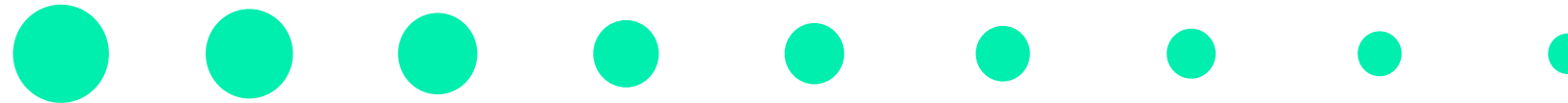


Waiver Provider Refresher Workshop

Debbie Hockla-Kaba, Provider Representative
Gainwell Technologies
December 2021

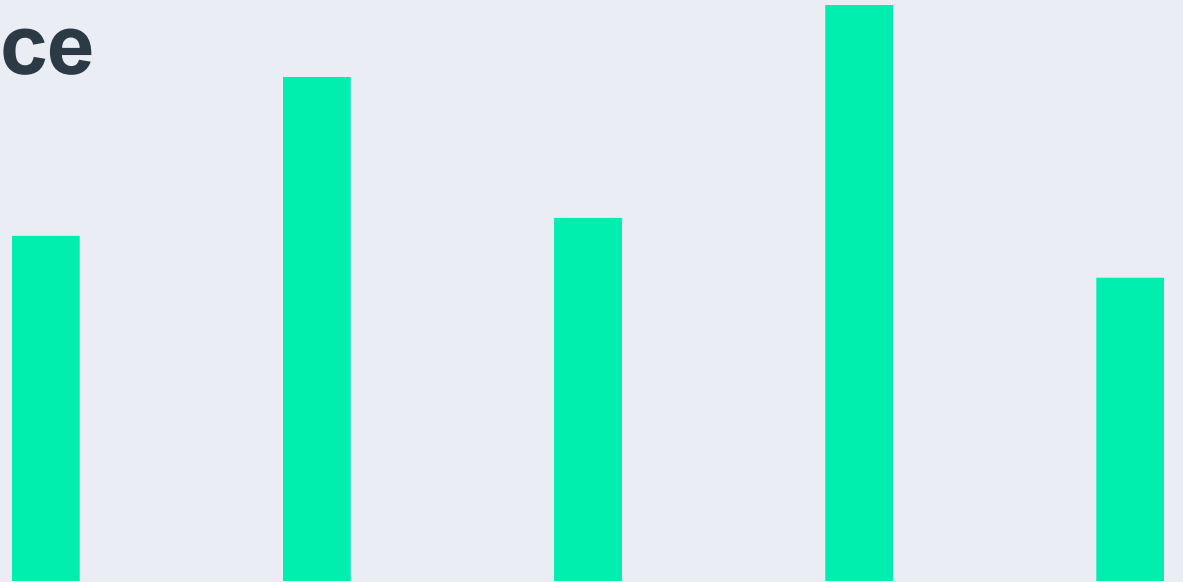


Agenda

- Program Updates - What's New in 2021
- Electronic Visit Verification (EVV) Updates
- Re-Enrollment – How to Avoid being Disenrolled
- Client Eligibility Verification
Resolution of Ineligibility
- Care Plan Review – Confirmation of Authorized Services
- Claim Submission
- Claim Denials and Resolution
- Monthly Claims Reprocessing
- Provider Tools and Resources
- Contacts
- Time for Questions

What's New in 2021 – A Review of Connecticut Medical Assistance Program Changes

Waiver Service Provider Refresher Workshop



What's New in 2021 – A Review of CT Medical Assistance Program Changes

Telemedicine – Update to Place of Service Requirements

Effective for dates of service **January 1, 2021**, and forward telemedicine claims should no longer be billed with Place of Service (POS) 02 identifying the services were rendered via telemedicine.

- Providers billing for telemedicine services **must indicate the POS that best describes where the service would have been rendered if the service was performed in-person.**
- Providers should refer to Provider Bulletin **PB 2020-100** located on the www.ctdssmap.com Web site. From the Home page Information > Publications > enter year and bulletin number.

What's New in 2021 – A Review of CT Medical Assistance Program Changes

All other 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 remain in place:

- **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 2021 – 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 cont.

Allowed Telehealth Services:

- ABI Waiver

Effective since 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 2021 – 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 cont.

Allowed Telehealth Services:

- **Autism Waiver**

Effective *since 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 2021 – 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 cont.

Allowed Telehealth Services:

CHC & PCA Waivers

Effective since **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 2021 – 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 since **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 2021 – 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 Allowed for the following services 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 2021 – 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 2021 – 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 as of **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 continue to be waived on select services for ABI Waiver**
 - 1536P – Companion Services per 15 min
 - 18 hr. per day maximum waived

What's New in 2021 – 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 continue to be in place**
 - **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 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.

What's New in 2021 – Electronic Visit Verification Updates (EVV)

Waiver Service Provider Refresher Workshop



What's New in 2021 – A Review of CT Medical Assistance Program Changes

Transition of Mobile Visit Verification (MVV) App to the Sandata Mobile Connect (SMC) app

- **As of March 31, 2021**
 - The Mobile Visit Verification (MVV) app was deactivated
- **For more information on the Sandata Mobile Connect (SMC)app**
 - Refer to Provider Bulletin **PB 2021-18** on the www.ctdssmap.com Web site. From the Home page Information > Publications > enter year and bulletin number.

What's New in 2021 – A Review of CT Medical Assistance Program Changes

Electronic Visit Verification (EVV) – Additional Languages Option

- Effective **October 6, 2021**, Sandata will be adding additional Language options to:
 - The **EVV toll-free phone number** used for calling in and out for visits
 - Only the initial language option prompt will be modified to include the updated additional languages
 - The **Sandata Mobile Connect (SMC) phone application** for the EVV Program.
 - User is given the option of changing the language in which they view their app for:
 - New users during initial set-up
 - Existing users after logging in via the menu icon (three line in top left corner of app)
- For more information on additional language options added to the **EVV toll-free phone number** or **(SMC)app**:
 - Refer to Provider Bulletin **PB 2021- 58** on the www.ctdssmap.com Web site. From the Home page Information > Publications > enter year and bulletin number.

What's New in 2021 – A Review of CT Medical Assistance Program Changes

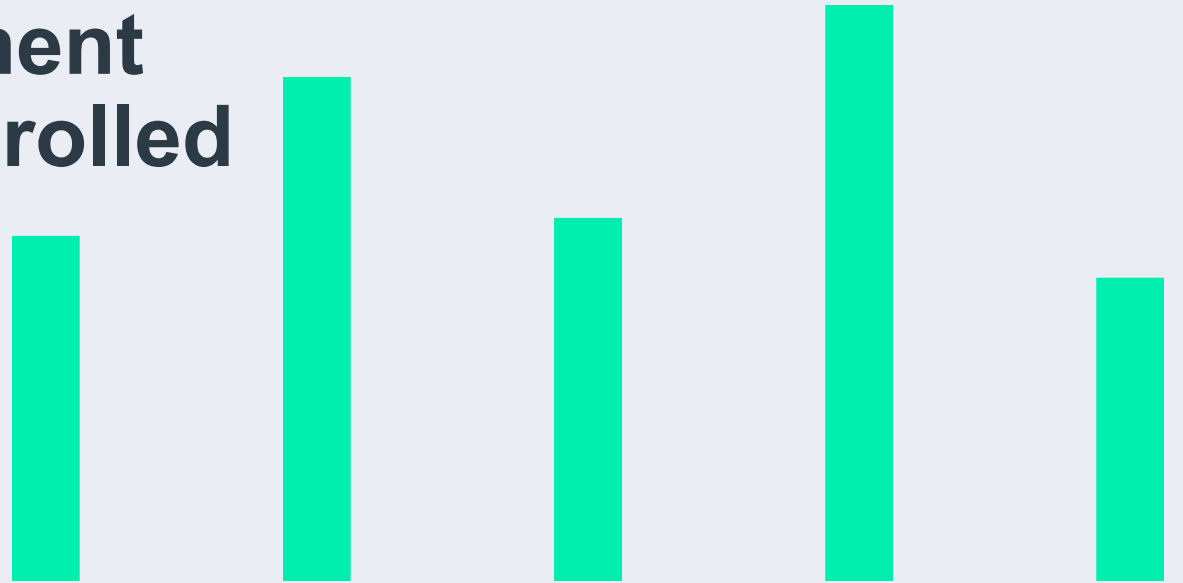
Electronic Visit Verification (EVV) – Task to Service Enhancement

- Effective **November 3, 2021**, Sandata will be implementing Task to Service Enhancement
 - This enhancement will create a new visit exception titled “**Invalid Task**” for **Sandata Mobile Connect (SMC) app**.
 - This exception will appear on any visit where a task selected is not valid for the service selected. If the exception is present, the user must acknowledge the exception before the improper task can be updated to the correct task.
- **The Task to Service Enhancement scheduled for implementation in the Sandata Agency Management (SAM) on November 3, 2021, has been postponed until further notice.** (Refer to Important Message posted 11/2/2021 to the www.ctdssmap.com Home page for more information.)
- For more information on the Task to Service Enhancement for the **(SMC)app**:
 - Refer to Provider Bulletin **PB 2021- 82** on the www.ctdssmap.com Web site. From the Home page > Information > Publications > enter year and bulletin number.
 - Refer to the **At Your Fingertips #41- Task to Service Enhancement** tip sheet. From the Home page > Electronic Visit Verification > At Your Fingertips Tip Sheets.

Re-Enrollment

How To Maintain your Enrollment Status and Avoid Being Disenrolled

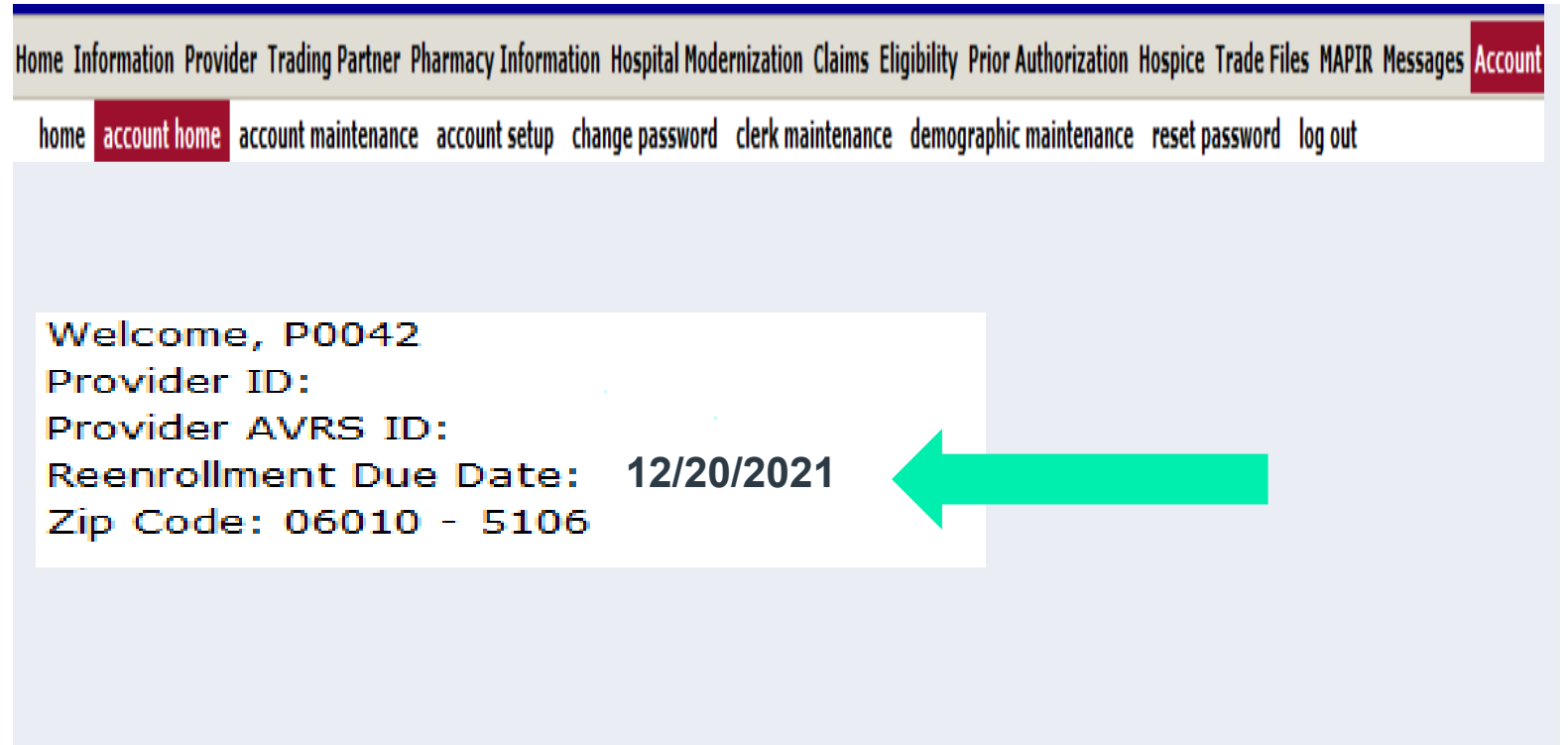
Waiver Service Provider Refresher Workshop



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

Welcome, P0042
Provider ID:
Provider AVRS ID:
Reenrollment Due Date: **12/20/2021**
Zip Code: 06010 - 5106

A large green arrow points to the Reenrollment Due Date.

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

Re-Enrollment (cont.)

Providers will receive a reminder letter when they are due for re-enrollment **6 months** prior to the end of their previous 2-year Waiver Service Provider contract. Providers enrolled in multiple Waiver Service contracts will receive a separate letter **6 months** prior to the re-enrollment due date of each contract enrolled.

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

Note: Re-enrollment notifications are sent via e-Delivery. The re-enrollment letter can be retrieved via the Trade Files menu on the secure web account of the Primary Account holder and clerks with role permission access to Trade Files.

Re-enrollment (cont.)

- **Prior to Re-enrolling:**

- CT Home Care, PCA and ABI service providers must be credentialed/re-credentialed by Allied Community Resources.
- 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
 - EVV, 837 via vendor software or via secure web account
 - 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.
 - 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 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)

The screenshot displays the website for the Connecticut Department of Social Services Medical Assistance Program. The header includes the department's logo and the date Wednesday, October 21, 2020. A navigation menu at the top highlights the 'Provider' tab. The main content area features a 'WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM' message and a list of icons for 'Information', 'Provider', 'Trading Partner', and 'Pharmacy'. The 'Provider' icon is highlighted with a red box. Below this, a 'Login' section contains a message about the secure website, instructions for users with Personal Identification Number letters, and a login form with fields for 'User ID*' and 'Password*', a 'login' button, and a 'reset password' button. The 'Secure Site' link in the left sidebar is also highlighted with a red box.

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 (name as stated on the Connect card)
- 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* 10/21/2020

To DOS* 10/21/2020

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

Service Type Code 3 Service Type Code 4

Service Type Code 5

search

clear

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 12/01/2021.

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="12/01/21"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="WAIVER"/>	To DOS*	<input type="text" value="12/01/21"/>
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 ^A	Benefit Month Effective Date	Effective Date	End Date	Message
CT Home Care Community Based Case Managed Waiver	12/01/2021	12/01/2021	12/01/2021	
Husky C. For Behavioral Health Services, call BHP at 877-552-8247	12/01/2021	12/01/2021	12/01/2021	

Gainwell Technologies Proprietary and Confidential

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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.
 - Both Home Health and Non-Medical CHC Services are covered under this 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.
 - 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 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 client's 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.
 - 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.
 - **Complete 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 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:
 - Make note of the **eligibility verification number** received. Dates of service corresponding to a favorable eligibility verification may be submitted for payment should services later be denied due to 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 will be 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.

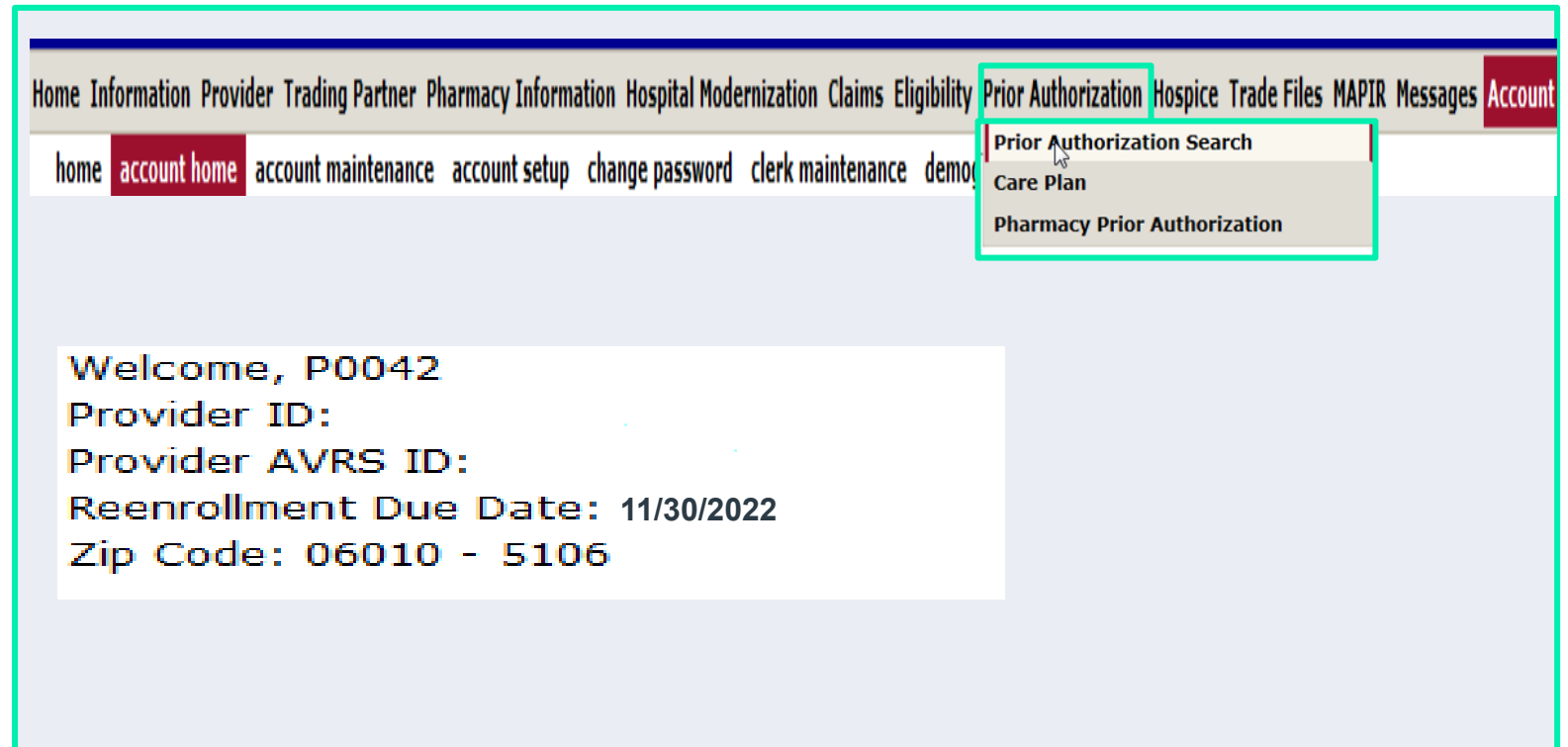
Prior Authorization (PA) – Viewing and Understanding the Care Plan

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 authorizedto reduce the number of PA records displayed from a client ID search.

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

home prior authorization search care plan pharmacy prior authorization

Quick Link

- Web Guide - Prior Authorization Search

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

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

Provider 008003693 MCD

Prior Authorization Search

Client ID

Client Name

Search Pharmacy PAs only

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assian - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Procedure Code List [Search]

Once search criteria has been entered click for results.

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

search

clear

Prior Authorization Search Panel.

Prior Authorization (cont.)

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

Search Results																			
Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedur	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	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, if applicable.

Base Information

Prior Authorization Number: 0719245098

Client ID: 000000000 PA Assignment: Mental Health Waiver

Last Name: Waiver First Name, MI: Betty

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

Diagnosis: [Search] Insurance: None

Estimated Date of Delivery: Patient Condition: Fair

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

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]

Proc/Mod List: [Search]

Procedure Code List: [Search]

Requested Eff./End Dates*: [Search]

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: [Search]

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 – The code authorized must be billed on the claim
 - Procedure Code with modifier(s) – The code and all modifiers authorized must be billed on the claim. Note: The service and service with modifier should be authorized on the same PA.
 - 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. **Please Note: Whenever there is a code list that contains the service you will be providing, the code list should be authorized, even though you may not be servicing for one or more of the procedure/modifier combinations on the list.**
 - Procedure Codes, Code Lists or Code/Modifier Lists are available on the applicable Waiver Procedure Code Crosswalk found on the www.ctdssmap.com Web site. From the Home Page click the Training link. Under the Materials heading, access the applicable Waiver Workshop link, then the Waiver Crosswalk 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 on 1 Saturday per month = 4 units per month authorized as **1210Z U2.**
 - A Procedure with the U2 modifier, unlike other modifiers, does not need to be authorized on the same PA as the procedure code without the modifier

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, or group home sharing a common area, 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/Case Management 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 Web site:

Access from the Provider Training Page:

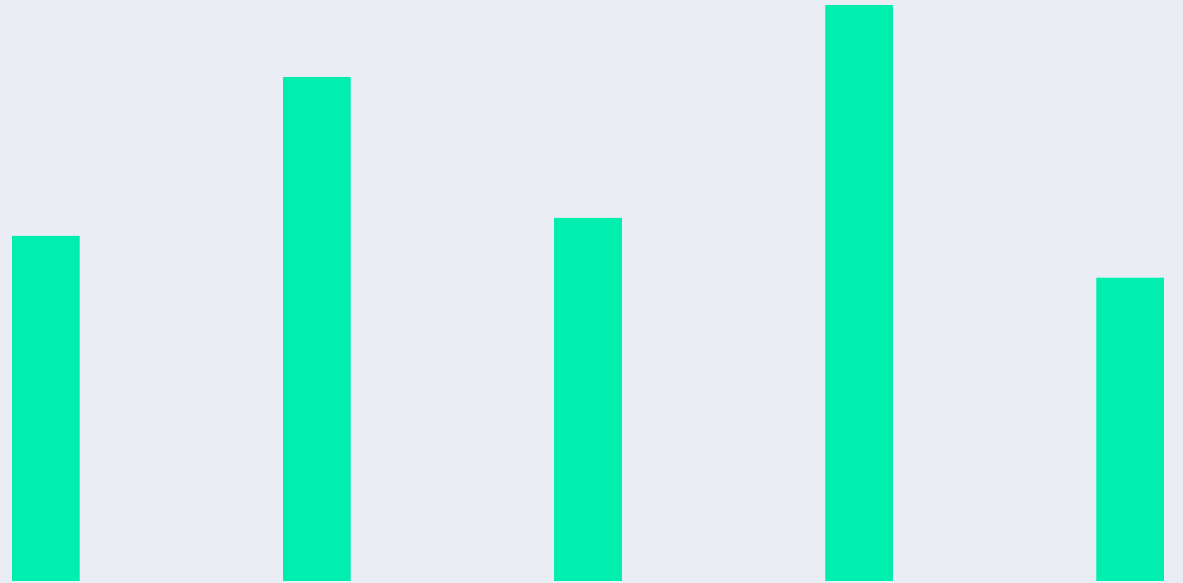
- From the Web site Home Page > Click the “Provider Training” link > Under the Materials Heading > Click on the applicable Waiver Workshop link > Click the corresponding “Procedure Code Crosswalk” link.

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 Web site for Secure Web account set-up
- Refer to Instructions for submitting Professional Claims via claims menu on the secure site.
- Refer to “Electronic Visit Verification (EVV) Alternate Claim Solution” (Provider Bulletin PB 18-17) or EVV menu > Important Documentation > Important Messages>Claims Assistance.

- **ASC X12N 837 Professional Claim Format File**

- EVV Mandated, Optional or N/A EVV Claims may be submitted using this Method
- Provider must be enrolled in CMAP
- Requires a Trading Partner Agreement
- Refer to Chapter 6 EDI on the www.ctdssmap.com Web site.
- Refer to “Electronic Visit Verification (EVV) Alternate Claim Solution” (Provider Bulletin PB 18-17) or EVV>Important Documentation >Important Messages>Claims Assistance.

- **Sandata EVV Santrax System**

- EVV Mandated or Optional service claims may be submitted via this method
- Provider must be enrolled in CMAP
- Provider must have completed required Training of the Santrax System via the Learning Management System
- Received Santrax Welcome Kit
- Refer to the Electronic Visit Verification Menu on the www.ctdssmap.com Web site.

Claims Process – Cycle Schedule

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

2021 Month	Claim Cycle Date	Electronic Claims Received by	Web RA Availability	Check Mail Dates	EFT/835 Dates
Jul					
	9-b	8	13	14	14
	23	22	27	28	28
Aug					
	6	5	10	11	11
	20	19	24	25	25
Sep					
	10-b	9	14	15	15
	24	23	28	29	29
Oct					
	8	7	13*	14*	14*
	22	21	26	27	27
Nov					
	5	4	9	10	10
	19	18	23	24	24
Dec					
	3	2	7	8	8
	17	16	21	22	22

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 21 005 123 456

1 2 3 4 5

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

Claims Submission (cont.)

- **When a claim processes through CMAP, it is subject to a series of edits that check the validity of claim data such as:**
 - The submitted Provider must be **actively enrolled** on the date of service.
 - Client must be **eligible** on date of service.
 - Procedure Code submitted must be **valid** for the Provider Type.
- **Each claim then passes through a series of audits.**
 - If claim date of service > 366 days was there a **previously submitted claim that did not deny for timely filing?**
 - 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.)

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

Your Password will expire in 61 days on January 30, 2022 Chan...

Welcome: John_Doe_Waiver
Provider ID: 1234567890 NPI
Reenrollment Due Date: **May 6, 2022**
Zip Code: 06106 - 5501
Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Trade Files HAPIR Messages **Account**
Maintenance reset password log out

Quick Link

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

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 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="text"/>
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

The screenshot shows a web application interface. At the top, there is a navigation menu with the following items: Home, Information, Provider, Trading Partner, ConnPACE, Pharmacy Information, Claims, Eligibility, Prior Authorization, Messages, and Account. The 'Claims' menu is expanded, showing a list of options: Claim Inquiry (highlighted with a red arrow), Professional, Institutional, Dental, and Claim History for Specific Services. Below the navigation menu, there is a message: "Your Password will expire in 61 days on January 20...". The main content area displays a welcome message: "Welcome: John_Doe_Waiver", "Provider ID: 1234567890 NPI", "May 6, 2022", "Reenrollment Due Date: ...", and "Zip Code: 06106 - 5501". Below this, there is a message: "Your R.A.s, or 835 transactions, are being sent to: Your download page in the Trade Files menu option." At the bottom, there is a "Global Messages" table with the following data:

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

Below the table, there is a "Secure Mailbox" section with the message: "*** 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:

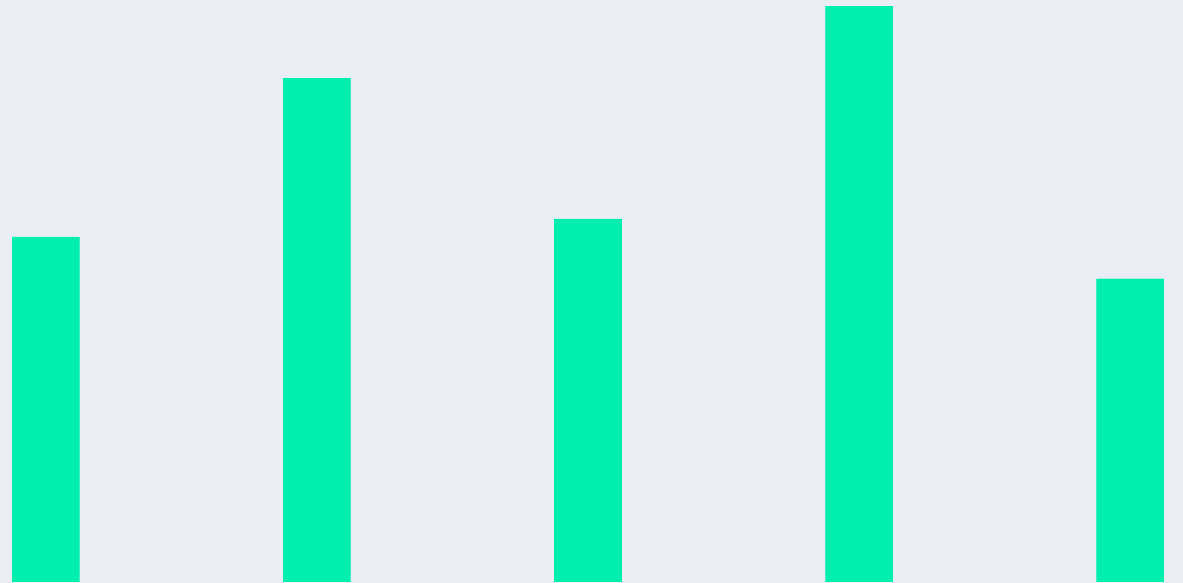
- re-submit** – Resubmit the claim (with or without making changes)
- cancel** – Cancel any alterations you have made
- new claim** – Create a brand-new claim

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

- **Denials Due to Timeliness of Claim Submission**

- **0512 Claim exceeds timely filing limit**

- The Department of Social Services timely filing limit for non-Behavioral Health Partnership services is one year. This EOB code will appear on the claim if any of the following conditions exist:

- The **date the claim was received** by Gainwell Technologies was **greater than 366 days from the claim date of service**
 - The **date the claim was received** by Gainwell Technologies was **greater than 366 days from the date the claim previously appeared on a Remittance Advice**
 - The claim **previously denied for timely filing.**

TPL Related Timely Filing Denials:

- The date the claim was received by Gainwell Technologies was greater than 366 days from the Other Insurance Explanation of Benefit or Medicare Explanation of Medicare Benefit date
 - The Explanation of Medicare Benefit denial date is greater than 549 days from the date of service
 - When there are multiple TPL Carriers and Medicare Carriers on the claim, if any one of the date checks do not meet these criteria, the EOB will set

Claim Denials and Resolution

- **Denials Due to Timeliness of Claim Submission**

- **0512 Claim exceeds timely filing limit cont.**

Note: The claim receipt date can be identified within the Internal Control Number (ICN). For example, ICN 2021031200100 indicates the claim was received January 31, 2021. The year is located in the third and fourth positions and the day of the year (Julian date) is located in the fifth through seventh positions.

Resolution:

- If the claim meets any of the noted criteria above, the claim exceeds the timely filing limit and cannot be paid.
- If the claim previously appeared on a Remittance Advice within the past 366 days, the claim must be resubmitted with the same provider ID, client ID, date of service, procedure/modifier and billed amount, otherwise, the claim will deny. If the previously processed claim denied for timely filing, the claim is not payable.

TPL Related denial

- If the claim denied with this error, but does not meet the noted criteria above, resubmit the claim with the appropriate supporting documentation (i.e. copy of Remittance Advice, Other Insurance Explanation of Benefit or Medicare Explanation of Medicare Benefit) and send the claim to the normal claim submission address located in Chapter 1 of the Provider Manual. Go to www.ctdssmap.com -> Information -> Publications -> Provider Manuals.

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 frequency 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 the correct Waiver Service or correct Waiver Service Provider ID based on the client's Waiver benefit plan.

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 a valid service on the 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

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
 - 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.

Issues of client ineligibility involving the DSS Benefit Center due to late or missing documentation required for redetermination of eligibility may take some time to resolve.

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.
 - Submit claims nearing timely filing that are pending PA to avoid timely filing denial. The claim will deny for PA, but you will be able to resubmit once the service/units have been updated on the PA file.

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.

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

Program Basics for Successful Claim Submission (cont.)

- **Conditions that Waive the Timely Filing Limit:**

- **Timeliness of Claim Submission**

Providers have one (1) year from the paid date (claim cycle date) indicating a denial to resubmit the claim, provided the denial was not for timely filing.

- **Other Payer Source (TPL)**

The date of service on the claim must fall within one (1) year of the issue date on the other insurance denial, providing the denial was not for timely filing. A copy of the carrier's Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) must be retained by the provider in the client's file.

- **Retroactive Client Eligibility**

The provider has one (1) year from the date the client's eligibility was **added** to the Connecticut interChange Medicaid Management Information System (MMIS) eligibility file to submit the claim.

- Providers should submit claims nearing timely filing, for eligible clients pending benefit plan **updates**, to avoid claim submission after eligibility resolution that is beyond the timely filing limits.

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 (such as Region 20 or 22= the original claim) 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 2021** 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 2021**.

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

Monthly Claims Reprocessing (cont.)

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

Monthly Claim Reprocessing - Claim Recouped

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

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

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

FP	--ICN--	SERVICE DATES	BIL	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	2200000000000	060314 061214	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	060314 061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	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.

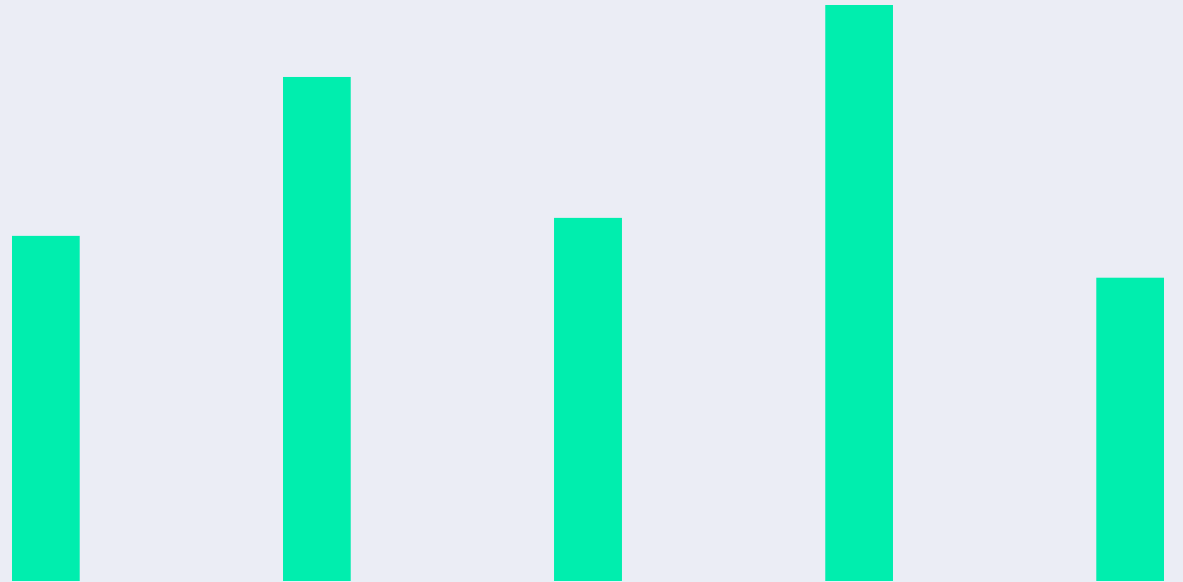
Monthly Claims Reprocessing (cont.)

- **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 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

[Attention Outpatient Hospitals: Ambulatory Payment Classification \(APC\) Weight Corrections \(Posted 11/10/21\)](#)

[COVID-19 Information and FAQs \(Updated 11/9/21\)](#)

[Hospital Monthly Important Message \(Posted 11/8/21\)](#)

[Postponed: Task to Service Enhancement for Sandata Agency Management \(SAM\) - Electronic Visit Verification \(EVV\) \(Posted 11/2/21\)](#)

[Attention Pharmacy and Durable Medical Equipment Providers: Pharmacy Coverage of V-Go Products \(Posted 10/28/21\)](#)

[CMAP Addendum B October 2021 \(Updated 10/26/21\)](#)

[Attention Inpatient Hospitals: Annual 3M Grouper Updates \(Updated 10/26/21\)](#)

[New Face-to-Face Requirements for Initial Orders of Home Health Services and Certain Durable Medical Equipment \(DME\) Updated as of 10/19/21](#)

[Attention All Providers: CDC Health Update: Expansion of Recall of LeadCare Blood Lead Tests Due to Risk of Falsely Low Results \(Posted 10/14/21\)](#)

[RESCHEDULED: Attention All Providers - Discontinuation of Internet Explorer Support \(Updated 10/13/21\)](#)

Information/Resources (cont.)

- **Publications**

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



Information/Resources (cont.)

- RA Banner Announcements

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

Banner Effective Date	Providers	Banner Page Announcement
11/05/2021-11/12/2021	Attention Connecticut Home Care Providers (CHC)	Attention Connecticut Home Care Providers (CHC). Reprocessed This CYCLE: The Department of Social Services (DSS) has requested that Gainwell Technologies reprocess claims for CHC waiver clients that had retroactive benefit plan changes from state funded CHC (CBCMS) eligible to HUSKY C with a CHC Waiver (CBCMF). These claims have been identified and reprocessed to eliminate cost share and override timely filing. Impacted claims will appear on the November 9, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.
11/05/2021-11/12/2021	Attention All Providers	Attention All Providers. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed claims which initially processed and paid under a temporary client ID as described in Provider Bulletin 2014-29. The claims were reprocessed to reflect the client's true (permanent) 9-digit Connecticut Medical Assistance Program (CMAP) ID. The claims which processed under a temporary client ID will be recouped and appear on the November 10, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52 and Explanation of Benefits (EOB) code 8239 "ACA CLIENT TEMP ID REPLACED WITH CMAP ID. NEW CLAIM WILL BE SYSTEMATICALLY GENERATED". The new claims will also appear on the November 10, 2021 RA with an ICN beginning with region code 27.
11/05/2021-11/12/2021	Attention Outpatient Hospital Provider	Attention Outpatient Hospital Provider. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and adjusted claims with dates of service August 12, 2021 through October 28, 2021 which incorrectly denied for Explanation of Benefit (EOB) code 4985 - "Procedure Restriction for RCC under Provider Contract". The denials occurred on claims submitted with procedure code 0003A (ADM SARSCOV2 30MCG/0.3ML 3RD Pfizer-Biontech) or 0013A (ADM SARSCOV2 100MCG/0.5ML 3RD Moderna) and revenue center code (RCC) 770 (Prevent Care Svc). The impacted claims have been reprocessed and will appear on your November 9, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52. Please note that any claims incorrectly submitted with procedure code 0003A or 0013A with RCC 771(Vaccine Administration) will need to be resubmitted by the provider to conform with billing requirements.
11/05/2021-11/12/2021	Attention Outpatient Hospital Provider	Attention Outpatient Hospital Provider. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed claims with dates of service August 12, 2021 through October 28, 2021 which incorrectly denied for Explanation of Benefit (EOB) code 4985 - "Procedure Restriction for RCC under Provider Contract". The denials occurred on claims submitted with procedure code 0003A (ADM SARSCOV2 30MCG/0.3ML 3RD Pfizer-Biontech) or 0013A (ADM SARSCOV2 100MCG/0.5ML 3RD Moderna) and revenue center code (RCC) 770 (Prevent Care Svc). The impacted claims have been reprocessed and will appear on your November 9, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 27. Please note that any claims incorrectly submitted with procedure code 0003A or 0013A with RCC 771(Vaccine Administration) will need to be resubmitted by the provider to conform with billing requirements.
11/05/2021-11/12/2021	Attention Providers	Attention Providers. REPROCESSED THIS CYCLE: Gainwell Technologies has identified and reprocessed Medicare crossover claims with dates of service July 1, 2021 through October 26, 2021, pursuant to the revised pricing methodology announced in Provider Bulletin 2021-49. The impacted claims have been reprocessed to reimburse at 100% of the rate listed on the Physician fee schedule(s) and will appear on your November 9, 2021 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 52.

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.

The screenshot displays a web interface for searching provider bulletins. At the top, there is a 'Bulletin Search' header. Below it, search filters are visible: 'Year' is set to '21', 'Provider Type' is 'CT Home Care Program', and there are empty input fields for 'Number' and 'Title'. 'search' and 'clear' buttons are on the right. Below the search area is a 'Search Results' section containing a table with three columns: 'Bulletin Number', 'Title', and 'Published Date'. The table lists 11 bulletins from PB21-82 down to PB21-18, with their respective titles and dates.

Bulletin Number	Title	Published Date
PB21-82	Electronic Visit Verification (EVV) - Task to Service Enhancement	10/18/2021
PB21-81	Advanced Practice Registered Nurses and Physician Assistants Authorized to Order...	10/18/2021
PB21-73	Other Insurance/Medicare Claim Submission Instruction Reminders	09/20/2021
PB21-62	Emergency Medicaid Coverage of Dialysis for End Stage Renal Disease	08/18/2021
PB21-58	Electronic Visit Verification Additional Languages	08/10/2021
PB21-38	Use of ICD-10-CM "Z" Codes for Social Determinants of Health	06/11/2021
PB21-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/17/2021
PB21-34	CMAP COVID-19 Response - Bulletin 54: ADDITIONAL Services Covered under the "COV...	05/17/2021
PB21-32	Reinstatement of Copayments for Medical Services Rendered to HUSKY B Members	05/12/2021
PB21-26	REVISED Reinstating Prior Authorization Requirements that were Suspended During ...	04/16/2021
PB21-18	Electronic Visit Verification (EVV) - End Date for Mobile Visit Verification (MV...	03/18/2021

Information/Resources (cont.)

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

2021 Important Messages Archived	
Message Effective Date	Title
10/25/2021-10/25/2021	CMAP Addendum B October 2021 (Posted 10/25/21)
10/25/2021-10/25/2021	Attention Inpatient Hospitals: Annual 3M Grouper Updates (Posted 10/25/21)
10/25/2021-11/08/2021	COVID-19 Information and FAQs (Updated 10/25/21)
10/22/2021-10/24/2021	COVID-19 Information and FAQs (Updated 10/22/21)
10/14/2021-10/18/2021	ATTENTION PROVIDERS: Automated Voice Response System Downtime Notification (Posted 10/14/21)
10/08/2021-11/07/2021	Hospital Monthly Important Message (Posted 10/8/21)
10/08/2021-10/30/2021	Attention All Providers: Health Resources & Services Administration (HRSA) Announces Phase 4 of Provider Relief Funds (Posted 10/8/21)
09/30/2021-10/12/2021	DELAYED: Attention All Providers - Discontinuation of Internet Explorer Support (Updated 9/30/21)

Information/Resources (cont.)

- **Provider Manual**

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

Information/Resources (cont.)

- **Provider Manual**

- **Chapter 1 – Introduction**

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

- **Chapter 2 – Provider Participation Regulations**

- Details the CMAP regulations for provider participation

- **Chapter 3 – Provider Enrollment**

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

- **Chapter 4 – Client Eligibility**

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

- **Chapter 5 – Claim Submission Information**

- Provides information on general claims processing and billing requirements

- **Chapter 6 – EDI Options**

- Provides information on electronic claim submission and electronic RAs

Information/Resources (cont.)

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

Information/Resources (cont.)

- **Provider Newsletters**

- Quarterly publications to providers on a wide range of topics

Provider Newsletters

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

- **Claims Processing Information**

- Guides and FAQs to assist with billing/claims processing

Claims Processing Information

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

Other CMAP Resources

Waiver Service Provider Refresher Workshop



Provider Fee Schedules

Connecticut Department of Social Services
Making a Difference

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Provider Enrollment
Provider Re-enrollment
Provider Enrollment Tracking
Provider Matrix
Provider Services
Provider Search
Drug Search
Provider Fee Schedule Download

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

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search **provider fee schedule download** promoting interoperability program fingerprint criminal background check info e-mail subscription secure site

Connecticut Provider Fee Schedule End User License Agreements

END USER LICENSE AGREEMENTS FOR CURRENT PROCEDURAL TERMINOLOGY (CPT) AND CURRENT DENTAL TERMINOLOGY (CDT) ARE DISPLAYED BELOW. TO ACCESS THE CONNECTICUT PROVIDER FEE SCHEDULES, REVIEW AND ACCEPT THE END USER LICENSE AGREEMENTS.

The license granted herein is expressly conditioned upon your acceptance of all terms and conditions contained in this agreement. If the foregoing terms and conditions are acceptable to you, please indicate your agreement by clicking below on the button labeled "I ACCEPT". If you do not agree to the terms and conditions, you may not access or use the software. Instead, you must click below on the button labeled "I DO NOT ACCEPT" and exit from this computer screen.

To access the CSV link for each Fee Schedule, hold down the CTRL key then click the CSV link.

*** Click here for the Fee Schedule Instructions ***

Provider Fee Schedule Download

- Acquired Brain Injury Case Management [CSV](#)
- Acquired Brain Injury DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Fiduciary [CSV](#)
- Acquired Brain Injury II DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Service Provider [CSV](#)
- Acupuncture [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Autism Waiver Fiscal Intermediary [CSV](#)
- Autism Waiver Service Provider [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)
- Clinic - Dialysis [CSV](#)
- Clinic - Family Planning / Abortion [CSV](#)
- Clinic - Medical [CSV](#)
- Clinic - Rehabilitation [CSV](#)
- Community First Choice - Assessments [CSV](#)
- Community First Choice - Services [CSV](#)
- Connecticut Housing Engagement and Support Services [CSV](#)
- CT Home Care [CSV](#)
- DDS Specialized Services NF Fee Schedule [CSV](#)
- Dental Adult [CSV](#)
- Dental DOS Prior to 09/01/2016 [CSV](#)
- Dental Pediatric [CSV](#)
- Home Health [PDF](#)
- Hospice [CSV](#)
- Hospital DRG Organ Acquisition [PDF](#)
- Hospital Outpatient Flat Fee [CSV](#)
- Independent Audiology and Speech and Language Pathology [CSV](#)
- Independent Physical Therapy and Occupational Therapy [CSV](#)
- Independent Radiology [CSV](#)
- Lab [CSV](#)
- Local Health Department [CSV](#)
- MEDS - DME [CSV](#)
- MEDS-Hearing Aid/Prosthetic Eye [CSV](#)
- MEDS-Medical/Surgical Supplies [CSV](#)
- MEDS-MISC [CSV](#)
- MEDS-Parenteral-Enteral [CSV](#)
- MEDS-Prosthetic/Orthotic [CSV](#)
- Mental Health Waiver Assisted Living Provider [CSV](#)
- Mental Health Waiver DOS Prior to 02/01/2020 [CSV](#)
- Mental Health Waiver Service and Fiscal Intermediary Provider [CSV](#)
- Natureopath [PDF](#)
- Optician/Eyeglasses [CSV](#)
- Personal Care Assistant [CSV](#)

Provider Training Workshop Presentations

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Trading Partner

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- Trading Partner Documents

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

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

Information Provider Trading Partner Pharmacy

Important Messages

Workshop Invitations

- [Home Health Refresher Workshop Invitation](#)
- [Waiver Service Provider Refresher Workshop Invitation](#)

Materials

- [ABI Service Provider Workshops](#)
- [Autism Waiver Service Provider Workshops](#)
- [Behavioral Health Clinicians Workshops](#)
- [Birth to Three Workshops](#)
- [CHC Workshops](#)
- [Connecticut Housing Engagement and Support Services \(CHESS\) – Enrollment Workshops](#)
- [Connecticut Housing Engagement and Support Services \(CHESS\) – Billing and Web Claims Workshops](#)
- [DDS Specialized Services Provider Workshops](#)
- [DDS Performing Provider Re-Enrollment Workshops](#)
- [Dental Workshops](#)
- [DMHAS Performing Provider Re-Enrollment Workshops](#)
- [Durable Medical Equipment Workshops](#)
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- [Hospice Workshops](#)
- [Hospital Workshops](#)
- [Long Term Care Workshops](#)
- [Mental Health Waiver Provider Workshops](#)
- [New Provider Workshops](#)
- [PCA Service Provider Workshops](#)

Click applicable provider type link to access Workshop PowerPoint Presentations and Procedure Code Crosswalk

Information Communications– Email Subscriptions

Providers MUST register to receive information electronically for new provider publications and notifications through the email subscription function on the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com. For complete E-mail subscription information, please see provider bulletin PB 15-23 on the CMAP Web site.

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Email Subscription

- [Register/Update Email Subscription](#)

Electronic Visit Verification

- [EVV Implementation Overview](#)

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.

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Confirm E-Mail

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Existing Subscribers

E-Mail

[Update](#)

Unsubscribe

E-Mail

[Unsubscribe](#)

Available Subscriptions

- **Provider**
 - ALL Provider Types
 - Acquired Brain Injury
 - Acupuncturist
 - 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
 - CT Housing Engagement and Support Services
 - Certified Nurse Midwife
 - Chiropractor
 - Clinic
 - Community First Choice
 - Community Services
 - DDS Employment and Day Supports
 - DDS Specialized Services
 - DME/Medical Supply Dealer
 - Dental
 - Drug and Alcohol Abuse Center
 - 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 H
 - Mental Health Waiver
 - Naturopath
 - Optical Shop
 - Optician
 - Optometrist
 - Personal Care Services
- **Topics**
 - EVV - Electronic Visit Verification
 - Hospital Modernization
 - Labeler/Drug Manufacturer
 - Promoting Interoperability (PI), formerly EHR Incentive, Program
 - Trading Partner

Information Resources - Electronic Visit Verification – EVV

The screenshot displays the website for the Connecticut Department of Social Services. The header includes the department's logo and name, along with navigation links for Home, Information, Provider, Trading Partner, Pharmacy Information, and Hospital Modernization. A dropdown menu is open over the 'Electronic Visit Verification' link, listing several options: New Provider Information, At Your Fingertips Tip Sheets, General Program Information and FAQ's, Important Documentation, Training Publications and Videos, and Archived Information. The main content area features a central banner for the 'HOME ASSISTANCE PROGRAM' and three columns: 'Information' (with a stack of books icon), 'Provider' (with a person icon), and 'Trading Partner' (with a key icon). A blue bar at the bottom contains 'Important Messages' regarding outpatient hospitals and COVID-19 information.

Connecticut Department of Social Services
Making a Difference

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- [Provider Electronic Solutions Billing Instructions](#)

Pharmacy

Electronic Visit Verification

- **New Provider Information**
- **At Your Fingertips Tip Sheets**
- **General Program Information and FAQ's**
- **Important Documentation**
- **Training Publications and Videos**
- **Archived Information**

HOME ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS PAGE PROVIDES CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM, ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY CHECK.

THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS PAGE PROVIDES PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS AND TRAINING MATERIALS.

Information

Provider

Trading Partner

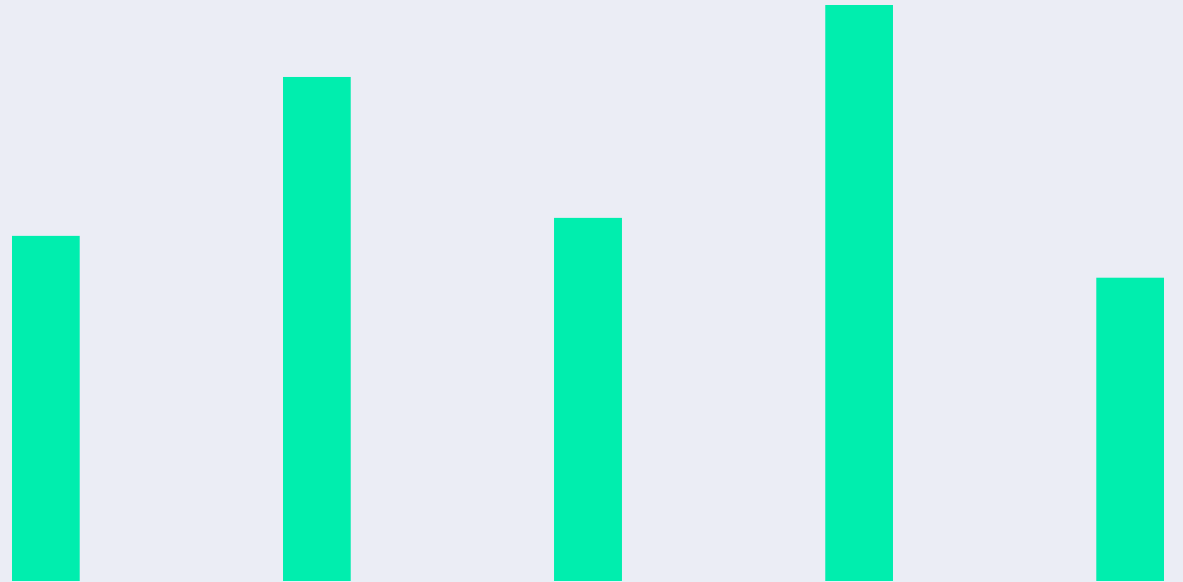
Important Messages

[Attention Outpatient Hospitals: Ambulatory Payment Classification \(APC\) Weight Corrections \(Posted 11/10/21\)](#)

[COVID-19 Information and FAQs \(Updated 11/9/21\)](#)

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

- ctdssmap-ProviderEmail@gainwelltechnologies.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@gainwelltechnologies.com

If you are:

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

then contact the EVV email box for assistance.

Contacts (cont.)

- **Sandata Customer Care**

- 1-855-399-8050 or ctcustomer@sandata.com
- If you are experiencing issues with the Santrax system or its functionality, please contact Sandata Customer Care for assistance.
- If you are unsure who to contact for assistance, please send an e-mail to ctevv@gainwelltechnologies.com.
- You are also encouraged to send an e-mail to the ctevv@gainwelltechnologies.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**

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**

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**

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.

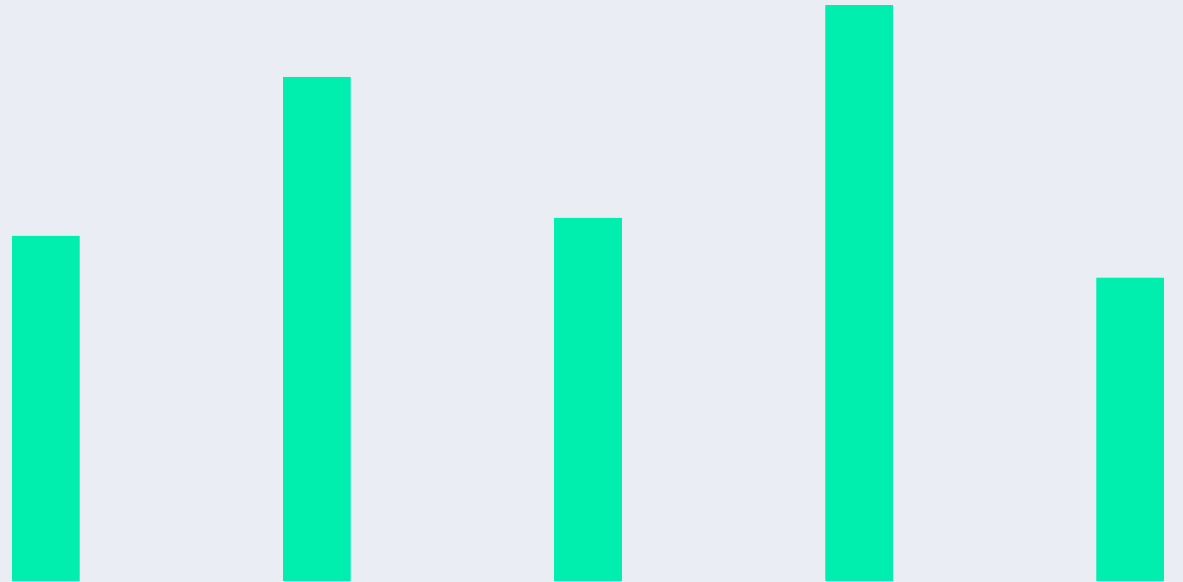
Contacts (cont.)

- **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 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.

Questions

Waiver Service Provider Refresher Workshop



Thank you.

Thank you for attending the Connecticut Medical Assistance Program Waiver Service Provider 2021 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!