

October 31, 2017

Waiver Provider Refresher Workshop

Presented by
The Department of Social Services
& DXC Technology



Waiver Provider Refresher Workshop

Agenda

➤ **What's New in 2017**

- ✓ Electronic Visit Verification
- ✓ Face-to-Face Requirements – Home Health
- ✓ More 2017 Updates

➤ **Waiver Review**

- ✓ Client Eligibility/Resolution



Waiver Provider Refresher Workshop


Agenda

➤ **Waiver Review cont.**

- ✓ Care Plan Review
- ✓ Claim Submission Guidelines
- ✓ Monthly Claims Reprocessing
- ✓ Claim Denials, Resolution and Resources

➤ **Program Resources**

➤ **Time for Questions**



What's New in 2017 – A Review of current Connecticut Medical Assistance Program Changes

Waiver Provider Refresher Workshop

Program Updates – 2017

Face-to-Face Requirements – Home Health

Effective for home health services (new or initial orders) ordered on or after July 1, 2017, a face-to-face visit and physician certification will be required for home health services that are paid under the Medicaid State Plan for HUSKY Health members (HUSKY A, B, C, and D). All home health services paid under the Medicaid State Plan as well as those provided to Medicaid waiver members must also comply with these requirements.

Full documentation on these requirements can be found in [Provider Bulletin PB17-02 New Face-to-Face Requirements for Initial Orders of Home Health Services](#) on the ctdssmap.com website.

- **Federal Regulations mandate the face-to-face encounter MUST:**
 - be related to the primary reason that the HUSKY Health member requires home health services;
 - occur between the HUSKY Health member and an enrolled physician; or between the HUSKY Health member and an enrolled non-physician practitioner* (NPP), defined as an APRN, PA, or CNM working in collaboration with an enrolled physician; and
 - occur within a period that is no more than 90 days before or 30 days after, the start for all initial orders for home health services.

(*Note: although NPPs are allowed practitioners to perform the face-to-face encounter, per federal regulations, only a physician can order home health services)

Program Updates – 2017

Face-to-Face Requirements – Home Health

(cont.)

Home Health Face-to-Face Encounter Documentation Requirements

- The ordering physician must maintain documentation, either in hard copy or electronic form, in the HUSKY Health member's medical record and also provide documentation to the home health agency (HHA) substantiating that the face-to-face requirements have been met.
- The HHA must ensure that it has received this documentation for each HUSKY Health member for whom a face-to-face visit is required.
- The HHA must also maintain the documentation, in hard copy or electronic form, in the HUSKY Health member's medical records at the home health agency.

Documentation must, at minimum, include ALL of the following:

- In the case where the face-to-face was performed by an authorized practitioner other than the physician ordering the home health service, the clinical findings of the face-to-face encounter, substantiating the need for home health services;
- The primary reason for which home health services are required;
- The date of the face-to-face encounter;
- The name, either hard copy or digital signature, and credentials of the practitioner who conducted the face-to-face encounter; and
- the dated signature of the enrolled physician who has prescribed the home health services if the face-to-face encounter was performed by a NPP

Program Updates – 2017

New Procedure Codes

Effective for dates of service May 1, 2017 and forward, the Department of Social Services (DSS) has added the following four (4) new Personal Care Assistance (PCA) procedure codes to the Acquired Brain Injury II, (ABI II) Waiver Program. The codes are:

- 1022Z PCA Overnight, Agency
- 3022Z PCA Overnight cannot be completed,
pro-rated hourly, Agency
- 1023Z PCA Per Diem, Agency
- 1225Z PCA Per Diem cannot be completed,
pro-rated hourly, Agency

The unit increment for 1022Z, PCA overnight, and 1023Z, PCA per diem, is one unit per day. The unit increment for 3022Z, PCA overnight, shift cannot be completed, is one unit per hour up to a maximum of eleven (11) hours of service. The unit increment for 1225Z, PCA per diem, shift cannot be completed, is one unit per hour up to a maximum of twenty- three (23) hours of service.

Program Updates – 2017

New Proc/Mod lists

Effective for dates of service May 1, 2017 and forward, DSS has also added the following three (3) new PCA Procedure/Modifier (Proc/Mod) Code lists to the ABI and CHC Waiver Programs. As a result, providers can bill any code combination associated to the list authorized, up to the number of units within the frequency authorized, as applicable to the services provided. All procedure codes listed are required on the client's Care Plan and are Electronic Visit Verification (EVV) mandated.

Personal Care Services	List Code - 33
Description of Service	Procedure Code
PCA, Per 15 minutes	1021Z
PCA, Per 15 min., subsequent client	1021Z TT

Personal Care Services, Per Diem	List Code – 35
Description of Service	Procedure Code
PCA Per Diem	1023Z
PCA Per Diem, subsequent client	1023Z TT

Personal Care Services, Overnight	List Code - 34
Description of Service	Procedure Code
PCA Overnight	1022Z
PCA Overnight, subsequent client	1022Z TT

Program Updates – 2017

ABI Providers – Requirement to Submit Written Reports

Acquired Brain Injury (ABI) Waiver providers are required to submit written reports regarding the status and progress of each individual to whom they provide ABI Waiver services.

- **Providers are required to submit reports for each of the first three (3) months of an individual’s participation in the ABI Waiver program, and quarterly thereafter.**
- **The reports are to be submitted to the appropriate care manager for each individual. See section 17b-260a-17(c) of the DSS ABI Waiver Operational Policy, effective July 1, 2016.**

Program Updates – 2017

Electronic Visit Verification (EVV) – At Your Fingertips



“At Your Fingertips” is a bi-monthly tip sheet designed to help providers navigate EVV by answering common questions and providing assistance for resolving common issues encountered by providers in their use of the EVV system. Topics will include who to contact when you need to resolve an issue, how to successfully perform visit maintenance, how to improve your claim submission experience, and many others. The tip topics are generated by questions submitted to Sandata Customer Care, the EVV mailbox (ctevv@dxc.com) or in communications to DSS for assistance. These tip sheets reflect real questions and issues that providers have as they use the EVV system.

Program Updates – 2017

Electronic Visit Verification (EVV) – Alternate Claims Solution

Effective Date: TBD

The alternate claims solution will allow both non-medical and medical providers the option to bill using one (1) or more of the following methods. Providers can:

- continue to use Santrax to submit claims to DXC Technology for adjudication, or
- submit or adjust claims directly through the DSS portal at www.ctdssmap.com, or
- submit or adjust claims through their own or vendor software using the ASC X12N 837 I (Institutional) or P (Professional) format, or
- continue to use Santrax to submit claims for select clients, and use either the DSS portal and/or vendor software for other clients.

There will be no restriction on which method the provider chooses.

Claims submitted outside of Santrax will be edited against visit data stored in Santrax to ensure that only those claims with a confirmed visit are paid. It is important to note that the following requirements will remain in place in order to maintain current program integrity:

- Use of single EVV solution (Santrax) for DSS Waiver clients
- Entry of schedules/staff with utilization of the check-in and check-out process for EVV mandated services
- Perform visit maintenance to ensure visits are confirmed prior to exporting claims in any of the three claim submission methods for adjudication.



Program Updates – 2017

Electronic Visit Verification (EVV) – Advanced Beneficiary Notice (ABN) and Third Party Liability (TPL)

Advanced Beneficiary Notice (ABN)

Effective July 1, 2017 for all dates of service April 3, 2017 and forward EVV mandated providers must enter the appropriate Medicare denial/ ABN information for each client into Santrax system prior to exporting claims. If the ABN information is not present on the claim prior to export, the claim will deny for EOB code 2522 – “Bill Medicare first or Provide Appropriate Adjustment Reason Code and Date of ABN or NOMNC”.

Third Party Liability

Effective April 3, 2017 for all dates of service April 3, 2017 and forward EVV mandated providers must enter the appropriate Third Party Liability information for each client into Santrax system prior to exporting claims. If the TPL information is not present on the claim prior to export, and the appropriate CARC provide, the claim will deny for EOB code 2504- “Bill Private Carrier First”.

Program Updates – 2017

Electronic Visit Verification (EVV) – Compliance

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



Determining and Resolving Eligibility Issues

CHC Service Provider Workshop

Access to Secure Web Account



Help
Thursday, September 07, 2017

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Information

- Publications
- Links
- Important Information
- RA Banner Announcements
- HIPAA
- Regional Office Locations
- Provider Satisfaction Survey

Provider

- Provider Services
- Provider Search
- Provider Enrollment
- EHR Incentive Program
- OOS Instructions/Information
- Fingerprint Criminal Background
- Check into
- Secure Site

Trading Partner

- Trading Partner Enrollment
- Trading Partner Documents
- Provider Electronic Solutions
- Billing Instructions

Pharmacy

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

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



Information



Provider



Trading Partner



Pharmacy

Important Messages

[Automated Voice Response System Downtime Notification \(Posted 9/7/17\)](#)

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

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

Access to Secure Web Account

home Information **Provider** Trading Partner Pharmacy Information

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search provider fee schedule download
ehr incentive program oos instructions/information **secure site**

Login

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

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

[setup account](#)

User ID*

Password*

[login](#)

If you have forgotten your password please click the reset password button.

[reset password](#)

Web Access

Eligibility Verification

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

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

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request			
Client ID	<input type="text"/>	last name	DOE <input type="text"/>
SSN	666-55-4444	First Name, MI	JOHN <input type="text"/> <input type="text"/>
Birth Date	<input type="text"/>	From DOS*	09/01/2014
Service Type Code 1	<input type="text"/>	To DOS*	09/30/2014
Service Type Code 2	<input type="text"/>	Service Type Code 2	<input type="text"/>
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>
Service Type Code 5	<input type="text"/>		
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

****When entering a full name as part of your search, a middle initial is required if present in their CMAP profile****

Determining and Resolving Eligibility Issues

Client Eligibility cont.

✓ Resources:

- Community Options at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to HomeandCommunityBasedServices.dss@ct.gov.
The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC Client Eligibility Issue", "ABI Client Eligibility Issue", or "PCA Client Eligibility Issue" in the subject line of the email.
 - Providers who identify an eligibility issue upon claim denial should contact the DSS Community Options Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.
 - The purpose of the HomeandCommunityBasedServices.dss@ct.gov mailbox is to identify and refer the issue to the appropriate staff. Eligibility issues often must be referred to a DSS Regional Office. Community Options does direct the work flow in these offices. Medicaid redeterminations not sent in on time may create lengthy periods of ineligibility. Providers should contact the client's care manager for assistance.



Viewing and Understanding the Care Plan

Waiver Service Provider Workshop

Viewing and Understanding the Care Plan

Prior Authorization Inquiry

The screenshot displays a web portal interface. At the top, a navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, MAPIR, Account, and ConnPACE. Below this, a secondary navigation bar offers options like home, account home, account maintenance, account setup, change password, reset password, and log out. The main content area shows a welcome message for user PCA001234567 and a re-enrollment due date of 02/25/2018. A dropdown menu is open under the 'Prior Authorization' link, showing 'Care Plan' and 'Pharmacy Prior Authorization'. A green arrow points to the 'Care Plan' option. To the right, a 'Quick Link' sidebar contains several links: Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, Download Remittance Advices, ACA Ordering/Prescribing/Referring Provider List, and an Email Subscription section with a Register/Update Email Subscription link. Below the main content, there are sections for 'Global Messages' and 'Secure Mailbox', both showing '*** No rows found ***'.

Viewing and Understanding the Care Plan

Prior Authorization Inquiry

PA Search Panel

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

home prior authorization search care plan

Quick Link

- Web Guide - Prior Authorization Search

Provider 008021184 MCD

Prior Authorization Search

Client ID

Prior Authorization

Client Name

PA Assignment

Requested Eff Date

PA Assign - Sub

Requested End Date

Procedure [Search]

Authorized Eff Date

Revenue Code [Search]

Authorized End Date

Proc/Mod List

Records 20 ▾

Viewing and Understanding the Care Plan

Prior Authorization Inquiry

The search results by client shows multiple Prior Authorizations (PAs) and services authorized.

Note: Search results can include PAs authorized by procedure code, procedure code with modifier, procedure code lists and proc/mod lists. For ease in viewing, data can be sorted by clicking on the desired sort field, until a triangle appears. Click on the triangle to sort in ascending or descending order.

» Search Results													
PA Number	Line Item	Authorized Eff. Date ▲	Authorized End Date	Date Received	Time Received	Assignment Code	PA Assign - Sub	Billing Provider ID	Prescribing/Ordering Provider ID	Service Code	Code Thru	Proc/Mod List	Frequency
0770801156	02	08/16/2016	10/22/2016	08/25/2016	06:00:10	Home Care Progra	Initial	008060343	MCD	1214Z			18 Per Calendar Week
0770801156	01	08/16/2016	10/22/2016	08/25/2016	06:00:10	Home Care Progra	Initial	008060343	MCD	1210Z			24 Per Calendar Week
0770900674	01	10/06/2016	10/06/2016	11/30/2016	20:03:49	Home Care Progra	Initial	008060343	MCD	1210Z			20 Per Calendar Week
0770862683	02	10/23/2016	03/02/2017	10/26/2016	06:00:11	Home Care Progra	Initial	008060343	MCD	1214Z			18 Per Calendar Week
0770862683	01	10/23/2016	03/02/2017	10/26/2016	06:00:11	Home Care Progra	Initial	008060343	MCD	1210Z			24 Per Calendar Week
0770862683	03	04/13/2017	04/19/2017	04/21/2017	06:00:11	Home Care Progra	Initial	008060343	MCD	1021Z			252 Per Calendar Week
0770862683	04	04/20/2017	08/13/2017	04/21/2017	01:46:43	Home Care Progra	Initial	008060343	MCD	1021Z			224 Per Calendar Week
0771155364	01	08/14/2017	08/15/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD	1021Z			224 Per Calendar Week
0771155364	02	08/16/2017	10/12/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD	1210Z			126 Per Calendar Week
0771155364	03	08/16/2017	10/12/2017	09/22/2017	06:00:13	Home Care Progra	Initial	008060343	MCD	1214Z			42 Per Calendar Week
0771155364	04	10/13/2017	08/31/2018	10/16/2017	20:00:08	Home Care Progra	Initial	008060343	MCD	1021Z			252 Per Calendar Week

Viewing and Understanding the Care Plan

➤ **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 Code(s) List – any combination of the codes on the list may be billed up to the number of units authorized
- ✓ Procedure Code/Modifier(s) List – any combination of the codes with associated modifier(s) on the list may be billed up to the number of units authorized

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

Authorized services are for a companion one time only service to a subsequent client with billing codes 1210Z U2 TT for 12 units = 3 hours of authorized service with an effective/end date of 4/4/2014.

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 NDC	Revenue Code List
01	12.000	\$0.00	12.000	\$0.00	Auto Approved for Care Plan	1210Z	U2	TT						

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code **1210Z** [Search] COMPANION SERVICE - AGENCY

Mod 1 **U2** [Search]

Mod 2 **TT** [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List [Search]

Requested Eff./End Dates* 04/04/2014 04/04/2014

Requested Units/Dollars* 12.000 \$0.00

NDC [Search]

Status Auto Approved for Care

Authorized Units/Dollars 12.000 \$0.00

Authorized Eff./End Dates 04/04/2014 04/04/2014

Used Units/Dollars 0 \$0.00

Available Units/Dollars 12 \$0.00

Frequency 12 Per Calendar Week

Notes

*** No rows found ***

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

This PA for meal one time only services is authorized with a Procedure Code/Modifier list ML. The Proc/Mod list ML includes the same procedure codes as in list code 970 with an added U2 modifier designating the service as one time only. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

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

Type changes below.

Line Item 01

Service Type Code* Procedure/Mod List

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List ML Meals - 1 Time Only

Procedure Code List

Requested Eff./End Dates* 04/13/2014 05/03/2014

Requested Units/Dollars* 15.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

NDC [Search]

Status Approved

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 04/13/2014 05/03/2014

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

*** No rows found ***

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (CHC)

A “list code,” when authorized will appear on the PA. However, providers must bill the procedure code or procedure code/modifier for the service provided.

Reminder: Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.

Meals	List Code = 970 (on care plan)
Description of Service	Procedure Code (on claim)
Single Meal	1218Z
Double Meal	1220Z
Kosher Meal	1221Z
Meals - One Time Only	List Code = ML (on care plan)
Description of Service	Procedure Code/Modifier (on claim)
Single Meal - One Time Only	1218Z U2
Double Meal – One Time Only	1220Z U2
Kosher Meal – One Time Only	1221Z U2

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (PCA)

This PA for Foster Care is authorized with Procedure Code list 972 which includes billing procedure codes S5140, 5140X, 5140Y, 5140Z. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

Click the PA line detail at search results to open the PA or PA line detail for additional service authorization information. Once the PA is open, Providers have access to the caremanager notes which may provide all or additional service authorization .

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	5,000	\$0.00	5,000	\$0.00	Auto Approved for Care Plan						972				

Line Item 01

Type changes below.

Service Type Code* Tooth Authorized Units/Dollars

Procedure Code Quad Authorized Eff./End Dates

Mod 1 Tooth Surface 1 Used Units/Dollars

Mod 2 Tooth Surface 2 Available Units/Dollars

Mod 3 Tooth Surface 3 Frequency

Mod 4 Tooth Surface 4

Revenue Code/List Tooth Surface 5

Proc/Mod List

Procedure Code List

Requested Eff./End Dates* Drug Name

Requested Units/Dollars* Status

*** No rows found ***

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

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (PCA)

Meals		List Code = 972 (on care plan)
Description of Service	Procedure Code (on claim)	
Foster Care, Adult, Per Diem 1	S5140	
Foster Care, Adult, Per Diem 2	5140X	
Foster Care, Adult, Per Diem 3	5140Y	
Foster Care, Adult, Per Diem 4	5140Z	
Foster Care – One Time Only		List Code = FF
Description of Service	Procedure Code/Modifier (on claim)	
Foster Care, Adult, Per Diem 1 – One Time Only	S5140 U2	
Foster Care, Adult, Per Diem 2 – One Time Only	5140X U2	
Foster Care, Adult, Per Diem 3 – One Time Only	5140Y U2	
Foster Care, Adult, Per Diem 4 – One Time Only	5140Z U2	

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (ABI)

This PA authorizes Adult Day Care services using Procedure Code List 971, which includes procedure codes 1200Z, 1201Z and 1202Z. Services relating to these codes can be provided interchangeably up to the units authorized of 5 per week from 4/13-5/3/2014, unless otherwise indicated in the notes by the care manager.

Line Item														
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List
01	15.000	\$0.00	15.000	\$0.00	Approved						971			

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List 971 Adult Day Care - CHC

Requested Eff./End Dates* 04/13/2014 05/03/2014

Requested Units/Dollars* 15.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 15.000 \$0.00

Authorized Eff./End Dates 04/13/2014 05/03/2014

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

NDC [Search]

Status Approved

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (ABI)

Meals	List Code = 971 (on care plan)
Description of Service	Procedure Code (on claim)
Adult Day Health – Full Day (Non-Medical Model Provider)	1200Z
Adult Day Health – Full Day (approved Medical Model Provider)	1201Z
Adult Day Health – Half Day (Less Than or Equal to 4 Hrs)	1202Z
Adult Day Health - One Time Only	List Code = AD (on care plan)
Description of Service	Procedure Code/Modifier (on claim)
Adult Day Health – Full Day (Non-Medical Model Provider) – One Time Only	1200Z U2
Adult Day Health – Full Day (approved Medical Model Provider) – One Time Only	1201Z U2
Adult Day Health – Half Day (Less Than or Equal to 4 Hrs) – One Time Only	1202Z U2

Viewing and Understanding the Care Plan

Prior Authorization Inquiry

Note the components of this PA for one time only Adult Day Care services authorized under Proc/Mod list AD. This Proc/Mod list includes the same procedure codes as in list code 971 with an added U2 modifier designating the service as one time only. The services relating to these codes can be provided interchangeably up to 2 units allowed per week between 4/13-5/3/2014, unless otherwise indicated in the care plan notes.

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
01	6.000	\$0.00	6.000	\$0.00	Approved							AD		
Type changes below.														
Line Item 01														
Service Type Code*		Procedure/Mod List		Tooth		[Search]		Authorized Units/Dollars		6,000		\$0.00		
Procedure Code		[Search]		Quad		[Search]		Authorized Eff./End Dates		04/13/2014		05/03/2014		
Mod 1		[Search]		Tooth Surface 1		[Search]		Used Units/Dollars		0		\$0.00		
Mod 2		[Search]		Tooth Surface 2		[Search]		Available Units/Dollars		6		\$0.00		
Mod 3		[Search]		Tooth Surface 3		[Search]		Frequency		2 Per Calendar Week				
Mod 4		[Search]		Tooth Surface 4		[Search]								
Revenue Code/List		[Search]		Tooth Surface 5		[Search]								
Proc/Mod List		AD		Adult Day Care - 1 Time Only										
Procedure Code List														
Requested Eff./End Dates*		04/13/2014		05/03/2014		NDC		[Search]						
Requested Units/Dollars*		6.000		\$0.00		Status		Approved						
Notes														
*** No rows found ***														

Viewing and Understanding the Care Plan

Prior Authorization Inquiry (ABI)

Meals	List Code = 971 (on care plan)
Description of Service	Procedure Code (on claim)
Adult Day Health – Full Day (Non-Medical Model Provider)	1200Z
Adult Day Health – Full Day (approved Medical Model Provider)	1201Z
Adult Day Health – Half Day (Less Than or Equal to 4 Hrs)	1202Z
Adult Day Health - One Time Only	List Code = AD (on care plan)
Description of Service	Procedure Code/Modifier (on claim)
Adult Day Health – Full Day (Non-Medical Model Provider) – One Time Only	1200Z U2
Adult Day Health – Full Day (approved Medical Model Provider) – One Time Only	1201Z U2
Adult Day Health – Half Day (Less Than or Equal to 4 Hrs) – One Time Only	1202Z U2

Viewing and Understanding the Care Plan

➤ Modifiers used in the Waiver programs include:

✓ Modifier **U2 - One Time Only Services** can be used to authorize:

- Additional units needed on a day service is provided
- Another day of service in an existing care plan
- An additional frequency to an existing service

- The **U2** Modifier can be authorized for all **non-medical services** except:
 - Highly Skilled Chore
 - PERS Service Installation
 - Assistive Technologies
 - Minor Home Modifications
 - Two-way PERS-ongoing service
 - Care Management

Viewing and Understanding the Care Plan

➤ Modifiers used in the Waiver program cont.

- ✓ Modifier **TT - Subsequent Client** can be used to authorize:
 - Service for an additional client residing in the home of a client already receiving the same service.
 - No procedure code restrictions
 - If authorized:
 - The **TT** modifier must be associated to the procedure code on the care plan/PA

Viewing and Understanding the Care Plan

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 should match:
 - ✓ the paper service order or
 - ✓ the service order noted in the notes section of the PA on your secure Web account (Access Agency Upload of Service Orders)
 - ✓ information in Santrax should match with your secure account

Note: Discrepancies should be reported to the Access Agency

Viewing and Understanding the Care Plan

- **Codes Authorized on the care plan are not always the codes to be billed on the claim. Providers should refer to the procedure code crosswalk for billing codes associated to codes authorized on the (PA).**
 - **If a Procedure Code or Procedure Code Modifier List is authorized, providers should:**
 - ✓ Refer to the Procedure Code Crosswalk applicable to the client's waiver program for billing codes and unit increments associated to the Procedure Code List or Procedure Code Modifier List authorized.
 - Codes associated to the list can be billed interchangeably, based on the service provided, up to the units authorized within the frequency, unless otherwise indicated by the care manager as documented on the service order.
 - If the procedure code on the service order is of a lessor reimbursement value than the service being provided from the code list, the provider must contact the care manager unless otherwise indicated in the external notes on the PA.
- **Providers should also refer to the procedure code crosswalk for unit increments which should match back to the number of hours the service was authorized.**

Viewing and Understanding the Care Plan

➤ **Procedure Code Crosswalk – A list of non-medical procedure codes, and procedure code modifier lists with associated procedure codes/modifiers that can be authorized under the CHC, ABI, or PCA 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
- Provider who can be authorized to bill the service
- If service can be spanned when consecutive dates of service are performed (N/A for home health services)
- Frequency of service
- Care Plan limitations (When PA is required by DSS or Beacon Health Options)
- Funding Source that covers the service
- If a service is EVV Mandated, Optional, or N/A
- For ABI Providers: Which ABI Benefit plan (1, 2, or both) the procedure code is applicable to

Viewing and Understanding the Care Plan

Claim Submission Points to Remember

Procedure Code Crosswalks can be obtained on the www.ctdssmap.com Web site as a link in Chapter 8 of the Home Health Provider manual in the modifier section of the claim submission instructions.

✓ From the Home page: Information > Publications > Provider Manuals > click on “View Chapter 8” > Choose “Connecticut Home Care”, “Acquired Brain Injury Services”, or “Personal Care Assistance” > field 24d

Claim Submission Guidelines

Wavier Provider Refresher Workshop

Access to Claim Submission

Home Information Provider Trading Partner ConnPACE Pharmacy Information **Claims** Eligibility Prior Authorization APIR Messages **Account**

home **account home** account maintenance account setup change passwr

Your password expires in 61 days on 08/08/16 at 12:00

Welcome: John_Doe_Waiver
Provider ID: 1234567890 NPI
Reenrollment Due Date: 02/25/2018
Zip Code: 06106 - 5501
Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Claim Inquiry

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

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 ***

Access to Claim Submission

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	<input type="text"/>	From Date	<input type="text"/>
Provider ID	##### NPI	To Date	<input type="text"/>
AVRS ID	#####	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text" value="v"/>
Last Name	<input type="text"/>	Total Charges	<input type="text" value="\$0.00"/>
First Name, MI	<input type="text"/>	Total Paid	<input type="text" value="\$0.00"/>
Date of Birth	<input type="text"/>	TPL Amount	<input type="text" value="\$0.00"/>
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Medical Record Number	<input type="text"/>	Medicare Crossover	<input type="text" value="v"/>
Referring Physician	<input type="text"/> [Search]	837 Version	<input type="text" value="v"/>
SSN	<input type="text"/>		
Accident Related	<input type="text" value="v"/>		
Accident Date	<input type="text"/>		

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident

Access to Claim Submission

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1			1.00	\$0.00		\$0.00

Type data below for new record.

Item	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Calc Allowed Amt	<input type="text" value="\$0.00"/>
Rendering Physician*	<input type="text"/> [Search]	Medicare Paid Amount	<input type="text" value="\$0.00"/>
SSN	<input type="text"/>	Medicare Deductible Amount	<input type="text" value="\$0.00"/>
Referring Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	<input type="text" value="\$0.00"/>
Ordering Provider	<input type="text"/> [Search]	Diagnosis Code Pointer	<input type="text"/>
		National Drug Code	<input type="text"/>
		NDC Quantity	<input type="text" value="0"/>
		NDC Unit of Measurement	<input type="text"/>

In the Detail Section enter the procedure code, date of service, units of the procedure, total charges for the service. If applicable, enter the rendering provider NPI.

To enter additional procedures, click on the button within the Detail Panel and enter the required information.

Do not click on the button after you've entered the last procedure for the client/date of service.

Access to Claim Submission

Diagnosis Panel

Diagnosis			
Diag-Sequence ▲	Diagnosis	Description	
Code Set	ICD 10 ▼		←
Principal	<input type="text"/>	[Search]	Other 1 <input type="text"/> [Search] Other 2 <input type="text"/> [Search]
Other 3	<input type="text"/>	[Search]	

* Diagnosis is **NOT** required for non-medical services.

Access to Claim Submission

TPL Panel

TPL										
Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth	
A	060	BC/BS OF CONNECTICUT	UPX8289514	\$0.00						

Type data below for new record.

Client Carriers: 060 - BC/BS OF CONNECTICUT

Carrier Code: 060 [Search] Relationship: [Select]

Plan Name: BC/BS OF CONNECTICUT Last Name: [Input]

Policy Number: [Input] First Name, MI: [Input] [Input]

Paid Amount*: \$100.00 Date of Birth: [Input]

Paid Date*: 06/01/2016

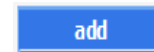
Adjustment Reason Code: [Input] [Search] [Input] [Search] [Input] [Search]

Adjustment Amount: \$0.00 \$0.00 \$0.00

[delete] [add]

Medicaid is always the payer of last resort. If the client has Other Insurance (OI) primary, the provider should bill that carrier first.

The OI information can be entered in the TPL panel by first clicking on the button in the TPL panel.



The required fields are Carrier Code for the OI, Paid Amount and Paid Date.

The three digit Carrier Code can be found on the client eligibility verification screen under TPL Information, or in the drop down "Client Carriers" field in the TPL panel on the Claim screen.

*** TPL is NOT applicable for non-medical services.**

Access to Claim Submission

Claim Status Panel

Claim Status Information	
Claim Status	Not Submitted yet

Claim Status Information	
Claim Status	PAID
Claim ICN	2216187050003
Paid Date	07/07/2016
Paid Amount	\$85.28

Claim Status Information	
Claim Status	DENIED
Claim ICN	2216190050002
Denied Date	
Paid Amount	\$0.00

EOB Information		
Detail Number	Code	Description
0	1802	TYPE OF BILL IS INVALID FOR THE PROVIDER.
0	0619	ZIP CODE IS NOT A VALID 9 DIGIT ZIP CODE
0	1912	BILLING PROVIDER'S TAXONOMY IS MISSING
0	0621	BILLING PROV ENTITY TYPE QUALIFIER TO PROV TYPE/SPECIALTY MISMATCH
1	9996	REFER TO HEADER EOB

Claim Status Information Panel shows the status of the claim.

Once a claim is submitted, it processes in real time and assigns an Internal Control Number (ICN) to the claim. The Claim Status will show if it has been submitted, paid, denied or suspended.

Claim Status on a paid claim will show the paid amount.

Claim Status on a processed claim will also show the Explanation of Benefit (EOB) codes that post at the header of the claim and at the details.

Access to Claim Submission

Claim Status Panel - Web Claim Function Buttons

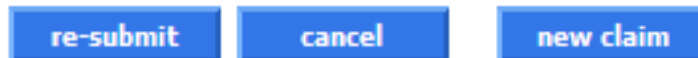
New Claim



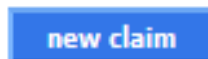
Paid claim



Denied claim



Suspended claim



Access to Claim Submission

Web Claims Submission – Error Messages


If required information is missing or is in an incorrect format, the self editing feature of Web claims generates error messages to alert the provider and will prevent the claim from being submitted until the errors have been corrected.

The following messages were generated:

Message Description	Panel	Field	Row
 A valid FTC is required	Detail	FTC	1

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1	07/15/2016	07/15/2016	99212	1.00	\$700.00	\$0.00

Type data below for new record.

Item	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text" value="07/15/2016"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text" value="07/15/2016"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text" value="99212"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
 Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>

The error message will point to the Panel, the Field and the Row where the error has occurred.

Access to Claim Submission

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.*
- The From and Through dates cannot span more than 93 days.

The screenshot displays the 'Claims' section of a web application. The navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Claims (highlighted), Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below the navigation bar, there are sub-links: home, claim inquiry (highlighted), professional, institutional, dental, and claim history for specific services. The main content area is titled 'Claim Search 008021184 MCD' and contains a search form with the following fields and controls:

- ICN: Text input field
- Client ID: Text input field
- TCN: Text input field
- FDOS: Text input field
- TDOS: Text input field
- Prescription No (Pharmacy Only): Text input field
- Claim Type: Dropdown menu
- Status: Dropdown menu
- FDate Paid: Text input field
- TDate Paid: Text input field
- Pending Claims:
- Exclude Adjusted Claims:
- Records: Dropdown menu set to 20
- Buttons: 'search' and 'clear'

Below the form, a note reads: 'To submit a new claim from an existing one enter ICN or client ID and From/To Date of Service. Click search. If multiple claim results click on the claim to open, scroll to the bottom of the claim and click copy.'

Access to Claim Submission

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

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

Claim Search [Redacted] NPI

ICN

Client ID

TCN

FDOS

TDOS

Prescription No (Pharmacy Only)

Claim Type

Status

FDate Paid

TDate Paid

Pending Claims

Exclude Adjusted Claims

Records

Search Results									
ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Status	Date Paid	Amount Billed	Amount Paid
221	[Redacted]	[Redacted]		06/27/2016	06/27/2016	Paid	07/09/2016	\$200.00	\$184.00
221	[Redacted]	[Redacted]		06/27/2016	06/27/2016	Paid	07/09/2016	\$200.00	\$156.8
591	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Denied	07/09/2016	\$188.00	\$0.00
591	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Denied	07/09/2016	\$188.00	\$0.00
221	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Adj/Voiced	07/09/2016	\$188.00	\$51.48
591	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Adj/Voiced	07/09/2016	\$188.00	\$85.28
221	[Redacted]	[Redacted]		07/06/2016	07/06/2016	Paid	07/09/2016	\$100.00	\$81.00
221	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Adj/Voiced	07/09/2016	\$188.00	\$100.00
221	[Redacted]	[Redacted]		07/05/2016	07/05/2016	Paid	07/09/2016	\$188.00	\$85.28
221	[Redacted]	[Redacted]		07/05/2016	07/05/2016	Paid	07/09/2016	\$188.00	\$146.00
591	[Redacted]	[Redacted]		07/06/2016	07/06/2016	Denied	07/09/2016	\$100.00	\$0.00
221	[Redacted]	[Redacted]		07/06/2016	07/06/2016	Adj/Voiced	07/09/2016	\$100.00	\$81.00
591	[Redacted]	[Redacted]		07/01/2016	07/01/2016	Adj/Voiced	07/09/2016	\$188.00	\$146.00

Access to Claim Submission

Claim Submission Points to Remember

Accessing claims for inquiry or new submission

- Log in under your correct secure Web account
- Your Local Administrator must give you access/permission for Claim Submission Inquiry (Chapter 10, section 9 of the provider manual)
 - If you don't have access, you will not be able to view the Claim tab when logging in to your secure Web account.
- When accessing claims click on the claim tab and select claim inquiry or Professional (first claim for new client) and click search.
- Perform a claim inquiry by entering at minimum:
 - The claim ICN
 - Client ID
 - Narrow your search using:
 - From/To dates of service (**Note: search cannot exceed 90 days**)
 - Claim status
- Click Search

Access to Claim Submission

Claim Submission – Spanning Dates

Dates of service can only be spanned for non-medical services submitted in the professional claim format when service is provided on consecutive dates which span the from and through dates of service on the claim detail. Please note: Spanning would NOT occur if billed thru EVV.

Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan/PA. *For example, if the chore service is to be provided 6 hours per week on consecutive days such as Monday through Wednesday for 2 hours per day for a total of 24 units, the span dates of service must begin on the Monday of the calendar week in which the service was performed and end on the Wednesday of the same calendar week for a total of 24 units.*

Spanned dates of service cannot span multiple line details on the care plan. *For example, in the example above a onetime only of an additional 4 hours on Thursday is needed for the above week. If the 4 additional hours on Thursday are added as an additional line detail on the PA, the services for Thursday, even though they are consecutive with the regular weekly services, must be billed on a separate line detail.*



Monthly Claims Reprocessing

Waiver Provider Refresher Workshop



Monthly Claims Reprocessing

Systematic Monthly Claims Reprocessing:

- Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Access Agency such as:
 - End dating and restarting a care plan due to periods of hospitalization.
 - Increasing or decreasing services.
 - End dating a care plan when the client leaves the Agency's service.



Monthly Claims Reprocessing

Systematic Monthly Reprocessing

In the first cycle of each month, DXC Technology will recoup (void) all paid claims impacted by the Access Agency changes made two months prior (Region 52 claims = a voided claim).

In the same cycle DXC Technology 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 2017 by the Access Agency will result in claims being voided (region 52) and reprocessed (region 24) in the first cycle of July 2017.

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

Monthly Claims Reprocessing

Impact to Provider Remittance Advice (Paper RA)

➤ If there is a financial impact (Change in \$ 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

PA Changes Made by Access Agency – Claim Recouped

REPORT: CRA-PHAD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIM ADJUSTMENTS

Date: 10/15/201
PAGE: 33

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	AMOUNT	INCOME	AMOUNT	CONTR.
		SERVICE DATES RENDERING					BILLED	ALLOWED				
PL	SERV	PROC CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	AMOUNT	AMOUNT	DETAIL	EOBS	

CLIENT NAME: Sally Client

CLIENT NO.: 0000000000

1	22000000000000	060314	061214	(116.16)		(0.00)		(0.00)		(0.00)	(0.00)	(0.00)
					(58.08)		(0.00)		(0.00)		(58.08)	
1	52000000000000	060314	061214	116.16		0.00		0.00		0.00	0.00	0.00
					0.00		0.00		0.00		0.00	0.00

HEADER EOBS: 8236

Monthly Claims Reprocessing

Impact to Provider Remittance Advice (Paper RA)

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

- Claim ICN (**Region 24**) in the paid/denied section of the RA.
- **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change.

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

Monthly Claims Reprocessing

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

REPORT: CRA-PHPD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

Date: 10/15/2014
PAGE: 2

Home Care Agency
555 Any ST
Somewhere, CT00000-0000

PAYEE ID
ISSUE DATE 10/15/2014
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	AMOUNT	INCOME	AMOUNT	CONTR.
	CLIENT NAME: Sally Client		CLIENT NO.:								
	2400000000000	060214 061214	116.16	75.00		0.00		0.00	0.00	0.00	75.00
							0.00		0.00		
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL	EOBS		
12	1210Z		20	060214 061214	MCD	116.16	75.00				

Header EOB: 8238

Monthly Claims Reprocessing

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
- **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 with:
 - **EOB code 8237** – Claim Systematically Reprocessed Due to PA Change-Information Only.

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

Monthly Claims Reprocessing

Impact to Provider's Secure Web Portal – PA Inquiry

- Region **24 claims** identify a change made to the care plan/PA.

- Region **24 claims** with **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change confirms there has been a change which has:
 - ✓ **Positively** or **negatively** impacted you financially.
 - ✓ May continue to impact you financially in the future.

- Providers should investigate reprocessed claims with a **negative** impact to determine if:
 - ✓ Providing appropriate level of service currently authorized.
 - ✓ Current service order matches the PA on their secure Web account. Report discrepancies to the Access Agency.

Monthly Claims Reprocessing

Impact to Provider's Secure Web Portal – PA Inquiry cont.

➤ **A PA may show negative units available, if the changes made by the Access Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.**

➤ **For example:**

PA authorized for 20 units per week for 4 weeks = 80 units authorized and available.

Claims are paid against the PA = 40 units used

Access Agency changes the PA to 10 units a week for 2 weeks = 20 units authorized and available.

Until claims are recouped and reprocessed, the PA will show 20 units available – 40 used = (20) negative units

Monthly Claims Reprocessing

Impact to Provider's Secure Web Portal – PA Inquiry cont.

- **Negative units indicate potential detail/claim denial when claims are voided and reprocessed, unless another service order is created that will allow the claims to be paid.**
- **To reduce the denial of claims processing against a PA with negative units, during the implementation of these changes:**
 - **DXC Technology is requesting providers stop submitting claim adjustments that will process against these PAs.**



Claim Denials, Resolution, and Resources

Waiver Provider Refresher Workshop

Claim Denials, Resolution, and Resources

➤ Claim Denials due to Electronic Visit Verification (EVV)

✓ Denial Reason

- **0630 Claims must be submitted via the EVV system** - DSS requires that effective for dates of service on or after January 1, 2017 for non-medical service providers and April 3, 2017 for Home Health service providers, providers must utilize Electronic Visit Verification (EVV) when providing EVV mandated services to ABI, CHC and PCA Waiver clients. Claims matching the service authorizations for the client must be submitted via the EVV system. Claims for EVV mandated services not submitted via the EVV system will deny and post the EOB code.

✓ Resolution

- **Verify that the services provided are EVV mandated services and submit claims for EVV mandated services through the EVV system.**

Claim Denials, Resolution, and Resources

➤ Claim Denials due to Client Eligibility

✓ Denial Reasons:

- **EOB code 2003** - Client Ineligible for dates of service
- **EOB code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have CHC, ABI, or PCA. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021).

✓ Resolution:

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

Claim Denials, Resolution, and Resources

➤ Claim Denials Related to Care Plan/PA Issues

- **EOB code 3015** – CHC Care Plan Required
 - Resolution: A care plan must be created by the Access Agency and uploaded to the DXC Technology system.
- **EOB code 3016** -Service not Authorized on the CHC Care Plan
 - Resolution: A service denied for not on care plan must be added by the Access Agency to the Care Plan.

Claim Denials, Resolution, and Resources

➤ Claim Denials Related to Care Plan/PA Issues cont.

- **EOB code 5151** – Units exceed the frequency units authorized on the care plan
 - Resolution: Units of service must be added to the frequency of an existing PA by the Access Agency.
 - This could also indicate user error. Check to make sure you did not enter an incorrect number of units on the claim.
- **EOB code 3003** - Prior Authorization is required for payment of the service (units for the service are exhausted)
 - Resolution: Units of service must be added by the Access Agency to an existing PA that is currently exhausted.
 - Providers should also re-check units billed to rule out user error (i.e. wrong number of units entered on claim submission screen)

Claim Denials, Resolution, and Resources

➤ Claim Denials Related to Care Plan/PA Issues cont.

✓ Resources:

- Care Managers create service orders and the Access Agencies enter them into the Care Management System.
- The Access Agency is responsible for uploading initial care plans and changes to care plans to DXC Technology, in Prior Authorization format, within seven (7) days of issuing the service order.
- If the provider **has a service order** and a **PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account** within **seven (7) days** of receipt of the service order, the provider should contact the applicable Access Agency.

Claim Denials, Resolution, and Resources

➤ Claim Denials Related to Care Plan/PA Issues cont.

✓ Care plans or changes to care plans that are not viewable via the provider's secure Web portal within seven (7) days of issuance may be the result of the Access Agency experiencing an upload issue to DXC Technology due to:

- Service overlaps

✓ These types of upload issues take time to resolve so it is important to confirm service order requests or changes have been uploaded as soon as possible to avoid unnecessary claim denials or further delay in prior authorization upload.

Note: If a client is eligible under a waiver benefit plan, a care plan for the services to be billed must be in place for both Medical and non-medical services or the claim will deny.

Claim Denials, Resolution, and Resources

➤ Claim Denials Due to Provider Error

✓ Claim denials due to

- **EOB code 3016-** Service not covered under CHC, ABI, or PCA care plan
 - May be the result of provider error due to:
 - Incorrect procedure code billed
 - Failure to communicate a change in service to the care manager
 - Example: PCA overnight **1022Z** services are authorized, the service can not be completed. Before the provider can bill the code for an incomplete shift, **3022Z**, the care manager must be notified and **3022Z** must be uploaded to the DXC Technology system. Until this occurs any claim submitted for **3022Z** will deny.

Claim Denials, Resolution, and Resources

➤ Provider Error cont.

✓ Claim denials due to:

- **EOB code 3003**- Prior Authorization is required for payment of this service, or
- **EOB code 5151**- Units exceed frequency units on CHC care plan
May also be the result of provider over service or keying errors when entering units of service.

✓ Claim denials due to:

- **EOB code 4140**- The service submitted is not covered under the client's benefit plan.
May be the result of submitting non-medical services under the provider's Home Health provider number or by using the incorrect wavier AVRS ID.

Claim Denials, Resolution, and Resources

EOB code 749 - Modifier U2 not allowed

Cause:

If the claim is submitted with a U2 modifier for one of the following services:

Highly Skilled Chore

Minor Home Modifications

PERS Service Installation

Two-way PERS-ongoing service

Assistive Technologies

Care Management

Resolution:

Claim must be resubmitted without the U2 modifier.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

- Check client eligibility on clients coming on service.
 - Contact DSS Community Options unit immediately with clients who are not eligible for a CHC, ABI, or PCA benefit at HomeandCommunityBasedServices.dss@ct.gov.
 - Be sure to include requested data to expedite the process.
 - 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.



Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

- **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 the appropriate Access Agency 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.



Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

➤ Claim submission review

- Prior to submitting claims be sure services provided match service 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.

Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

➤ 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, minimizes changes needed for resubmission
- ✓ Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces key strokes and the number of details on a claim

Example: a homemaker service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 10/3/17 to 10/5/17 1214Z for 30 units.

- Maximize reimbursement time
- Reduce claim errors due to poorly aligned claim data fields



Claim Denials, Resolution, and Resources

Program Basics for Successful Claim Submission

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

Claim Denials, Resolution, and Resources

➤ Claims Resolution

- ✓ Reconcile claims as entered via the web or leave time before claim cycle cutoff to correct and resubmit.
- ✓ Submit eligibility issues not already addressed to DSS Community Options unit.
- ✓ Submit care plan discrepancies not already addressed to Access Agency.
- ✓ Reconcile RA for the current cycle before receiving next RA to identify problems early to avoid major reimbursement issues.
 - Refer to list of EOB code descriptions at the end of the RA to determine reason(s) for denial.
 - Use Claim Resolution Guide (**Chapter 12** of Provider Manual) to determine the cause of a denial and its resolution.
 - Use Claim Submission **Chapter 8** for waiver providers to determine claim resolution.
 - Contact the Provider Assistance Center at 1-800-842-8440 with issues you cannot resolve.



Program Resources

Waiver Provider Refresher Workshop

Program Resources

➤ Procedure Code Crosswalk

- ✓ Contains authorized codes and associated billing codes
- ✓ Service descriptions
- ✓ Unit increments
- ✓ Billing Provider (Allied or Waiver Service Provider)
- ✓ If spanning code is allowed
- ✓ Valid frequency (which can be used by Access Agency to authorize the service)
- ✓ If a service is EVV Mandated, Optional, or N/A
- ✓ For ABI Providers: Which ABI Benefit plan (1, 2, or both) the procedure code is applicable to

This document can be found as a link in Chapter 8 of the Home Health Provider manual in the modifier section of the claim submission instructions, field 24D.

Program Resources

➤ *CT Medical Assistance Provider Manual*

- ✓ *Provider access from the www.ctdssmap.com Homepage> Information> Publications> 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 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.

Program Resources

Provider Manual

Chapter 1 – Introduction

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

Chapter 2 – Provider Participation Policy

- Details the CMAP regulations for provider participation.

Chapter 3 – Provider Enrollment and Re-enrollment

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

Chapter 4 – Client Eligibility

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



Program Resources

Provider Manual

Chapter 5 – Claim Submission Information

- Provides information on general claims processing and billing requirements.

Chapter 6 – Electronic Data Interchange Options

- Provides information on electronic claim submission and electronic Remittance Advice.



Program Resources

Provider Manual

Chapter 7- Specific Policy/Regulation

- This chapter contains the Medical Policy section that pertains to the chosen provider type.

Chapter 8 – Provider Specific Claims Submission Instructions

- Provides information on provider specific billing requirements.
- **Procedure Code Crosswalks** can be found as a link in Chapter 8 of the Home Health Provider manual, Claim Submission Instructions, field 24D.

Program Resources

Provider Manual

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 both the AVRS and the Web Portal functions of interChange.

Chapter 11 – Other Insurance and 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.



Program Resources

Provider Manual

➤ **Provider Manual (Important Waiver Chapters)**

- ✓ Chapter 7 (Policies)
- ✓ Chapter 8 (Claim Submission Instructions)
- ✓ Chapter 12 (Claim Resolution Guide)
 - This chapter is also a link on the provider secure Web portal. Click on claims then on professional.
- ✓ Chapter 10 (Web Portal)

➤ **Web Claim Submission Instructions**

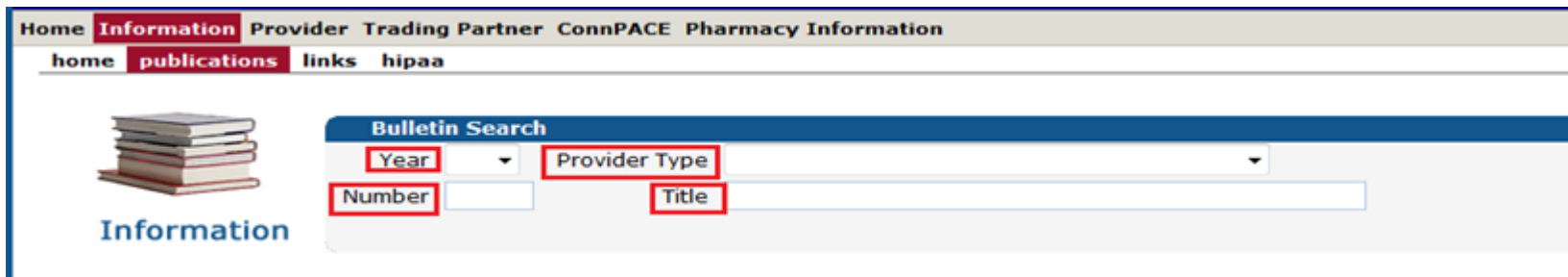
- ✓ Located on secure Web account
- ✓ Under claims select professional
- ✓ Click on the claim submission instructions link in the upper left portion of the screen.

Program Resources

Information – Provider Bulletins

Publications emailed 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.



The screenshot shows a web application interface for searching bulletins. At the top, there is a navigation bar with links: Home, Information (highlighted), Provider, Trading Partner, ConnPACE, and Pharmacy Information. Below this, a secondary navigation bar includes: home, publications (highlighted), links, and hipaa. On the left side, there is an icon of a stack of books and the word "Information". The main content area features a "Bulletin Search" section with a blue header. This section contains four input fields: "Year" (a dropdown menu), "Provider Type" (a dropdown menu), "Number" (a text input field), and "Title" (a text input field). Each of these four input fields is highlighted with a red rectangular box.

Program Resources

Information – E-mail Subscriptions

Providers MUST register to receive information electronically for new provider publications and notifications such as provider bulletins, workshop invitations, newsletters, and important messages through the email subscription function on the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com

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

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search provider fee schedule download oos instructions/information aca ordering/prescribing/referring provider list **e-mail subscriptions** secure 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

Confirm E-Mail

[Register](#)

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
- CHC Access Agency
- CHC Assisted Living
- CHC PCA Fiduciary
- CHC Service Providers
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Community First Choice
- Community Services
- DDS Employment and Day Supports
- DME/Medical Supply Dealer
- Dental
- Drug and Alcohol Abuse Center
- Early Childhood Autism Waiver
- Extended Care Facility/Long Term Care
- FQHC - Behavioral Health

Program Resources

Contacts

DXC Technology Provider Assistance Center (PAC)

1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays -
CTDSSMAP-ProviderEmail@dxc.com

DXC Technology Electronic Data Interchange (EDI) Help Desk

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

Connecticut Community Care (CCCI)- serviceauthissues@ctcommunitycare.org

Providers must include the following information when submitting service authorization issues to CCCI: provider name, client name, client EMS number, CCCI number, EOB code on rejecting claim at HP, from and to dates of service, the type of service (SNV, homemaker, MOW, etc.), the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

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

Please have the following information available when contacting WCAA: client name, the client EMS number, the type of service (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Program Resources

Contacts

South Western Connecticut Area on Aging (SWCAA)- SWCAABillings@swcaa.org

Please have the following information available when contacting SWCAA: client name, the client EMS number, the type of service (SNV, homemaker, MOW, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Agency on Aging of South Central CT (AASCC)

pcaldwell@aoascc.org

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

- **Department of Social Services (DSS) – For Self Directed clients on the CHCPE Program, please contact Melva Cooper, RN at DSS, at (860) 424-5863 or melva.cooper@ct.gov**



Program Resources

Electronic Visit Verification

Electronic Visit Verification Implementation Important Message

ctdssmap.com Web site > Information

Revised often with the most up-to-date information

Frequently Asked Questions (FAQs)

Learning Management System Enrollment Instructions and Web site links

Refresher Training videos - Interface Specifications

EVV Service Code Listing - Reason Code/Task lists

EVV publications list



Program Resources

Electronic Visit Verification

EVV contacts

For questions and issues related to prior authorizations, claims and the EVV implementation please send an email to the following e-mail address:

ctevv@dxc.com

For questions and issues related to the Santrax software please send an email to the following email address: ctcustomer care@sandata.com

Sandata CT EVV Customer Care Number (toll free) 1-855-399-8050

- *Remember to document your call tracking number for both your records and to provide to HPE if you need further assistance.*

Questions?





Thank you.