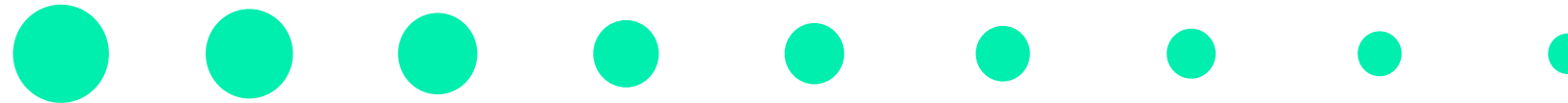


# Waiver Provider Refresher Workshop

Debbie Hockla-Kaba, Provider Representative  
Gainwell Technologies  
November 2020

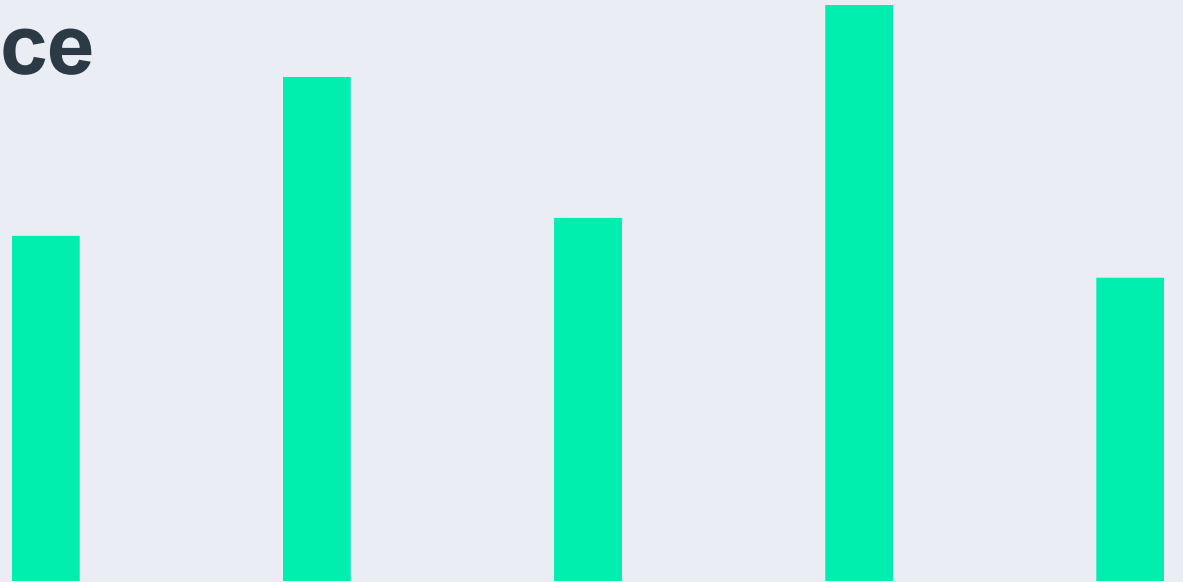


# Agenda

- Program Updates - What's New in 2020
- 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

Waiver 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 ABI, Autism, CHC and PCA services:

- **Permits select telehealth services**
  - Reimbursement rates for telemedicine services are the same as for equivalent in-person services.
  - Documentation must be maintained by the provider to substantiate the services provided.
  - If a telehealth 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.
  - Providers must submit claims with modifier
    - 95 (member located in home)
    - GT (member in healthcare facility or office)

# 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 ABI, Autism, CHC and PCA services: Telehealth cont.

- **ABI Waiver**

Effective March 16, 2020, the following select services are permitted to be provided electronically or telephonically:

- 1536P Companion Services, per 15 min., up to two hours per day
- Adult Day Programs permitted to provide Video Communication Services to include a virtual assessment of each participant and the delivery of at least two (2) meals per day
  - 1200Z Full Day (Non-Medical Model Provider)
  - 1201Z Full Day (Approved Medical Model Provider)
  - 1202Z Half Day (less than or equal to 4 hours)
- 971 Proc Mod List (1200Z, 1201Z, 1202Z)
- AD Proc Mod List (1200Z U2, 1201Z U2, 1202Z U2)

# 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 ABI, Autism, CHC and PCA services: Telehealth cont.

- **Autism Waiver**

**Effective *March 16, 2020* - Select services are permitted to be provided via telehealth using a real time audio and video system:**

- 1304Z – Life Skills Coach, Agency
- H2019 – Therapy Behavior Service

# 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 ABI, Autism, CHC and PCA services: Telehealth cont.

## CHC & PCA Waivers

*Effective March 16, 2020* - the following select services are permitted to be provided electronically or telephonically:

- 1247Z - Mental Health Counseling Individual (45-50 min) Out of Home
- Adult Day Programs permitted to provide Video Communication Services to include a virtual assessment of each participant and the delivery of at least two (2) meals per day
  - 1200Z Full Day (Non- Medical Model Provider)
  - 1201Z Full Day (Approved Medical Model Provider)
  - 1202Z Half Day (less than or equal to 4 hours)
- 971 Proc Mod List (1200Z, 1201Z, 1202Z)
- AD Proc Mod List (1200Z U2, 1201Z U2, 1202Z U2)

# 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 ABI, Autism, CHC and PCA services:

- **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:
- **ABI Waiver**
  - 1021Z Personal Care Services, per 15 min.
  - 1211P Recovery Assistant
  - 1212P Recovery Assistant II
  - 1536P Companion 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 ABI, CHC and PCA services: Overtime Rate cont.

- **CHC Waiver**

- 1021Z Personal Care Services, per 15 min.
- 3027 Personal Care Respite Services, Agency, per 15 min.
- 1210Z Companion Service, Agency, per 15 min.
- 1226Z Respite Companion Care, In Home, per 15 min
- 1213M Recovery Assistance, Agency, per 15 min

- **PCA Waiver**

- 1021Z Personal Care 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 ABI, Autism, CHC and PCA services: Overtime Rate Cont.

- Proc/Mod lists should be authorized whenever available for flexibility of service and reduction of PA requests. The following Proc/Mod lists have been updated to include the TU modifier for PCA per 15 min service:
  - **33** - PCA per 15 min allows (1021Z, 1021Z TU, 1021Z TT, 1021Z TT TU)
  - **41** - PCA per 15 min allows (1021Z U2, 1021Z U2 TU, 1021Z U2 TT, 1021Z U2 TT TU)
- When a Proc/Mod list is not available, the Authorization of the Procedure code with the TU modifier and any other applicable modifier should be placed on the same PA with the corresponding stand-alone code (i.e. 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 ABI, CHC and PCA and CFC Waiver services:

- **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 **ABI, CHC, PCA and CFC Waivers** for the billing of shelf stable meals:
  - S5170 Home Delivered Prepared Meal – Single Shelf Stable
  - 1931Z Home Delivered Prepared Meals – Double Shelf Stable

- **Per Day unit maximums waived on select services for ABI Waiver**

- 1536P – Companion Services per 15 min
  - 18 hr. per day maximum waived

# 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 ABI, Autism, CHC and PCA services:

- **Temporary Suspension of Select Mandated EVV Services**
  - **Providers do not have to use EVV to capture visit data or submit claims on the following services:**
    - 1536P – Companion Services per 15 min. (ABI Waiver)
    - 1304Z – Life Skills Coach, Agency, per 15 min. (Autism Waiver)
    - 1247Z – Mental Health Counseling, Individual, In Home (CHC & PCA Waivers)
  - **A confirmed visit is not required to bill and get paid for services performed**
  - **The following explanation of benefit codes (EOBs) will not set on claims for the above noted services:**
    - 3327 – Confirmed Visit Not Found
    - 3328 – Confirmed Visit Units are Exhausted
    - 0047 – Confirmed Visits Units are Exceeded

# 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 ABI, Autism, CHC and PCA waiver services, please refer to the following publications:

## **Provider Bulletin 2020-09**

[New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program \(CMAP\)](#)

## **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 ABI, Autism, CHC and PCA waiver services, please refer to the following publications (cont.):

## Provider Bulletin 2020-36

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

## ABI, Autism, CHC or PCA Procedure Code Crosswalks

For access to one or more of the ABI, Autism, CHC or PCA Waiver crosswalks – from the [www.ctdssmap.com](http://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 Connecticut Home Care Program for Elders (CHCPE), Acquired Brain Injury (ABI), Personal Care Assistance (PCA), Mental Health and Autism Waiver Service providers. Providers should refer to Provider Bulletin PB 20-77 [Rate Increases](#) for impacted services.
- Fee schedules will be updated and can be found on the Connecticut Medical Assistance Program (CMAP) Web site, [www.ctdssmap.com](http://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 allowable rate via EVV must first fully recoup the claims using the [www.ctdssmap.com](http://www.ctdssmap.com) secure Web portal or via an 837 electronic transaction. Claims must then be rolled back in EVV and resubmitted to obtain the new rate.

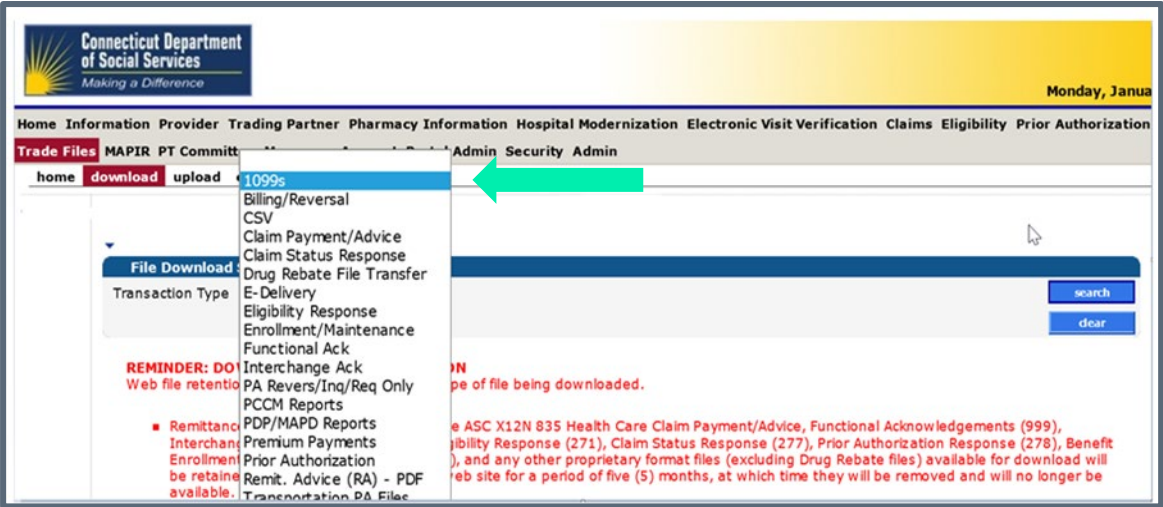
# Program Updates – 2020 (cont.)

- **Rate Increases cont.**

- CHCPE, ABI, PCA and Autism Waiver service providers who submit Electronic Visit Verification (EVV) mandated and optional services to Gainwell Technologies for claim adjudication via the Santrax system **must enter their updated usual and customary rates for dates of service September 1, 2020 and forward via the Sandata database prior to submitting claims for dates of service September 1, 2020 and forward via the Sandata system.**
- Providers who have **submitted claims at the previously allowed rate outside of EVV** 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** will have their claim systematically adjusted in the next 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 their secure portal on the Connecticut Medical Assistance Program (CMAP) Web site, [www.ctdssmap.com](http://www.ctdssmap.com).
  - The retention period for 1099s on the secure Web portal account 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](http://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. 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.
  - Providers 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.

# Re-Enrollment

## How To Maintain your Enrollment Status and Avoid Being Disenrolled

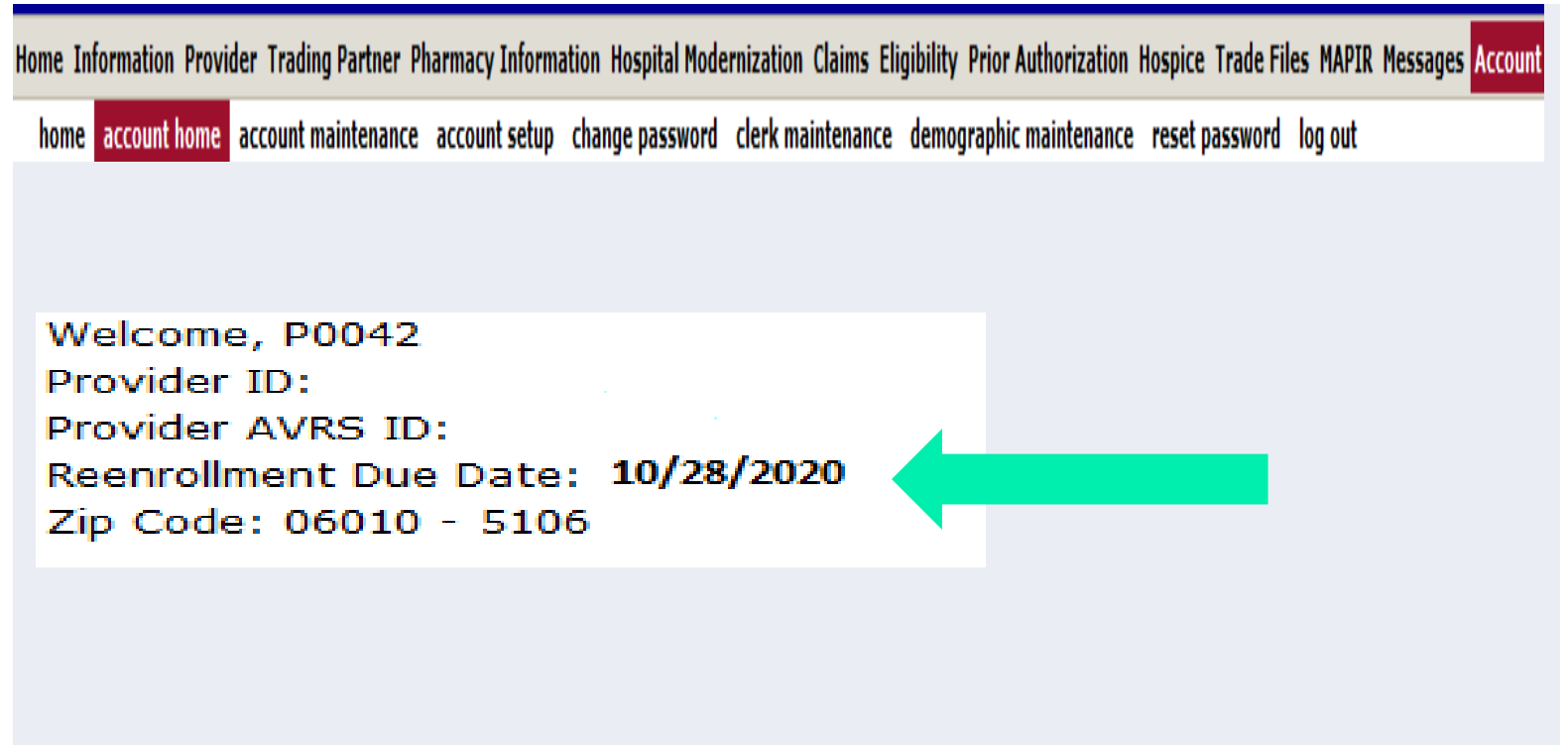
Waiver Service Provider Refresher Workshop



# 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 displays the provider's account home page. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below this is a secondary navigation bar with links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The main content area shows a white box with the following text: Welcome, P0042; Provider ID: ; Provider AVRS ID: ; Reenrollment Due Date: **10/28/2020**; and 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](http://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](http://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:**

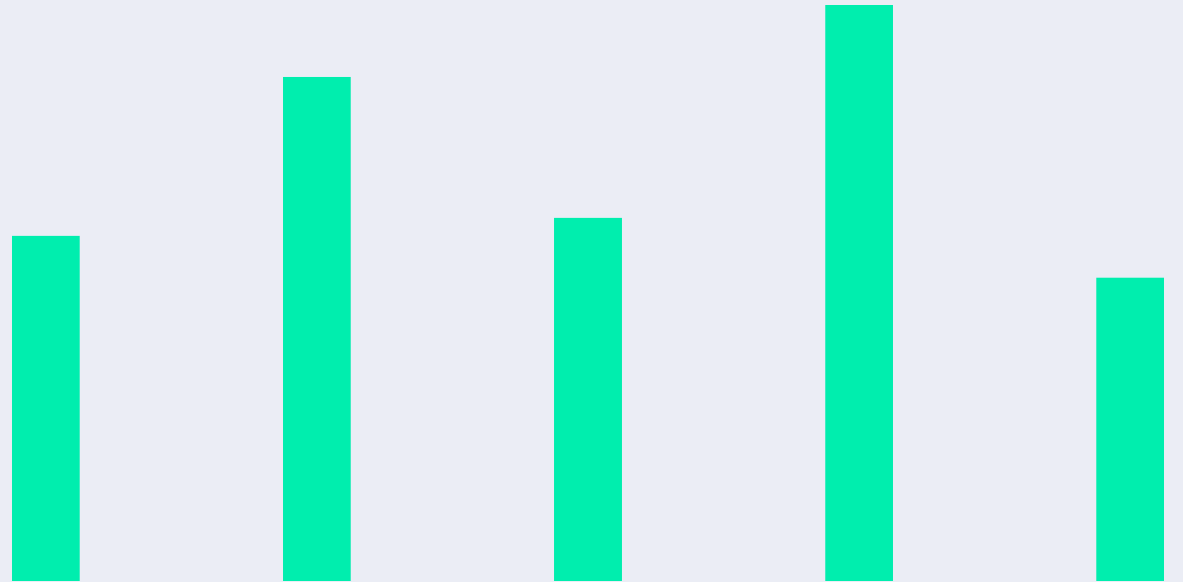
- CT Home Care, PCA and ABI service providers must be credentialed/re-credentialed by Allied and Autism providers must be credentialed/re-credentialed by Beacon Health Options or the Department of Social Services (DSS).
- The credentialing entity will issue a letter to the provider confirming their credentials to continue to provide Waiver services.
- Providers must submit the credentialing letter as a follow-on document (FOD) to Gainwell Technologies.
- The Application Tracking Number 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

Waiver Service Provider Refresher Workshop



# Secure Web Account Set-up

- **Providers who have successfully enrolled as an ABI, Autism, CHC or PCA Waiver Service Provider will 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
    - 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

Waiver Service Provider Refresher Workshop



# Eligibility

## Client Eligibility Verification

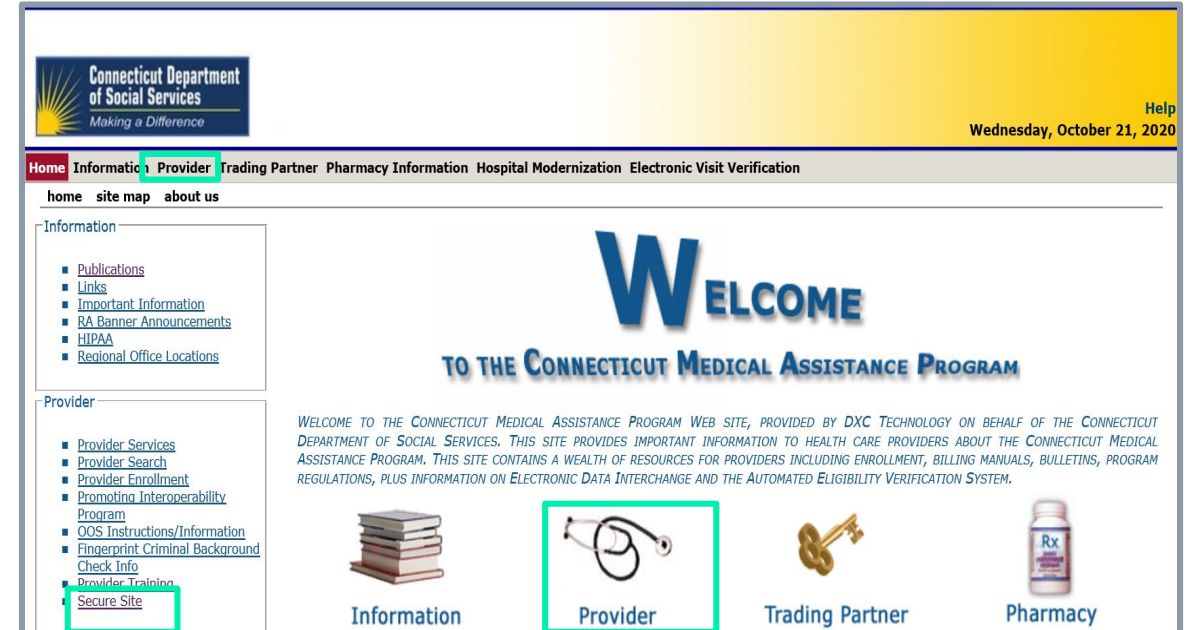
- **Eligibility verification can be performed using any of the following methods:**
  - Internet Web site at [www.ctdssmap.com](http://www.ctdssmap.com).
  - Automated Voice Response System (AVRS).
  - Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
  - Provider Electronic Solutions (PES) software.
- **CMAP Guidelines for Client Eligibility Verification:**
  - Providers should verify client eligibility on the date of service, prior to rendering the service as eligibility can change at anytime.
- **It is recommended that providers at a minimum verify client eligibility:**
  - upon receipt of the initial service order
  - at the resumption of care
  - at a change in the plan of care
  - at regular intervals

# Eligibility (cont.)

## Access to Client Eligibility Verification

Login to your secure Web account on the [www.ctdssmap.com](http://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)



Connecticut Department of Social Services  
Making a Difference

Help  
Wednesday, October 21, 2020

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

home site map about us

Information

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

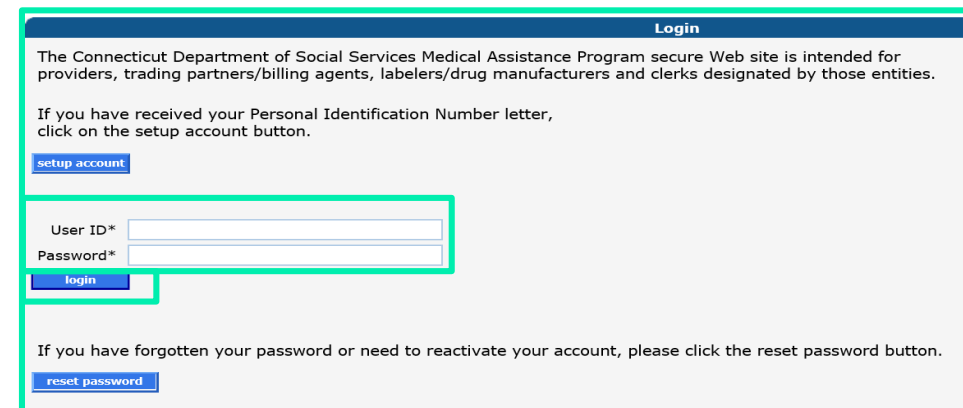
Provider

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

**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



**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

Select a search combination and enter in the required fields

Eligibility Response Quick Reference Guide

**Eligibility Verification Request**

Client ID  last name

SSN  First Name, MI

Birth Date

From DOS\*

To DOS\*

Service Type Code 1  Service Type Code 2

Service Type Code 3  Service Type Code 4

Service Type Code 5

# Eligibility (cont.)

Based on the client and service data entered, the eligibility response indicates the client is eligible.

Access to the benefit plan information indicates:

- the client has a CT Home Care (CHC) Community Based Case Managed Waiver on the date of service
- non-medical services by a CHC Waiver Service provider will be covered for 10/21/20

Retain the verification number in the event your claim is denied when submitted due to client ineligible on date of service.

**Eligibility Verification Request**

Client ID	<input type="text"/>	last name	<input type="text" value="CLIENT"/>	From DOS*	<input type="text" value="10/21/2020"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="WAIVER"/>	To DOS*	<input type="text" value="10/21/2020"/>
Birth Date	<input type="text" value="08/09/1990"/>				
Service Type Code 1	<input type="text" value="30 - Health Benefit Plan Coverage"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

**Eligibility Verification Response**

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

**Benefit Plan**

Service Information ▲	Benefit Month Effective Date	Effective Date	End Date	Message
CT Home Care Community Based Case Managed Waiver	10/01/2020	10/21/2020	10/21/2020	
Husky C. For Behavioral Health Services, call BHP at 877-552-8247	10/01/2020	10/21/2020	10/21/2020	

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# Eligibility (cont.)

## Waiver Eligibility Points to Remember

Clients may be eligible for only the CT Home Care Program for Elders (CHCPE) benefit plan.

- Clients who are ABI, Autism, CHC and PCA “Waiver” eligible:
  - must also be HUSKY A, HUSKY C or HUSKY D eligible, depending on the Waiver
  - must also be HUSKY A, HUSKY C or HUSKY D eligible to be eligible for services under Community First Choice (CFC) .

# Eligibility (cont.)

## Important Resources to Resolve Eligibility Issues Upon Request for Service

- The Community Options Unit 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 [Waiver.DSS@ct.gov](mailto:Waiver.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”, “PCA Client Eligibility Issue” or “Autism Client Eligibility Issue” in the subject line of the email.
- The [Waiver.DSS@ct.gov](mailto:Waiver.DSS@ct.gov) mailbox helps to identify and refer the eligibility issue to the appropriate staff.
  - Eligibility issues often must be referred to the DSS Benefit Center.
    - Community Options does not direct the work-flow in these offices.

# Eligibility (cont.)

## Important Resources to Resolve Eligibility Issues Upon Claim Denial

- Providers who identify an eligibility issue upon claim denial should contact the client's care manager at the Access Agency (CHC or PCA), Case Management Agency (ABI) or DSS Autism Case Manager for assistance to confirm if all redetermination and financial verifications have been submitted to DSS for processing.
  - If the clients Medicaid redetermination and financial verifications have been submitted to DSS and the access agency cannot be of further support, the Community Options Unit, formerly the Alternate Care Unit, at DSS should be notified of the eligibility issue. Providers should send an encrypted email to [Waiver.DSS@ct.gov](mailto:Waiver.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", "PCA Client Eligibility Issue" or "Autism Client Eligibility Issue" in the subject line of the email.
  - Medicaid redeterminations not sent in on time may create lengthy periods of ineligibility.
  - To avoid further claim denials, providers should check eligibility before resubmitting a claim.
  - The [Waiver.DSS@ct.gov](mailto:Waiver.DSS@ct.gov) mailbox helps to identify and refer the eligibility issue to the appropriate staff.
  - Eligibility issues often must be referred to the DSS Benefit Center.
    - Community Options does not direct the work-flow in these offices.

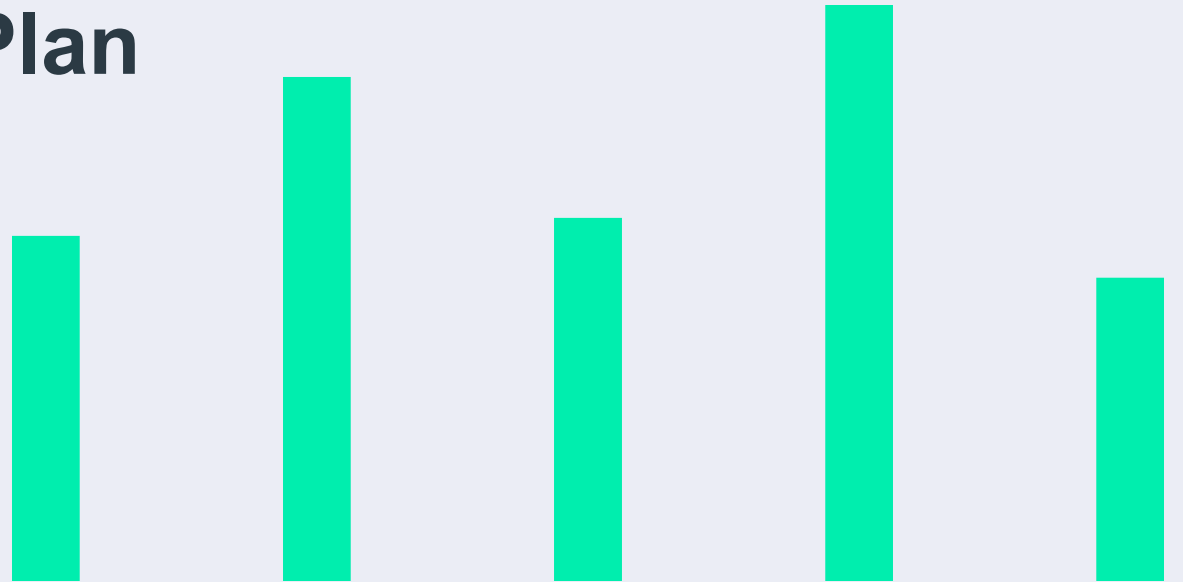
# Eligibility (cont.)

## 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.
- The Community Options Unit 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.

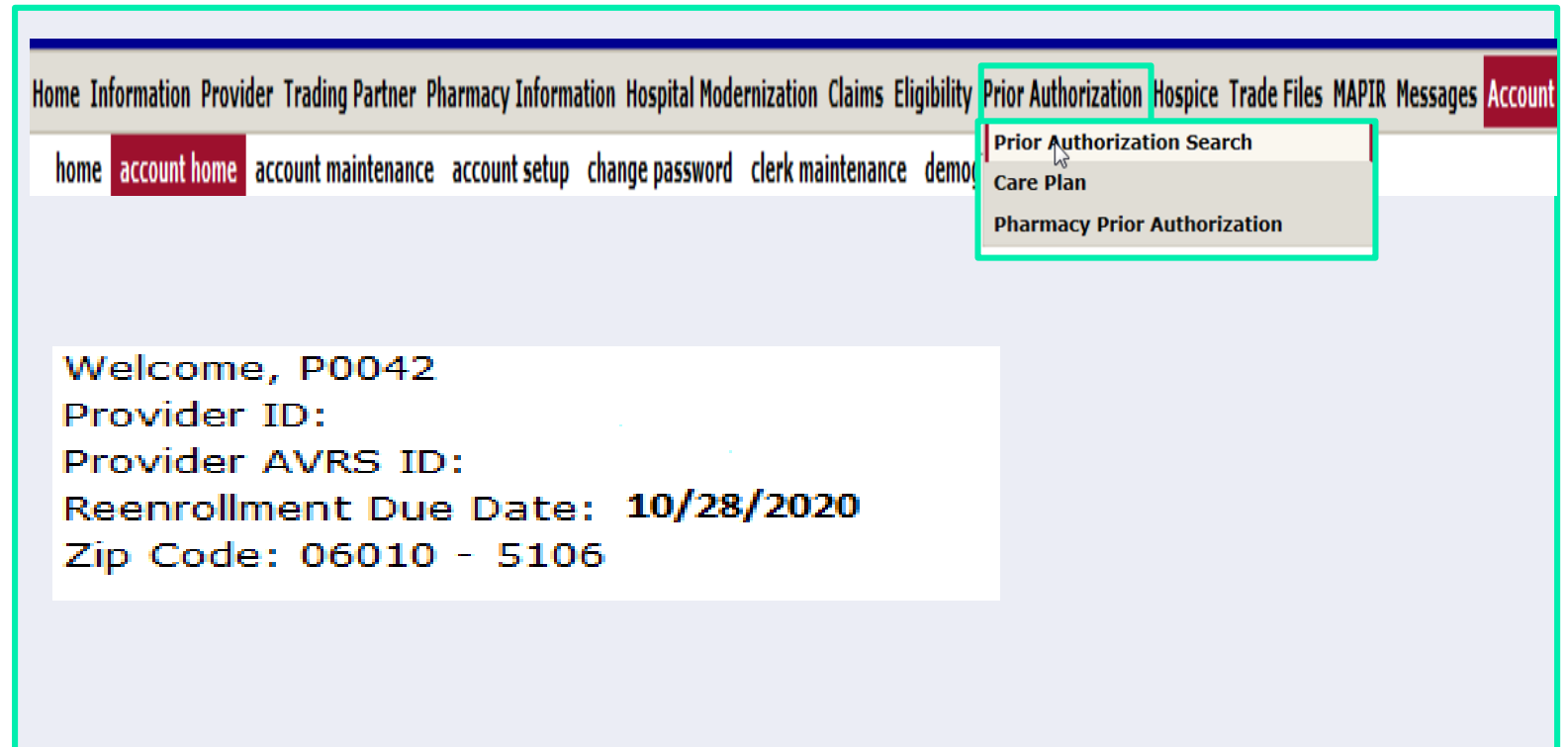
# Prior Authorization (PA) – Viewing and Understanding the Care Plan

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
    - 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.

The screenshot shows the 'Prior Authorization Search' interface. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims Eligibility, **Prior Authorization**, Hospice, MAPIR, Account. Below this is a breadcrumb trail: home > prior authorization search > care plan > pharmacy prior authorization. A 'Quick Link' box contains a link to 'Web Guide - Prior Authorization Search'. An arrow points from this link to a text box that says 'Search for a PA by PA #, if known, Client ID or Client ID with procedure code for the most defined search.' and another arrow points to the text 'Use the Web guide for further information regarding navigation and field definitions.' The main search area is titled 'Prior Authorization Search' and includes a 'Provider 008003693 MCD' header. The search form contains several fields: 'Client ID' (highlighted with a red box), 'Client Name', 'Search Pharmacy PAs only' (checkbox), 'Requested Eff Date', 'Requested End Date', 'Authorized Eff Date', 'Authorized End Date', 'Prior Authorization' (dropdown), 'PA Assignment' (dropdown), 'PA Assian - Sub' (dropdown), 'Procedure' (text input with a red box and a 'Search' button), 'Revenue Code' (text input with a '[ Search ]' button), 'Proc/Mod List' (text input), 'Procedure Code List' (text input with a '[ Search ]' button), and a 'Records' dropdown menu set to '20' (highlighted with a red box). A 'search' button (highlighted with a red box) and a 'clear' button are at the bottom right. A text box says 'Once search criteria has been entered click for results.' with a downward arrow pointing to the search button. Another text box says 'Click to view if more than 20 records match search results.' with an arrow pointing to the 'Records' dropdown.

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

Search Results																			
Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	IDC	Proc/Mod List	Procedure Code List	Frequency
2017275003	01	01012018	02282018	12	\$0.00	Approved		AUTISM		1223Z									1 Per Calendar Month
2017256001	01	01012018	01312018	10	\$0.00	Approved		AUTISM		1302Z									2 Per Calendar Week
2017256001	02	01012018	02282018	8	\$0.00	Approved	09/13/2017	AUTISM		1404Z									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  
 Last Name: Waiver  
 Billing Provider: [ ] MCD  
 Diagnosis: [ ] [ Search ]

PA Assignment: Mental Health Waiver  
 First Name, MI: Betty  
 Date of Birth: 10/06/1986  
 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 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
  - Procedure Codes, Code Lists or Code/Modifier Lists are available on the applicable Waiver Procedure Code Crosswalk found on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site Training page by accessing the Waiver Workshop link.

# Prior Authorization (cont.)

- **Non-Medical Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier or Proc/Mod lists:
  - Modifier **U2 - One Time Only Services** can be used to authorize:
    - Additional units needed on a day a **Waiver** service is provided
    - Another day of service in an existing care plan when a **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 1210Z, Companion Services, Agency, 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 **1210Z U2.**

# Prior Authorization (cont.)

- **Non-Medical Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier or Proc/Mod lists:
  - 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.)

- 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 or DSS Autism Case Manager.***

# Prior Authorization (cont.)

- 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 lesser 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.

# Prior Authorization (cont.)

## Service Authorization Reference Document

- The Procedure Code Crosswalk provides a quick reference to the list of non-medical procedure codes, procedure code lists and procedure codes/modifier lists that can be authorized under the Autism, 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
- Billing Provider who can be 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
- For ABI Providers: ABI Waiver Benefit plan (1, 2, or both) the procedure code is covered
- 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](http://www.ctdssmap.com) Web site:

## Access from the Provider Training Page:

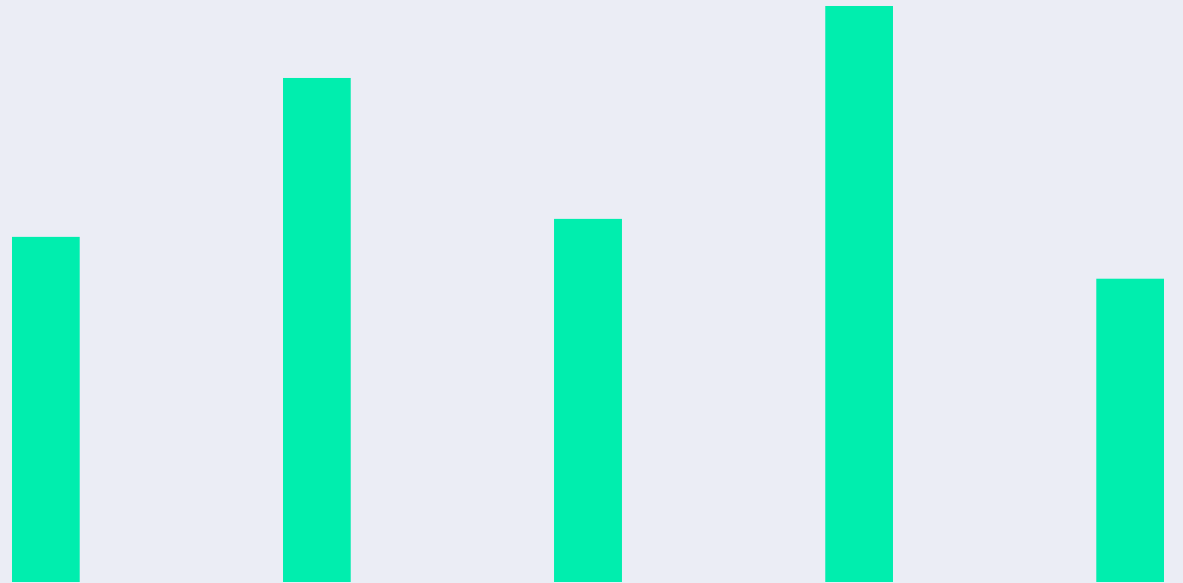
- From the Web site Home Page > Click the “Provider Training” link > Under the Materials Heading > Click on the applicable Waiver Workshop link > Click the corresponding “Procedure Code Crosswalk” link.

## Access from Chapter 8 of the Waiver Service Provider Manual:

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

# Claim Submission

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](http://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](http://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](http://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.

2020 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Dates
<b>Jul</b>	10-b	9	14	15	15
	24	23	28	29	29
<b>Aug</b>	7	6	11	12	12
	21	20	25	26	26
<b>Sep</b>	4	3	9*	10*	10*
	18	17	22	23	23
<b>Oct</b>	9-b	8	14*	15*	15*
	23	22	27	28	28
<b>Nov</b>	6	5	10	12***	12***
	20	19	24	25	25
<b>Dec</b>	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  
 \*\*\* Denotes a 1 day delay in availability due to Wednesday 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)(19)(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 (**19** = 2019)
- **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, there are sub-links: home, account home, account maintenance, account setup, and change password. A notification states: "Your Password will expire in 61 days on 12/28/2020". A "Change Password" link is visible. The main content area includes a welcome message for "John\_Doe\_Waiver" with details: Provider ID: 1234567890 NPI, Reenrollment Due Date: 07/01/2021, and Zip Code: 06106 - 5501. A note mentions that R.A.s or 835 transactions are sent to a download page in the Trade Files menu. A dropdown menu is open under "Claims", listing: Claim Inquiry, Professional (highlighted), Institutional, Dental, and Claim History for Specific Services. A "Quick Link" box contains: Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, and Download Remittance Advices. At the bottom, there is a "Global Messages" table and a "Secure Mailbox" section.

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  
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.

**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

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.)

- Denial Reasons due to Care Plan not on File :

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

- **Resolution:**

A care plan must be created by the Access Agency or DSS Autism Case Manager 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 the Access Agency or DSS Autism Case Manager to the Care Plan.
    - **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 Access Agency or DSS Autism Case Manager.
    - **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 Access Agency or DSS Autism Case Manager 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 Access Agency or DSS Autism Case Manager 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

Waiver Service Provider Refresher Workshop



# 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 [Waiver.DSS@ct.gov](mailto:Waiver.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.**

# 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 the appropriate Access Agency or DSS Autism Case Manager 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 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.

# 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: a homemaker service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 10/26/20 to 10/28/20 5151D for 30 units.

- Minimizes reimbursement time

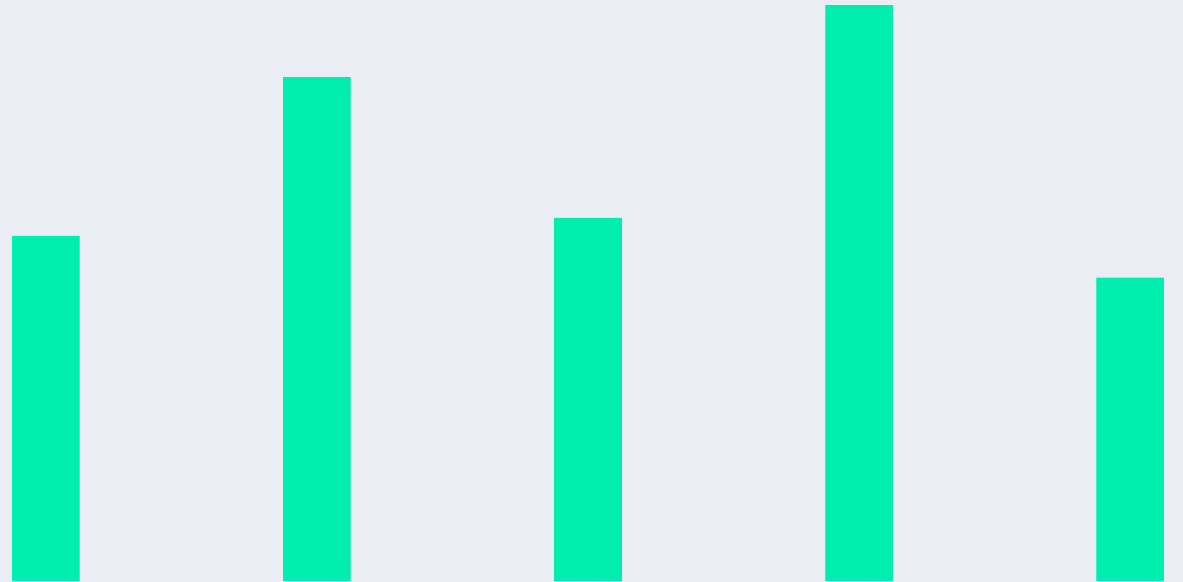
# Program Basics for Successful Claim Submission (cont.)

- **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

Waiver Service Provider Refresher Workshop



# Monthly Claims Reprocessing

- The Access/Case Management Agencies or DSS Autism Case Manager can make retroactive changes to Care Plans even when claims are paid against the Prior Authorization (PA) for a CHC, PCA, ABI or Autism Waiver client.
  - Access/Case Management Agencies or DSS Autism Case Managers 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 all CHC, PCA, ABI or Autism 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 the Access/Case Management Agencies or DSS Autism Case Managers.

# 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 Access Agency/DSS Autism Case Manager 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 2019** by the Access Agency/DSS Autism Case Manager will result in claims being **voided** (region 52) and **reprocessed** (region 24) in **the first cycle of July 2019**.

***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	22000000000000	060314	061214	(116.16)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
					(58.08)	(0.00)	(0.00)	(0.00)	(0.00)		0.00
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	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 the Access/Case Management Agency or DSS Autism Case Manager.

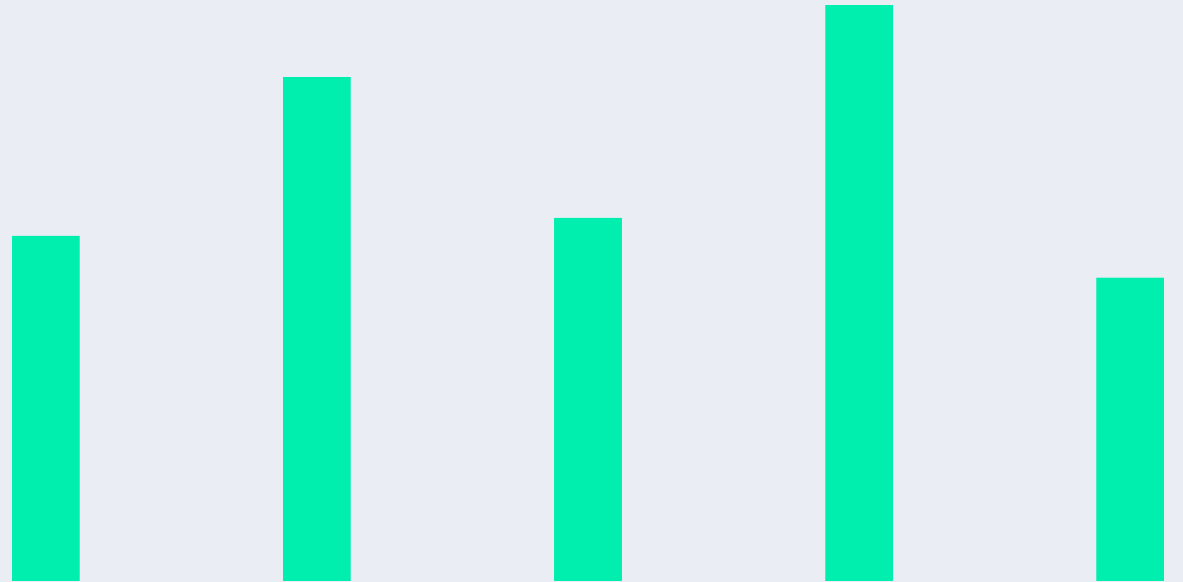
# Monthly Claims Reprocessing (cont.)

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

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

# Information/Resources

Waiver Service Provider Refresher Workshop



# Information/Resources

## Important Messages

- [www.ctdssmap.com](http://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 \(Updated 10/21/20\)](#)

[Attention Home and Community-Based Waiver Providers, Access Agencies and Home Health Agencies: Rate Increases \(Posted 10/20/20\)](#)

[Attention Providers: Delayed Implementation of the Diabetic Supply Program Notification \(Posted 10/19/20\)](#)

[Attention Select Providers: SUPPORT ACT 1003 Planning Grant Provider Assessment \(Posted 10/14/20\)](#)

[Hospital Monthly Important Message \(Posted 10/8/20\)](#)

[Attention All Providers: DXC Technology Becomes Gainwell Technologies \(Posted 10/7/20\)](#)

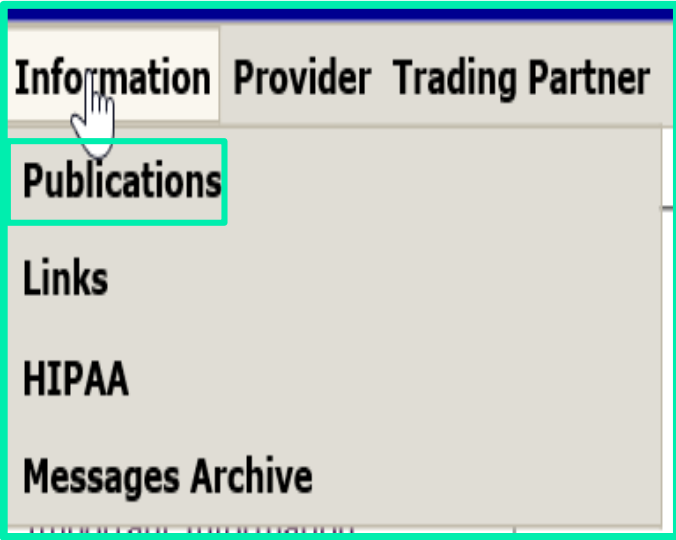
[Attention Electronic Visit Verification \(EVV\) Service Providers: Enhancement to Social Security Number \(SSN\) Editing \(Posted 10/2/20\)](#)

[Revised Monthly Provider Manual Chapters \(Updated 10/1/20\)](#)

# Information/Resources (cont.)

- **Publications**

- A majority of the information available on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site is located on the Publications page
- Access the Publications page by selecting Publications from either the Information box on the left 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

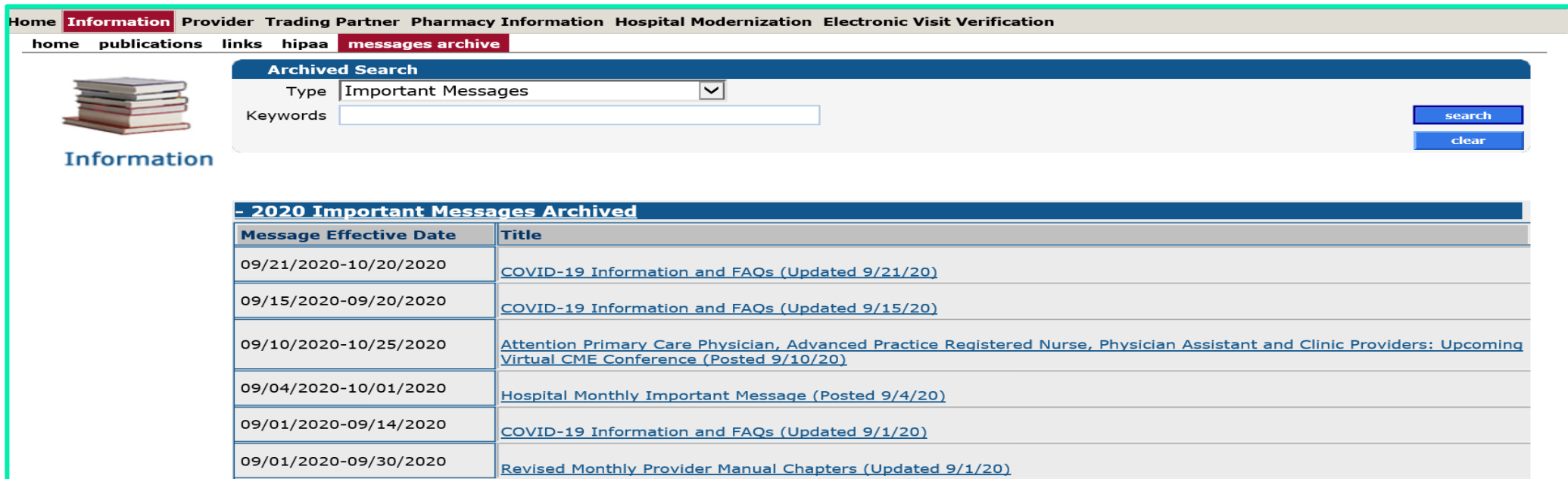
Number  Title

#### Search Results

Bulletin Number	Title	Published Date
PB20-75	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
PB20-34	CMAP COVID-19 Response - Bulletin 21: Select Added Services to the Emergency Tem...	05/11/2020
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](http://www.ctdssmap.com) Web site. Only the most current messages will be posted in the main areas on the Web for a limited time; thereafter, providers will be able to retrieve previously published Important Messages and Banner Announcements from messages archive. To access the messages archive page, select messages archive from the Information drop-down menu on the home page.
  - RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.



The screenshot shows the 'messages archive' page on the CTDSSMAP website. The navigation bar includes 'Home', 'Information' (highlighted), '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' (highlighted). The main content area features an 'Archived Search' section with a 'Type' dropdown menu set to 'Important Messages' and a 'Keywords' input field. To the left of the search section is an 'Information' icon consisting of a stack of books. Below the search section is a table titled '- 2020 Important Messages Archived'.

Message Effective Date	Title
09/21/2020-10/20/2020	<a href="#">COVID-19 Information and FAQs (Updated 9/21/20)</a>
09/15/2020-09/20/2020	<a href="#">COVID-19 Information and FAQs (Updated 9/15/20)</a>
09/10/2020-10/25/2020	<a href="#">Attention Primary Care Physician, Advanced Practice Registered Nurse, Physician Assistant and Clinic Providers: Upcoming Virtual CME Conference (Posted 9/10/20)</a>
09/04/2020-10/01/2020	<a href="#">Hospital Monthly Important Message (Posted 9/4/20)</a>
09/01/2020-09/14/2020	<a href="#">COVID-19 Information and FAQs (Updated 9/1/20)</a>
09/01/2020-09/30/2020	<a href="#">Revised Monthly Provider Manual Chapters (Updated 9/1/20)</a>

# 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](http://www.ctdssmap.com). Communications are no longer mailed to providers and must be downloaded from the DSS Web site.
- For complete E-mail subscription information, please see Provider Bulletin 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](http://www.ctdssmap.com) daily to obtain newly published information.

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

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

**New Subscriber**

E-Mail

Confirm E-Mail

**Existing Subscribers**

E-Mail

**Unsubscribe**

E-Mail

**Available Subscriptions**

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

# Information/Resources (cont.)

- **Provider Manual**

- Access via the [www.ctdssmap.com](http://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's responsibilities and resources

- **Chapter 2 – Provider Participation Regulations**

- Details the CMAP regulations for provider participation

- **Chapter 3 – Provider Enrollment**

- Provides information on provider eligibility in 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

- [August 2020 interChange Newsletter](#)
- [April 2020 interChange Newsletter](#)
- [December 2019 interChange Newsletter](#)
- [November 2019 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

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](http://www.ctdssmap.com)

- [ctdssmap-ProviderEmail@dxc.com](mailto: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.)

- **EVV Email Mailbox**

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

If you are:

- missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan and has a valid PA;
  - or if a prior authorization (PA) is present on the [www.ctdssmap.com](http://www.ctdssmap.com) portal but is not present in the Santrax system.
    - **NOTE: it can take up to 48 hours before a PA that is present on the [www.ctdssmap.com](http://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 care@sandata.com](mailto:ctcustomer care@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](mailto:ctevv@dx.com).
- You are also encouraged to send an e-mail to the [ctevv@dx.com](mailto: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.**

# Contacts (cont.)

- **Access Agencies**

- **Community Care (CCCI) - [ServiceAuthIssues@ctcommunitycare.org](mailto:ServiceAuthIssues@ctcommunitycare.org)**

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

- **South Western Connecticut Area on Aging (SWCAA) - [SWCAABillings@swcaa.org](mailto:SWCAABillings@swcaa.org)**

Please have the following information available when contacting SWCAA:

Client name, the client Medicaid ID number, the type of service (SNV, Med Admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

# Contacts (cont.)

- **Access Agencies continued**

- **Agency on Aging of South Central CT (AOASCC) - [chcbilling@aoascc.org](mailto:chcbilling@aoascc.org)**

Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. All other provider information may be faxed to (203)752-3064. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax. Service Order inquiries must include, on an Excel spreadsheet, the applicable following information when contacting AASCC: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

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

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

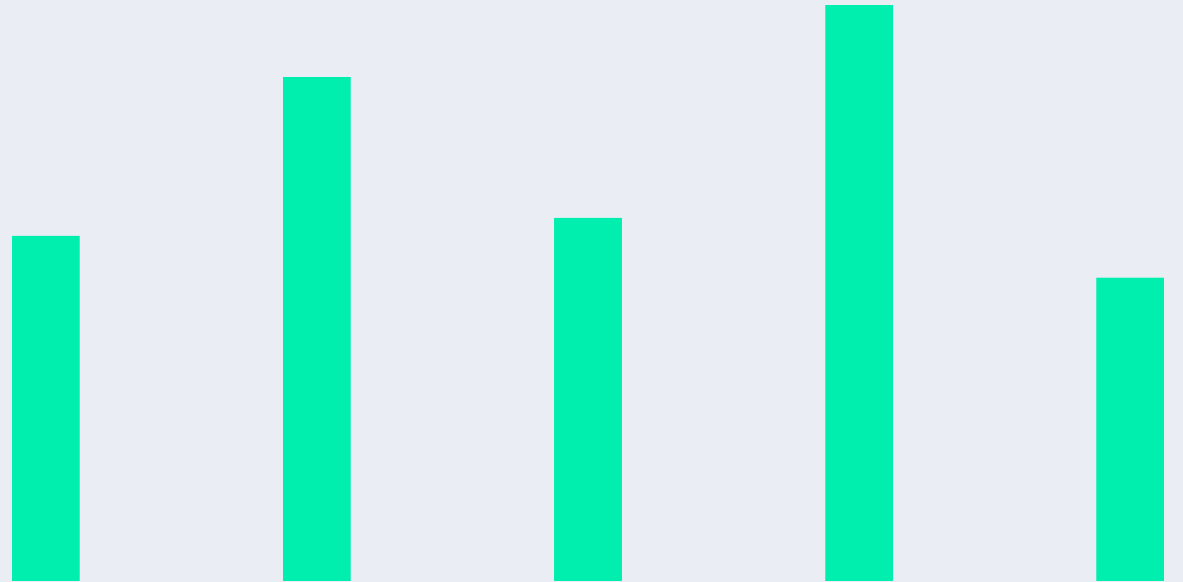
# Contacts (cont.)

- **Contacts continued**

- **Department of Social Services (DSS)** – For Self Directed clients on the CHCPE Program, please contact Melva Cooper, RN directly via e-mail at [melva.cooper@ct.gov](mailto:melva.cooper@ct.gov) or by phone at (860) 424-5863.
- **Community Option Unit at DSS**- For assistance in correcting a waiver client's eligibility file, please send an email to [Waiver.DSS@ct.gov](mailto:Waiver.DSS@ct.gov).

# Questions

Waiver Service Provider Refresher Workshop



# Thank you.

Thank you for attending the Connecticut Medical Assistance Program 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!