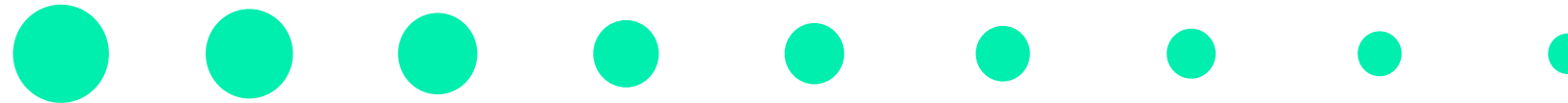


Mental Health Waiver (MHW) Service Provider Refresher Workshop

Debbie Hockla-Kaba, Provider Representative
Gainwell Technologies
April 2021

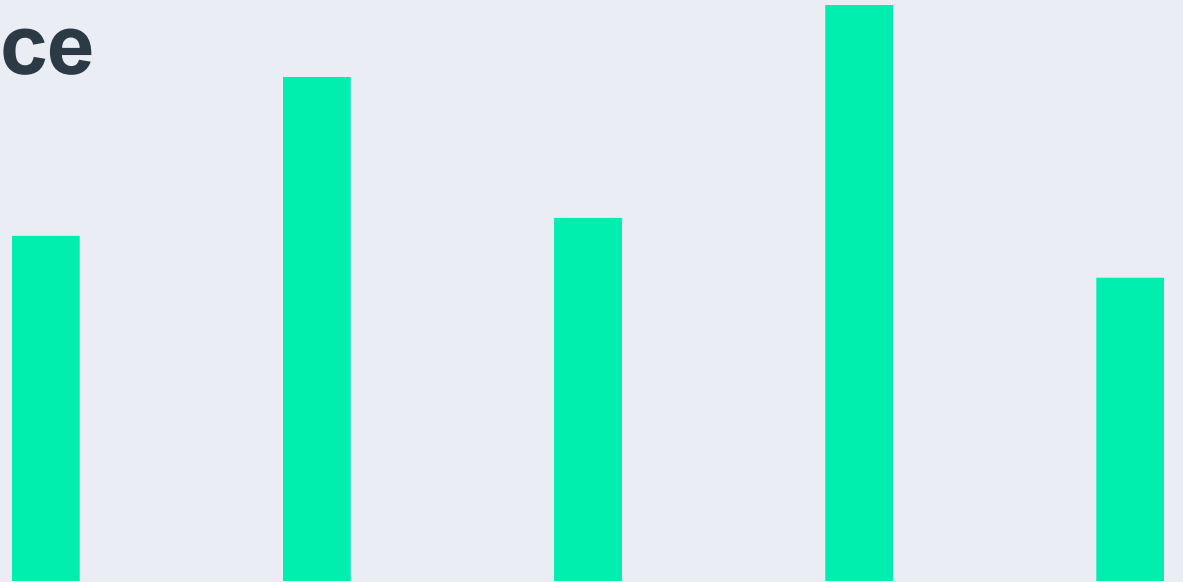


Agenda

- Program Updates - What's New since 2020 Implementation
- Upcoming Changes – Introduction to Electronic Visit Verification (EVV)
- Re-Enrollment – How to Avoid being Disenrolled
- Client Eligibility – Eligibility and Ineligibility Resolution
- Care Plan Review – Confirmation of Authorized Services
- Claim Submission
- Monthly Claims Reprocessing – Remittance Advice Impact
- Claim Denials – Resolution and Resources
- Provider Resources and Contacts
- Time for Questions

What's New in 2020 – A Review of Connecticut Medical Assistance Program Changes

MHW Service Provider Refresher Workshop



What's New in 2020 – A Review of CT Medical Assistance Program Changes

Interim measures implemented by DSS in response to the Governor's declaration of a public health emergency as a result of the outbreak of COVID-19 with impact to MHW Service Providers:

- **Permits select telephonic services**
 - Reimbursement rates for telephonic services are the same as for equivalent in-person services.
 - Documentation must be maintained by the provider to substantiate the services provided.
 - If a telephonic service cannot be provided or completed for any reason, such as due to technical difficulty, the provider shall not submit a claim for that service.
- **Telephonic Services allowed, effective March 16, 2020:**
 - **1213M** Recovery Assistant, Agency per 15 min.
 - **H2015** Comprehensive Community Support Services, per 15 min.

What's New in 2020 – A Review of CT Medical Assistance Program Changes (cont.)

Interim measures implemented by DSS in response to the Governor's declaration of a public health emergency as a result of the outbreak of COVID-19 with impact to MHW Service Providers:

- **Overtime rate implemented for select services**

- Effective **March 16, 2020** - Permits an overtime rate for select services billed with Modifier TU for a caregiver who exceeds service with a single client in excess of 40 hours per calendar week.

- Allowed services include:

- **1213M** Recovery Assistant Agency, per 15 min.

NOTE: Authorization of the procedure code with the TU modifier and any other applicable modifier should be placed on the same prior authorization (PA) with the corresponding stand-alone code (code without the modifier).

What's New in 2020 – A Review of CT Medical Assistance Program Changes (cont.)

Interim measures implemented by DSS in response to the Governor's declaration of a public health emergency as a result of the outbreak of COVID-19 with impact to MHW Service Providers:

- **Implementation of Shelf Stable Meals**

- Effective **April 1, 2020** – Shelf Stable Meals (single and double) are allowed during the COVID – 19 Public Health Emergency Period
- The following new procedure codes were added to the **MHW** for the billing of shelf stable meals:
 - S5170 Home Delivered Prepared Meal – Single Shelf Stable
 - 1931Z Home Delivered Prepared Meals – Double Shelf Stable

What's New in 2020 – A Review of CT Medical Assistance Program Changes (cont.)

For further information regarding these claim related changes implemented during the COVID -19 Public Health Emergency Period, in addition to other temporary changes impacting **MHW** services, please refer to the following publications:

Provider Bulletin 2020-27

[CMAP COVID-19 Response – Bulletin 12: Waiver of Certain Requirements and Temporary Procedural Changes for Home and Community-Based Waiver Programs](#)

Provider Bulletin 2020-35

[CMAP COVID-19 Response – Bulletin 20: TU Modifier - Overtime](#)

What's New in 2020 – A Review of CT Medical Assistance Program Changes (cont.)

For further information regarding these claim related changes implemented during the COVID -19 Public Health Emergency Period, in addition to other temporary changes impacting **MHW** services, please refer to the following publications (cont.):

Provider Bulletin 2020-36

[CMAP COVID-19 Response – Bulletin 22: Meals on Wheels Changes](#)

MHW Procedure Code Crosswalk

For access to the **MHW crosswalk** – from the www.ctdssmap.com Home page > Provider Training link > Under the Materials Heading > Select the Waiver Service Provider Workshop link of your choice > then click on the corresponding Waiver Procedure Code Crosswalk.

Program Updates – 2020

- **Rate Increases**

- Effective for dates of service on or after September 1, 2020, the Department of Social Services (DSS) has increased rates for services in response to the 2.3% increase in the state's minimum wage for MHW Service providers. Providers should refer to **Provider Bulletin PB 20-77** for impacted services.
- The MHW Fee schedule was updated and can be found on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com. Once on the CMAP Web site, choose Provider > Provider Fee Schedule Download. Once the applicable Waiver fee schedule is opened, providers should refer to the rate line detail of the procedure code with a September 1, 2020 effective date.
- Providers who have **submitted claims at the previously allowed rate** must adjust their claims via the Web portal or electronic 837 transaction to obtain the new rate.
- Providers who have submitted **claims equal to or greater than the new allowable rate** would have had their claims systematically adjusted in the rate mass adjustment cycle following the month in which rates were received.

Program Updates – 2020 (cont.)

- **1099s now available on the secure Web portal**

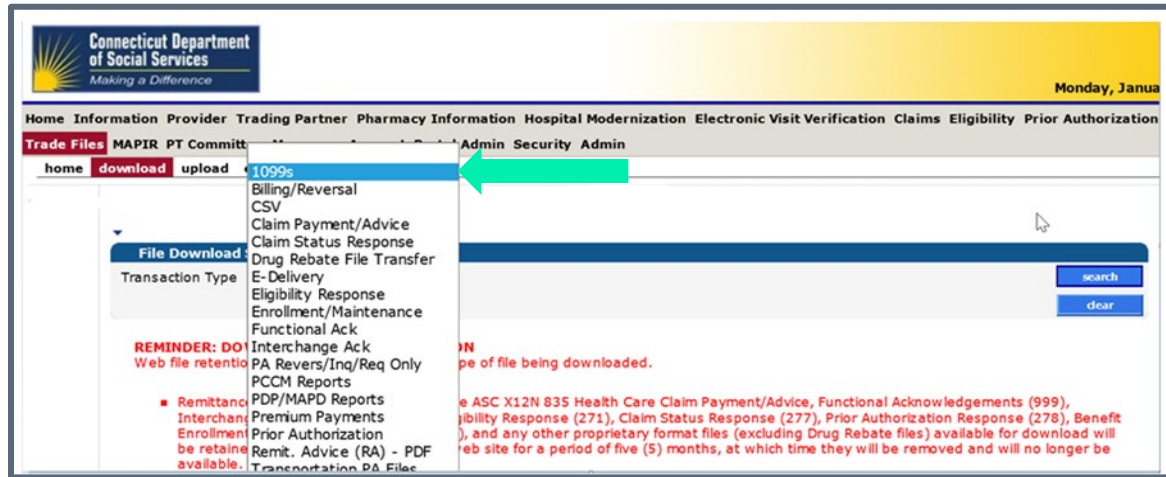
- Providers are now able to download their 1099s from the secure portal on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com. **Reference:** Most current Important Message (IM) posted 1/28/21 for the 2020 1099 availability notification.

- The retention period for 1099s on the secure Web portal is three (3) years. The functionality to download the 1099s is available for all Master Users and any clerk accounts that have access to download PDF Remittance Advice files.

- To access your 1099s:

- Log into secure Web account from www.ctdssmap.com

- Select Trade Files > Download. Click on the 1099s selection located at the top of the drop-down menu and then click on Search.



2020 Updates - DXC Technology Becomes Gainwell Technologies

- On October 1, 2020, DXC Technology sold their State and Local Health and Human Services business to Veritas Capital to form a new company, Gainwell Technologies. As a result of this purchase, providers have been noticing the following changes to:
 - the Gainwell Technologies logo or the Gainwell Technologies name on correspondence.
 - emails received from the @gainwelltechnologies.com email address rather than the @dxc.com email address.
 - hearing the Gainwell Technologies name when calling the Provider Assistance Center.

Upcoming Changes – Introduction to Electronic Visit Verification (EVV)

MHW Service Provider Refresher Workshop



Upcoming Changes – Introduction to EVV

The Department of Social Services (DSS) will be implementing Electronic Visit Verification (EVV) in the Mental Health Waiver Program. The use of EVV will be mandated for the following services:

Procedure Code	Service Description
1206Z	Chore Service, Agency
1213M	Recovery Assistant, Agency, per 15 min.
1217M	Recovery Assistant Overnight, per 15 min.
1229Z	Brief Episode Stabilization, per 15 min.
G9012	Other Specified Case Management, Service Not Elsewhere Qualified
H0038	Self Help Peer Service, per 15 min.
H2015	Comprehensive Community Support Services, per 15 min.
H2023	Supported Employment, per 15 min.
1247Z (new code pending)	Mental Health Counseling, per 15 min.

Upcoming Changes – Introduction to EVV (cont.)

What is Electronic Visit Verification (EVV)?

Electronic Visit Verification (EVV) is a telephonic and computer-based system that documents the precise visit time(s) performed by your caregivers.

Why is DSS implementing EVV in the MHW Program?

In response to the federal requirements set forth in the 21st Century Cures act, DSS is implementing EVV in the MHW program to ensure that individuals with the MHW benefit plan are receiving the services authorized and that claims submitted for payment contain the correct client, service and visit duration provided.

When will DSS implement EVV in the MHW Program?

DSS will be implementing EVV into the MHW Program effective **May 3, 2021**.

Upcoming Changes – Introduction to EVV (cont.)

How do I use EVV?

To use EVV, caregivers are required to check - in and check - out of their scheduled visit(s) using one of two (2) visit time capture methods. Caregivers will be able to use:

- 1) a toll-free phone number for Telephone Visit Verification (TVV)
- 2) the Sandata Mobile Connect (SMC) app on a smartphone.

Will there be training in how to use these EVV time capture methods?

Yes. Training on the Santrax® system will be offered to all providers, both new and current users of the Santrax® system.

Providers who are not currently using the Santrax® system are required to complete training prior to receiving access to their Santrax® system and will have the opportunity to attend a live virtual training.

The EVV trainings educate providers on activating clients in their Santrax® system, creating schedules and resolving exceptions in the Visit Maintenance panel of Santrax®, among other topics. Further information regarding the methods of visit time capture will be provided during training and can be found on the www.ctdssmap.com Web site Home page under the Electronic Visit Verification menu.

Upcoming Changes – Introduction to EVV (cont.)

Will EVV change the way we submit claims?

Yes, the Santrax System offers an alternate method of claim submission which can be used alone or in combination with your current method(s) of claim submission.

What if I choose to continue submitting claims using my current method of claim submission?

You can continue to use the secure Web portal or your own billing system to submit claims. Additional edits, however, have been implemented to ensure service visit validation.

Upcoming Changes – Introduction to EVV (cont.)

How can I begin preparing for the EVV Implementation?

All EVV related materials, updates, and additional information regarding the program are available on the CMAP Web site (www.ctdssmap.com). From the Home page, please select the “**Electronic Visit Verification**” menu.

Among the resources provided are At Your Fingertips tip sheets, provider bulletins, training videos in the use of the different methods of visit time capture and a Frequently Asked Questions (FAQ) document.

Providers are encouraged to review the information available to them on the Electronic Visit Verification section of the www.ctdssmap.com Web site prior to their training session so they are familiar with the EVV program and the Santrax® system.

Upcoming Changes – Introduction to EVV (cont.)

To access the EVV Web page, navigate to www.ctdssmap.com and select Electronic Visit Verification in the header.



The screenshot shows the website for the Connecticut Department of Social Services. The header includes the logo and tagline "Making a Difference" on the left, and "Help" and the date "Monday, March 8, 2021" on the right. A navigation menu contains links for "Home", "Information", "Provider", "Trading Partner", "Pharmacy Information", "Hospital Modernization", and "Electronic Visit Verification". The "Electronic Visit Verification" link is highlighted with a red box, and a red arrow points to it from below. Below the navigation menu are links for "home", "site map", and "about us". The main content area features a large "WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM" banner. Below the banner is a welcome message: "WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE; PROVIDED BY GAINWELL TECHNOLOGIES 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." At the bottom of the page are icons for a stack of books, a stethoscope, a key, and a pill bottle.

Connecticut Department of Social Services
Making a Difference

Help
Monday, March 8, 2021

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

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- Provider Search
- Provider Enrollment
- Promoting Interoperability Program
- OOS Instructions/Information
- Fingerprint Criminal Background Check Info
- Provider Training
- Secure Site

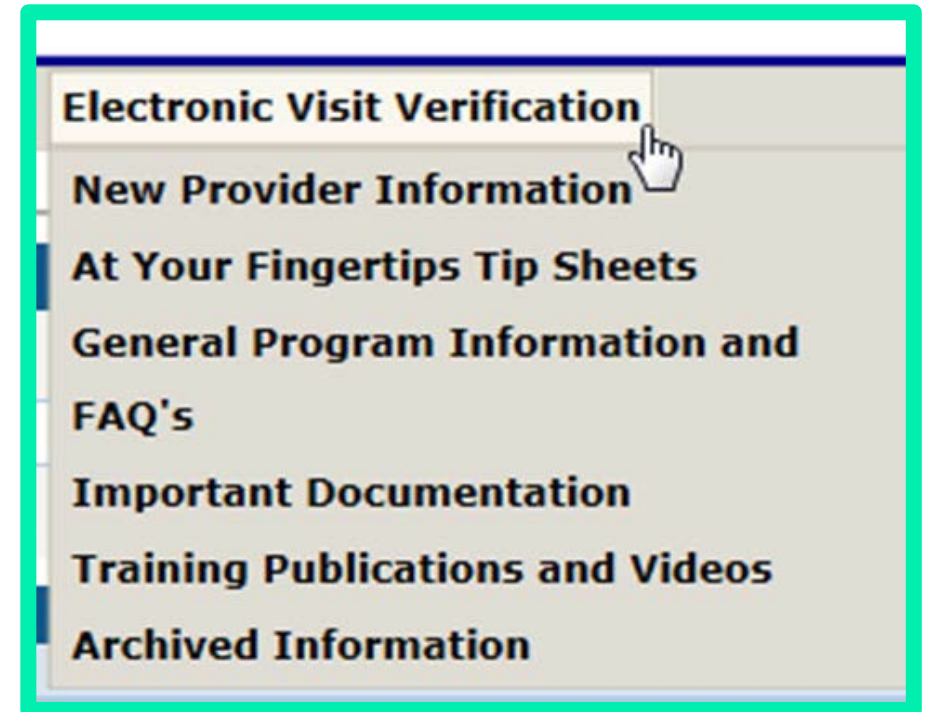
WELCOME
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Stack of books, Stethoscope, Key, Pill bottle (Rx)

Upcoming Changes – Introduction to EVV (cont.)

From the EVV Overview Implementation Page, a user can navigate to the subpage of their choice. Once on the EVV Web page, users can navigate to one of six (6) different pages for more specific information.



Upcoming Changes – Introduction to EVV (cont.)

Who Should Use the EVV Web page?

All agencies and their office staff that service clients with an EVV mandated waiver. The EVV Web page has information for new users, including newly enrolled agencies, and for providers who may just want a refresher on the EVV system and its functionality. All providers who use EVV, including schedulers, billers and office staff, are encouraged to familiarize themselves with the EVV Web page.

Upcoming Changes – Introduction to EVV (cont.)

To ensure your agency does not miss any important EVV communications, be sure to sign up for e-messaging. Each subscriber may select multiple subscriptions.

The screenshot shows a web interface for managing EVV subscriptions. It is divided into three sections, each with a title and a form:

- New Subscriber:** Contains two text input fields labeled "E-Mail" and "Confirm E-Mail", and a blue "Register" button below them.
- Existing Subscribers:** Contains one text input field labeled "E-Mail" and a blue "Update" button below it.
- Unsubscribe:** Contains one text input field labeled "E-Mail" and a blue "Unsubscribe" button below it.

To receive all M H Waiver and related EVV communications:

Available Subscriptions

- **Provider**
 - ALL Provider Types
 - Home Health Agency
 - Hospice Agency
 - Hospital
 - Laboratory
 - Local Health Department
 - Mental Health Group Home
 - Mental Health Waiver
 - Naturopath
 - Optical Shop
 - Optician
 - Optometrist
 - Personal Care Services

To receive all EVV communications regardless of provider type:

■ Topics

- EVV - Electronic Visit Verification
- Hospital Modernization
- Labeler/Drug Manufacturer
- Promoting Interoperability (PI), formerly EHR Incentive, Program
- Trading Partner

Re-Enrollment

How To Maintain your Enrollment Status and Avoid Being Disenrolled

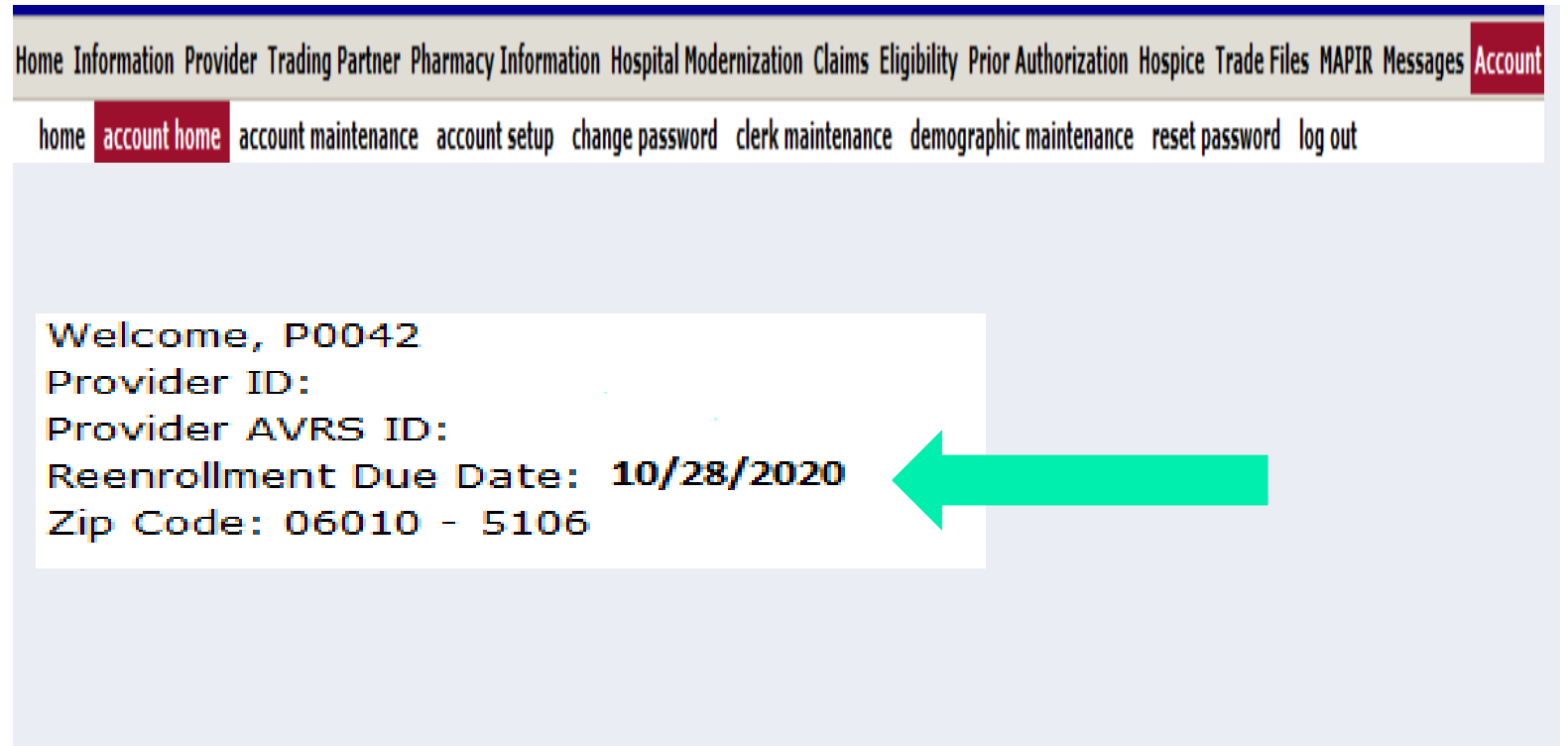
M H Waiver Service Provider Refresher Workshop



Re-Enrollment

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

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



The screenshot shows a navigation bar at the top with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below the navigation bar is a secondary menu with links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The main content area displays the following information:

Welcome, P0042
Provider ID:
Provider AVRS ID:
Reenrollment Due Date: **10/28/2020**
Zip Code: 06010 - 5106

A large green arrow points to the Reenrollment Due Date.

Provider Secure Account Home page indicates the Re-Enrollment Due Date. This date is available to the provider each time the provider accesses their Secure Web Account on the www.ctdssmap.com Home page.

Re-Enrollment (cont.)

Providers will receive a reminder letter when they are due for re-enrollment 6 months prior to the end of their previous 2-year contract.

- The reminder letter will include an **Application Tracking Number (ATN)**.
- To re-enroll, providers should:
 - Access the www.ctdssmap.com Web site
 - From the Home Page, click Provider > **Provider Re-enrollment**
 - Enter the **ATN** received in the re-enrollment reminder letter
 - Enter **NPI** or Non-medical provider identifier (**AVRS ID**)

Re-enrollment (cont.)

- **Prior to Re-enrolling:**

- Mental Health Waiver Service Providers must be credentialed by Advanced Behavioral Health (ABH), the Department of Social Services' Mental Health Waiver Fiscal Intermediary.
- A copy of the provider's **current credentialing letter from ABH** must be submitted as a follow-on document (FOD) to Gainwell Technologies once the online Re-enrollment Application has been submitted.
- The ATN should be noted in the upper right-hand corner of the FOD to ensure the association of the FOD to the provider's re-enrollment application.

Re-enrollment (cont.)

- Providers should successfully **complete the re-enrollment application as quickly as possible** upon receipt of their notice.
 - Providers with **re-enrollment applications** that are **not fully completed by** the provider's re-enrollment **due date** will receive a notice advising they have been **dis-enrolled** from the Connecticut Medical Assistance Program (CMAP). As a result:
 - Case Managers may not be able to enter new PAs for future services.
 - Providers will not be able to bill and be paid for services performed after their re-enrollment due date.
 - *DSS' Quality Assurance may not expedite the process for late re-enrollments.*
- A Provider Enrollment contract will not be reinstated until the **application is finalized**.
 - Reinstatement of contracts w/out a finalized application violates Affordable Care Act (ACA) policies.

Secure Web Account Set-Up and Access

M H Waiver Service Provider Refresher Workshop



Secure Web Account Set-up

- **Providers who successfully enroll as M H Waiver Service Providers receive:**
 - An approval letter with their new AVRS/Medicaid ID
 - Additional letter under separate mailing containing their Personal Identification Number (PIN)
- The AVRS ID and PIN allow the provider initial access to the Connecticut Medical Assistance Program Secure Web Portal to create a secure Web account for the “Primary Account Holder/Local Administrator”.
- Providers should refer to Chapter 10 – “**Web Portal/Automated Voice Response System (AVRS)**” for secure account set-up and more information on secure Web Account Capabilities.

Access to Secure Web Portal

- **Secure Web Account allows providers to:**
 - Verify their re-enrollment due dates
 - Change their passwords
 - Allows the Primary Account Holder to:
 - Make changes to their provider file to update demographic information such as:
 - Address/phone numbers/EFT and languages
 - Set up clerk accounts to allow multiple users access to areas of the secure web portal to perform job tasks
 - Switch Provider functionality
 - Allows switching from one provider secure web account to another to allow clerks that have been associated to multiple provider accounts easy access.

Access to Secure Web Portal (cont.)

- **Secure Web Account access allows providers to:**
 - Verify Client Eligibility
 - Review Service Authorizations (Prior Authorizations)
 - Create, submit, resubmit, adjust, void, and copy claims regardless of their original method of submission
 - Web format is Professional HIPAA 5010 compliant
 - Query Claims
 - Download Trade Files such as:
 - Remittance Advices (claim activity report for the financial cycle)
 - 1099 Forms
 - e-Delivery Notifications including such notifications as Re-enrollment letters
 - Determine the source and resolution of missing clients, Prior Authorizations and unpaid claims for EVV mandated and optional services scheduled and billed via the Santrax system.

Eligibility Determination and Resolution of Eligibility Issues

M H Waiver Service Provider Refresher Workshop



Eligibility

Eligibility Verification

- Only clients with a HUSKY C Benefit plan, if eligible, will have a MHW Benefit plan.
 - Clients must have a HUSKY C Benefit plan with a M H Waiver for the following services to be reimbursed to a MHW Service or ALSA provider:
 - MHW non-medical services
 - ALSA services
 - Clients must have a HUSKY C Benefit plan for the following services to be reimbursed to providers servicing MHW clients:
 - Community First Choice services
 - Home Health services

Eligibility (cont.)

Eligibility Verification

- A Mental Health Waiver Benefit plan will not be viewable to the provider when checking client eligibility.
 - To reduce claim denials due to client ineligibility:
 - DSS notifies ABH on a monthly basis of client ineligibility issues.
 - ABH will notify the servicing provider(s) of the client's ineligibility.
 - Client ineligibility occurs most often due to client/representative issues in following through with the redetermination process.
 - DSS now notifies ABH when a client is up for redetermination.
 - ABH reaches out to resources who can assist the client/client representative with the redetermination process.
- Providers will not be paid for services until the issue of ineligibility is resolved.

Eligibility (cont.)

Eligibility Verification Methods

- Providers who wish to verify HUSKY C eligibility may do so using any of the following eligibility verification methods:
 - Internet Web site at www.ctdssmap.com.
 - Automated Voice Response System (AVRS).
 - Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
 - Provider Electronic Solutions (PES) software.

Eligibility (cont.)

Access to Client Eligibility Verification

Login to your secure Web account on the www.ctdssmap.com Web site to access the Eligibility tab.

- Further information regarding the methods of checking client eligibility under the CT Medical Assistance Program (CMAP) may be obtained via the “Publications” link to the Provider Manual:
 - Chapter 4 Eligibility
 - Chapter 6 Electronic Data Interchange (EDI)
 - Chapter 10 (Web Portal/AVRS)

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Tuesday, April 6, 2021

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- OOS Instructions/Information
- Fingerprint/Criminal Background Check Info
- Provider Training
- **Secure Site**

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Information Provider Trading Partner Pharmacy

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](#)

Eligibility (cont.)

To verify a client's eligibility in the CMAP:

- Click on the Eligibility tab on the main menu
- Enter data for a valid eligibility search combination
 - When entering a full name as part of your search, the name entered must match the CMAP profile.
 - Dates of service entered cannot span months or exceed one year from the date of eligibility verification.
 - Contact the Provider Assistance Center to verify eligibility for dates of service greater than one year from the current date of request.
 - Click Search.

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID Last Name

SSN First Name, MI

Birth Date

From DOS* 03/19/2021

To DOS* 03/19/2021

Service Type Code 1 30 - Health Benefit Plan Coverage Service Type Code 2

Service Type Code 3 Service Type Code 4

Service Type Code 5

Eligibility cont.

Eligibility Verification

- The **client must have a MHW benefit plan** for the MHW Service provider to be reimbursed for services provided to a MHW client and billed directly to Gainwell Technologies by the MHW Service provider.
- **The Mental Health Waiver Benefit Plan will not display in the Eligibility Verification.** The provider must contact ABH with MHW benefit plan questions.
- The client must also have a HUSKY C benefit to have a M H Waiver benefit plan.

Eligibility Verification Request

Client ID	<input type="text"/>	Last Name	<input type="text"/>	From DOS*	<input type="text" value="03/19/2021"/>
SSN	<input type="text"/>	First Name, MI	<input type="text"/>	To DOS*	<input type="text" value="03/19/2021"/>
Birth Date	<input type="text"/>				
Service Type Code 1	30 - Health Benefit Plan Coverage	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

Eligibility Verification Response

Verification Number:

Response Text:

Benefit Plan

Service Information	Benefit Month			Message 1	Message 2
	Effective Date	Effective Date	End Date		
Husky C. For Behavioral Health Services, call BHP at 877-552-8247	03/01/2021	03/19/2021	03/19/2021		

Eligibility (cont.)

Important Eligibility Reminders

- Client Eligibility must be verified prior to providing services to avoid claim denials because of ineligibility:
 - The client must first appear eligible in CMAP before they will be eligible in the EVV Santrax system.
 - A client present in the EVV system does not automatically mean they are eligible for the services provided.
 - Eligibility can change at any time.
 - Prior Authorization does not guarantee that the client is eligible for the services to be provided.
- If a client is ineligible and the service provided is an EVV mandated service:
 - A check-in/check-out can still occur.
 - Using the temporary client feature, the visit can be scheduled and, when completed, confirmed in Santrax.
 - The visit **CANNOT** be exported or uploaded to Gainwell Technologies for claim adjudication.

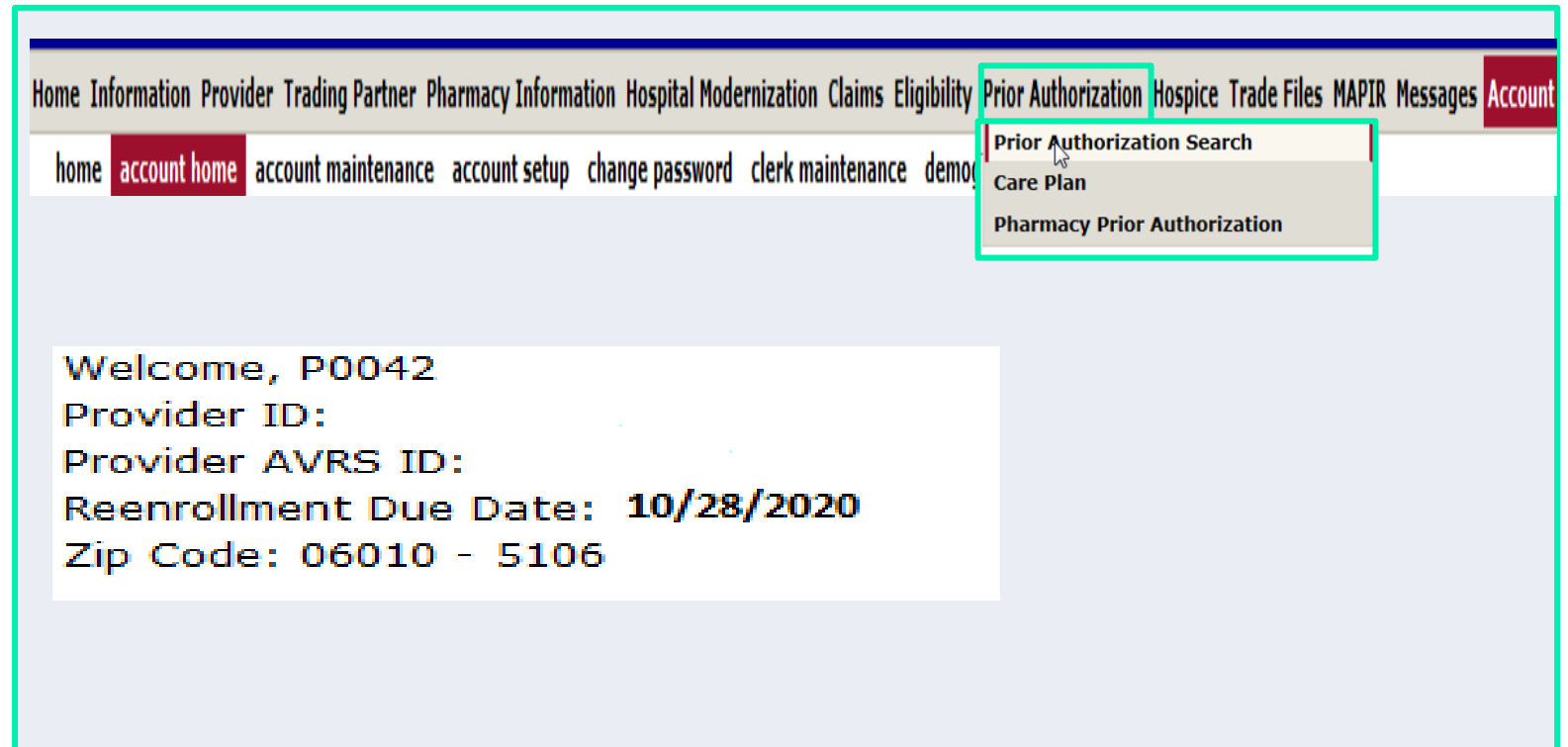
Prior Authorization (PA) – Viewing and Understanding the Care Plan

M H Waiver Service Provider Refresher Workshop



Prior Authorization (PA)

- Primary Account holders and clerks assigned PA permission have access to PA via their secure Web account.
 - Available service authorizations can be accessed by selecting:
 - “Prior Authorization Search” from the PA menu



Secure Web Account Home Page with Prior Authorization Access

Prior Authorization (cont.)

Enter applicable search criteria:

- Enter search criteria and click search for results.
 - PA number will provide the most definitive results.
 - Client ID will provide all PA records authorized since the provider has serviced the client.
 - Use other criteria such as:
 - Service Procedure Code
 - requested/authorized effective and end dates
 - procedure code or code list to be authorized
- to reduce the number of PA records displayed from a client ID search.

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

home prior authorization search care plan pharmacy prior authorization

Quick Link

- Web Guide - Prior Authorization Search

Search for a PA by PA #, if known, Client ID or Client ID with procedure code for the most defined search.

Use the Web guide for further information regarding navigation and field definitions.

Provider 008003693 MCD

Prior Authorization Search

Client ID

Client Name

Search Pharmacy PAs only

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assian - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Procedure Code List [Search]

Once search criteria has been entered click for results.

Click to view if more than 20 records match search results.

Records 20

search

clear

Prior Authorization Search Panel.

Prior Authorization (cont.)

- PA search results as noted below may be sorted for ease in viewing.
 - Each heading may be sorted in ascending or descending order.
 - Data may further be sorted by:
 - PA Number
 - Effective or end date of service
 - Service Authorization code

Click on a column heading to sort results in ascending or descending order.

Search Results																				
Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedur	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency	
2019244001	01	09/01/2019	02/28/2019	12	\$0.00	Approved	09/01/2019	Mental Health Waiver		1222Z										1 Per Calendar Month
0719245033	01	09/01/2019	02/28/2019	10	\$0.00	Approved	09/02/2019	Mental Health Waiver		1220Z										2 Per Calendar Week
0719245033	02	09/01/2019	12/31/2019	8	\$0.00	Approved	09/02/2019	Mental Health Waiver		1218Z										4 Per Calendar Month

Prior Authorization (cont.)

Additional Care Plan Information can be viewed by opening a PA from the PA Search Results Inquiry. Once a PA line detail is open, providers have access to units available and units used in addition to case manager notes.

Base Information

Prior Authorization Number: 0719245098

Client ID: 000000000 PA Assignment: Mental Health Waiver

Last Name: Waiver First Name, MI: Betty

Billing Provider: [] MCD Date of Birth: 10/06/1986

Diagnosis: [] [Search] Insurance: None [v]

Estimated Date of Delivery: []

Patient Condition: Fair [v]

Line Item

Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List	Drug Name
01	10.000	\$0.00	10.000	\$0.00	Approved	H2023									
02	8.000	\$0.00	8.000	\$0.00	Approved	H0038									

Type changes below.

Line Item: 01

Service Type Code*: Procedure Code [v]

Procedure Code: H2023 [Search] Supported Employment, per 15 min

Mod 1: [] [Search]

Mod 2: [] [Search]

Mod 3: [] [Search]

Mod 4: [] [Search]

Revenue Code/List: [] [Search] [] [Search]

Proc/Mod List: []

Procedure Code List: []

Requested Eff./End Dates*: [] []

Requested Units/Dollars*: 10.000 \$0.00

Tooth: [] [Search]

Quad: [] [Search]

Tooth Surface 1: [] [Search]

Tooth Surface 2: [] [Search]

Tooth Surface 3: [] [Search]

Tooth Surface 4: [] [Search]

Tooth Surface 5: [] [Search]

Drug Name: []

Status: Approved

Authorized Units/Dollars: 10 0.00

Authorized Eff./End Dates: 09/01/2019 09/30/2019

Used Units/Dollars: 0 0.00

Available Units/Dollars: 10 0.00

Frequency: 10 Per Calendar Month

Notes

*** No rows found ***

Prior Authorization (cont.)

- **Non-Medical Waiver Services may be authorized by:**
 - Procedure Code – code authorized must be billed on the claim
 - Procedure Code with modifier(s) – code and all modifiers authorized must be billed on the claim
 - Procedure Codes are available on the applicable Waiver Procedure Code Crosswalk found on the www.ctdssmap.com Web site Training page by accessing the Waiver Workshop link.

Prior Authorization (cont.)

- **Non-Medical M H Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier:
 - Modifier **U2 - One Time Only Services** can be used to authorize:
 - Additional units needed on a day a **M H Waiver** service is provided
 - Another day of service in an existing care plan when a **M H Waiver** service is provided
 - An additional frequency to an existing service when **additional services are required outside of the existing frequency.**
 - For example: Client receives H2023 Supported employment, per 15 min (M-F x 4 units per day = 20 units per week). Client also receives 4 additional units per month when working one Saturday per month = 4 units per month authorized as **H2023 U2.**

Prior Authorization (cont.)

- **Non-Medical M H Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier:
 - Modifier **TT** - Subsequent Client, can be used to authorize:
 - **Waiver** services for an additional client residing in the home of a client already receiving the same service.
 - If the **TT** modifier is authorized, it must be associated to the procedure code on the care plan/PA.
 - The **TT** modifier reduces the subsequent client payment for service by **50%**.

Prior Authorization (cont.)

- **Non-Medical M H Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier:
 - Modifier **GW** – Service not Related to the Hospice Patient’s Terminal Condition
 - A GW modifier must be billed with the procedure code for each service on the claim not related to the client’s Hospice condition
 - M H Waiver Service Providers should contact the Hospice provider, as noted in the “lock-in” section of the client’s eligibility verification, with any questions they may have regarding duplication of service.

Prior Authorization (cont.)

- Points to remember when viewing the client's Service Order/Prior Authorization on your secure Web Account:
 - The procedure code, modifiers, from and through dates of service, units and frequency billed should match the service authorization
 - information in Santrax should match with your secure account
 - ***Note: Discrepancies should be reported to ABH.***
 - Providers should refer to the **Procedure Code Crosswalk** for unit increments associated to the Procedure Code authorized.

Prior Authorization (cont.)

Service Authorization Reference Document

- The Procedure Code Crosswalk provides a quick reference to the list of non-medical procedure codes that can be authorized under the M H Waiver.
- Providers should access the Procedure Code Crosswalks for the following information:



- A list of procedure codes and procedure code/modifier combinations authorized under a procedure code/modifier list
- Service descriptions
- Unit increments
- Billing Provider authorized to bill the service
- If service can be spanned when consecutive dates of service are performed
- Care Plan limitations (Service Auto approved or PA required by DSS)
- Frequency of service

- Funding Source that covers the service
- If a service is EVV Mandated, Optional, or N/A
- Effective/End Date of Service.

Additional COVID-19 Information: Refer to Crosswalk Footnotes:

- Service Allowed via Telehealth
- Services Applicable to the OT Rate
- Shelf Stable Meals

Prior Authorization (cont.)

The Procedure Code Crosswalks can be obtained on the www.ctdssmap.com Web site:

Access from the Provider Training Page:

- From the Web site Home Page > Click the “Provider Training” link > Under the Materials Heading > Click on the M H Waiver Workshop link > Click the corresponding “Procedure Code Crosswalk” link.

Access from Chapter 8 of the Waiver Service Provider Manual:

- From the Home page: Information > Publications > Provider Manuals > click on “View Chapter 8” > Choose Mental Health Waiver > Claim Submission Instructions - field 24d

Claim Submission

M H Waiver Service Provider Refresher Workshop



Methods of Claim Submission

- **Web Claim Submission**
 - EVV Mandated, Optional or N/A EVV Claims may be submitted using this Method
 - Provider must be enrolled in CMAP
 - Requires a Secure Web Account
 - Refer to Chapter 10 on the www.ctdssmap.com Web site for Secure Web account set-up
 - Refer to Instructions for submitting Professional Claims via claims menu on the secure site.
 - Refer to Alternate Claim Submission for EVV mandated services billed outside of Santrax.
- **ASC X12N 837 Professional Claim Format File**
 - EVV Mandated, Optional or N/A EVV Claims may be submitted using this Method
 - Provider must be enrolled in CMAP
 - Requires a Trading Partner Agreement
 - Refer to Chapter 6 EDI on the www.ctdssmap.com Web site.
 - Refer to Alternate Claim Submission for EVV mandated services billed outside of Santrax
- **Sandata EVV Santrax System**
 - EVV Mandated or Optional service claims may be submitted via this method
 - Provider must be enrolled in CMAP
 - Provider must have completed required Training of the Santrax System via the Learning Management System
 - Received Santrax Welcome Kit
 - Refer to the Electronic Visit Verification Menu on the www.ctdssmap.com Web site for additional EVV information.

Claims Process – Cycle Schedule

- A Claim Cycle Schedule Bulletin is published semi-annually for the periods of January – June and July – December.
- Claims are usually processed twice per month.
 - Periodically a claim cycle will be three weeks in duration.
- Providers are strongly encouraged to review each semi-annual cycle bulletin to prepare in advance for these three-week cycles.
 - Providers are strongly encouraged to submit enough claims prior to the 3-week cycle to meet their organizations/agency’s operational needs.

2021 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Availability
Jan	8-b	7	12	13	13
	22	21	26	27	27
Feb	5	4	9	10	10
	19	18	23	24	24
Mar	12-b	11	16	17	17
	26	25	30	31	31
Apr	9	8	13	14	14
	23	22	27	28	28
May	7	6	11	12	12
	21	20	25	26	26
Jun	4	3	8	9	9
	18	17	22	23	23

b – Denotes 3 week cycle
 c – Denotes Thursday cycle
 * Denotes a 1 day delay in availability due to Monday Holiday
 ** Denotes a 1 day delay in availability due to Tuesday Holiday

Claims Submission

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

(20)(21)(005)(123)(456)

1 2 3 4 5

- **1 Claim Region** – Identifies the manner in which the claim was submitted (**20** = Electronic Claims with No Attachments. The ICN Region Code List can be found on our Web site under Information> Publications> Claims Processing Information.)
- **2 Year of Receipt** – Indicates the year in which the claim was received by Gainwell Technologies (**21** = 2021)
- **3 Julian Date of Receipt** – The Julian calendar date of receipt (**005** = the fifth day of the year; January 5)
- **4 Batch Number** – An internal number assigned by Gainwell Technologies to uniquely identify a batch (**123**)
- **5 Claim Number** – A sequential number assigned to uniquely identify claims within a batch (**456**)

Claims Submission (cont.)

- When a claim processes through CMAP, it is subject to a series of edits that check the validity of claim data such as:
 - The submitted Provider must be **actively enrolled** on the date of service.
 - Client must be **eligible** on date of service.
 - Procedure Code submitted must be **valid** for the Provider Type.

Each claim then passes through a series of audits.

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

Claim Submission – Web Account Access (cont.)

The screenshot displays a web account interface. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, ConnPACE, Pharmacy Information, Trade Files, HAPIR, Messages, and Account. Below this, a secondary navigation bar includes: home, account home, account maintenance, account setup, change password, maintenance, reset password, and log out. A warning message states: "Your Password will expire in 26 days on May 10, 2021". A "Change Password" link is visible. The main content area includes a welcome message for "John_Doe_Waiver" with the following details: Provider ID: 1234567890 NPI, Reenrollment Due Date: 07/01/2021, and Zip Code: 06106 - 5501. It also notes that R.A.s or 835 transactions are being sent to the download page in the Trade Files menu option. A "Quick Link" section contains five links: Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, and Download Remittance Advices. A "Global Messages" table is shown below, with one row of data. At the bottom, a "Secure Mailbox" section displays "*** No rows found ***".

Home Information Provider Trading Partner ConnPACE Pharmacy Information Trade Files HAPIR Messages Account

home account home account maintenance account setup change password maintenance reset password log out

Your Password will expire in 26 days on May 10, 2021 Change Password

Welcome: John_Doe_Waiver
Provider ID: 1234567890 NPI
Reenrollment Due Date: 07/01/2021
Zip Code: 06106 - 5501
Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Quick Link

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

Global Messages						
Category	Subject	Message	Sent Date	Effective Date	End Date	
Notification	Web Claim Submission is Here!	Web claim submission is now...	12/22/2009	12/22/2009	12/31/2299	

Secure Mailbox

*** No rows found ***

Claim Submission – Web Account Access (cont.)

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

home claim inquiry **professional** institutional dental claim history for specific services

Quick Links

- Internet Claims Submission FAQ
- Instructions for submitting Professional claims
- Claim Resolution Guide

Click on "FAQ" or "Instructions for Submitting Professional Claims" for help with submitting a claim.

Professional Claim

ICN		From Date	
Provider ID	##### NPI	To Date	
AVRS ID	#####	Admission Date	
Client ID*		EPSDT Referral	
Last Name		Total Charges	\$0.00
First Name, MI		Total Paid	\$0.00
Date of Birth		TPL Amount	\$0.00
Patient Account #		CoPay Amount	\$0.00
Medical Record Number		Medicare Crossover	No
Referring Physician	[Search]	837 Version	5010
SSN			
Accident Related	No		
Accident Date			

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident

NPI and AVRS ID auto populate based on secure web account login

Claim Submission

- Claim inquiry allows the provider to query previously submitted claims based on criteria entered in the search panel below.
 - From and To Dates are limited to a three-month (93) date span.
 - Pending Claims are those submitted, but not yet processed, in a financial cycle.

Claim Search 1234567890 NPI

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"/>
		Records	20
		<input type="button" value="search"/>	<input type="button" value="clear"/>

Home Information Provider Trading Partner ConnPACE Pharmacy Information
home account home account maintenance account setup change password

Your Password expires in 61 days on November 1, 2019 [Change Password](#)

Welcome: John_Doe_Waiver
Provider ID: 1234567890 NPI
Renrollment Due Date: 07/01/2021
Zip Code: 06106 - 5501

Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Claims Eligibility Prior Authorization

- Claim Inquiry**
- Professional
- Institutional
- Dental
- Claim History for Specific Services

Global Messages

Category	Subject	Message	Sent Date	Effective Date	End Date
Notification	Web Claim Submission is Here!	Web claim submission is now...	12/22/2009	12/22/2009	12/31/2299

Secure Mailbox

*** No rows found ***

Claim Submission

- **Web Claim Submission Options**

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:

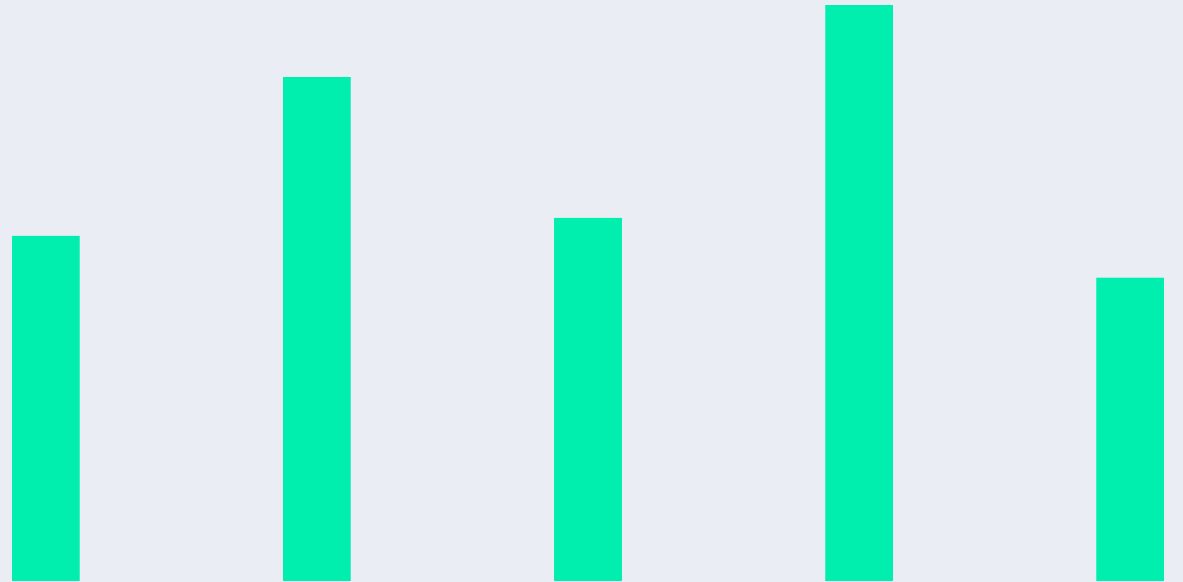
- re-submit** – Resubmit the claim (with or without making changes)
- cancel** – Cancel any alterations you have made
- new claim** – Create a brand-new claim

Suspended claims allow you to:

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

Claim Denials and Resolution

M H Waiver Service Provider Refresher Workshop



Claim Denials and Resolution

- **Denial Reasons Due to Eligibility:**

- **EOB Code 2003** – Client Ineligible for dates of service

- **EOB Code 4021** – Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have a Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021).

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

- **Resolution:**

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

Claim Denials and Resolution (cont.)

Denials Due to Eligibility Issues cont.

- DSS currently notifies ABH upon client enrollment and on a monthly basis of any M H Waiver client ineligibility issues.
 - ABH immediately passes this information on to the provider of service.
 - Provider should not submit claims for clients with eligibility issues until they are resolved to avoid claim denials.
- DSS further notifies ABH when a client is up for redetermination so that ABH can reach out to community support resources who can assist clients with the redetermination process.
- Providers who have questions regarding M H Waiver eligibility on a specific client should contact ABH.

Claim Denials and Resolution (cont.)

- **Denial Reasons due to Care Plan not on File :**

- **EOB Code 3015 – Care Plan Required**

- **Resolution:**

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

Claim Denials and Resolution (cont.)

- **Denial Reason due to Service not Authorized on the care Plan:**
 - **EOB Code 3016** – Service not Authorized on the Care Plan.
 - **Resolution 1:** A service denied for not on care plan must be added by ABH.
 - **Resolution 2:** Incorrect Procedure code billed by provider. Provider must correct the claim and resubmit.

Claim Denials and Resolution (cont.)

- **Denial Reason due to Units Billed Exceeding Frequency :**
 - **EOB Code 5151** – Units exceed the frequency units authorized on the care plan.
 - **Resolution 1:** Units of service must be added to the frequency of an existing PA by ABH.
 - **Resolution 2:** Units exceeded due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution (cont.)

- **Claim Denial Reason due to PA Exhausted:**
 - **EOB Code 3003** – Prior Authorization is required for payment of the service (units for the service are exhausted).
 - **Resolution 1:** Units of service must be added by ABH to an existing PA that is currently exhausted.
 - **Resolution 2:** PA exhausted may be due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution (cont.)

- **Claim Denial Reason due to Provider Not Allowed to Submit Claims for Care Plan:**
 - **EOB Code 3017** – Provider not Allowed to Submit claims for Care Pan
 - **Cause:**
Provider Submitting Claim for Waiver Client or Service under a Provider Type or Specialty not allowed for the client's Care Plan.
 - **Resolution :** Provider must resubmit claim under their Waiver Service or correct Waiver Service Provider ID.

Claim Denials and Resolution (cont.)

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

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

- **Cause:**

- Prior Authorization does not contain a U2 Modifier

- **Resolution:**

- Remove U2 modifier and resubmit the claim

- If one-time only service, contact ABH who must enter a PA for service with a U2 modifier

- **Cause:**

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

- **Resolution:**

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

Claim Denials and Resolution (cont.)

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

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

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

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

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

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

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

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

Claim Denials and Resolution (cont.)

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

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

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

Resolution: increase the units on the confirmed visit.

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

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

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

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

Program Basics for Successful Claim Submission

M H Waiver Service Provider Refresher Workshop



Program Basics for Successful Claim Submission

- **Check client eligibility on clients coming on service**
 - Contact ABH to confirm the client is eligible for the M H Waiver benefit.
 - Set up a periodic check system to determine when the client is eligible so claims may be submitted, if applicable.

Note: Most issues of client ineligibility are resolved within a few days of notification.

Program Basics for Successful Claim Submission (cont.)

- **Check the client's care plan (PA) to be sure the services you have been requested to provide have been authorized.**
 - Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.
 - Report discrepancies to ABH immediately.
 - Review the care plan when you are notified of changes to be sure the services you are being requested to provide are on the care plan/PA.

Program Basics for Successful Claim Submission (cont.)

- **Claim submission review**
 - Prior to submitting claims be sure services provided match services authorized and services to be billed.
 - Identify discrepancies early to avoid over service or potential billing errors which may cause claims to deny such as:
 - Exceeding units on a claim frequency.
 - Omission of a modifier on a claim detail(s).
 - Spanning dates of service across frequencies or PA line details.

Program Basics for Successful Claim Submission (cont.)

- **Claim submission review**

- Submitting claims electronically and/or via the Web:

- Minimize claim submission time by:

- Copying a prior paid claim, especially when billing for like services, minimizing changes needed for resubmission

- Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces keystrokes and the number of details on a claim

- Example: Adult Day Health – Full Day (non-medical) on Mon, Tues, Wed can be billed on a single line detail such as 4/26/2021- 4/28/2021 for 3 units.

- Minimizes reimbursement time

Program Basics for Successful Claim Submission (cont.)

- **EVV System**

- All claims are validated in the EVV system prior to direct submission
 - Right Client
 - Authorized Services
 - Right Caregiver Type
 - Verified Visit Data
- Only validated claims can be submitted for payment
- EVV Check in and Check out determines visit duration for claim

Monthly Claims Reprocessing - Remittance Advice Impact

M H Waiver Service Provider Refresher Workshop



Monthly Claims Reprocessing

- ABH can make retroactive changes to Care Plans even when claims are paid against the Prior Authorization (PA) for a M H Waiver client.
 - ABH can make changes to individual care plans without requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.
 - As a result, Systematic Monthly Claims Reprocessing for M H Waiver claims occurs in the first financial cycle of each month to:
 - Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by ABH.

Monthly Claims Reprocessing (cont.)

- **Systematic Monthly Reprocessing**

- In the first cycle of each month, Gainwell Technologies will recoup (void) all paid claims impacted by the ABH changes made two months prior (Region 52 claims = a voided claim).
- In the same cycle, Gainwell Technologies will reprocess, deny and/or pay claims posting to the correct PA/PA line detail (Region 24 claims = a new day claim).

For example: **changes made to PAs in May 2021** by ABH will result in claims being **voided** (region 52) and **reprocessed** (region 24) in **the first cycle of July 2021**.

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

Monthly Claims Reprocessing (cont.)

- **Impact to Provider Remittance Advice (RA)**
 - If there is a financial impact (change in reimbursement amount up or down) between the voided claim (**region 52**) and the reprocessed claim (**region 24**):
 - **Providers will see in the adjustment section of their RA:**
 - The previously paid claim ICN (**Region 20, 22, 59, 10** etc.)
 - Recouped/Voided claim ICN (**Region 52**)
 - **EOB Code 8236** – Claim was recouped due to PA change

Monthly Claim Reprocessing - Claim Recouped

REPORT: CRA-PHAD-R interChange MMIS Date: 10/15/201
 RA#: MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 33
 PROVIDER REMITTANCE ADVICE
 CMS 1500 CLAIM ADJUSTMENTS

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

PAYEE ID
 ISSUE DATE 10/15/201
 TAXONOMY -----
 P. AVRS ID

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

CLIENT NAME:	Sally Client	CLIENT NO.:	0000000000								
1	2200000000000	060314	061214	(116.16)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	060314	061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HEADER EOBS:		8236									

Monthly Claims Reprocessing (cont.)

- **Impact to Provider Remittance Advice (RA)**
 - A new claim will be systematically created. Providers will see the new day claim on their RA.
 - Claim ICN (**Region 24**) in the paid/denied section of the RA.
 - **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change.

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

Monthly Claims Reprocessing (cont.)

- **Impact to provider's secure Web Portal - Claim Inquiry**
 - Regardless of the financial impact (more, less or no \$ change):
 - All **region 52** and **region 24** claims will appear on the provider's secure web account when performing a claim inquiry.
 - **Region 24** claims with no financial impact (i.e. region 24 claims paid the same as voided region 52 claims) **will appear on the web only** with:
 - **EOB code 8237** – Claim Systematically Reprocessed Due to Retro Change-Information Only.

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

Monthly Claims Reprocessing (cont.)

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

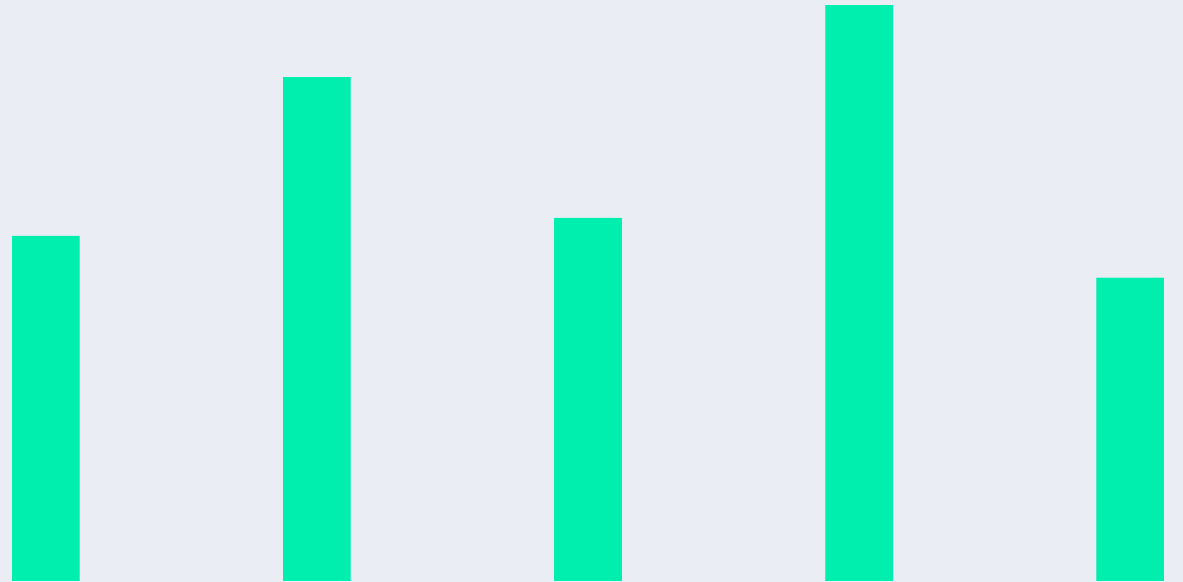
Monthly Claims Reprocessing (cont.)

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

- A PA may show negative units available, if the changes made by ABH reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.
- **For example:**
 - PA authorized for 4 units per week for 4 weeks = 16 units authorized and available.
 - Claims are paid against the PA = 16 units used
 - ABH changes the PA to 4 units a week for 3 weeks = 12 units authorized and available
 - Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Information/Resources

M H Waiver Service Provider Refresher Workshop



Information/Resources

- www.ctdssmap.com contains a wealth of information for providers:
 - **Important Messages**
 - Available on the Home page and on the Information page
 - Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes. Reference the COVID-19 IM for FAQs, Bulletins and IMs with important DSS communications during the Emergency period.



Information

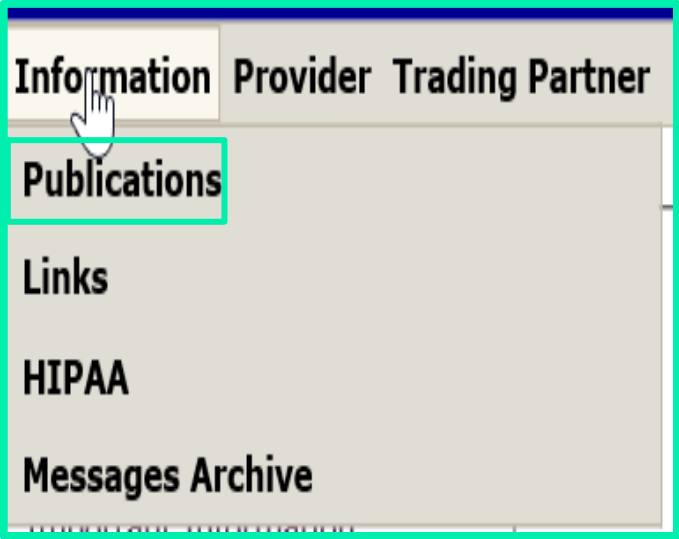
Important Messages

- [COVID-19 Information and FAQs \(Updated 3/30/21\)](#)
- [Attention MEDS Providers: Reinstating Standard Medical Equipment, Devices and Supplies \(MEDS\) Requirements: Signed Delivery Receipts and Prior Authorization Extensions \(Posted 3/30/21\)](#)
- [Attention Providers: Reinstatement of Prior Authorization Requirements \(Posted 3/26/21\)](#)
- [Hospital Monthly Important Message \(Posted 3/9/21\)](#)
- [Attention Providers: Janssen COVID-19 Vaccine \(Posted 3/3/21\)](#)
- [Attention All Providers: 2020 1099s Available for Download \(Posted 1/28/21\)](#)
- [HHS Announces Provider Relief Fund Reporting Update \(Posted 1/22/21\)](#)
- [Attention Providers: Lab Fee Schedule and CMAP Addendum B Update Notification \(Posted 1/19/21\)](#)
- [Attention All Providers: Telemedicine: Update to Place of Service Requirements \(Posted 12/23/20\)](#)
- [Program Year 2020 - Objective 5 Pre-Payment Requirements \(Posted 11/16/20\)](#)
- [Attention Primary Care and Outpatient Hospital Providers: Billing of Influenza Vaccines for the 2020-2021 Influenza Season \(Posted 11/11/20\)](#)
- [HUSKY Health Primary Care Payment Program Extension Notification](#)

Information/Resources (cont.)

- **Publications**

- A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page
- Access the Publications page by selecting Publications from either the Information box on the left side of the home page or from the Information drop-down menu.



Information/Resources (cont.)

- RA Banner Announcements

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

Banner Effective Date	Providers	Banner Page Announcement
10/09/2020-10/16/2020	Attention All Providers	Attention All Providers. DXC TECHNOLOGY BECOMES GAINWELL TECHNOLOGIES: On October 1, 2020, DXC Technology sold their State and Local Health and Human Services business to Veritas Capital to form a new company, Gainwell Technologies. Providers will notice the following changes in the coming weeks: - Providers will begin to see the Gainwell Technologies logo or the Gainwell Technologies name on correspondence. - Provider will begin to receive emails from the @gainwelltechnologies.com email address rather than the @dxc.com email address. - Providers will hear the Gainwell Technologies name when calling the Provider Assistance Center.

Information/Resources (cont.)

- **Provider Bulletins**

- Publications posted to relevant provider types / specialties documenting changes or updates to the CT Medical Assistance Program
- Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000.

Bulletin Search

Year Provider Type

Number Title

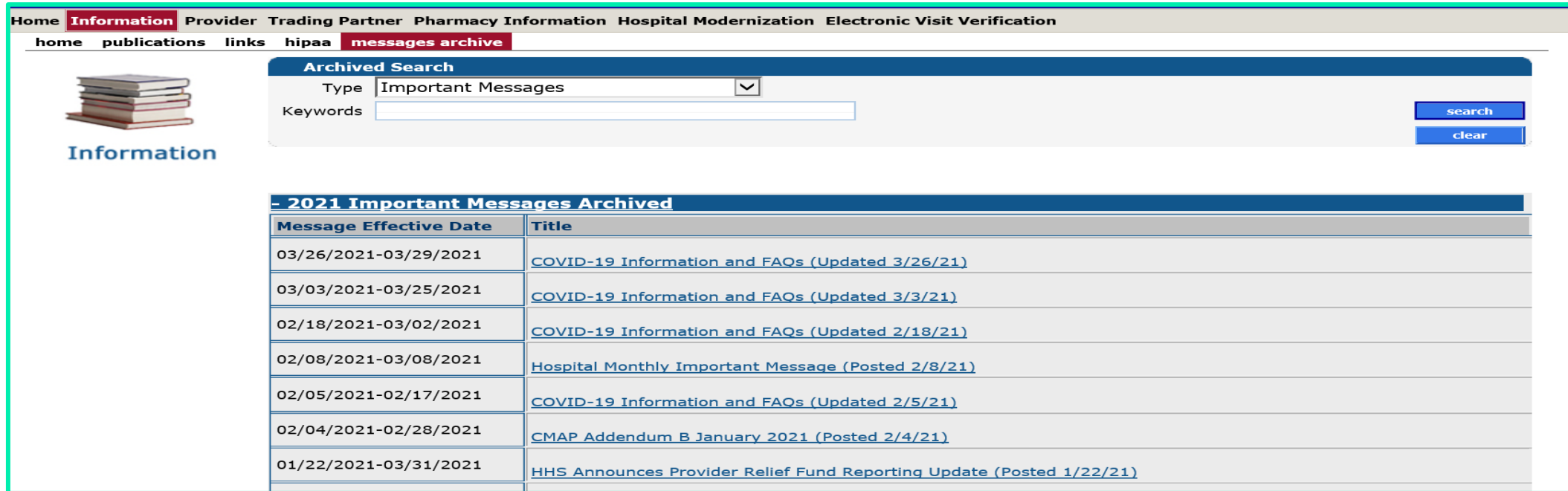
Search Results

Bulletin Number	Title	Published Date
PB20-100	Telemedicine: Update to Place of Service Requirements	12/21/2020
PB20-90	CMAP COVID-19 RESPONSE - Bulletin 46: Clarifying Guidance for Expanded Use of S...	12/21/2020
PB20-88	Payment Error Rate Measurement (PERM) Program Audit Requests	12/06/2020
PB20-82	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedul...	11/13/2020
PB20-77	Rate Increases	11/02/2020
PB20-75	Medical Authorization Portal	10/20/2020
PB20-51	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/27/2020
PB20-48	REVISED CMAP COVID-19 Response - Bulletin 32: Services Covered Under the Optiona...	05/15/2020
PB20-45	CMAP COVID-19 Response - Bulletin 29: Updated Guidance Regarding Audio-Only Tel...	05/11/2020
PB20-44	CMAP COVID-19 Response - Bulletin 30: Updated Audio-Only Behavioral Health (Tele...	05/11/2020
PB20-43	CMAP COVID-19 Response - Bulletin 28: Emergency Medicaid for Non-Citizens	04/30/2020
PB20-42	CMAP COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured ...	04/30/2020
PB20-39	CMAP COVID-19 Response - Bulletin 25: Non-Emergency Medical Transportation and N...	04/13/2020
PB20-38	CMAP COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Tel...	04/16/2020
PB20-36	CMAP COVID-19 Response - Bulletin 22: Meals on Wheels Changes	04/16/2020
PB20-35	CMAP COVID-19 Response - Bulletin 20: TU Modifier - Overtime	04/13/2020
PB20-33	CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Require...	04/13/2020
PB20-27	CMAP COVID-19 Response - Bulletin 12: Waiver of Certain Requirements and Tempora...	03/27/2020
PB20-15	CMAP COVID-19 Response - Bulletin 5: Elimination of Copayments for Services Rend...	03/18/2020
PB20-14	CMAP COVID-19 Response - Bulletin 4: Expanded Telemedicine and New Audio-Only (T...	03/19/2020
PB20-11	Accessing the Provider's Re-enrollment Due Date	03/16/2020
PB20-10	CMAP COVID-19 Response - Bulletin 1: Emergency Temporary Telemedicine Coverage	03/11/2020
PB20-09	New Coverage of Specified Telemedicine Services Under the Connecticut Medical As...	03/11/2020

Information/Resources (cont.)

- **Archive Important Messages and Banner Announcements**

- Important Messages and RA Banner Announcements are available on the Home page of the www.ctdssmap.com Web site. Only the most current messages will be posted in the main areas on the Web for a limited time; thereafter, providers will be able to retrieve previously published Important Messages and Banner Announcements from messages archive. To access the messages archive page, select messages archive from the Information drop-down menu on the home page.
- RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.



The screenshot shows the 'messages archive' page on the CTDSSMAP website. The navigation bar includes 'Home', 'Information' (selected), 'Provider', 'Trading Partner', 'Pharmacy Information', 'Hospital Modernization', and 'Electronic Visit Verification'. Below the navigation bar, there are links for 'home', 'publications', 'links', 'hipaa', and 'messages archive' (selected). On the left, there is an icon of a stack of books and the word 'Information'. The main content area is titled 'Archived Search' and includes a dropdown menu for 'Type' set to 'Important Messages', a 'Keywords' search box, and 'search' and 'clear' buttons. Below the search box is a table titled '- 2021 Important Messages Archived' with the following data:

Message Effective Date	Title
03/26/2021-03/29/2021	COVID-19 Information and FAQs (Updated 3/26/21)
03/03/2021-03/25/2021	COVID-19 Information and FAQs (Updated 3/3/21)
02/18/2021-03/02/2021	COVID-19 Information and FAQs (Updated 2/18/21)
02/08/2021-03/08/2021	Hospital Monthly Important Message (Posted 2/8/21)
02/05/2021-02/17/2021	COVID-19 Information and FAQs (Updated 2/5/21)
02/04/2021-02/28/2021	CMAP Addendum B January 2021 (Posted 2/4/21)
01/22/2021-03/31/2021	HHS Announces Provider Relief Fund Reporting Update (Posted 1/22/21)

Information/Resources (cont.)

- **E-Mail Subscriptions**

- Providers **MUST** register to receive information electronically for new provider publications and notifications through the email subscription function on the CMAP Web site at www.ctdssmap.com. Communications are no longer mailed to providers and must be downloaded from the DSS Web site.
- For complete E-mail subscription information, please see Provider Bulletin PB15-23 [Implementation of Electronic Messaging](#) on the CMAP Web site.

E-Mail Subscriptions

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

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

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

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

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

New Subscriber

E-Mail

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E-Mail

Unsubscribe

E-Mail

Available Subscriptions

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

Information/Resources (cont.)

- **Provider Manual**

- Access via the www.ctdssmap.com Web site Home page >Information > Resources > Provider Manuals
- The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission
- It is the primary source of information for submitting CMAP claims, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions
- The Provider Manual is divided into twelve (12) chapters
- Click on the chapter title to open the document (*disable* pop-up blockers)
- Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter
- Chapter 11 is claim-type specific

Information/Resources (cont.)

- **Provider Manual**

- **Chapter 1 – Introduction**

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

- **Chapter 2 – Provider Participation Regulations**

- Details the CMAP regulations for provider participation

- **Chapter 3 – Provider Enrollment**

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

- **Chapter 4 – Client Eligibility**

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

- **Chapter 5 – Claim Submission Information**

- Provides information on general claims processing and billing requirements

- **Chapter 6 – EDI Options**

- Provides information on electronic claim submission and electronic RAs

Information/Resources (cont.)

- **Provider Manual cont'd**
 - **Chapter 7 – Regulations/Program Policy**
 - This section contains the Medical Services Policy sections that pertain to the chosen provider type
 - **Chapter 8 – Billing Instructions**
 - Provides information on provider specific billing requirements and instructions
 - **Chapter 9 – Prior Authorization**
 - Provides information on how to obtain Prior Authorization for designated services
 - **Chapter 10 – Web Portal/Automated Voice Response System (AVRS)**
 - Provides information on both the AVRS and the Web Portal functions
 - **Chapter 11 – Other Insurance/Medicare Billing Guides**
 - Provides claim-type specific information on other insurance and Medicare billing
 - **Chapter 12 – Claim Resolution Guide**
 - Provides descriptions of common EOBs and, if applicable, information to resolve the errors

Information/Resources (cont.)

- **Provider Newsletters**

- Quarterly publications to providers on a wide range of topics

Provider Newsletters

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

- **Claims Processing Information**

- Guides and FAQs to assist with billing/claims processing

Claims Processing Information

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

Contacts

M H Waiver Service Provider Refresher Workshop



Contacts

- **Gainwell Technologies Provider Assistance Center (PAC)**

- 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays

- www.ctdssmap.com

- ctdssmap-ProviderEmail@dxc.com

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

- **Gainwell Technologies Electronic Data Interchange (EDI) Help Desk**

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

Contacts cont.

- **Advanced Behavioral Health (ABH)**

For Client Eligibility Issues:

Lori-Lynn French

Telephone – 860.704.6177

Email _lfrench@abhct.com

For Prior Authorization (PA) Issues:

Telephone – 860.704.6201

Contacts (cont.)

- **EVV Email Mailbox**

- ctevv@dxc.com

If you are:

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

then contact the EVV email box for assistance.

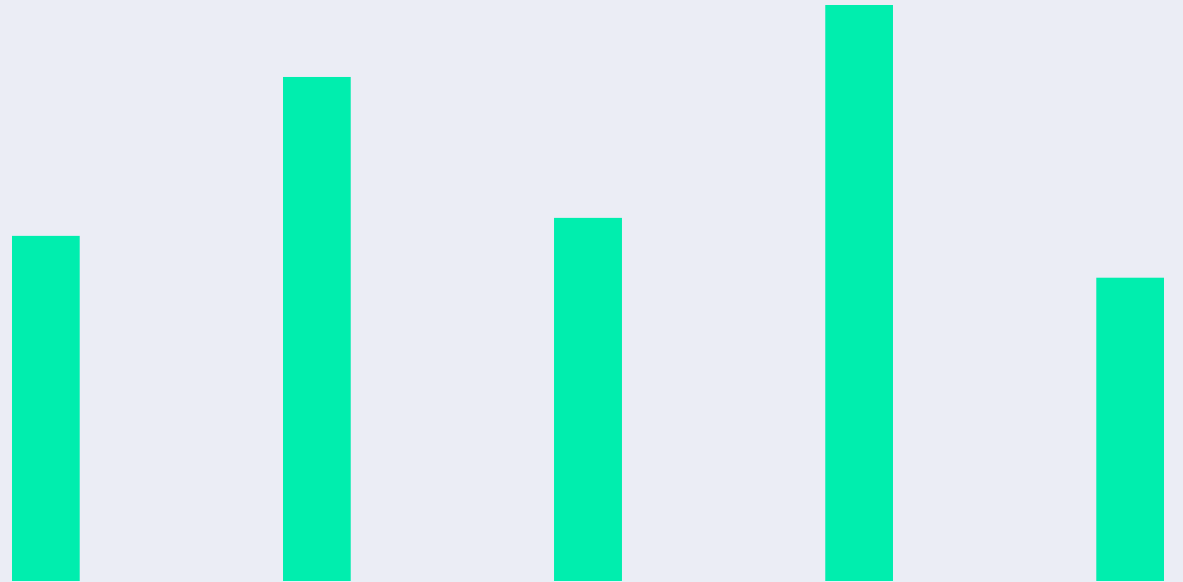
Contacts (cont.)

- **Sandata Customer Care**

- 1-855-399-8050 or ctcustomer@sandata.com
- If you are experiencing issues with the Santrax system or its functionality, please contact Sandata Customer Care for assistance.
- If you are unsure who to contact for assistance, please send an e-mail to ctevv@dx.com.
- You are also encouraged to send an e-mail to the ctevv@dx.com mailbox if you feel you need additional support resolving your issue.
- **Please be sure to include your Sandata ticket number if applicable.**

Questions

M H Waiver Service Provider Refresher Workshop



Thank you.

Thank you for attending the Connecticut Medical Assistance Program Mental Health (MH) Waiver Service Provider 2020 Refresher Workshop!

All questions and comments regarding this training are welcome.

Please fill out the online workshop survey, as our feedback helps us to improve future workshops!