

Connecticut Medical Assistance Program



CHC Service Provider Workshop

Presented by:

The Department of Social Services & HP
for Billing Providers

CHC Service Provider Workshop

Agenda

- Introduction
- Program Enhancements – April 2014
- Viewing and Understanding a Care Plan
- Changes to Claim Submission
- Claims Resolution
- Program Basics – Building Blocks for Successful Claim Submission
- Important Program Resources
- Future Program Enhancements
- Time for Questions



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Introduction

Due to the changes made to the Connecticut Home Care Program for Elders (CHCPE) effective July 1, 2013 DSS has recognized a need for:

- Greater flexibility in updating care plans - (April 2014)
- Need for one time only services – (April 2014)
- Retroactive changes to care plans -when claims paid against the Prior Authorization (PA)
- Mass Adjustment Process to
 - Recoup claims due to care plan changes (hospitalization)
 - Adjust claims to pay more/less
 - Adjust claims to pay against the correct PA/line detail (no impact to provider)



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Program Enhancements – April 2014

□ Adding the use of Modifiers

- One Time Only Services – Modifier **U2** can be used to authorize:
 - Additional units needed on a day service is provided
 - Another day of service in an existing care plan
 - An additional frequency to an existing service
 - When authorized, the **U2** modifier will be associated to a procedure code on the care plan. Both the **procedure code** and **modifier must be** billed **on the claim.**

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



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Program Enhancements – April 2014

□ Adding the use of Modifiers cont.

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

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Program Enhancements – April 2014 cont.

□ Introduction of Procedure Code Lists

- **Applicable to Meal, Adult Day Care and Adult Family Living/Foster Care services only**
- Procedure Code Lists allow the Access Agency to order a specific service (on the service order) while authorizing (on the PA) a list of procedure codes for a similar type of service that can be provided to the client without further authorization.
 - **Note: 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 have more flexibility in providing service based on client needs.
- Providers can bill codes interchangeably, unless otherwise indicated on the care plan, that are inclusive of the list without:
 - Requesting prior authorization for a procedure code not on the initial service order.
 - Recouping claims so the initial service order can be modified.



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Program Enhancements – April 2014 cont.

□ Introduction of Procedure Code/Modifier Lists

- Applicable to Meal, Adult Day Care and Adult Family Living/Foster Care services only
- Procedure Code/Modifier Lists allow the Access Agency to order a one time only specific service, that appears on the service order while authorizing a list of procedure codes (on the PA) for one time only services of the same type that can be provided to the client without further authorization.
 - **Note: If the procedure code/modifier on the service order is of a lesser reimbursement value than the service being provided from the code list on the care plan, the provider must contact the care manager unless otherwise indicated in the external notes on the PA.**
- Providers have more flexibility in providing additional units of the same service based on client needs.
- Providers can bill codes interchangeably, unless otherwise indicated on the care plan, that are inclusive of the list without:
 - Requesting prior authorization for a procedure code not on the initial service order. (see above when service is of a higher reimbursement)
 - Recouping claims so the initial service order can be modified.



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Program Enhancements – April 2014 cont.

The following **procedure code list** and **procedure code/modifier list** have been added for **meal services**. A “**list code**,” when **authorized** will appear **on the care plan**. However, Providers **must bill** the **procedure code or procedure code/modifier** for the service provided. **Reminder:** Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.

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



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Program Enhancements – April 2014 cont.

The following **procedure code list** and **procedure code/modifier list** have been added for **Adult Day Care services**. A “list code,” when **authorized** will appear **on the care plan**. However, Providers **must bill** the **procedure code or procedure code/modifier** for the service provided. **Reminder:** Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.

Adult Day Care	List Code = 971 (on care plan)
Description of Service	Procedure Code (on claim)
Full Day - Non-Medical	1200Z
Full Day - Medical	1201Z
Half Day	1202Z
Adult Day Care - One Time Only	List Code = AD (on care plan)
Description of Service	Procedure Code/Modifier (on claim)
Full Day - Non-Medical One Time Only	1200Z U2
Full Day - Medical One Time Only	1201Z U2
Half Day – One - Time Only	1202Z U2



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Program Enhancements – April 2014 cont.

Adult Family Living/Foster Care

- ❑ Adult Family Living/Foster Care services were added to the CHCPE effective **July 1, 2013.** Providers interested in providing these services should refer to the following Provider Bulletins:
 - **PB 2014-16** – Adult Family Living/Foster Care Credentialing/Enrollment and Claim Submission Guidelines.
 - **PB 2013-50** – CT Home Care Program for Elders – Adult Family Living for service guidelines.
- The following procedure code list and procedure code/modifier list have been added for Adult Family Living/Foster Care services. A **“list code,”** when authorized will appear **on** the care plan. However, Providers **must bill** the **procedure code** for the service provided. **Reminder:** Contact the care manager, if reimbursement for the service to be provided is greater than the procedure code on the service order.



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Program Enhancements – April 2014 cont.

Adult Family Living/Foster Care Procedure Code list and Procedure Code/Modifier Code List.

Adult Family Living/Foster Care		List Code = 972 (on care plan)
Description of Service	Procedure Code (on claim)	
Level 1	S5140	
Level 2	5140X	
Level 3	5140Y	
Level 4	5140Z	
Adult Family Living/Foster Care – One Time Only		List Code = FF (on care plan)
Description of Service	Procedure Code (on claim)	
Level 1 - One Time Only	S5140 U2	
Level 2 - One Time Only	5140X U2	
Level 3 - One Time Only	5140Y U2	
Level 4 - One Time Only	5140Z U2	



CHC Service Provider Workshop

Viewing and Understanding the Care Plan - Care Plan Access

CONNECTICUT DEPARTMENT
OF SOCIAL SERVICES

-- Caring for Connecticut --

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Friday, March 28, 2014

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WELCOME

TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HP 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



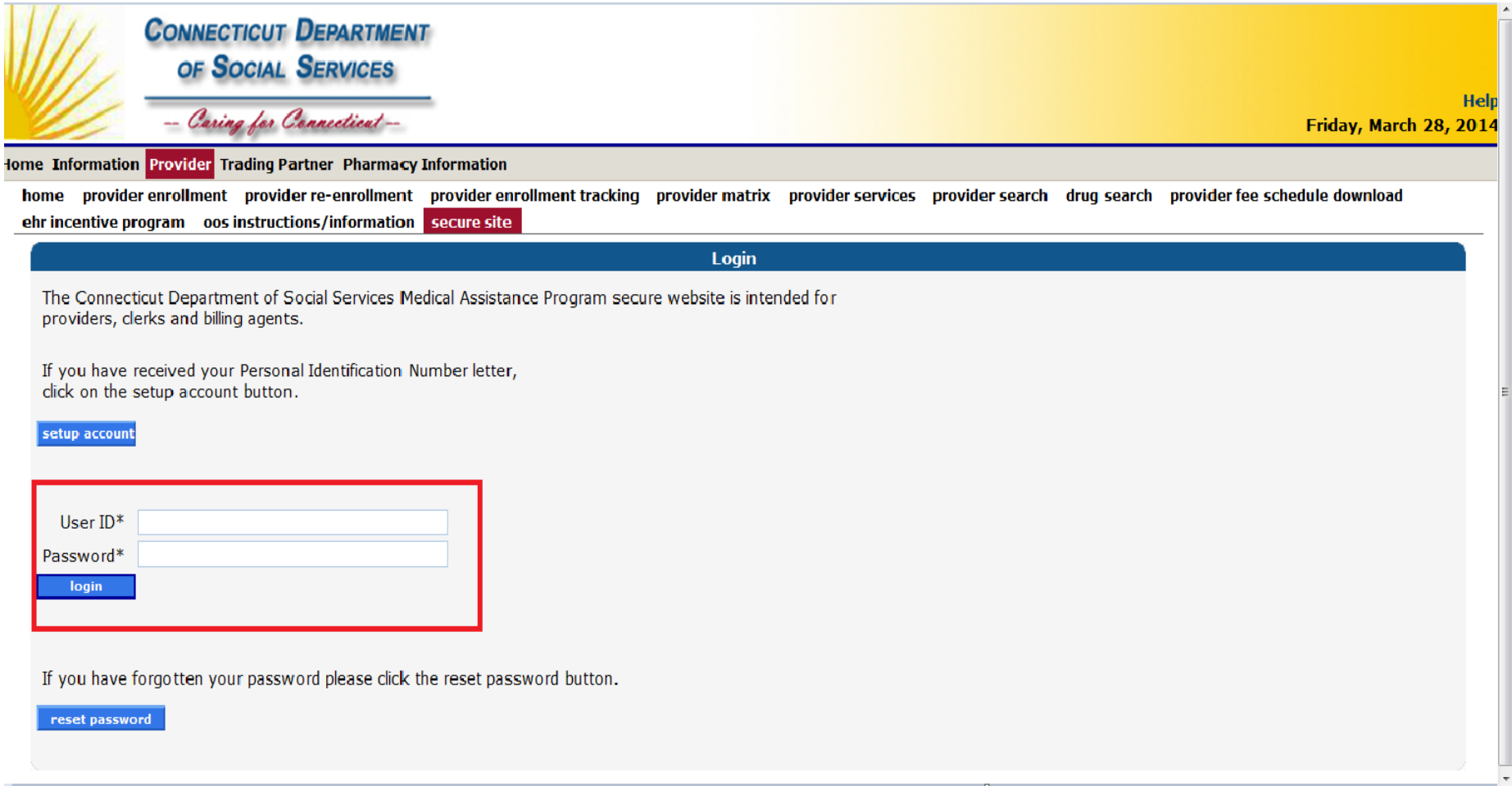
Pharmacy

Important Messages



CHC Service Provider Workshop

Viewing and Understanding the Care Plan - Care Plan Access



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Home Information **Provider** Trading Partner Pharmacy Information

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

Login

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

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

[setup account](#)

User ID*

Password*

[login](#)

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

[reset password](#)



CHC Service Provider Workshop

Viewing and Understanding the Care Plan – Care Plan Access

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Help

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

home **account home** account maintenance account setup change password **Prior Authorization Search** clinic maintenance reset password log out

Care Plan

Welcome, P008021184

Provider ID: 008021184 MCD

Provider AVRS ID: 008021184

Zip Code: 06032 - 1254

Your R.A.s, or 835 transactions, are being sent to:

Your download page in the Trade Files menu option.

Quick Link

- [Check E-messages](#)
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Global Messages

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Viewing and Understanding the Care Plan – Care Plan Access

The screenshot displays the Connecticut Department of Social Services web portal. At the top left is the department logo with the tagline "Caring for Connecticut". The top right shows the date "Monday, March 31, 2014" and a "Help" link. A navigation bar contains links for Home, Information, Provider, Trading Partner, Pharmacy Information, Claims, Eligibility, **Prior Authorization**, Hospice, Trade Files, MAPIR, Messages, and Account. Below the navigation bar, there are breadcrumb links: home, **prior authorization search**, and care plan. A "Quick Link" box contains a link to "Web Guide - Prior Authorization Search". The main content area shows "Provider 008021184 MCD" and a "Prior Authorization Search" form. The form includes fields for Client ID, Client Name, Requested Eff Date, Requested End Date, Authorized Eff Date, Authorized End Date, Prior Authorization, PA Assignment, PA Assign - Sub, Procedure, Revenue Code, and Proc/Mod List. There are also "Search" and "clear" buttons. The "Records" dropdown is set to 20.

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Help
Monday, March 31, 2014

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

home **prior authorization search** care plan

Quick Link

- Web Guide - Prior Authorization Search

Provider 008021184 MCD

Prior Authorization Search

Client ID

Client Name

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assign - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Records 20



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Care Plan Points to Remember

□ Accessing the Care Plan

- Log in under your correct secure Web account
- Your Local Administrator must give you access/permission for Prior Authorization Inquiry (Chapter 10, section 9 of the provider manual)
 - If you don't have access, you will not be able to view the Prior Authorization (PA) tab when logging in to your secure Web account.
- When accessing the care plan click on the PA tab and select PA Search.
- Perform a PA inquiry by entering at minimum:
 - The PA number
 - Client ID
 - Narrow your search using:
 - Authorized effective end dates (note: search cannot exceed 90 days)
 - The Procedure code, Procedure code with Modifier(s), Procedure code list or Proc/Mod list.
- Click Search



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Viewing and Understanding the Care Plan

The search results by client shows multiple PAs and services authorized. **Note:** Search results now include modifiers, proc/mod lists and procedure code lists. For ease in viewing, data can be sorted by clicking on the desired sort field, until a triangle appears. Click on the triangle to sort in ascending or descending order.

Search Results

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Authorized Status	Determination Date	PA Assignment	PA Assign - Sub	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084034	01	04/04/2014	04/04/2014	12	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z	U2	TT							12 Per Calendar Week
2014084038	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial									970	5 Per Calendar Week
2014084040	01	04/13/2014	05/03/2014	6	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								AD		2 Per Calendar Week
2014084036	01	04/01/2014	04/12/2014	6	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								ML		3 Per Calendar Week
2014084032	01	04/01/2014	04/12/2014	80	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z									40 Per Calendar Week
2014084039	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial									971	5 Per Calendar Week
2014084041	01	04/13/2014	05/03/2014	15	\$0.00	Approved	03/25/2014	Home Care Program for Elders	Initial								ML		5 Per Calendar Week
2014084033	01	04/03/2014	04/03/2014	8	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1210Z	U2								8 Per Calendar Week
2014084035	01	04/01/2014	04/12/2014	10	\$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial	1220Z									5 Per Calendar Week

Authorized Meals include: Proc/Mod List ML = 1218Z U2 + 1220Z U2 + 1221Z U2
Procedure Code List 970 = 1218Z + 1220Z + 1221Z

Authorized Adult Day Care include: Proc/Mod List AD = 1200Z U2 + 1201Z U2 + 1202Z U2
Procedure Code List 971 = 1200Z + 1201Z + 1202Z



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Viewing and Understanding the Care Plan

Click on any PA Line to open a PA from the Care Plan search results

Prior Authorization ▲	Line Item	Authorized Effective date	Authorized End date	Authorized Units
2014084032	01	04/01/2014	04/12/2014	80
2014084033	01	04/03/2014	04/03/2014	8
2014084034	01	04/04/2014	04/04/2014	12
2014084035	01	04/01/2014	04/12/2014	10
2014084036	01	04/01/2014	04/12/2014	6
2014084038	01	04/13/2014	05/03/2014	15
2014084039	01	04/13/2014	05/03/2014	15
2014084040	01	04/13/2014	05/03/2014	6
2014084041	01	04/13/2014	05/03/2014	15

Reminder: Search results data can be sorted by any field name order. Click on the field name for the desired sort until the triangle appears, then sort your data in ascending or descending order by clicking on the triangle.

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
1210Z									40 Per Calendar Week
1210Z	U2								8 Per Calendar Week
1210Z	U2	TT							12 Per Calendar Week
1220Z									5 Per Calendar Week
							ML		3 Per Calendar Week
								970	5 Per Calendar Week
								971	5 Per Calendar Week
							AD		2 Per Calendar Week
							ML		5 Per Calendar Week

Care plan search results show the services authorized by procedure code, procedure code with modifier(s), procedure code with proc/mod list and procedure code list with proc/mod list. Note the frequency is the units of service authorized that can be provided for the span of time indicated.



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Viewing and Understanding the Care Plan

Note the key components of this authorization for a companion one time only service to a subsequent client for 12 units = 3 hours of authorized service with an effective/end date of 4/4/2014.

Line Item														
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List
01	12.000	\$0.00	12.000	\$0.00	Auto Approved for Care Plan	1210Z	U2	TT						

Type changes below.

Line Item

Service Type Code* [Search]

Procedure Code [Search] [Search]

Mod 1 [Search] [Search]

Mod 2 [Search] [Search]

Mod 3 [Search] [Search]

Mod 4 [Search] [Search]

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

Proc/Mod List

Procedure Code List

Requested Eff./End Dates* NDC [Search]

Requested Units/Dollars* Status

Authorized Units/Dollars

Authorized Eff./End Dates

Used Units/Dollars

Available Units/Dollars

Frequency

Notes

*** No rows found ***



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Viewing and Understanding the Care Plan

This PA for meal service is authorized with **Procedure Code list 970** which includes procedure codes 1218Z, 1220Z and 1221Z. The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

Line Item														
Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List
01	15.000	\$0.00	15.000	\$0.00	Approved						970			

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List 970 Meals -CHC

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

Requested Units/Dollars* 15.000 \$0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 15.000 \$0.00

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

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

NDC [Search]

Status Approved

Notes

*** No rows found ***



CHC Service Provider Workshop

Viewing and Understanding the Care Plan

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

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

Type changes below.

Line Item 01

Service Type Code* Procedure/Mod List

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List ML Meals - 1 Time Only

Procedure Code List

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

Requested Units/Dollars* 15.000 \$0.00

NDC [Search]

Status Approved

Authorized Units/Dollars	15.000	\$0.00
Authorized Eff./End Dates	04/13/2014	05/03/2014
Used Units/Dollars	0	\$0.00
Available Units/Dollars	15	\$0.00
Frequency	5 Per Calendar Week	

Notes

*** No rows found ***



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Viewing and Understanding the Care Plan

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

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

Type changes below.

Line Item 01

Service Type Code* Procedure Code [Search] Tooth [Search]

Procedure Code [Search] Quad [Search]

Mod 1 [Search] Tooth Surface 1 [Search]

Mod 2 [Search] Tooth Surface 2 [Search]

Mod 3 [Search] Tooth Surface 3 [Search]

Mod 4 [Search] Tooth Surface 4 [Search]

Revenue Code/List [Search] [Search] Tooth Surface 5 [Search]

Proc/Mod List

Procedure Code List 971 Adult Day Care - CHC

Requested Eff./End Dates* 04/13/2014 05/03/2014 NDC [Search]

Requested Units/Dollars* 15.000 \$0.00 Status Approved

Authorized Units/Dollars 15.000 \$0.00

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

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week



CHC Service Provider Workshop

Viewing and Understanding the Care Plan

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

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



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Care Plan Points to Remember

□ Viewing and Understanding the Care Plan Detail.

➤ Click on the PA line detail to view authorized services:

- Procedure Code
- Procedure Code with one modifier **U2 or TT**
- Procedure code with two modifiers **U2 and TT**
- Procedure Code list:
 - **970** – Meals (1218Z, 1220Z, 1221Z)
 - **971** - Adult Day Care (1200Z, 1201Z, 1202Z)
 - **972** - Adult Family Living/Foster Care (S5140, 5140X, 5140Y, 5140Z)

Authorized codes can be serviced interchangeably unless otherwise indicated in the Care Plan notes by the Care Manager.

Note: Each list contains a unique set of procedure codes (refer to CHC Procedure Code Crosswalk document for complete listing of codes, unit increments, authorized billing provider, span dates of service, valid frequency).



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Care Plan Points to Remember

❑ Viewing and Understanding the Care Plan Detail cont.

➤ Click on the PA line detail to view authorized services:

- Procedure Code/Modifier list:
 - **ML** – Meals one time only (1218Z U2, 1220Z U2, 1221Z U2)
 - **AD** - Adult Day Care one time only (1200Z U2, 1201Z U2, 1202Z U2)
 - **FF** - Adult Family Living/Foster Care one time only (S5140 U2, 5140X U2, 5140Y U2, 5140Z U2)

Authorized codes can be serviced interchangeably unless otherwise indicated in the Care Plan notes by the Care Manager.

Note: Each list contains a unique set of procedure codes (refer to CHC Procedure Code Crosswalk document for complete listing of codes, unit increments, authorized billing provider, span dates of service, valid frequency)



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Care Plan Points to Remember

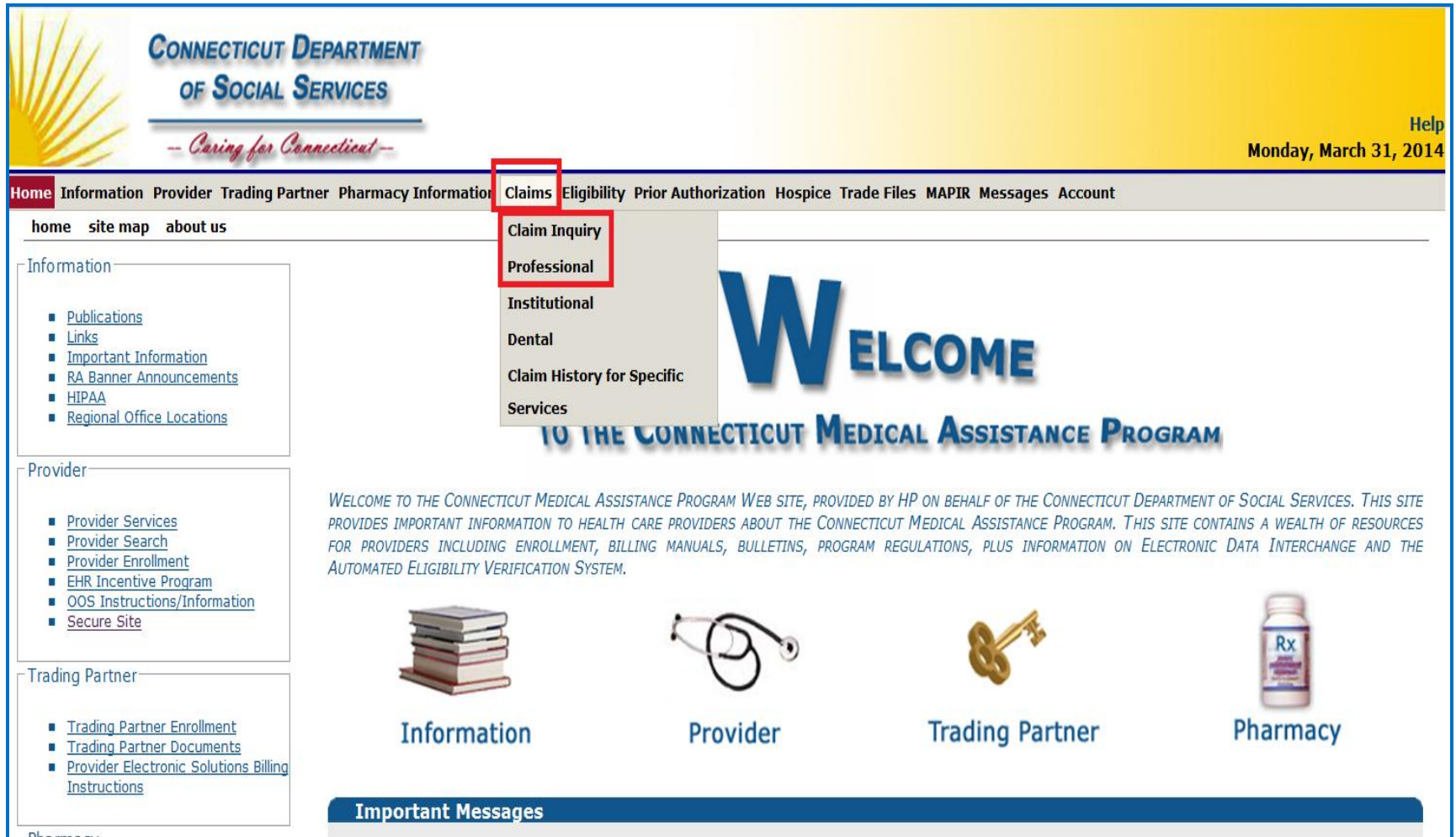
□ Viewing and Understanding the PA line detail cont.

- **Authorized effective/end date of service** (note this date can differ from the requested effective/end date.
- **Units authorized** (total number of units authorized within the PA detail effective/end dates.
- **Units used** (units paid to the provider)
- **Units available** (units which can be paid upon claim submission)
- **Frequency**
 - Units of service to be provided within a frequency of time that is within the effective/end dates of the PA line detail
 - Refer to Procedure code crosswalk for unit increments which vary by procedure code.



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Access to Claim Submission



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Help
Monday, March 31, 2014

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Provider

- Provider Services
- Provider Search
- Provider Enrollment
- EHR Incentive Program
- OOS Instructions/Information
- Secure Site

Trading Partner

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

CLAIMS menu:
Claim Inquiry
Professional
Institutional
Dental
Claim History for Specific Services

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDED BY HP 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 (stack of books)
Provider (stethoscope)
Trading Partner (key)
Pharmacy (Rx bottle)

Important Messages



CHC Service Provider Workshop

Access to Claim Submission

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --

Monday, March 31, 2014

Home Information Provider Trading Partner Pharmacy Information **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

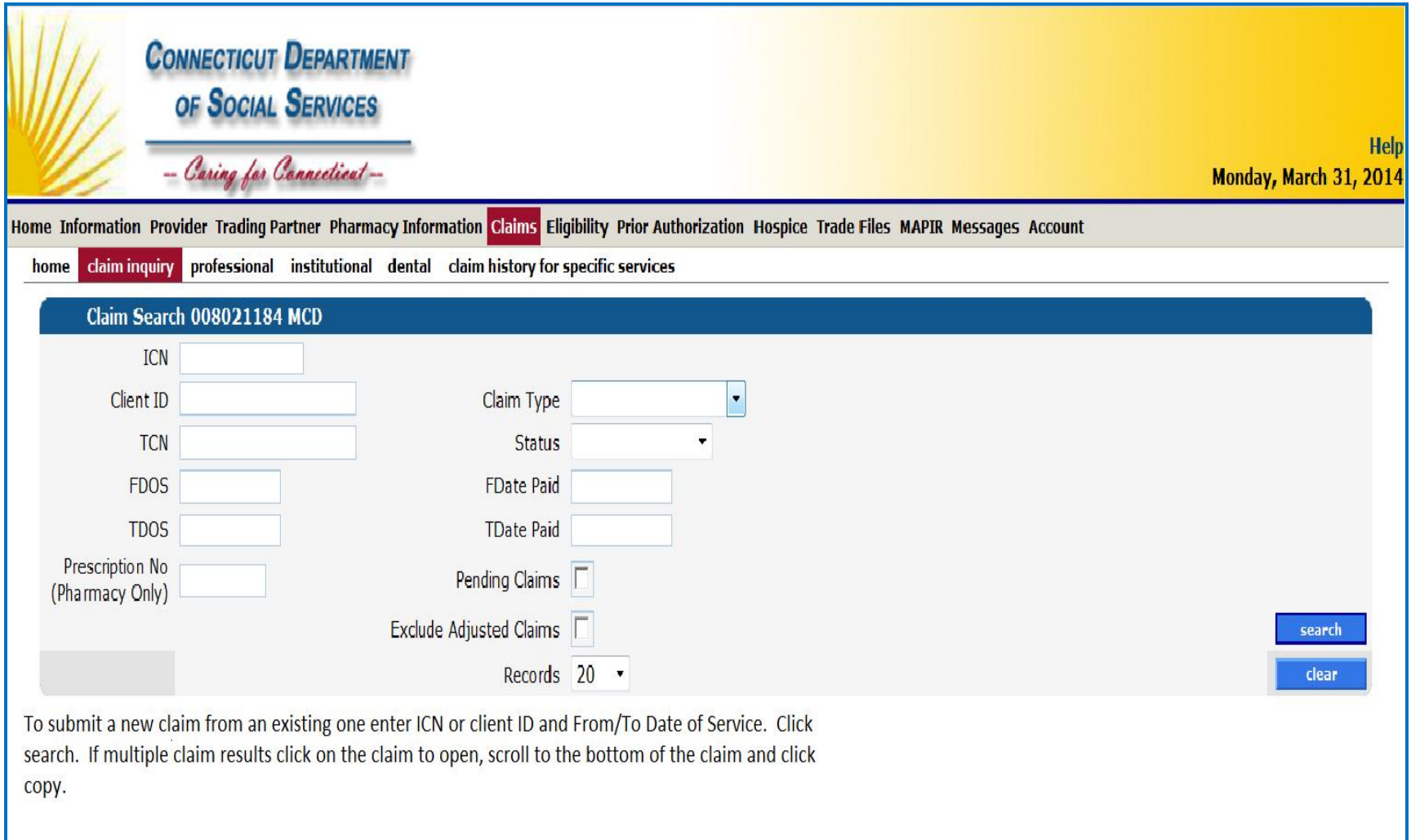
Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	008021184 MCD	To Date	<input type="text"/>
AVRS ID	008021184	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	\$0.00
First Name, MI	<input type="text"/>	Total Paid	\$0.00
Date of Birth	<input type="text"/>	TPL Amount	\$0.00
Patient Account #	<input type="text"/>	CoPay Amount	\$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	No
Referring Physician	<input type="text"/> [Search]	837 Version	5010
Accident Related	No	Accident Date	<input type="text"/>



CHC Service Provider Workshop

Access to Claim Submission



CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
-- Caring for Connecticut --

Help
Monday, March 31, 2014

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

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

Claim Search 008021184 MCD

ICN
Client ID Claim Type
TCN Status
FDOS FDate Paid
TDOS TDate Paid
Prescription No (Pharmacy Only) Pending Claims
Exclude Adjusted Claims
Records 20

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



CHC Service Provider Workshop

Claim Submission Points to Remember

□ Accessing claims for inquiry or new submission

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



CHC Service Provider Workshop

Claim Submission

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084032	01	04/01/2014	04/12/2014	80	1210Z									40 Per Calendar Week
2014084033	01	04/03/2014	04/03/2014	8	1210Z	U2								8 Per Calendar Week
2014084034	01	04/04/2014	04/04/2014	12	1210Z	U2	TT							12 Per Calendar Week

Detail									
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount		
A	1	04/01/2014	04/03/2014	1210Z	40.00	\$160.00	\$0.00		
A	2	04/03/2014	04/03/2014	1210Z U2	8.00	\$32.00	\$0.00		
A	3	04/04/2014	04/04/2014	1210Z U2 TT	12.00	\$48.00	\$0.00		

Type data below for new record.

Item	3	Status	
From DOS*	04/04/2014	Emergency Indicator	No
To DOS*	04/04/2014	Pregnancy	Not pregnancy Related
Procedure*	1210Z [Search]	EPSDT Referral	None
Modifiers	U2 [Search] TT [Search]	Family Planning	No
Units*	12.00	Allowed Amount	\$0.00
Facility Type Code*	11 [Search]	CoPay Amount	\$0.00
Charges*	\$48.00	Medicare Paid Date	
Rendering Physician*	[Search]	Medicare Calc Allowed Amt	\$0.00
Referring Provider	[Search]	Medicare Paid Amount	\$0.00
Ordering Provider	[Search]	Medicare Deductible Amount	\$0.00
Diagnosis Code Pointer		Medicare Coinsurance Amount	\$0.00
National Drug Code			
NDC Quantity	0.000		
NDC Unit of Measurement			

The PA indicates companion services are being provided for 40 units per week. **Line 1** services show spanned dates of service totaling 40 units. The dates of service are spanned as they are performed consecutively. **Line 2** is a separate one time only service for the 8 units authorized on the PA. **Line 3**, also a separate service, indicates a one time only service for the client who for this date is the subsequent client for the services performed. Note: TT is a pricing modifier which will pay 50% of the allowed amount for line detail 3.



CHC Service Provider Workshop

Claim Submission

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084035	01	04/01/2014	04/12/2014	10	1220Z									5 Per Calendar Week
2014084036	01	04/01/2014	04/12/2014	6								ML		3 Per Calendar Week

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A 1	04/01/2014	04/03/2014	1220Z	3.00	\$27.00		\$0.00
A 2	04/04/2014	04/04/2014	1218Z	1.00	\$5.00		\$0.00
A 3	04/05/2014	04/05/2014	1220Z	1.00	\$9.00		\$0.00

Type data below for new record.

Item	2	Status	
From DOS*	04/04/2014	Emergency Indicator	No
To DOS*	04/04/2014	Pregnancy	Not pregnancy Related
Procedure*	1218Z [Search]	EPSDT Referral	None
Modifiers	U2 [Search]	Family Planning	No
Units*	1.00	Allowed Amount	\$0.00
Facility Type Code*	12 [Search]	CoPay Amount	\$0.00
Charges*	\$5.00	Medicare Paid Date	
Rendering Physician*	[Search]	Medicare Calc Allowed Amt	\$0.00
Referring Provider	[Search]	Medicare Paid Amount	\$0.00
Ordering Provider	[Search]	Medicare Deductible Amount	\$0.00
Diagnosis Code Pointer		Medicare Coinsurance Amount	\$0.00
National Drug Code			
NDC Quantity	0.000		
NDC Unit of Measurement			

A first time meal service order has been authorized using both procedure code **1220Z** and **proc/mod list ML**, inclusive of **1218Z U2**, **1220Z U2** and **1221Z U2**. Line **detail 1** of the claim shows spanned dates for meal services performed consecutively for 3 days of double meal service (**1220z**). In **detail 2** only a single meal is needed, which is **authorized under list code ML**, but **billed using the procedure code (1218Z)**. Line 3 resumes the double meal service for Saturday only, as even if service is performed on consecutive dates, claim details cannot span multiple calendar weeks (frequencies).



CHC Service Provider Workshop

Claim Submission

Prior Authorization ^A	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	NDC	Proc/Mod List	Procedure Code List	Frequency
2014084039	01	04/13/2014	05/03/2014	15									971	5 Per Calendar Week
2014084040	01	04/13/2014	05/03/2014	6								AD		2 Per Calendar Week

Detail

Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A 1	04/13/2014	04/13/2014	1201Z U2	1.00	\$75.00		\$0.00
AD Proc/Mod 1 of 2 units authorized							
A 2	04/14/2014	04/15/2014	1201Z	2.00	\$150.00		\$0.00
A 3	04/16/2014	04/16/2014	1202Z U2	1.00	\$75.00		\$0.00
AD Proc/Mod 2 of 2 units authorized							
A 4	04/17/2014	04/18/2014	1201Z	2.00	\$150.00		\$0.00

Type data below for new record.

Item	4	Status	
From DOS*	04/17/2014	Emergency Indicator	No
To DOS*	04/18/2014	Pregnancy	Not pregnancy Related
Procedure*	1201Z [Search]	EPSDT Referral	None
Modifiers	[Search] [Search]	Family Planning	No
Units*	2.00	Allowed Amount	\$0.00
Facility Type Code*	99 [Search]	CoPay Amount	\$0.00
Charges*	\$150.00	Medicare Paid Date	
Rendering Physician*	[Search]	Medicare Calc Allowed Amt	\$0.00
Referring Provider	[Search]	Medicare Paid Amount	\$0.00
Ordering Provider	[Search]	Medicare Deductible Amount	\$0.00
Diagnosis Code Pointer	[] [] [] []	Medicare Coinsurance Amount	\$0.00
National Drug Code			
NDC Quantity	0.000		
NDC Unit of Measurement			

delete add

In this claim example Adult Day Care services have been authorized by the **971 Procedure code list** inclusive of **1200Z, 1201Z and 1202Z** for 5 units per calendar week and **AD Proc/Mod list inclusive of 1200Z U2, 1201Z U2 and 1202Z U2** for two one time only units per week. **Assume the care plan notes indicate the client is to receive full day medical Adult Day Care M-F.** In this claim example only 4 units of 1201Z are billed for Monday, Tuesday, Thursday and Friday services. Sunday, a full day and Wednesday, a half day, are the exceptions and are billed with the applicable procedure code and U2 modifier. Note: Spanning dates of service is allowed with like services and within the service frequency.



CHC Service Provider Workshop

Claim Submission Points to Remember

□ Care Plan Interpretation for Claim Submission

➤ Procedure Codes

- **Code billed** must be on the care plan and must be the **same** as what is **on the care plan** when service is authorized by procedure code or procedure code with Modifier
 - ❖ Example: If service authorized is **1214Z U2** then **1214Z U2** must be billed on the claim.

➤ Procedure Code List

- The List code on the care plan should not be submitted on the claim. Submit a procedure code associated with the list code for the service provided on the claim.
 - ❖ Example: If **list code 970** is on the care plan, then **1218Z**, **1220Z** or **1221Z** may be billed, depending on the service provided.

Reminder: Alpha characters are case sensitive and must be submitted in upper case on both the care plan and on the claim.



CHC Service Provider Workshop

Claim Submission Points to Remember

□ Care Plan Interpretation for Claim Submission cont.

➤ Procedure Code/Modifier List (Proc/Mod List)

The List code on the care plan should not be submitted on the claim. Submit a **procedure code and U2 modifier** associated with the list code for the service provided on the claim.

Example: If list code **ML** is on the care plan, then **1218Z U2**, **1220Z U2** or **1221Z U2** may be billed, depending on the service provided.

Reminder: Alpha characters are case sensitive and must be submitted in upper case on both the care plan and on the claim.



CHC Service Provider Workshop

Claim Submission – Spanning Dates

Dates of service can only be **spanned** for non-medical services submitted in the professional claim format when service is provided on **consecutive dates** which span the **from and through** dates of service on the claim detail.

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

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



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 749 - Modifier U2 not allowed (New Edit)

Cause:

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

Highly Skilled Chore

Minor Home Modifications

PERS Service Installation

Two-way PERS-ongoing service

Assistive Technologies

Care Management

Resolution:

Claim must be resubmitted without the U2 modifier.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 3003- [Prior Authorization is required for payment of this service](#)

Cause:

If the claim is for a client enrolled in the Connecticut Home Care for Elder's program, the client does not have any remaining units authorized by the client's care manager for the service billed on the claim.

Resolution:

The service is not payable unless the care manager increases the number of units for the date(s) of service being billed.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 3015- CHC care plan required

Cause:

The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and a care plan has not yet been established for this client.

Resolution:

The service is not payable unless the care manager creates a care plan and adds the service to the care plan. Contact the care manager for assistance.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 3016- Service not covered under CHC care plan

Cause:

The claim is for a client enrolled in the Connecticut Home Care for Elder's benefit plan and the service billed is not an authorized service on the client's care plan. This edit will also set if the service authorization is uploaded to the claims processing system with the incorrect servicing provider ID or if the provider submitted an incorrect procedure code.

Resolution:

The service is not payable unless the care manager adds the service to the client's care plan, **the provider bills the service as authorized on the care plan (which includes all applicable modifiers)**, service authorization is uploaded to the claims processing system with the correct servicing provider NPI or AVRS ID and the provider submits the correct procedure code. Contact the care manager for assistance.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 5151- Units exceed frequency units on CHC care plan

Cause:

The claim was submitted with units that exceed the frequency or an incorrect service was submitted on the care plan established by the care manager. If only a portion of the units billed remain authorized, the claim will make payment on the available units.

Resolution:

The service is not payable unless the care manager increases the frequency for the date(s) of service submitted on the claim.



ELIGIBILITY VERIFICATION

Benefit Plans eligible for CHC coverage with services required to be in the Care Plan:

➤ **CHC Waiver Benefit Plans** – *(Medical and non-medical services for elder and disabled clients in the CHC Program).*

- ✓ **1915C** CHC 1915i Case Managed Clients
- ✓ **1915S** CHC 1915i Self Directed Clients
- ✓ **CBCMD** CHC Program for Disabled Adults Community Based
- ✓ **CBCMF** CHC Community Based Case Managed Waiver
- ✓ **CBCMS** CHC Community Based Case Managed State Funded
- ✓ **SDIRF** CHC Self Directed Waiver
- ✓ **SDIRS** CHC Self Directed State Funded

The following HUSKY clients may also be eligible for one of the above CHC Waiver benefit plans, but non-medical services won't be covered:

- HUSKY A
- HUSKY C

****For more information refer to section 4.4 Internet Web Site Portal Eligibility in the Chapter 4-Client Eligibility provider manual located at www.ctdssmap.com.****



CHC Service Provider Workshop

Care Plan Denials and Resolution

EOB 4021- [The procedure billed is not a covered service under the client's benefit plan](#)

Cause:

If the claim is Connecticut Home Care (CHC) Program claim and the client does not have an active CHC benefit plan in effect yet for the date of service submitted on the claim.

Resolution:

The Alternate Care Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the client's eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to AlternateCare.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" in the subject line of the email.



CHC Service Provider Workshop

Claim Denials and Resolution

EOB 4140- The service submitted is not covered under the client's benefit plan.

Cause:

The claim was submitted with a billing provider who is restricted from submitting the procedure based on the client's benefit plan.

Resolution:

Either the billing provider on the claim needs to be changed, or the client's benefit plan must be changed, otherwise the claim is not payable.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

- **Check client eligibility on clients coming on service.**
 - Contact DSS Alternate Care unit immediately with client who are not eligible for a CHC benefit at AlternateCare.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.

- **Check the client's care plan** to be sure the services you have been requested to provide are on the care plan and report discrepancies to the appropriate Access Agency immediately.
 - Review the care plan carefully to ensure all services to be provided are on the initial care plan.
 - 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.



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

➤ Claim submission review

- Prior to submitting claims be sure services provided match service authorized to 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
- Submit claims electronically and/or via the web rather than on paper to:
 - Maximize reimbursement time
 - Reduce claim errors due to poorly aligned claim data fields



CHC Service Provider Workshop

Program Basics for Successful Claim Submission

➤ Claims Resolution

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



CHC Service Provider Workshop

Future Enhancements

Phase II

- Retroactive changes to care plans -when claims paid against the Prior Authorization (PA)
- Mass Adjustment Process to:
 - Recoup claims due to care plan changes (hospitalization)
 - Adjust claims to pay more/less
 - Adjust claims to pay against the correct PA/line detail (no impact to provider)



CHC Service Provider Workshop

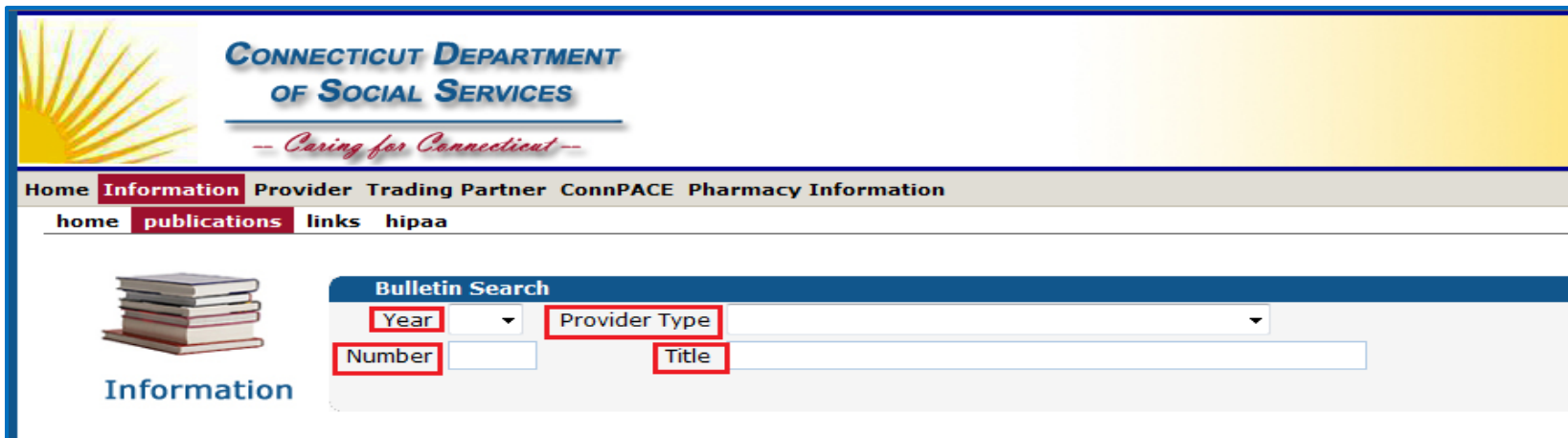
PROGRAM RESOURCES

INFORMATION-PROVIDER BULLETINS

➤ Provider Bulletins:

Publications mailed 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 the website for the Connecticut Department of Social Services. At the top left is a logo with a sunburst and the text "CONNECTICUT DEPARTMENT OF SOCIAL SERVICES" and the tagline "-- Caring for Connecticut --". Below this is a navigation bar with links: Home, Information, Provider, Trading Partner, ConnPACE, and Pharmacy Information. Underneath, there are sub-links: home, publications, links, and hipaa. On the left side, there is an icon of a stack of books and the word "Information". The main content area features a "Bulletin Search" form with the following fields: "Year" (a dropdown menu), "Provider Type" (a dropdown menu), "Number" (a text input field), and "Title" (a text input field). Red boxes highlight the "Year", "Provider Type", "Number", and "Title" fields.

INFORMATION – PROVIDER MANUAL

[\(Provider Manual\) Homepage > Information > Publications > Provider Manuals at \[www.ctdssmap.com\]\(http://www.ctdssmap.com\).](#)

- The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission.
- It is the primary source of information for submitting CMAP claims and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions.
- 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 – PROVIDER MANUAL

Chapter 1 – Introduction

- Provides information on the CT Medical Assistance Program, the Department of Social Services' and Hewlett-Packard's responsibilities and resources.

Chapter 2 – Provider Participation Regulations

- Details the CMAP regulations for provider participation.

Chapter 3 – Provider Enrollment

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

Chapter 4 – Client Eligibility

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



INFORMATION – PROVIDER MANUAL

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 Remittance Advices.

Chapter 7- Regulations/Program Policy

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

Chapter 8 – Billing Instructions

- Provides information on provider specific billing requirements.



INFORMATION – PROVIDER MANUAL

Chapter 9 – Prior Authorization

- Provides information on how to obtain Prior Authorization for designated services.

Chapter 10 – Web Portal/Automated Voice Response System (AVRS)

- Provides information both the AVRS and the Web Portal functions of interChange.

Chapter 11 – Other Insurance/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.



CONTACTS

- **HP Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
 - CTDSSMAP-ProviderEmail@hp.com
- **HP Electronic Data Interchange (EDI) Help Desk**
 - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
- **Connecticut Community Care (CCCI)-** serviceauthissues@ctcommunitycare.org
- **Western Connecticut Area on Aging (WCAA)-** contact WCAA directly at (203)465-1000
- **South Western Connecticut Area on Aging (SWCAA)-** Dayna Serra dserra@swcaa.org or 203-814-3625 or Bill Schempp at bschempp@swcaa.org or 203-814-3645
- **South Central Connecticut Area on Aging (SCCAA)-** Carolyn Feliciano at cfeliciano@aoascc.org or contact her directly at 203-752-2991
- **www.ctdssmap.com**



CHC Service Provider Workshop

Time for questions