – New Web Claim Submission Panel
- PB22-92 Activating Attending Provider Requirements

  Effective with claims submitted on or after March 1, 2023, claims will be denied if the attending provider is not submitted and/or the attending provider is not enrolled in CMAP.

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

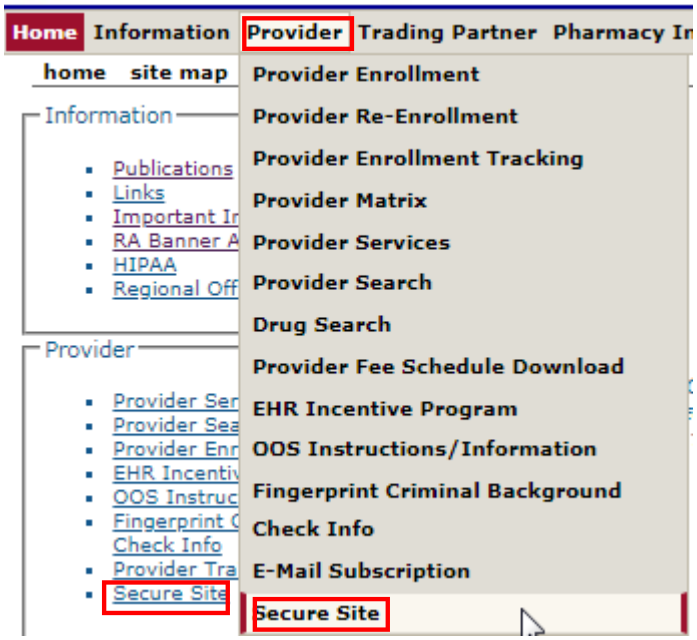
Eligibility Verification

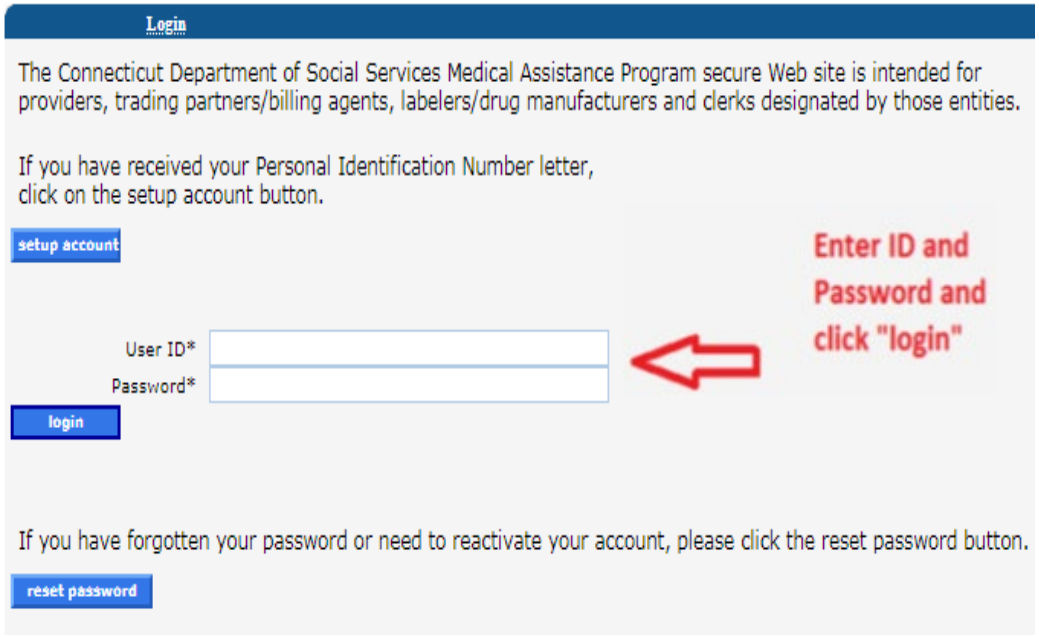
Welcome page at www.ctdssmap.com

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.”**

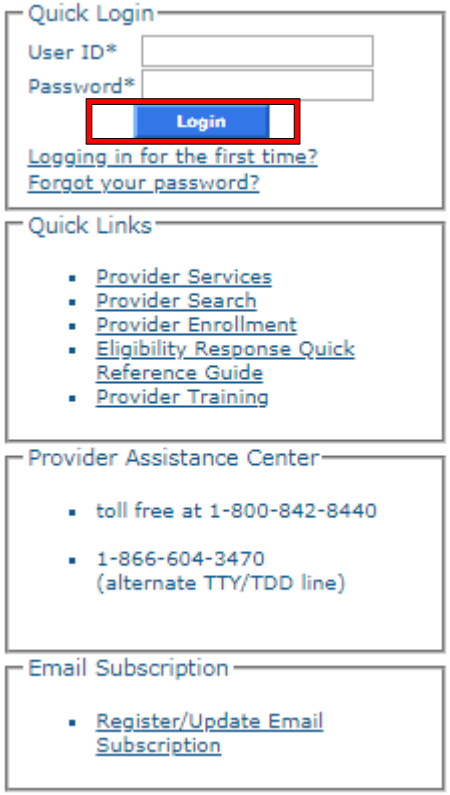




Eligibility Verification

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



Eligibility Verification

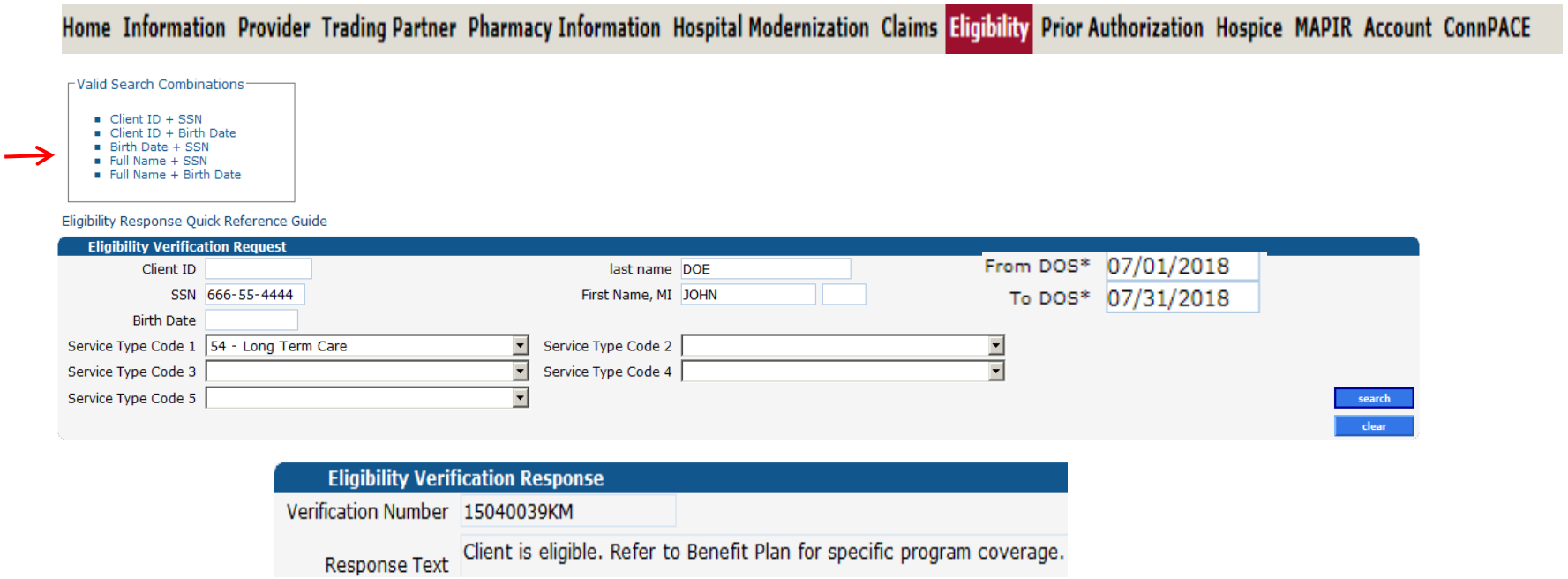
Service Codes

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

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

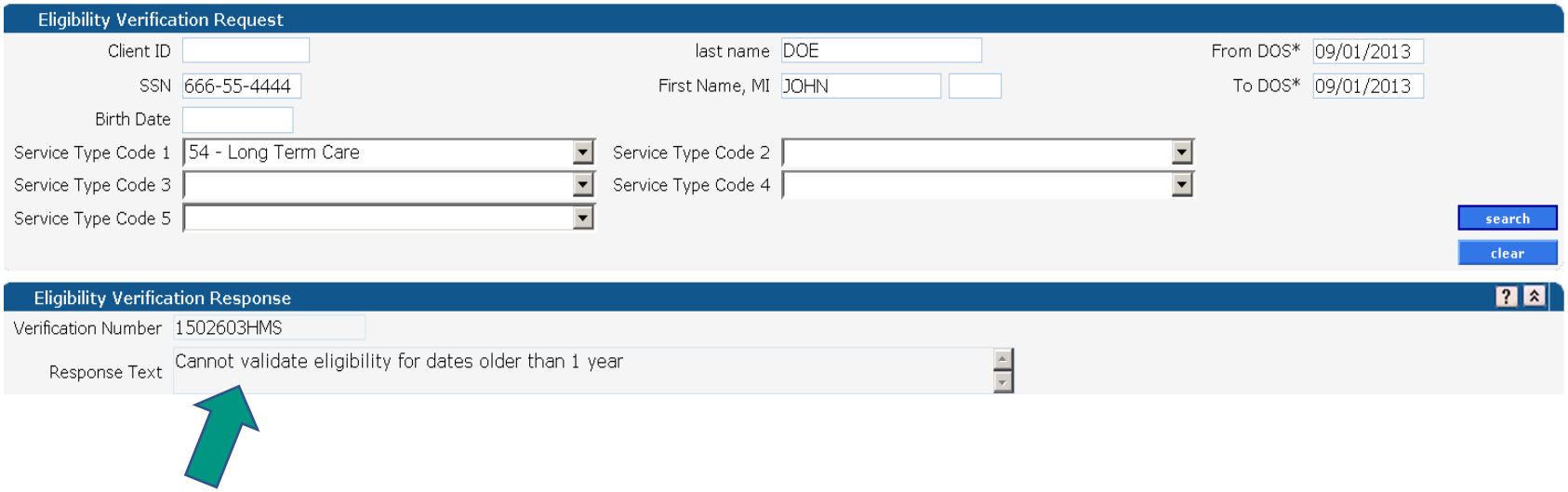


- **Eligibility verification can only look back one year, dates of service older than a year must be verified by contacting the Provider Assistance Center (Example on slide 12)**
- **Eligibility verifications can not span months, submitting a request that spans multiple months will result in an error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

Eligibility Verification

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

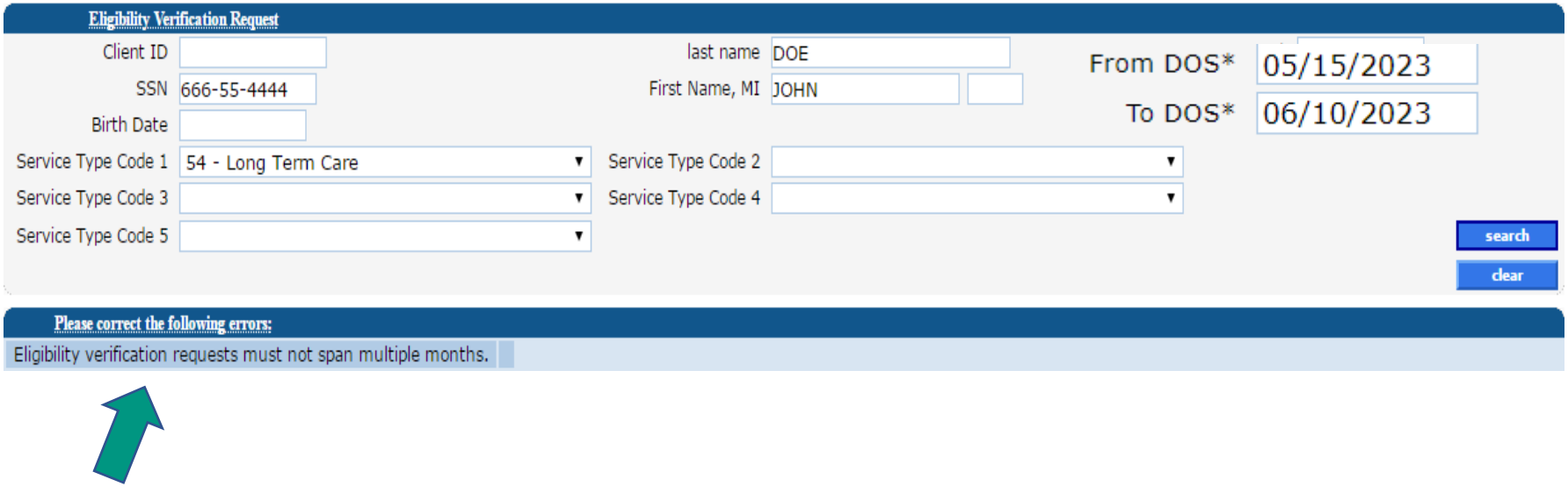
- In this specific case – the client's eligibility cannot be verified for the requested dates (Sept. 1, 2013) – eligibility verification can only look back one year
- Changing the dates of the eligibility request to within the allowable one year window creates a different result



Eligibility Verification

The Eligibility Verification Response window returns an error message

- Eligibility searches cannot span multiple months
    - 5/15/2023 – 6/10/2023 is not valid; 5/15/2023 – 5/31/2023 and 6/1/2023 – 6/10/2023 are valid
    - Submitting a request that spans multiple months will result in an error message.



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

HOSPICE-MEDICARE 08/16/2017 08/16/2018

Lockin

Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	08/05/2014	08/05/2015	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)

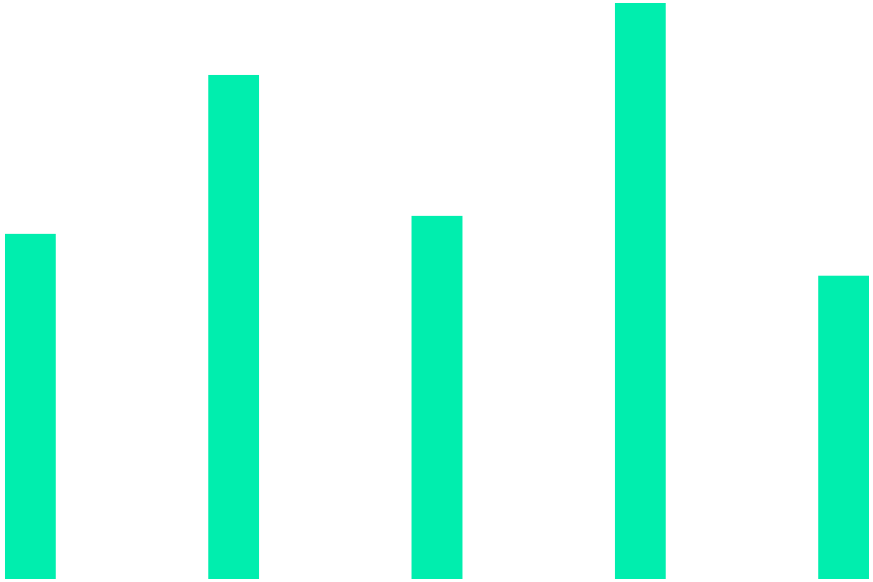
TPL (Third Party Liability)

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

Assessment Pro Overview



Assessment Pro Overview

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

Assessment Pro Overview

Assessment Pro, Tracking and Screening

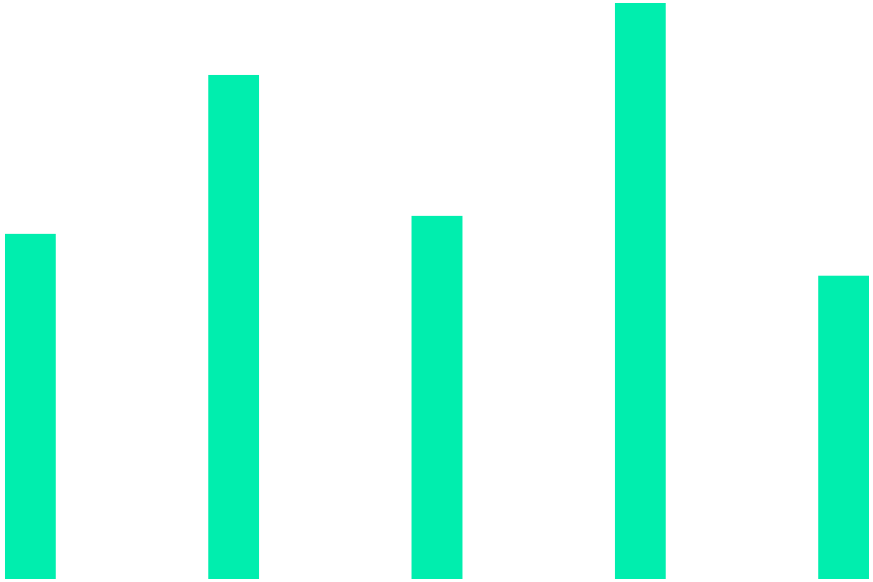
Tracking and Screening of Nursing Facility Admissions, Transfers, Discharges and Deaths

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

- 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

- ***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 Gainwell Technologies 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

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

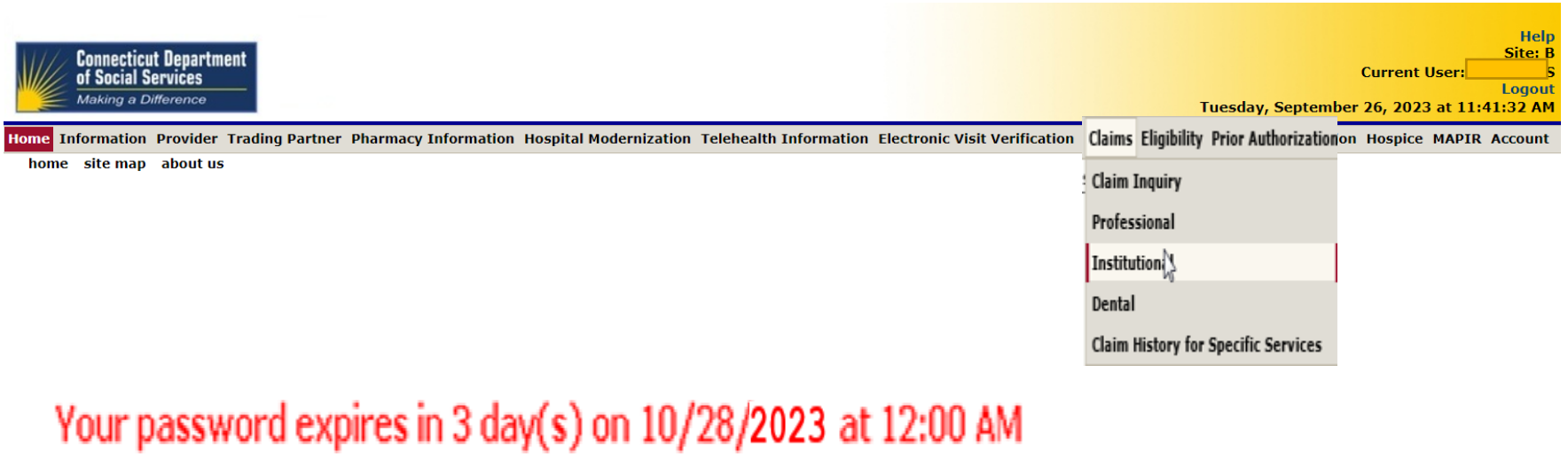
Each claim then passes through a series of *audits* that check the validity of claim data and claims in history:

- 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

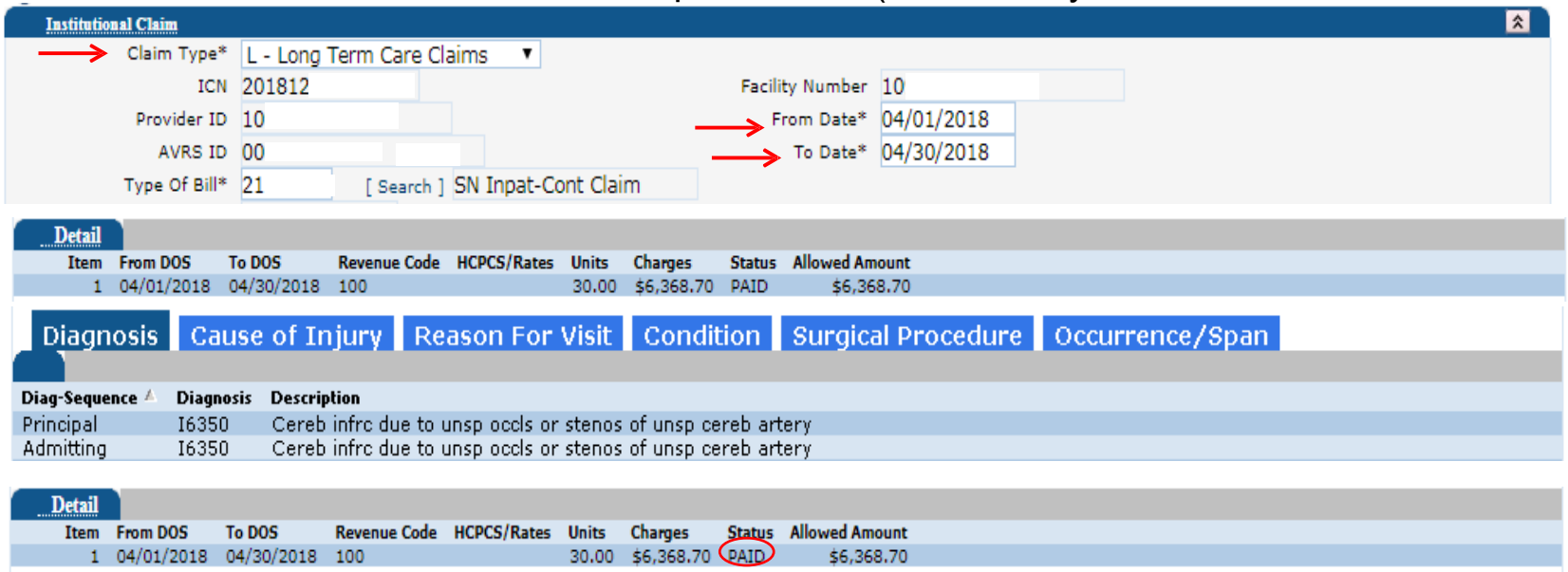


Web Claim Submission Overview

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)



- 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 

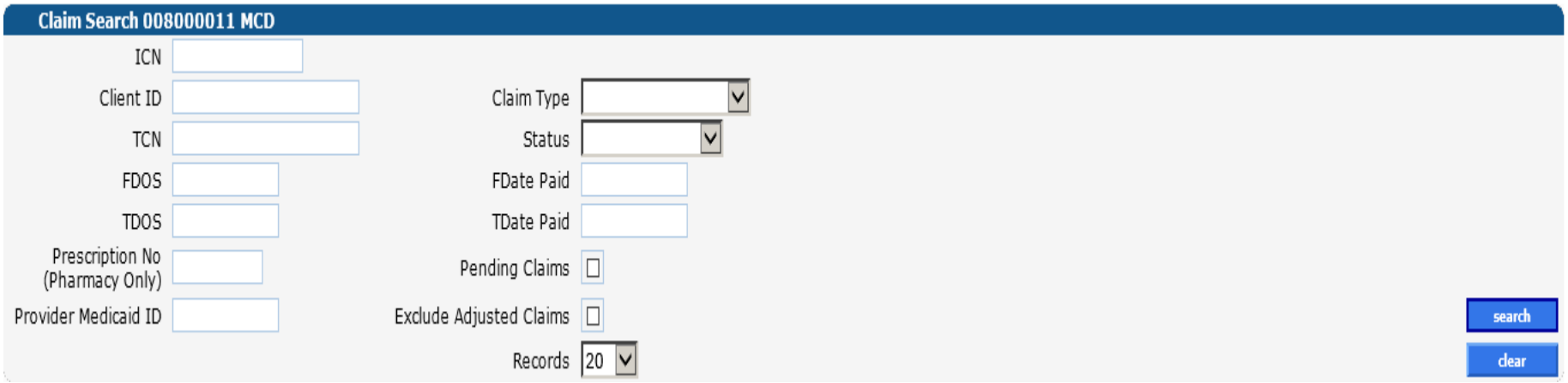
- Claims process immediately and return a status of ***Paid, Denied*** or ***Suspended***

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

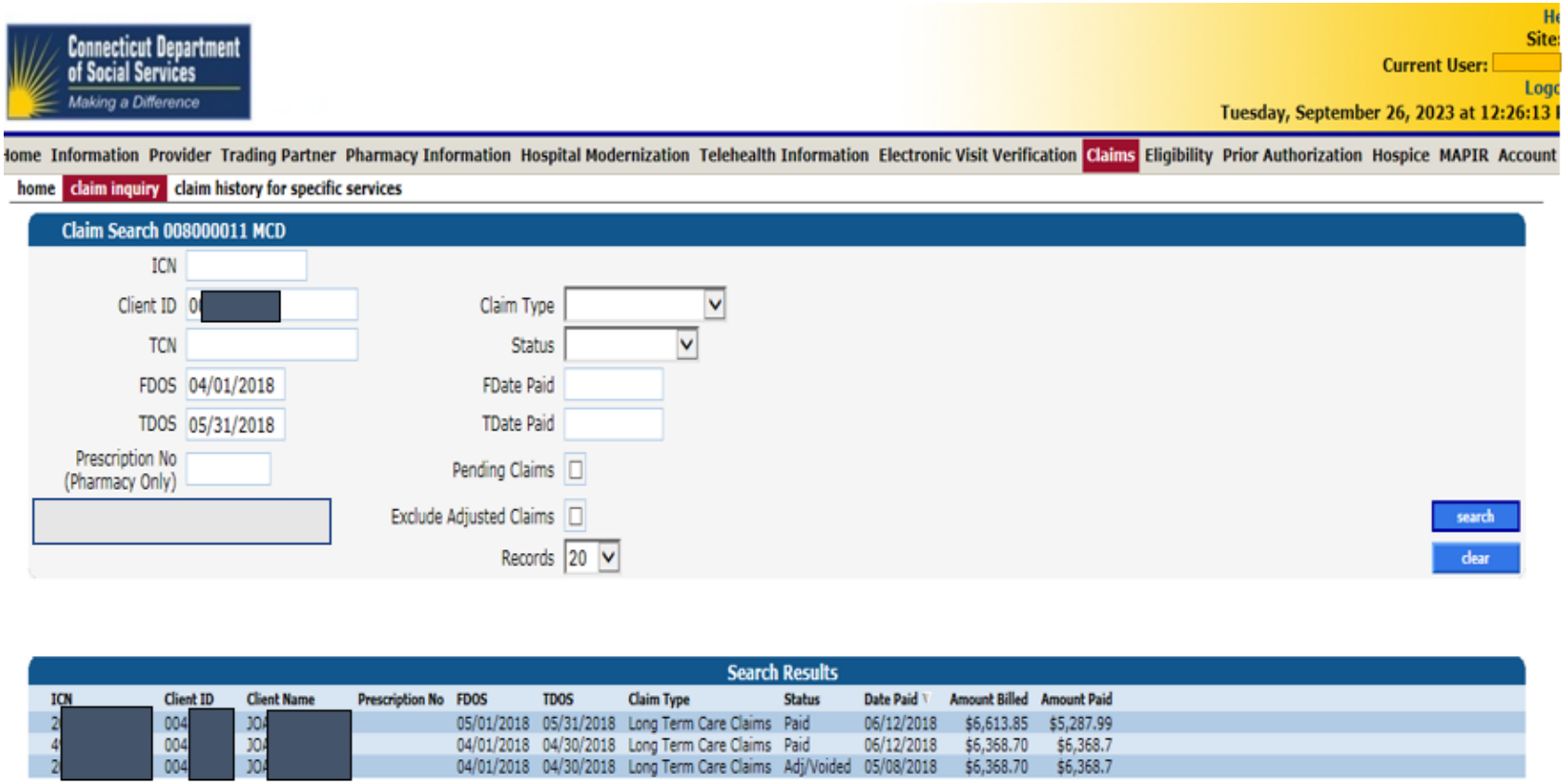
Enter enough information to satisfy at least one of the following criteria*:*

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



Web Claim Submission Overview

Web Claim Inquiry



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 is 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 Gainwell Technologies 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 Claims

Medicare requires claims to be submitted for a full month. When a client's Medicare coverage exhausts after 100 days, room and board charges deny as a duplicate claim against the last Medicare claim.

Solution:

Go to Web site, www.ctdssmap.com
Log on to Provider secure site
Go to Claims
Claim Inquiry
Search for an Institutional Crossover for the month of conflict
Click on paid crossover claim
Void claim by clicking on Void button at bottom of claim
Click on Copy Claim
Change header and detail dates of service (DOS) to only reflect Medicare covered days and submit the claim

Web Claim Submission Overview

Medicare Coinsurance and/or Deductible Claims Processing

The following information sent to Gainwell Technologies electronically must match the Explanation of Medicare Benefits (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

Web Claim Submission

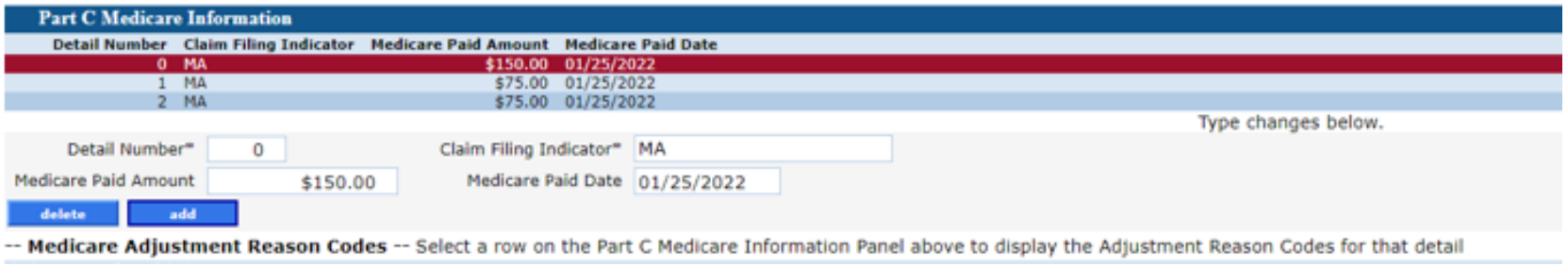
Medicare Outpatient Crossover

Provider Bulletin 2022-87

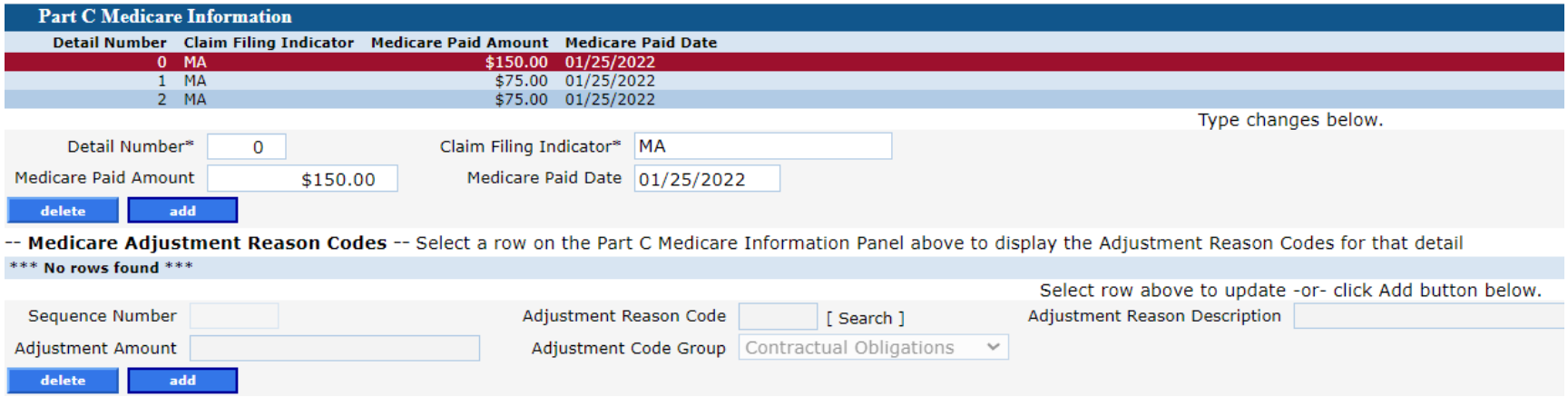
To submit a new claim with data on the new Part C Medicare Information Panel, you must ensure that:

Use the Add Button

- The Claim Filing Ind only contains MA or MB
- If the Other Payer (Medicare or Medicare Advantage) Payment is at the HEADER, that there is ONE segment ONLY with 'Detail Number' = 0 with its corresponding CARCs (Adjustment Reason Codes)
- If the Other Payer Payment is at the HEADER and DETAIL, that there is more than ONE segment with 'Detail Number' = 0, 1, 2, 3 etc. (1, 2, 3 refers to the Claim's detail #).
- If the Other Payer Payment is at the DETAIL, that you enter the Claim's detail information first (one at the time), then enter its corresponding Other Payer Payment
- If claim has more than 1 detail, and with Other Payer Payment at the detail, you repeat the 3rd bullet until all details and their corresponding Other Payer Payment are entered



Web Claim Submission
Medicare Outpatient Crossover



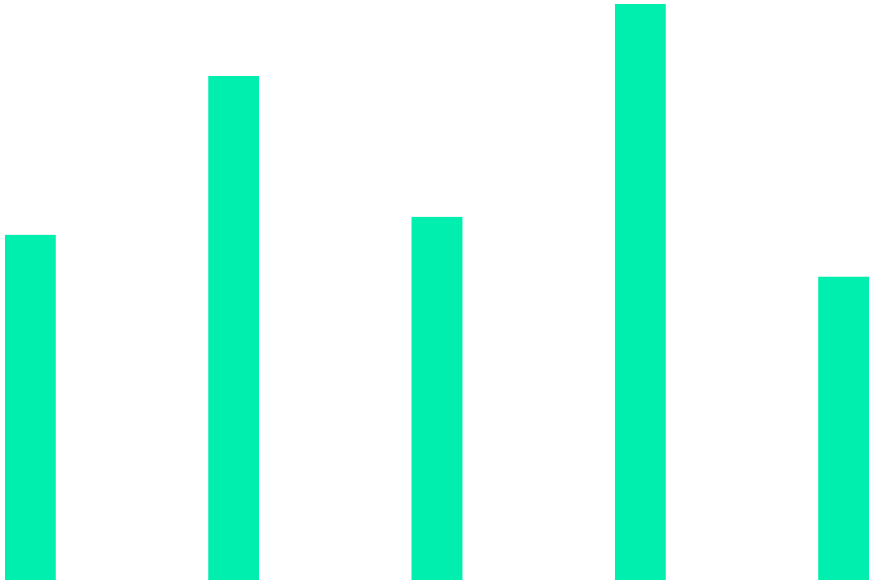
<u>Medicare Adjustment Reason Code Section</u>:

Click the Add button

This is where the Reason codes from your EOMB are entered on the claim. The Sequence Number should match your EOMB, 0 for the Header and 1,2,3,… for any detail lines

- Deductible (claim adjustment reason code = 1)
- Co-insurance (claim adjustment reason code = 2)
- Copay for outpatient crossovers only (claim adjustment reason code = 3)

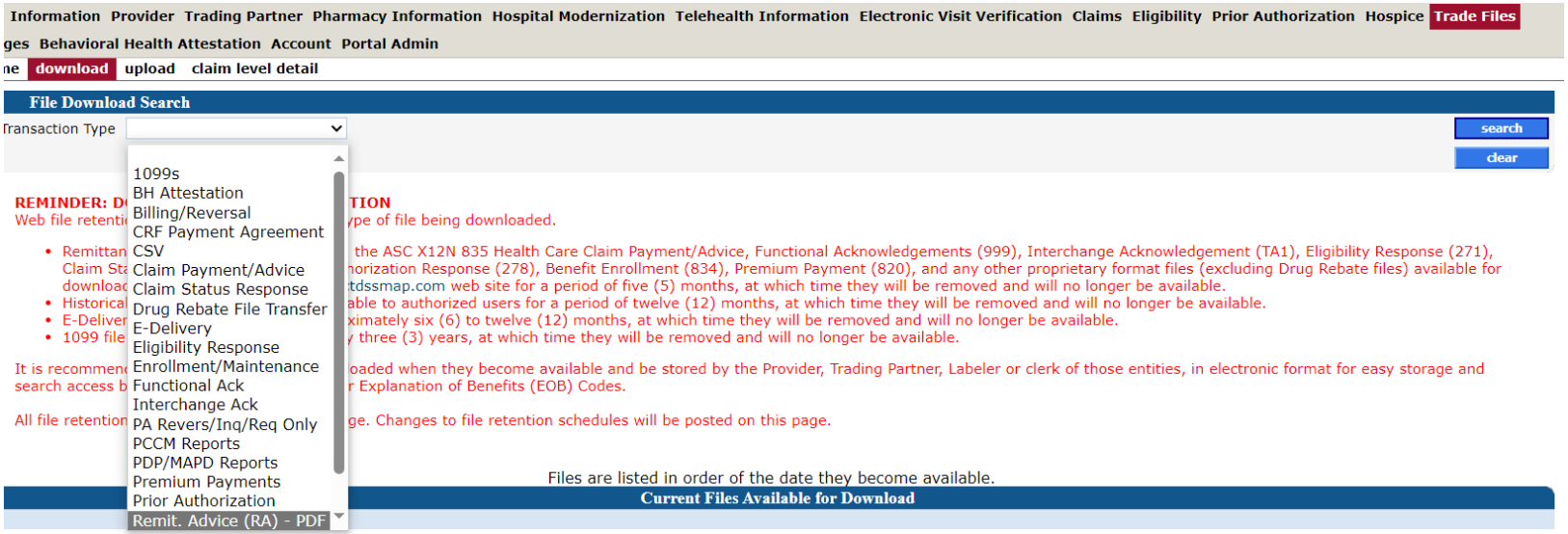
Remittance Advice Overview



Remittance Advice Overview

All claims processed by Gainwell Technologies are reported to the provider by cycle on a 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 version of the RA is found under Trade Files, Download, Transaction Type on drop down menu Remit Advice (RA) - PDF

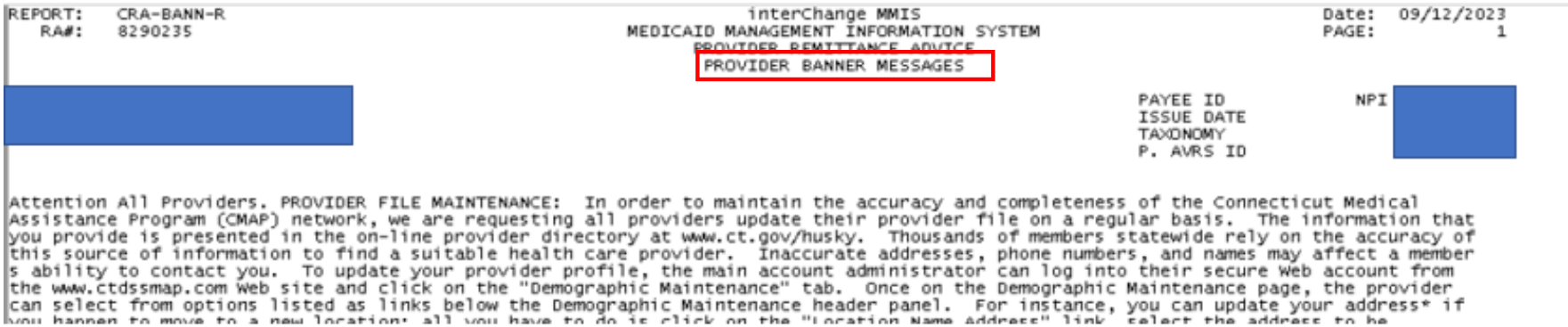


Remittance Advice Overview

- 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
- Gainwell Technologies 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 Gainwell Technologies Web site.** RAs older than the last ten (10) will **no longer** be available

Remittance Advice Overview

Banner page



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REPORT:   CRA-BANN-R                    interChange MMIS                    Date:  09/12/2023
  RA#:    8290235                MEDICAID MANAGEMENT INFORMATION SYSTEM    PAGE:         1
                                      PROVIDER REMITTANCE ADVICE
                                    PROVIDER BANNER MESSAGES
[redacted]                                                          PAYEE ID          NPI [redacted]
                                                                    ISSUE DATE
                                                                    TAXONOMY
                                                                    P. AVRS ID

Attention All Providers. PROVIDER FILE MAINTENANCE:  In order to maintain the accuracy and completeness of the Connecticut Medical
Assistance Program (CMAP) network, we are requesting all providers update their provider file on a regular basis.  The information that
you provide is presented in the on-line provider directory at www.ct.gov/husky.  Thousands of members statewide rely on the accuracy of
this source of information to find a suitable health care provider.  Inaccurate addresses, phone numbers, and names may affect a member
s ability to contact you.  To update your provider profile, the main account administrator can log into their secure Web account from
the www.ctdssmap.com Web site and click on the "Demographic Maintenance" tab.  Once on the Demographic Maintenance page, the provider
can select from options listed as links below the Demographic Maintenance header panel.  For instance, you can update your address* if
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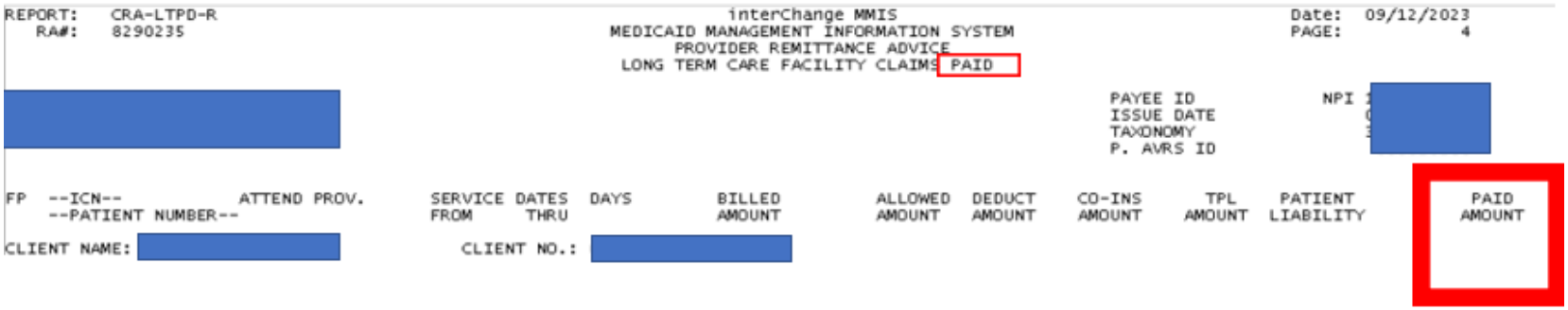
Claim Information (Paid, Long Term)



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REPORT:   CRA-LTPD-R                    interChange MMIS                    Date:  09/12/2023
  RA#:    8290235                MEDICAID MANAGEMENT INFORMATION SYSTEM    PAGE:         4
                                      PROVIDER REMITTANCE ADVICE
                                LONG TERM CARE FACILITY CLAIMS PAID
[redacted]                                                          PAYEE ID          NPI [redacted]
                                                                    ISSUE DATE
                                                                    TAXONOMY
                                                                    P. AVRS ID

FP  --ICN--           ATTEND PROV.   SERVICE DATES  DAYS    BILLED     ALLOWED  DEDUCT   CO-INS    TPL    PATIENT      PAID
    --PATIENT NUMBER--               FROM     THRU          AMOUNT     AMOUNT   AMOUNT   AMOUNT   AMOUNT LIABILITY    AMOUNT

CLIENT NAME: [redacted]          CLIENT NO.: [redacted]
```

Remittance Advice Overview

Claim Adjustments

[redacted]

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

Date:
PAGE:

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI

[redacted]

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.

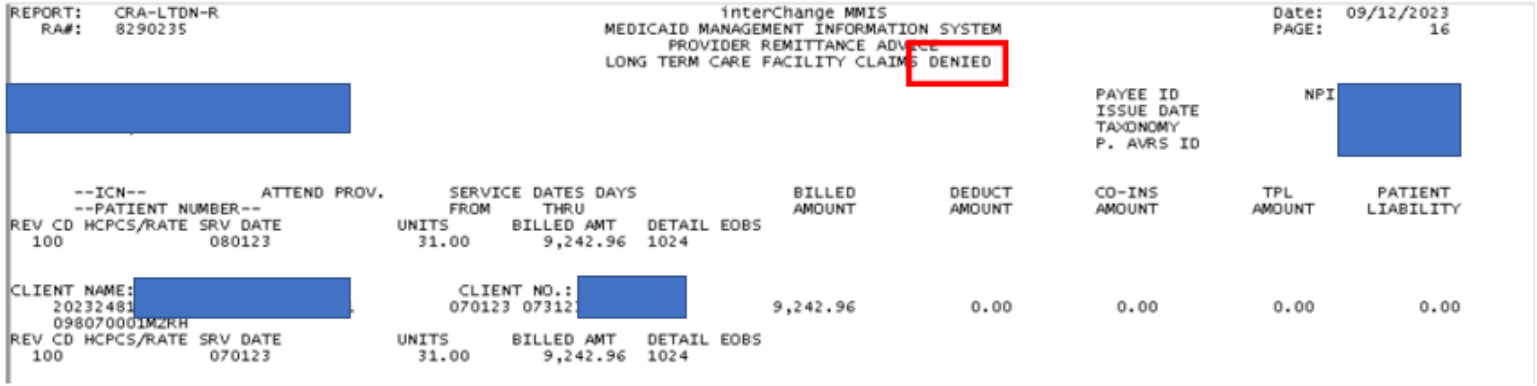
----------ACCOUNTS RECEIVABLE----------

A/R NUMBER	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	B400	003648940	[redacted]	
5918207005162	08/10/2018	98.00	98.00	98.00	0.00	B400	004088902		

----------1099 ADJUSTMENTS----------

Remittance Advice Overview

Claim Information - Denied



REPORT: CRA-LTDN-R
RA#: 8290235

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

Date: 09/12/2023
PAGE: 16

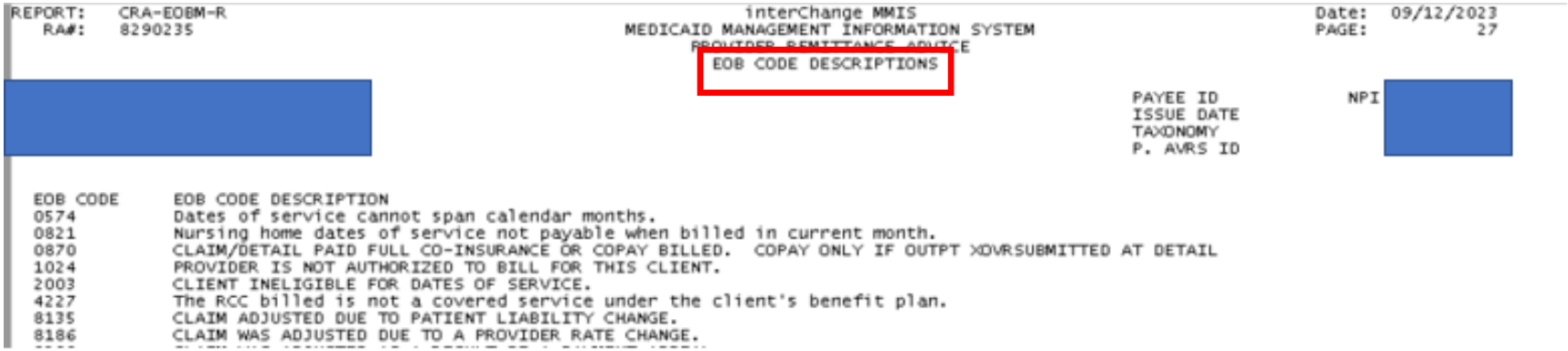
[redacted]

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI [redacted]

--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	SERVICE DATES THRU	DAYS	BILLED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	PATIENT LIABILITY
REV CD HCPCS/RATE SRV DATE	UNITS	BILLED AMT	DETAIL EOBS						
100 080123	31.00	9,242.96	1024						
CLIENT NAME: [redacted]		CLIENT NO.: 070123 07312[redacted]			9,242.96	0.00	0.00	0.00	0.00
20232481 [redacted]									
098070001MZRH									
REV CD HCPCS/RATE SRV DATE	UNITS	BILLED AMT	DETAIL EOBS						
100 070123	31.00	9,242.96	1024						

EOB Code Descriptions



REPORT: CRA-EOBM-R
RA#: 8290235

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

Date: 09/12/2023
PAGE: 27

[redacted]

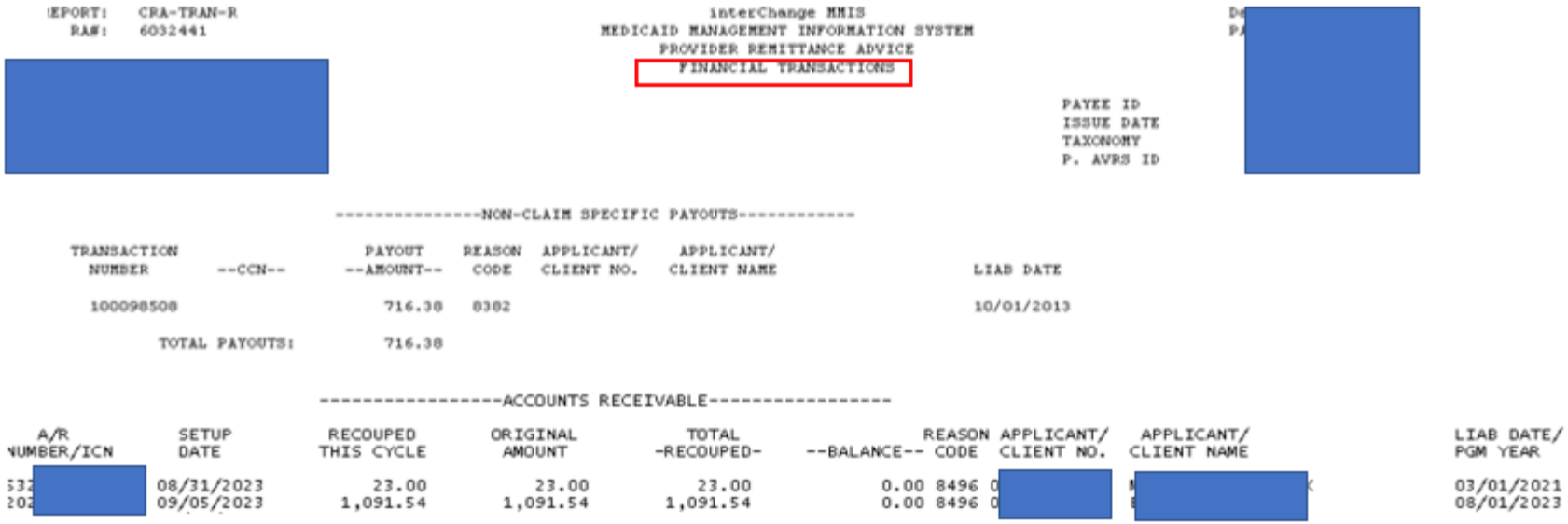
PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI [redacted]

EOB CODE	EOB CODE DESCRIPTION
0574	Dates of service cannot span calendar months.
0821	Nursing home dates of service not payable when billed in current month.
0870	CLAIM/DETAIL PAID FULL CO-INSURANCE OR COPAY BILLED. COPAY ONLY IF OUTPT XOVRSUBMITTED AT DETAIL
1024	PROVIDER IS NOT AUTHORIZED TO BILL FOR THIS CLIENT.
2003	CLIENT INELIGIBLE FOR DATES OF SERVICE.
4227	The RCC billed is not a covered service under the client's benefit plan.
8135	CLAIM ADJUSTED DUE TO PATIENT LIABILITY CHANGE.
8186	CLAIM WAS ADJUSTED DUE TO A PROVIDER RATE CHANGE.

Remittance Advice Overview

Financial Transactions



EPORT: CRA-TRAN-R
RA#: 6032441

[redacted]

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

[redacted]

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

TRANSACTION NUMBER	--CCN--	PAYOUT --AMOUNT--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE
100098508		716.30	8382			10/01/2013
TOTAL PAYOUTS:		716.30				

----------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
532 [redacted]	08/31/2023	23.00	23.00	23.00	0.00	8496	[redacted]	[redacted]	03/01/2021
202	09/05/2023	1,091.54	1,091.54	1,091.54	0.00	8496			08/01/2023

Financial Transactions Reason Codes

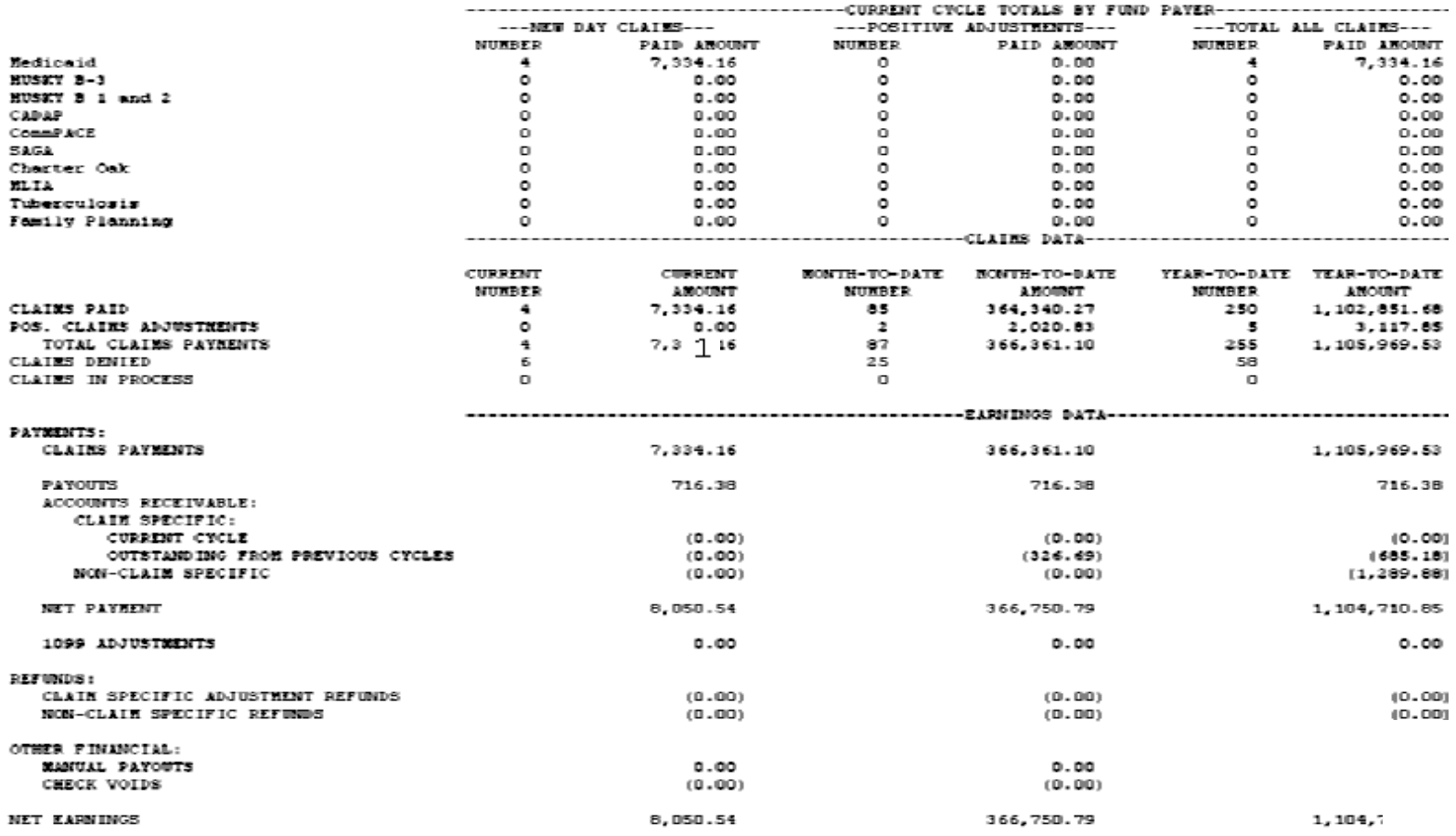
FINANCIAL TRANSACTIONS REASON CODES

ACCOUNT RECEIVABLES REASON CODES

RSN CODE	REASON CODE DESCRIPTION
8400	Result of claim adjustment
8495	Pat. Liab. AR from Denied Adj
8496	Patient Liability or Applied Income

Remittance Advice Overview

Summary



CURRENT CYCLE TOTALS BY FUND PAYER

	NEW DAY CLAIMS NUMBER	NEW DAY CLAIMS PAID AMOUNT	POSITIVE ADJUSTMENTS NUMBER	POSITIVE ADJUSTMENTS PAID AMOUNT	TOTAL ALL CLAIMS NUMBER	TOTAL ALL CLAIMS PAID AMOUNT
Medicaid	4	7,334.16	0	0.00	4	7,334.16
HUSKY B-3	0	0.00	0	0.00	0	0.00
HUSKY B 1 and 2	0	0.00	0	0.00	0	0.00
CADAP	0	0.00	0	0.00	0	0.00
CommPACE	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	0	0.00	0	0.00	0	0.00
Tuberculosis	0	0.00	0	0.00	0	0.00
Family Planning	0	0.00	0	0.00	0	0.00

CLAIMS DATA

	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	7,3 1 16	87	366,361.10	255	1,105,969.53
CLAIMS DENIED	6		25		58	
CLAIMS IN PROCESS	0		0		0	

EARNINGS DATA

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)	(326.69)	(685.18)
NON-CLAIM SPECIFIC	(0.00)	(0.00)	(1,289.88)
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	1,104,7

Remittance Advice Overview

Summary

CURRENT CYCLE TOTALS BY FUND PAYER

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

CLAIMS DATA

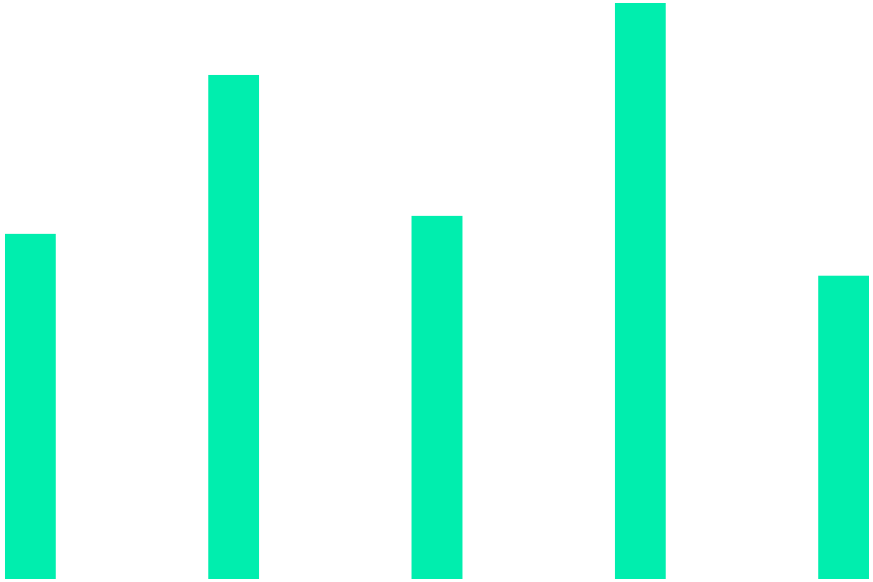
	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	2,376	346,187.55	5,557	809,655.63	29,311	4,268,250.86
POS. CLAIMS ADJUSTMENTS	1	14.01	13	118.02	142	222.03
TOTAL CLAIMS PAYMENTS	2,377	346,201.56	5,570	809,773.65	29,453	4,268,472.89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

EARNINGS DATA

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

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



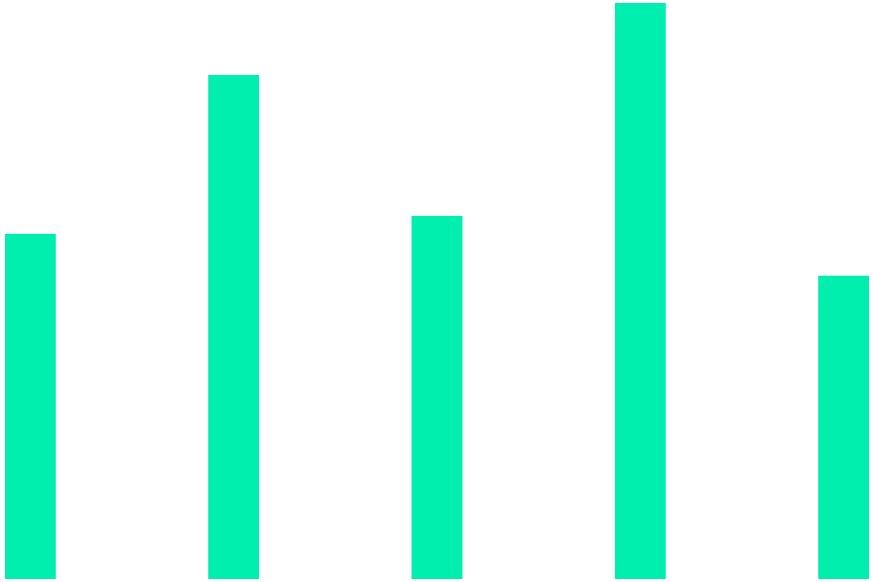
Provider Electronic Solutions (PES) Software

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

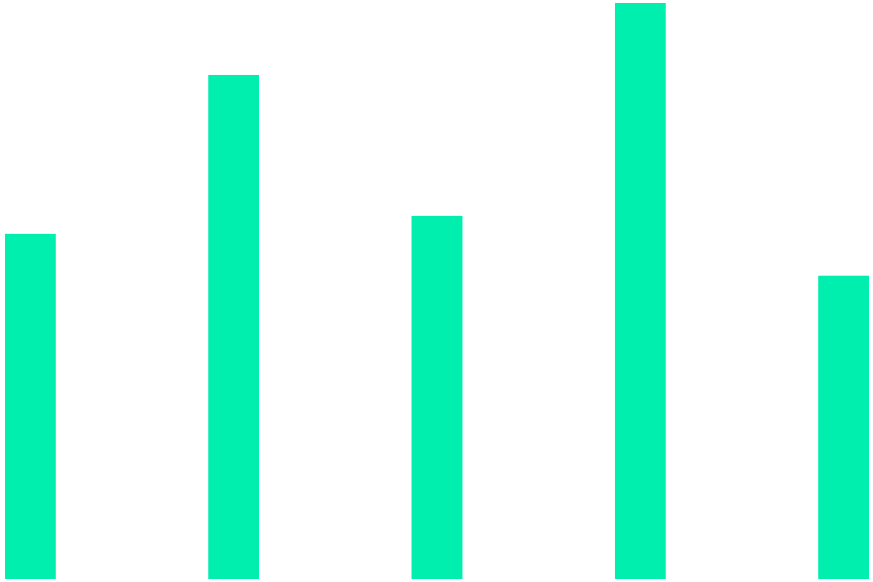
Mass adjustments due to patient liability changes within clients' profiles will occur as those amounts are often retroactively changed by DSS

- 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 Gainwell Technologies 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 Gainwell Technologies
- 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 – This is still a requirement for Hospice patients
- The Hospice agency submits the Nursing Facility or ICF/IID per diem rate charges directly to Gainwell Technologies 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

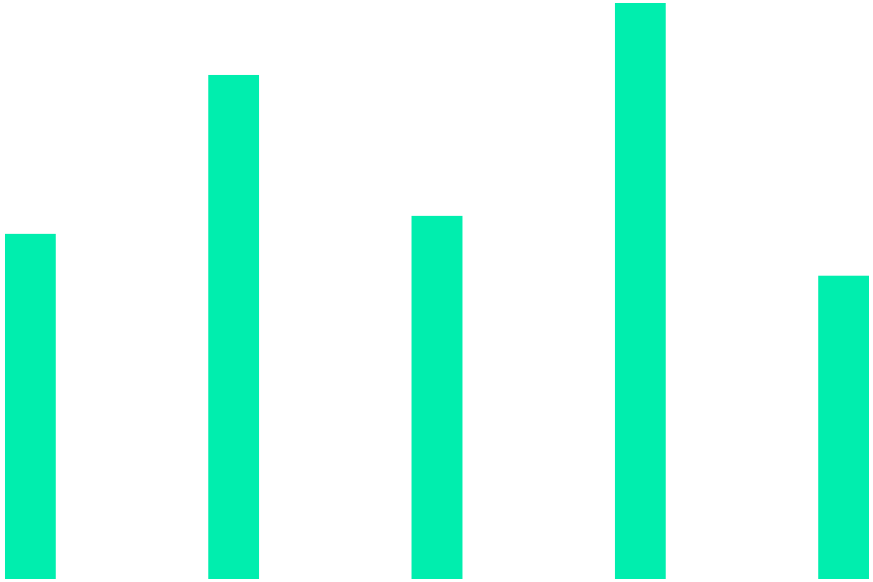
Patient liability is deducted from the first claim processed for the month in which patient liability is due

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 and Leave Days for ICF/IID



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

Hospitalization Bed Reserve Guidelines

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 re-serve 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"

ICF/IID Leave Day Changes

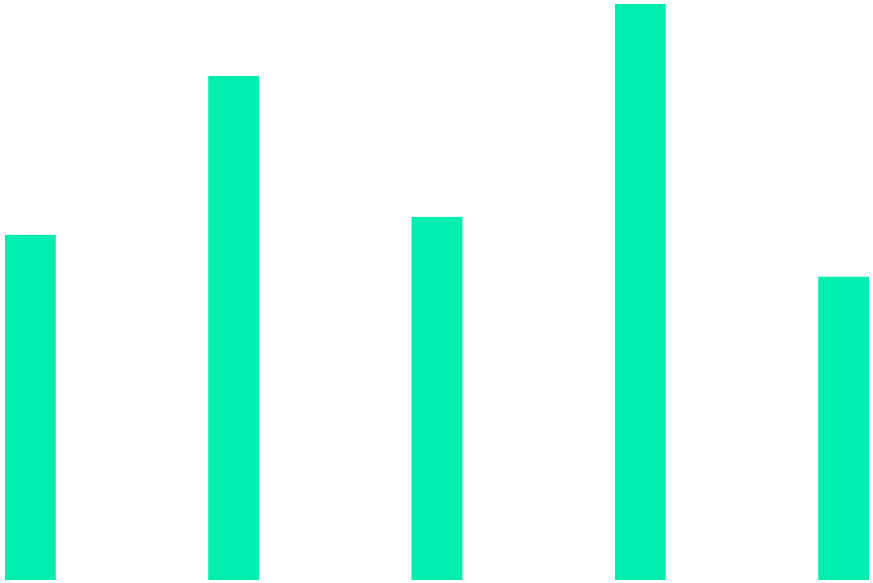
Provider Bulletin 2021-29

DSS reinstated the requirement for home and hospital leave days being limited to the authorized limits for dates of service April 28, 2021 and forward.

Effective April 28, 2021, the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) provider may be reimbursed for the following leave days:

- Up to fifteen (15) days of hospital leave days as noted in Section 17b-262-306 of the Connecticut General Statutes,
- Up to thirty-six (36) home leave days as noted in Section 17b-262-307 of the Connecticut General Statutes.

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*

Provider Enrollment / Re-enrollment on the Web

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 Gainwell Technologies 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, reducing the amount of time the process takes to complete the re-enrollment application

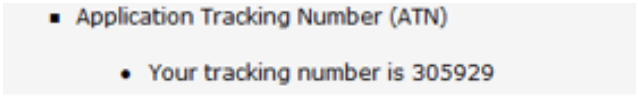
Provider Enrollment / Re-enrollment on the Web

Application Submitted

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

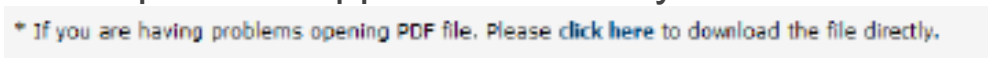
Gainwell Technologies
Provider Enrollment Unit
P.O. Box 5007
Hartford, CT 06102-5007

- 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



- Provides a link you can use to 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



- Please do not submit a hard copy of the application to Gainwell Technologies

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

Provider Enrollment / Re-enrollment on the Web

What's Next?

- Gainwell Technologies 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" (FODs)** to Gainwell Technologies 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 Gainwell Technologies
- If any information is missing, invalid, or if Gainwell Technologies 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:
  Gainwell Technologies
  Provider Enrollment Unit
  P.O. Box 5007
  Hartford, CT 06102-5007
- **All additional information sent to Gainwell Technologies will need the ATN entered on the upper right hand corner of each document**

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***

- In this example, Gainwell Technologies is waiting for additional information from the provider

01/15/2021

Provider Enrollment/Re-enrollment on the Web

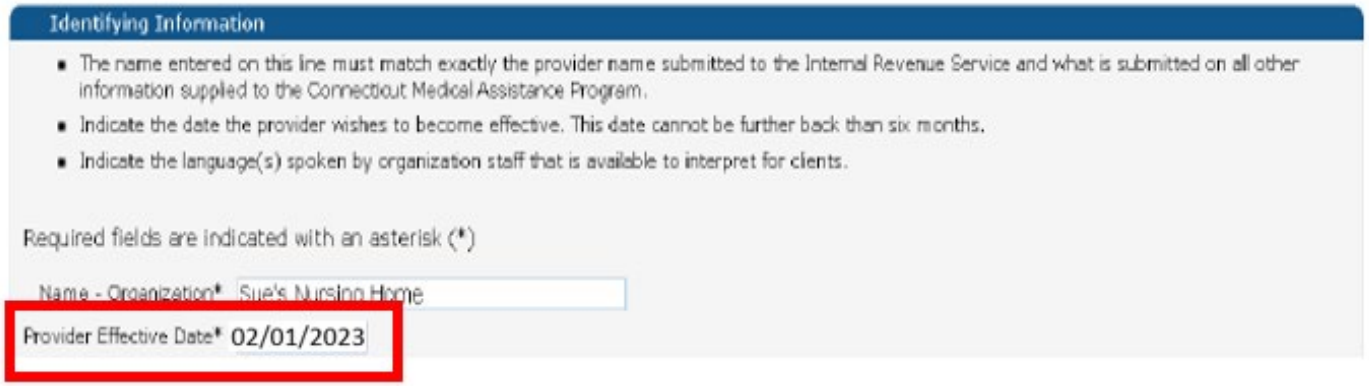
Notification of Enrollment/Re-enrollment Decision:

- 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 Gainwell Technologies 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 Gainwell Technologies 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



- 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

Attending Provider Enrollment Requirement

Provider Bulletin 2022-92 – Attending/Performing providers must be enrolled.

To determine whether a provider is fully enrolled, go to: https://www.huskyhealthct.org/members/provider_lookup.html. Attending providers not enrolled must enroll using the Provider Enrollment Wizard located on the Web site www.ctdssmap.com. From the Home page, click on the Provider tab, and then click on Provider Enrollment to begin the enrollment process. Providers must complete the entire enrollment application to enroll in CMAP.

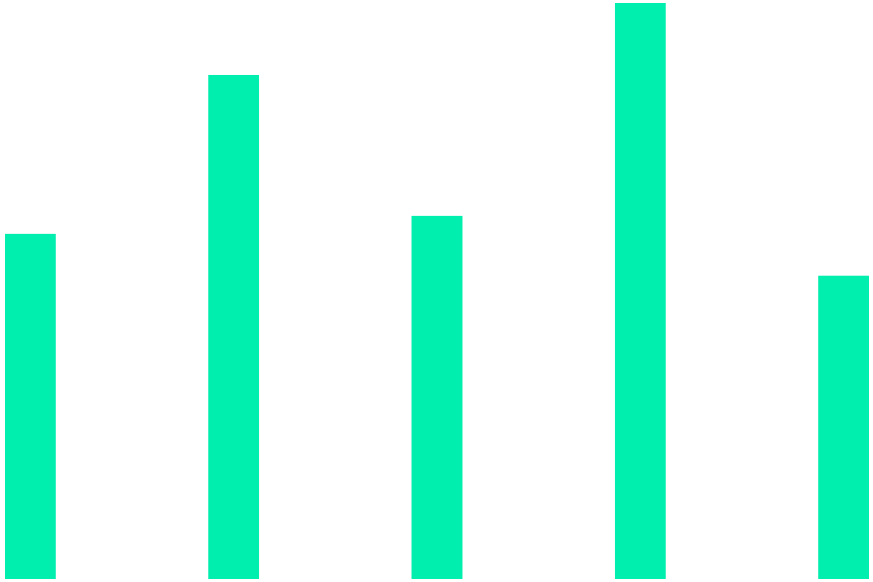
Denials effective March 1, 2023:

- 1033 “Attending physician not enrolled on date of service.”
- 381 “Attending Provider Number is Missing.”

The attending physician’s NPI should be entered in the fields identified below:

- Web claim: Institutional Claim Panel “Attending Phys”
- ASC X12 837 I Loop: 2310A ID Qualifier 71
- Paper UB04 – Field 76

eDelivery



eDelivery

- Letters to Organizations Confirming Changes Made via Secure Web Portal Maintain Organization Members Panel
- Electronic Funds Transfer (EFT) Letters
- Provider re-enrollment/add alternate service location address notification, reminder, approval, and denial letters
- Letters to performing providers when joining/separated from organization
- HUSKY Health Primary Care Payment Program approval, denial and update letters
- Out of State Provider license verification request and deactivation letters
- Vehicle registration expiration letters
- Provider fingerprint background check related follow-up letters (note: the initial fingerprint letter will be mailed)
- Non-Pharmacy Prior Authorization (PA) letters
- Trauma letters
- Trading Partner New Transaction Approval letters
- Trading Partner Update letters

PLEASE NOTE: Providers/trading partners are reminded to regularly check your spam folder (may also be called Junk Email folder depending on the email software used) if you are not receiving the email notifications alerting you that a letter has been posted to your Secure Web portal account.
***IMPORTANT: Whether you are a provider/trading partner master user or a clerk, it is very important to ensure your email address remains current.**

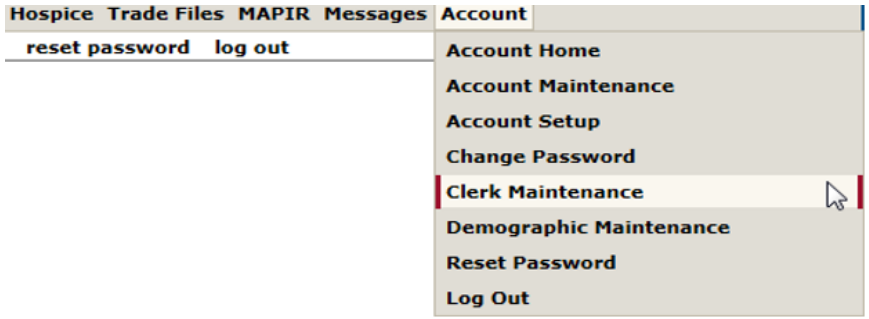
eDelivery – Update

Clerk Maintenance

A clerk can access e-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:

- the existing role of Trade Files (has been re-named Trade Files Includes E-Delivery) – allows access to download all files
- a new role of Trade Files E-Delivery Only – allow access to eDelivery letters only

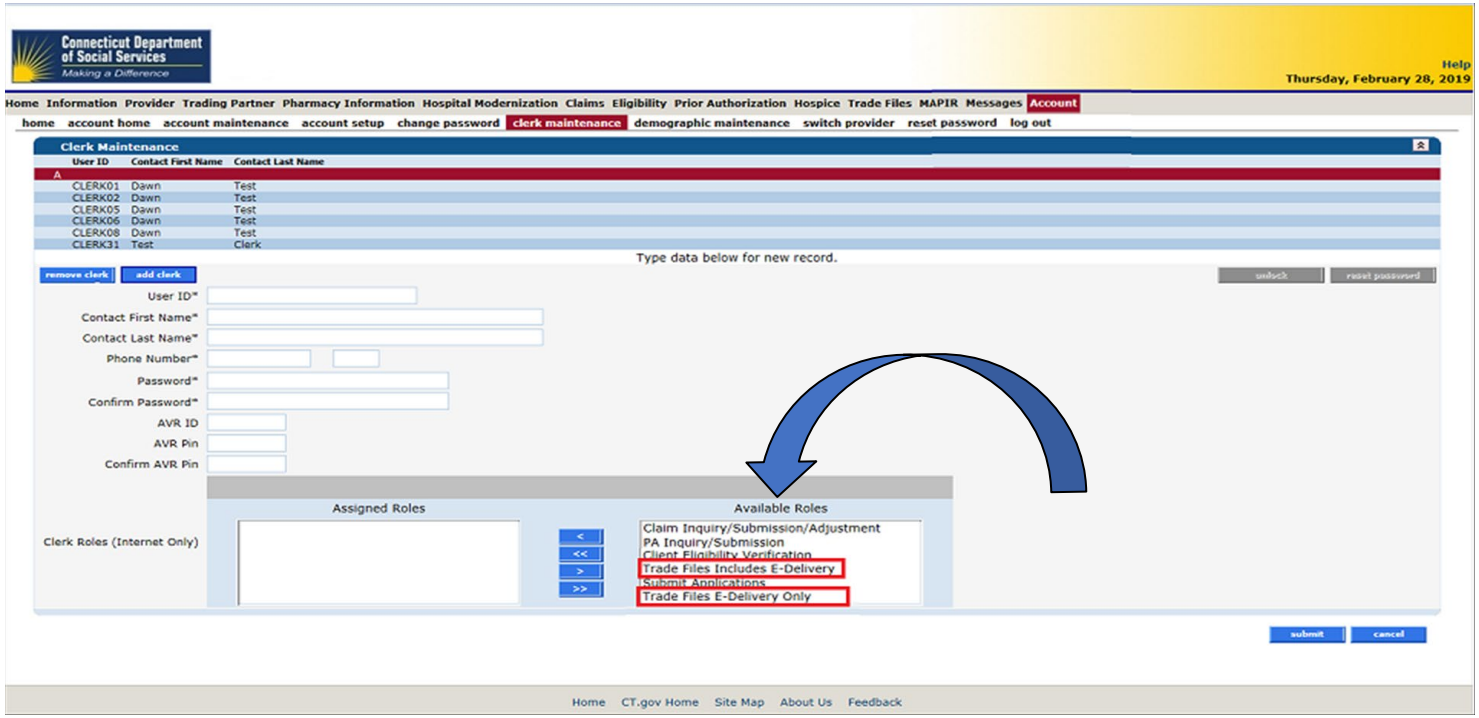
Access the Clerk Maintenance section of the Secure Site by selecting **Clerk Maintenance** from either the Account submenu or the Account drop-down menu.



eDelivery – Update

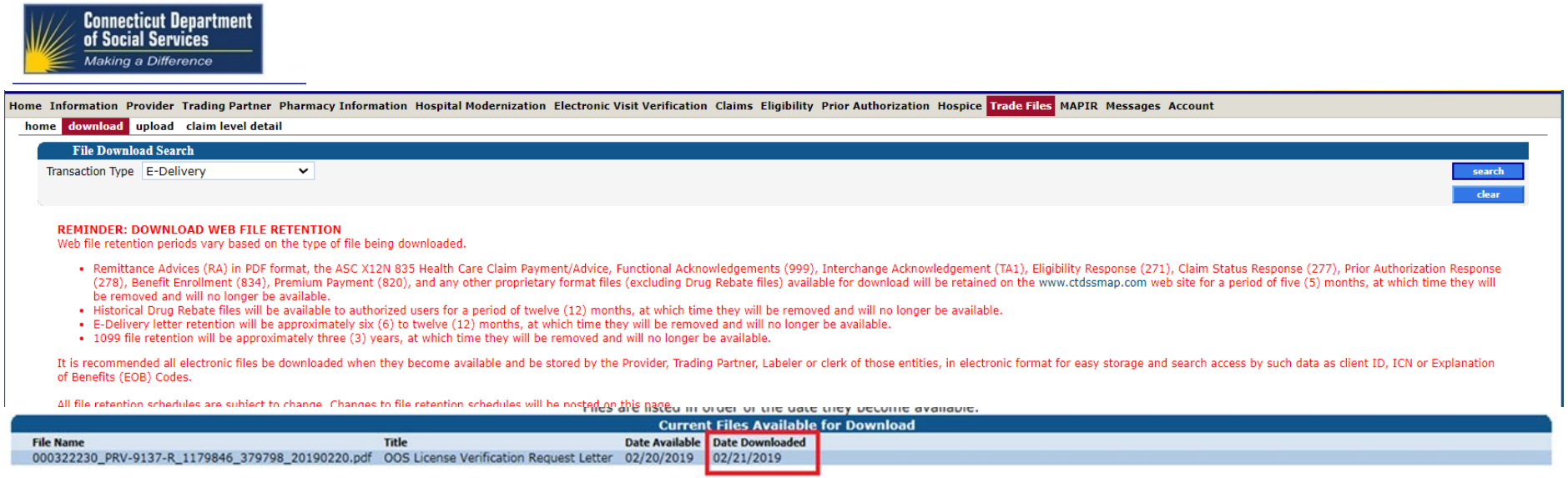
The following screenshot displays the two roles that can be assigned to a clerk that include eDelivery: (Clerks can be assigned either role, but not both)

- Trade files includes E-Delivery
- Trade files E-Delivery Only



eDelivery – Update

- A user can download their letters by selecting **Trade Files** and then Download from the menu items.
- Select **E-Delivery** from the Transaction Type field.
- A user can also sort their letters by title, date available and date downloaded.



eDelivery –Update

Notification

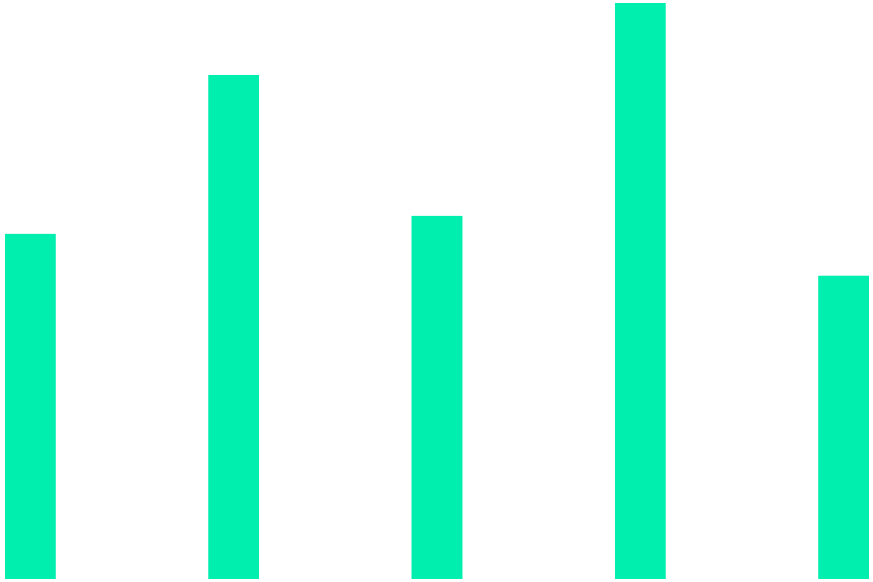
- Email notification will be sent to the email address associated with the primary account holder and clerk's Secure Web portal account
- Email sent daily for letters posted the day prior
- Only one email generated, even if multiple letters posted the previous day
- If a clerk is associated to multiple master users, the email will indicate the master user(s) to which the posted letters apply
- **Sample Email text:**

  From: ctdssmap@gainwelltechnologies.com

  Subject: CMAP E-Delivery Alert – Letter(s) Available

REMINDER: It is important that all users keep their data updated, including their contact email information, as well as clerk data.

Web Site Information



Web Site Information

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

Information > Publications **> Bulletins**

- *Provider Type = Extended Care Facility*

Bulletin Search

Year 23 Provider Type Extended Care Facility

Number Title

search clear

Search Results

Bulletin Number	Title	Published Date
PB23-61	Veyo Transition to MTM	09/08/2023
PB23-55	New Medicaid Coverage of Targeted Case Management for Integrated Care for Kids (...	07/14/2023
PB23-42	Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL...	05/31/2023
PB23-42	July 1, 2023 Changes to the Connecticut Medicaid Preferred Drug List (PDL)	05/31/2023
PB23-42	Pharmacy Web PA Tool	05/31/2023
PB23-42	Reminder About the 5-day Emergency Supply	05/31/2023
PB23-41	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedu...	05/17/2023
PB23-40	Revised W10 Form/Inter-Agency Patient Referral Report	06/05/2023
PB23-38	REVISED Guidance for Services Rendered via Telehealth	05/11/2023
PB23-34	Public Health Emergency Eligibility Unwinding	04/13/2023
PB23-32	Discontinuation of the Optional COVID-19 Testing Group - Effective May 12, 2023	04/13/2023
PB23-31	Sunsetting Provider Bulletins Issued in Response to the COVID-19 Public Health E...	05/02/2023
PB23-29	New Eligibility Group - State Funded Postpartum Care for Non-Citizens	03/28/2023
PB23-19	Reinstating Non-Emergency Medical Transportation and Non-Emergency Ambulance Tra...	03/16/2023
PB23-18	New Guidance for Services Rendered via Telehealth under the Connecticut Medical ...	03/27/2023
PB23-15	New Hepatitis C Policy	03/13/2023
PB23-03	Provider Satisfaction Survey	01/10/2023

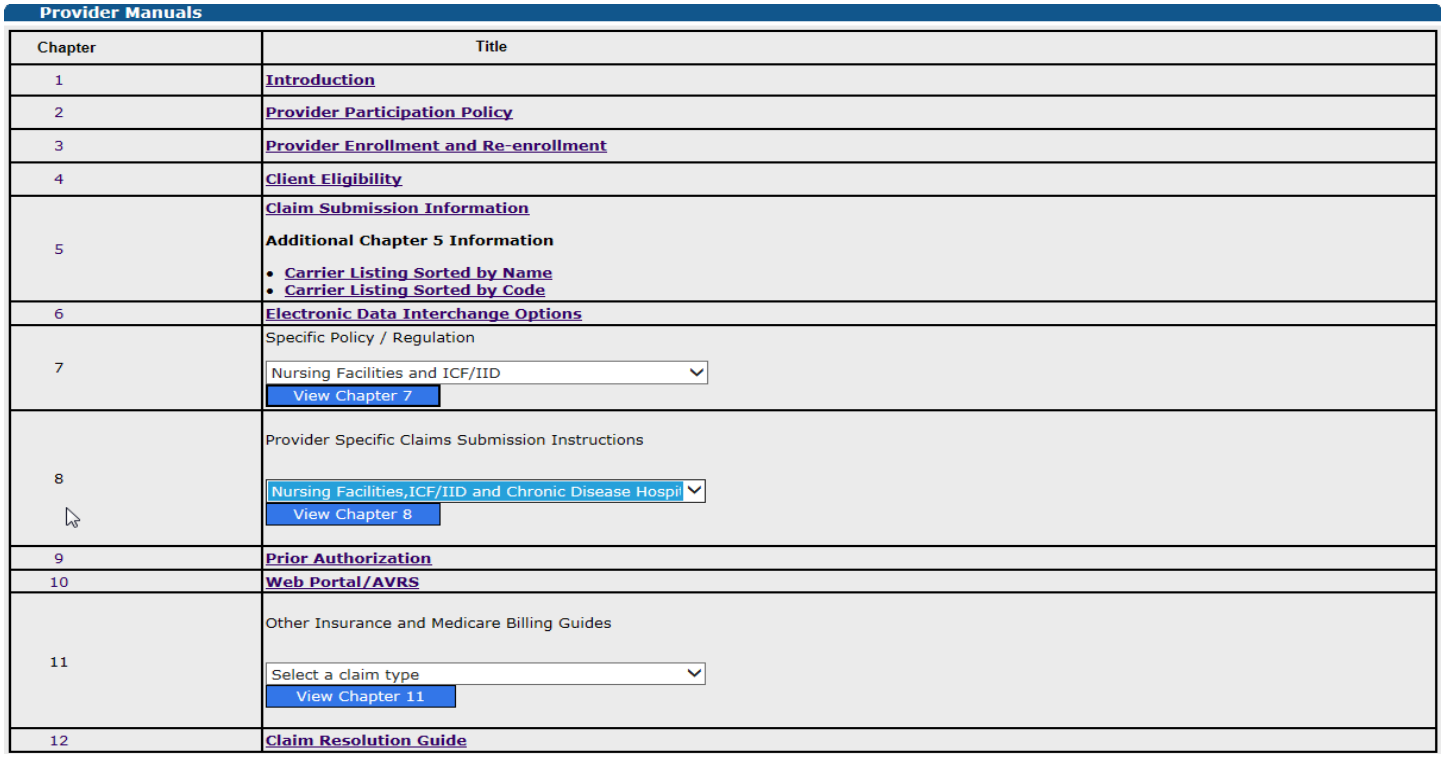
Web Site Information

Information > Publications **> Provider Manuals**

Chapter 7 – Select Nursing Facilities and ICF/IID from drop down menu

Chapter 8 – Select Nursing Facilities, ICF/IID and Chronic Disease Hospitals from drop down menu

Chapter 12 – Claims Resolution Guide (EOB Reference) - slides 80 to 84 examples



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** • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation Nursing Facilities and ICF/IID View Chapter 7
8	Provider Specific Claims Submission Instructions Nursing Facilities,ICF/IID and Chronic Disease Hospi View Chapter 8
9	Prior Authorization
10	Web Portal/AVRS
11	Other Insurance and Medicare Billing Guides Select a claim type View Chapter 11
12	Claim Resolution Guide

Web Site 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”.

Web Site Information

Provider Manual

- *Chapter 1 – Introduction*
  Provides information on the CT Medical Assistance Program, the Department of Social Services' and Gainwell Technologies responsibilities and resources

- *Chapter 2 – Provider Participation Regulations*
  Details the CMAP regulations for provider participation

- *Chapter 3 – Provider Enrollment*
  Provides information on provider eligibility regarding 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

Web Site Information

Provider Manual

- *Chapter 7 – Regulations/Program Policy* **select Nursing Facilities and ICF/IID**
  This section contains the Medical Services Policy sections that pertain to the chosen provider type

- *Chapter 8 – Billing Instructions* **select Nursing Facilities, ICF/IID and Chronic Disease Hospitals**
  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

Web Site Information

Home > **Important Messages**

Important Messages

Attention Behavorial Health Clinics: UPDATE Performing Providers Required for Behavioral Health Clinic Claim Submission (Posting 9/22/23)

Hospital Monthly Important Message (Posted 9/18/23)

Attention CT BHP Behavioral Health Providers Enrolled in Independent Practice and Group Practice, Psychologists, Licensed Marital and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Alcohol and Drug Counselors (LADCs): Behavioral Health Clinician Groups and Individual Clinicians in Independent Practice FAQ (Posted 9/12/23)

Information > Publications > **Provider Newsletters**

- Quarterly publications to providers on a wide range of topics

Provider Newsletters

- June 2023 interChange Newsletter
- March 2023 interChange Newsletter
- December 2022 interChange Newsletter
- September 2022 interChange Newsletter
- Provider Newsletter Archives

Information > Publications > **Claims Processing Information**

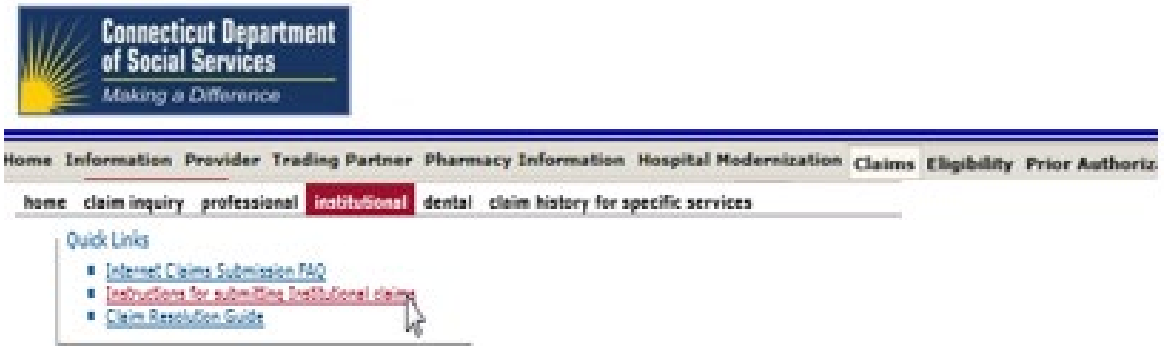
Claims Processing Information

- 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

Web Site Information

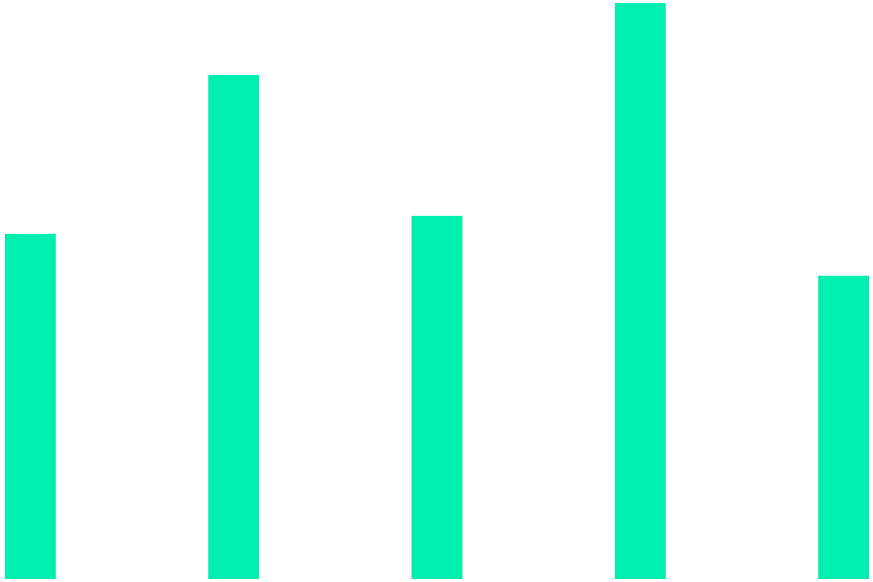
Where to go for more information www.ctdssmap.com

- 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”.



- **Gainwell Technologies Provider Assistance Center (PAC)**
  - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- **Gainwell Technologies Electronic Data Interchange (EDI) Help Desk**
  - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

Common Billing Denials and Resolution



Common Billing Denials

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.

Common Billing Denials

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.

Common Billing Denials

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.

Common Billing Denials

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.

Common Billing Denials

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

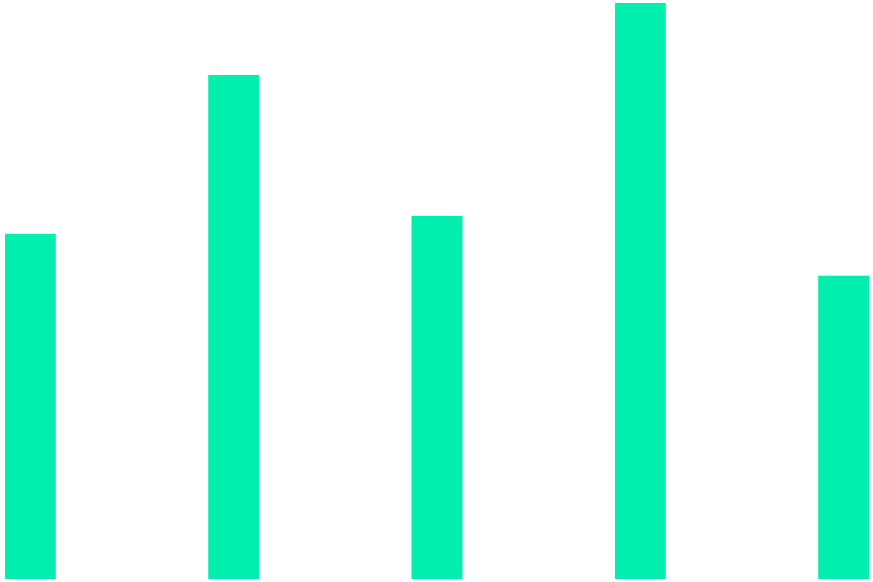
185

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.

Contacts



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Gainwell Technologies Electronic Data Interchange (EDI) Help Desk

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

Carelon Behavioral Health CTBHP

- 1-877-552-8247– Monday through Friday, 9 a.m. to 7 p.m. (EST)

HMS (client third party liability/insurance issues)

- 1-866-252- 0671

DSS Husky

- **www.ct.gov/husky**

Medicaid Website

- **www.ctdssmap.com**

Husky Member Website CHN

- **www.huskyhealthct.org**

Time for Questions