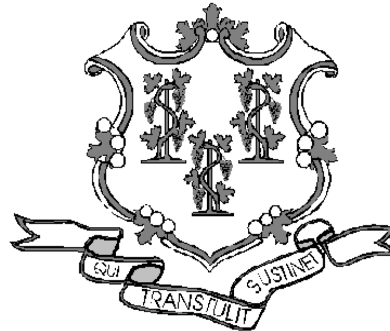
Connecticut Medical Assistance Program (CMAP)

Home Health Provider Billing Workshop Review 2013



Presented by
The Department of Social Services
& HP Enterprise Services

WORKSHOP AGENDA

- ✓ CHC Program Changes
- ✓ Web Capabilities
- ✓ Eligibility Verification
- ✓ Care Plan Access
- ✓ Claim Processing Guidelines
- ✓ Claim Denials/ Care Plan Issues/Resolution
- ✓ ACA OPR Requirements
- ✓ ICD-10 2014
- ✓ Resources/Contacts
- ✓ Questions

CHC PROGRAM CHANGES
CLAIM SUBMISSION

Effective for dates of service ***July 1, 2013:***

- ***Home Health Agencies***– Will submit their ***medical service*** claims to HP using their ***existing Home Health Agency billing provider number*** used to submit medical claims directly to HP for HUSKY clients.

- ***Home Health Agencies*** will continue to submit **medical service** claims for **CHC only clients** for dates of service through ***June 30, 2013*** directly to the Access Agencies for reimbursement.

PROGRAM CHANGES
CARE PLAN

All Home Health services and units of service billed ***must*** be on the care plan for the provider of service ***to be reimbursed***.

Assessments and Status Reviews ***(Serviced and billed by the Access Agencies)*** will ***not*** be on the care plan.

- Second status reviews in a Nursing Home requires PA.
  - A paper PA form must be submitted to HP.

SECURE WEB PORTAL

Users have multiple access to logging on to their secure Web account from the www.ctdssmap.com Home page.

WEB ACCOUNT CAPABILITIES

Accessing your provider secure web account allows you to:

- **Update your demographic information :**
  - Chapter 10-Web Portal/AVRS-Section 10.16 Provider Demographic Maintenance
- **Set Up clerk accounts:**
  - **Chapter 10**-Web Portal/AVRS-Section 10.9.3 Creating Clerk Accounts
- **Switch Provider:**
  - Switch from one provider to another, to allow clerks that have been associated to multiple provider accounts easy access.
  - **Chapter 10**-Web Portal/AVRS-Section 10.9.4.3 Ongoing Clerk Maintenance
- **Check client eligibility via the Web:**
  - **Chapter 4**-Client Eligibility-Section 4.4 Internet Web Site Portal Eligibility
- **Access client care plans:**
  - Care Plan Inquiry (Access Agencies)
  - Prior Authorization Inquiry (CHC Service Providers)
    - **Chapter 10**-Web Portal/AVRS-Section 10.12.2 Searching for PA Request

WEB ACCOUNT CAPABILITIES CONT.

- **Create and Submit claims:**
  - Web claim format is HIPAA 5010 compliant
  - Institutional
  - **Chapter 10**-Web Portal/AVRS-Section 10.10 Claim Submission, Resubmission, Adjustments and Inquiry

- **Perform claim inquiries:**
  - **Chapter 10**-Web Portal/AVRS-Section 10.10.4 Searching for a Claim

- **Resubmit, Adjust, Void, and Copy claims:**
  - Even those previously submitted electronically or via paper.
  - Region 12 and 13 claims cannot be adjusted.
  - **Chapter 10**-Web Portal/AVRS-Section 10.10.5 Adjusting and Resubmitting Claims

SWITCH PROVIDER FUNCTION

- If multiple providers create clerk accounts using an ***identical clerk User ID***, the clerk in question will have the ability to switch back and forth between submitting online transactions for those providers.
  - To switch between providers, select ***switch provider*** from either the *Account* submenu or the *Account* drop-down menu.
  - Select the line of the provider you wish to switch to; click ***switch to***. A window will appear asking you to verify the switch; click ***ok***.

Switch Provider

Trading Partner/ Provider ID		Provider AVRS ID	Provider Type	Address	City	State	Zip	Zip + 4	Default Provider/ Trading Partner
1234567890	NPI	123456	Dentist	15 MAIN STREET	WILLIMANTIC	CT	06226	1948	☑
1122334450	NPI	111222	Clinic	47 CRESCENT STREET	WILLIMANTIC	CT	06226	3606	☐

Select row above to update.

switch to

Current Provider/Trading Partner	1234567890 NPI		
Provider/Trading Partner ID	1234567890 NPI	Address	15 MAIN STREET
Provider AVRS ID	123456	City	WILLIMANTIC
Provider Type	Dentist	State	CT
Default Provider/Trading Partner	☑	Zip	06226 1948

WEB CLAIM INQUIRY

- To search for claims using the www.ctdssmap.com *secure site*, click on the claims > claim inquiry tab on the main menu.

Home Information Provider Trading Partner ConnPACE 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

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

- Enter enough information to satisfy at least one of the following criteria listed below and then click search.
  - *ICN*, *From* and *Through Dates of Service*, *From* and *Through Dates of Payment* or check off the *Pending Claims* box.

Claim Search 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
search
clear

WEB CLAIM INQUIRY

Once a claim has been submitted ***(Using any method of claim submission),*** providers have many options to submit re-submit claims, based on the status of the claim.

- **Paid claims allow you to:**
  - ✓ Cancel any alterations you have made.
  - ✓ Adjust the claim.
  - ✓ Void the claim.
  - ✓ Copy the claim and use it as a template to create a new claim.
  - ✓ Create a new claim from scratch.
- **Denied claims allow you to:**
  - ✓ Resubmit the claim. (With or without making changes)
  - ✓ Cancel any alterations you have made.
  - ✓ Create a new claim from scratch.
- **Suspended claims allow you to:**
  - ✓ Create a new claim from scratch.

** For further information please refer to **Chapter 10** of the provider manual **section-10.10.4 Searching for a Claim** located at www.ctdssmap.com.**

Web Claim Submission Benefits

- **Top 5 reasons to use the Web claim submission tool:**

➢ Easily resubmit previously denied claims.

➢ Submit secondary claims containing payments or denials from Other Insurance or Medicare.

➢ Adjust claims on the Web and eliminate paper Paid Claim Adjustment Requests (PCAR).

➢ Claim results are immediate.

➢ Eliminate paper claims.

Learn more by attending a Web Claim Submission Workshop. The workshop schedule is located at www.ctdssmap.com Homepage> Provider> Provider Services> Provider Training.

ELIGIBILITY VERIFICATION

- DSS recommends that providers ***verify*** a client's ***eligibility on the date of service prior to performing the service, doing so will prevent unnecessary claim denials such as;***
  - The client was not eligible on the date of service.
  - The service provided was not a covered service under the client's benefit plan.

- Eligibility verification can be performed in the following ways:
  - 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.

** Ineligibility at the time of verification does **not** mean the provider will not be paid for the service rendered to a "CHC only" client.

ELIGIBILITY VERIFICATION

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

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

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

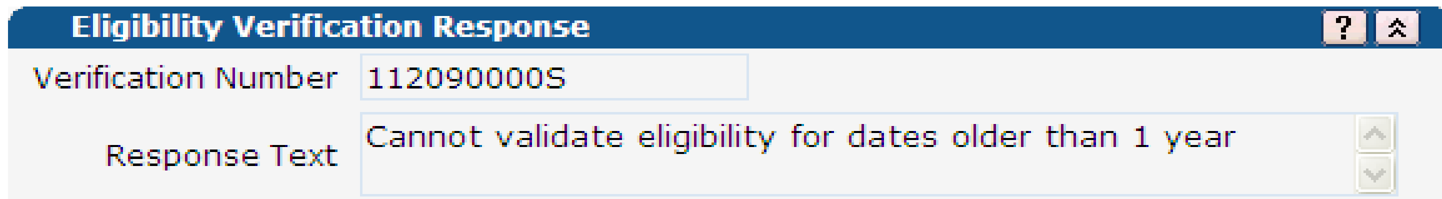
Eligibility Verification Request

Client ID		last name	DOE	From DOS*	03/24/2013
SSN	123-45-6789	First Name, MI	JOHN S	To DOS*	03/24/2013
Birth Date					
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

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

ELIGIBILITY VERIFICATION

- The ***<u>Eligibility Verification Response</u>*** window provides the search results.



- **Eligibility verification can only look as far back as one year.**
- **Eligibility searches cannot span multiple months.**
  - 04/15/2013 – 05/14/2013 (invalid span)
  - 05/24/2013 – 05/29/2013 (valid span)

  This search will allow providers to search for eligibility to the end of the month (future dates). Providers must validate eligibility on the actual date of service.

- ***Eligibility Verification Response***
  - Provides a verification number that should be kept on record in case the client's coverage is retroactively changed at a later date.
  - Reports client's eligibility status for the requested date(s) of service.

Eligibility Verification Response

Verification Number	1120900015
Response Text	Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information

Client ID	009999999	Last Name	THOMAS
SSN	111-99-9999	First Name, MI	THOMAS
Birth Date	01/20/1997	Street	1 MAIN ST
Gender	M	City, State, Zip	TORRINGTON, CT 06790

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	01/01/2012	01/11/2012	01/22/2012

Service Type Codes - HP Services

Service Type Code	Service Type Information
1	Medical Care
33	Chiropractic
35	Dental Care
4	Diagnostic X-Ray
42	Home Health Care
45	Hospice
47	Hospital
5	Diagnostic Lab
54	Long Term Care
56	Medically Related Trans

1 2 3 Next >

TPL

*** No rows found ***

Lockin

*** No rows found ***

Medicare

Coverage
Medicare A

ELIGIBILITY VERIFICATION

– ***Benefit Plan***

- The benefit plan(s) with which the client was an active member on the date(s) of service requested.

Client is covered for "Medicare Covered Services" for the effective/end dates of service verified. Home Health claims will deny.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date
Medicare Covered Services	05/01/2013	05/25/2013	05/25/2013

Client is covered for "Medicare Covered Services" and is a state funded CHC, HUSKY CHC Waiver or HUSKY only client for the effective/end dates of service verified. Medical services will deny to bill Medicare first. Provider must submit claim with the required adjustment reason code and date HHABN or NOMNC was issued to the client.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date
CT Home Care Community Based Case Managed State Funded	05/01/2013	05/25/2013	05/25/2013
Medicare Covered Services	05/01/2013	05/25/2013	05/25/2013

ELIGIBILITY VERIFICATION

When clients are covered for the CHC Assessment only, no other medical CHC services will be covered for the effective/end date of service verified.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date
CT Home Care Assessment Only State Funded	02/05/2013	02/05/2013	02/05/2013

Lockin

Note1: The hospice develops a plan of care that coordinates with the waiver case manager to eliminate overlap of services. These services must appear on the care plan.

Note2: Home Health Services for HUSKY only clients locked into Hospice require PA.

Lockin

Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	08/05/2011	08/05/2011	HOSPICE AGENCY	(860)555-1234

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:

HUSKY A – (*Medical Services for low income families with dependent children)*

HUSKY C – *(Medical services for individuals who are aged, blind or disable)*

Note: Services for these clients must also be on the care plan.

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.**

CARE PLAN ACCESS

Home Health Agencies *will have access to the care plans of the client's they service via the* ***secure Web portal*** *within the* ***Prior Authorization (PA) subsystem.***

- Each service on the care plan will have its own **unique PA#.**
- Each PA# will be tied to and **viewable** to the **servicing provider** via **PA inquiry.**

- *PA's already on file prior to July 1, 2013 for* ***medical*** *services to* ***CHC only (State Funded)*** *clients will continue to be tied and* ***viewable only*** *to the* ***Access Agency.***

- All CHC ***medical*** services for ***Waiver*** and **State Funded** *CHC* clients ***must be on the care plan*** for the **services** to be ***reimbursed.***

CARE PLAN ACCESS SECURE WEB PORTAL

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

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search provider fe
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*

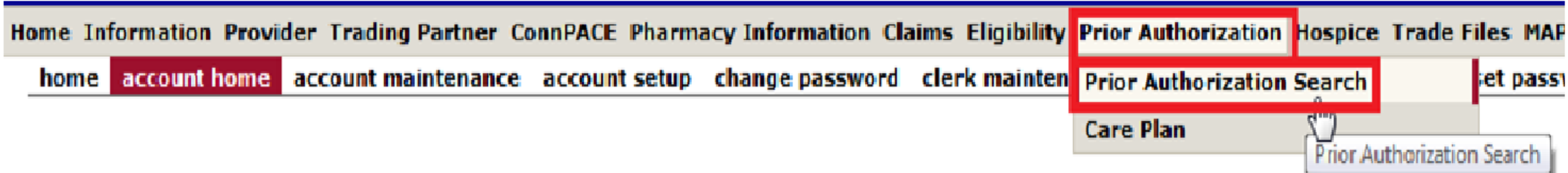
login

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

reset password

CARE PLAN ACCESS
PRIOR AUTHORIZATION (PA) SEARCH

Once on the secure site, click ***Prior authorization*** > ***Prior authorization search***.



Your Password Expires in 60 days on 12/31/2013 Change Password

Welcome, P008021185
Provider ID: 008021185 MCD
Provider AVRS ID: 008021185
Zip Code: 06032 - 1234

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

Global Messages
*** No rows found ***

Secure Mailbox
*** No rows found ***

CARE PLAN SEARCH
ACCESS TO CARE PLAN SERVICES - SEARCH PERFORMED BY CLIENT ID

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

home prior authorization search care plan

Care Plan Search

Care Plan Number

Client ID 001111011 [Search] Procedure Code [Search]

Last Name Revenue Code [Search]

First Name Proc/Mod List

Access Agency Provider ID 004071692 Effective Date

Service Provider ID [Search] End Date

Prior Authorization

Records 20

search

clear

add

SEARCH BY CLIENT ID RESULTS - SINGLE PA WITH ONE SERVICE LINE DETAIL

Home Information Provider Trading Partner ConnPACE 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	001111011	Prior Authorization	
Client Name	PATSY Claus	PA Assignment	
Requested Eff Date		PA Assign - Sub	
Requested End Date		Procedure	[Search]
Authorized Eff Date		Revenue Code	[Search]
Authorized End Date		Proc/Mod List	
		Records	20

search

clear

Search Results

Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedure	Revenue	NDC	Proc/Mod List	Frequency
2013256002	01	07/01/2013	12/31/2013	65	$0.00	Auto Approved for Care Plan	0	Home Care Program for Elders	Initial				SN	65 Per Date Span

SELECT LINE DETAIL TO DETERMINE UNITS USED, AVAILABLE AND FREQUENCY OF SERVICE

Line Item

Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Procedure Code List	Proc/Mod List	NDC	Revenue Code	Revenue Code List
01	65.000	$0.00	65.000	$0.00	Auto Approved for Care Plan			SN			

Type changes below.

Line Item	01				
Service Type Code*	Procedure/Mod List	Tooth	[Search]	Authorized Units/Dollars	65.000 / $0.00
Procedure Code/List	[Search] 1 [Search]	Quad	[Search]	Authorized Eff./End Dates	07/01/2013 / 12/31/2013
Modifier 1	[Search]	Tooth Surface 1	[Search]	Used Units/Dollars	0 / $0.00
Modifier 2	[Search]	Tooth Surface 2	[Search]	Available Units/Dollars	65 / $0.00
Modifier 3	[Search]	Tooth Surface 3	[Search]	Frequency	65 Per Date Span
Modifier 4	[Search]	Tooth Surface 4	[Search]		
Revenue Code/List	[Search] [Search]	Tooth Surface 5	[Search]		
Proc/Mod List	SN				
Requested Eff./End Dates*	07/01/2013 / 12/31/2013	NDC	[Search]		
Requested Units/Dollars*	65.000 / $0.00	Status	Auto Approved for Care		

Notes

*** No rows found ***

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

Description

Changes to the plan of care are reflected in the notes.

PROCEDURE CODE/FREQUENCY CROSSWALK

Procedu	Description	Unit Increment	Billing Provide	Span DC	Valid Frequency	Care Plan limitat	Funding Source
1021Z	SERVICES: PER 15 MINUTES, AGENCY	Per 15 min	CHC SERVICE PROV ONLY	Y	Per week or month		State Funded, Waiver
1022Z	SERVICES: OVERNIGHT,AGENCY	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		State Funded, Waiver
3022Z	PCA AGENCY OVERNIGHT CANNOT BE COMPLETED PRORATED HOURLY	11 per day	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1023Z	SERVICES: PER DIEM,AGENCY	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		State Funded, Waiver
1225Z	DIEM,CANNOT BE COMPLETED PRORATED HOURLY	23 per day	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
T1019	PER 15 MINUTES INDIVIDUAL	Per 15 min	Allied Only	Y	Per week or per month		State Funded, Waiver
1019Z	PERSONAL CARE SERVICES INDIVIDUAL PER DIEM	1 per day	Allied Only	Y	Per week or per month		State Funded, Waiver
1227Z	DIEM CANNOT BE COMPLETED PRORATED HOURLY	23 per day	Allied Only	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1020Z	PERSONAL CARE SERVICES INDIVIDUAL OVERNIGHT	1 per day	Allied Only	Y	Per week or per month		State Funded, Waiver
3020Z	PCA INDIV OVERNIGHT CANNOT BE COMPLETED PRORATED HOURLY	11 per day	Allied Only	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1200Z	ADULT DAY HEALTH – FULL DAY (NON-MEDICAL MODEL PROVIDER)	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1201Z	FULL DAY (APPROVED MEDICAL MODEL PROVIDER)	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1202Z	ADULT DAY HEALTH – HALF DAY (LESS THAN OR EQUAL TO 4 HRS)	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1206Z	CHORE SERVICE AGENCY 1/4 HOUR	Per 15 min	CHC SERVICE PROV ONLY	Y	Per week or per month		State Funded, Waiver
1208Z	CHORE SERVICE – HIGHLY SKILLED / HOUR	$S	CHC SERVICE PROV ONLY	N	not applicable. Dollars authorized, not units.	All services req PA	1915i, Medicaid, State Funded, Waiver
1209Z	MINOR HOME MODIFICATIONS	$S	CHC SERVICE PROV ONLY	N	not applicable. Dollars authorized, not units.	All services req PA	1915i, Medicaid, State Funded, Waiver

PROCEDURE CODE/FREQUENCY CROSSWALK

Procedi	Description	Unit Increment	Billing Provide	Span DC	Valid Frequency	Care Plan limita	Funding Source
1210Z	COMPANION SERVICE - AGENCY PER 1/4 HOUR	Per 15 min	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1214Z	HOMEMAKER SERVICE - AGENCY - PER 1/4 HOUR	Per 15 min	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1218Z	MEAL SERVICE - SINGLE HOT MEAL/MEAL SERVICE - SINGLE MEAL- HOT/COLD	1 single meal per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1220Z	DOUBLE MEAL (ONE HOT - ONE COLD) PER DOUBLE MEAL/MEAL SERVICE - DOUBLE (ONE HOT & ONE COLD) PER DOUBLE MEAL	1 double meal per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1221Z	KOSHER MEALS DOUBLE	1 double meal per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1222Z	PERS SERVICE INSTALLATION	1 installation per year	CHC SERVICE PROV ONLY	N	Per year		1915i, Medicaid, State Funded, Waiver
1223Z	TWO-WAY PERS SYSTEM ONGOING SERVICES	1 ongoing service per month	CHC SERVICE PROV ONLY	N	Per month		1915i, Medicaid, State Funded, Waiver
1226Z	RESPITE CARE IN THE HOME 1/4 HOUR- COMPANION/RESPITE CARE IN THE HOME- 1/4 HR. COMPANION	Per 15 min	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1228Z	RESPITE CARE IN THE HOME 1/4 HOUR - HOMEMAKER/RESPITE CARE IN THE HOME 1/4 HOUR- HOMEMAKER	Per 15 min	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1230Z	RESPITE CARE IN THE HOME 1/4 HOUR - HOME HEALTH AIDE	Per 15 min	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, , Waiver
1232Z	RESPITE CARE IN THE HOME PER HOUR-OTHER	Per Hour	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1234Z	RESPITE CARE- REST HOME WITH NURSING SUPERVISION- PER DAY/RESPITE CARE-REST HOME WITH NURSING SUPERVISION-PER DAY	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1236Z	RESPITE CARE- CHRONIC CONVALESCENT NURSING FACILITY- PER DAY/RESPITE CARE-CHRONIC CONVALESENT NURSING FACILITY-PER DAY	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver

PROCEDURE CODE/FREQUENCY CROSSWALK

Procedure	Description	Unit Increment	Billing Provider	Span DOS	Valid Frequency	Care Plan limitation	Funding Source
1240Z	RESPITE CARE LICENSED HOME FOR THE AGED-PER DAY/RESPITE CARE- LICENSED HOME FOR THE AGED PER DAY	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1244Z	RESPITE CARE OUT OF THE HOME-PER HOUR-OTHER/RESPITE CARE OUT OF THE HOME PER HOUR OTHER	24 per day	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
1247Z	MENTAL HEALTH COUNSELING-INDIVIDUAL-(PROVIDED IN CLIENT'S HOME)	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded Medicare
1256Z	MENTAL HEALTH COUNSELING – INDIVIDUAL (45 – 50 MIN) OUT OF HOME/MENTAL HEALTH COUNSELING-INDIVIDUAL(45-50 MIN)-OUT OF HOME	1 per day	CHC SERVICE PROV ONLY	Y	Per week or per month		1915i, Medicaid, State Funded, Waiver
1262Z	SOCIAL TRANSPORTATION – TAXI – PER TRIP	PER TRIP	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded,, Waiver
1264Z	SOCIAL TRANSPORTATION – LIVERY – PER TRIP	PER TRIP	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded,, Waiver
1266Z	SOCIAL TRANSPORTATION – INVALID COACH – PER TRIP	PER TRIP	CHC SERVICE PROV ONLY	N	Per week or per month		1915i, Medicaid, State Funded,, Waiver
1286Z	CASE MGMT SERVICES (ACTIVITIES RELATED TO IMPLEMENTATION, COORDINATION & MONITORING PLAN OF CARE)	1 PER DAY	ACCESS Agency only	Y	Billable by Access Agency only but included in the care plan. Per day		1915i, Medicaid, State Funded, Waiver
1397Z	ASSISTIVE TECHNOLOGY	$	ALLIED COMMUNITY RESOURCES AND CHC SERVICE PROVIDERS	N	Frequency not applicable. Dollars authorized, not units.		1915i, Medicaid, State Funded, Waiver
	HOME HEALH SERVICES BILLED BY HOME HEALTH AGENCIES						
S9128/441	SPEECH THERAPHY, IN THE HOME, PER DIEM/SPEECH THERAPY, IN THE HOME, PER DIEM	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 2 per week or in excess of 10 per month	1915i, Medicaid, State Funded, Waiver

PROCEDURE CODE/FREQUENCY CROSSWALK

Procedu	Description	Unit Increment	Billing Provider	Span DC	Valid Frequency	Care Plan limitat	Funding Source
S9129/431	OCCUPATIONAL THERAPY, IN THE HOME, PER DIEM	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	of 1 per week or in excess of 5 per month	1915i, Medicaid, State Funded, Waiver
S9131/421	PHYSICAL THERAPY; IN THE HOME, PER DIEM	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	of 2 per week or 10 per month	1915i, Medicaid, State Funded, Waiver
T1001	NURSING ASSESSMENT/EVALUATION	1 per eval	HOME HEALTH AGENCY ONLY	N	Per Date Span		State Funded, Waiver
T1002	RN SERVICES, UP TO 15 MINUTES (Must be billed in conjunction with S9123)	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
T1003	LPN/LVN SERVICES, UP TO 15 MINUTES (Must be billed in conjunction with S9124)	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month		1915i, Medicaid, State Funded, Waiver
T1004	SERVICES OF A QUALIFIED NURSING AIDE, UP TO 15 MINUTES	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	of 56 per week or in excess of 248 per month	1915i, Medicaid, State Funded, Waiver
SN	Skilled Nursing S9123 S9123 TT S9124 S9124 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	of 2 per week of any combination of SN and MA.	1915i, Medicaid, State Funded, Waiver
MA	Medication Administration T1502 T1502 TT T1503 T1503 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	of 2 per week of any combination of SN and MA.	1915i, Medicaid, State Funded, Waiver

Please Note: Dates of service can only be spanned when service is provided consectively on each date of service within the claim detail.
Spanned dates of service cannot exceed the frequency time frame (weekly or monthly) for the service as noted on the care plan.
Spanned dates of service cannot exceed the number of units allowed on the weekly or monthly frequency for the service billed as noted on the plan of care.
noted on the care plan.

The **CHC Procedure Code/Frequency Crosswalk can be found by going to the **Homepage> Information> Claims Processing Information** located at www.ctdssmap.com.

CLAIMS PROCESSING / SUBMISSION INFORMATION

- Claims for services rendered to CMAP clients may be submitted:
  - Internet Web site at www.ctdssmap.com
    - HIPAA compliant Institutional claim format
    - Interactive with ***immediate response*** of claim payment or denial.
    - Allows provider to ***adjust or correct and resubmit*** within the ***same claims processing cycle.***
  - Vendor Software utilizing the following HIPAA ASC X12N transactions:
    - 837I – Health Care Claim Institutional

CLAIMS PROCESSING / SUBMISSION INFORMATION

- Provider Electronic Solutions HIPAA compliant free windows based software offered by DSS via HP.
  - Effective ***October 1, 2014*** this software will ***no longer be supported by HP.***
  - Use as ***interim solution*** to ***obtaining vendor software*** for batch claim.
  - Requires provider to enroll as a ***Trading Partner.***
    - *Instructions on how to enroll as a Trading Partner can be located at www.ctdssmap.com* ***Homepage> Trading Partner > Trading Partner Enrollment/Profile****.*
- Paper
  - UB-04 Claim Form

*****Note: HP mailing address for paper claims submission depends upon claim type. (See Chapter 1 of the CMAP Provider Manual for correct mailing address.)***

CLAIMS PROCESSING / SUBMISSION INFORMATION

- Claims submitted to HP are each assigned a unique 13-digit Internal Control Number (ICN) that is used 20 | 12 | 032 | 123 | 456 for tracking and research.

  1 2 3 4 5

  - **1** *Claim Region* – Identifies the manner in which the claim was submitted. (**20** = *Electronic Claims with No Attachments)*
  - **2** *Year of Receipt* – Indicates the year in which the claim was received by HP. (**12** = *2012)*
  - **3** *Julian Date of Receipt* – The Julian calendar date of receipt (**032** = *the thirty-second day of the year. (February 1)*
  - **4** *Batch Number* – An internal number assigned by HP to uniquely identify a batch. (**123**)
  - **5** *Claim Number* – A sequential number assigned to uniquely identify claims within a batch. (**456**)

CLAIMS PROCESSING/SUBMISSION INFORMATION

- Claims processed through the Connecticut interChange system are subject to a series of ***edits*** that check the validity of claim data such as:
  - ***Submitting*** 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.***

- Claims are then subject to a series of ***audits.***
  - Is the ***procedure code(s)*** billed ***on*** the client's ***plan of care*****?**
  - If the billed ***procedure code*** requires prior authorization (PA), has the ***PA*** been ***approved?***
  - The claim is compared to previously paid claims
    - Is the current claim a ***duplicate*** of a ***paid claim*****?**

CLAIMS PROCESSING/SUBMISSION INFORMATION

Spanning Calendar Months

Claims will deny edit 580 (formerly 574) "Detail dates not in same month" if:

- **Cost share** is calculated on a claim for a CHC only eligible client.
- **Applied income** is calculated on a claim for a CHC and/or HUSKY eligible client.

This edit will not set on:

- HUSKY C only clients.
- CHC clients with or without HUSKY C, when applied income is not being calculated.

CLAIMS PROCESSING/SUBMISSION INFORMATION

Medicare Cost Avoidance Guidelines

- Medical services provided by Home Health Agencies to CHC clients are subject to the same Medicare Cost Avoidance rules in place for HUSKY clients today.

- Claims for **CHC and/or HUSKY Medicare eligible clients will deny** if not submitted with an adjustment reason code of:
  - 151, 152 or 153

  and
  - Date the Home Health Advanced Beneficiary Notice (HHABN) or Notice of Medicare Non-Coverage (NOMNC) was issued to the client.

Refer to PB 10-06 for further details.

CLAIMS PROCESSING / SUBMISSION INFORMATION

Third Party Liability (TPL) Information

- Commercial/private insurance coverage other than Medicare or Medicaid under which the client may be covered.
  - Connecticut Medical Assistance Program is the payer of last resort, Home Health claims for the following clients **will cost avoid (deny)** if commercial/private insurance is on the client's eligibility file:
    - Medical CHC only (State Funded) claims
    - Medical CHC Waiver (HUSKY A or C)
    - HUSKY only
  - Providers must investigate the possibility of clients having other insurance coverage and pursue payment prior to submitting their claim to HP.

THIRD PARTY LIABILITY UPDATE

To correct or update Third Party Liability (TPL) information:

- **Obtain TPL forms**

  - Print out form located on Web site at www.ctdssmap.com under Information → Publications → Forms → Third Party Liability Forms→ TPL Information Form.
  - Call Health Management System, Inc. (HMS) 1-866-277-4271. HMS staff will mail or fax the form to the provider.
  - E-mail request to ctinsurance@hms.com and form will be e-mailed back to provider.

- **Submit completed forms**

  - Mail to Health Management Systems, Inc. Attn: CT Insurance Verification Unit 5615 High Point Dr, Suite 100 Irving, Texas 75038
  - Fax to HMS with HIPAA compliant letter to 1-214-560-3932
  - Scan completed forms and submit through e-mail to ctinsurance@hms.com

CLAIMS PROCESSING / SUBMISSION INFORMATION

- **Timely Filing Guidelines**
  - Effective January 1, 2012 the timely filing limits are as follows:

    - **CHC State Funded**
      - (Medical services) – **1 year**
    - **HUSKY C with CHC Waiver**
      - (*Medical* services) -**1 year**
      - *(Behavioral Health* services) – **1 year**
    - **HUSKY A**
      - (*Medical* services) – **1 year**
      - *Behavioral Health* services – **120 days**

CLAIMS PROCESSING / SUBMISSION INFORMATION

- **Conditions that Waive the Timely Filing Limit**
  - Situations that allow the timely filing limit to be bypassed (1 year or 120 days depending on benefit plan and claim type):
    - Claim submission date is within range of the detail through date of service (TDOS).
    - Client eligibility has been added or updated where the claim date of service is within the effective dates of the update *and* the claim submission date is within range of the update.
    - Medicare and/or Other Insurance Payment:
      - TPL or Medicare paid amount is greater than $0.00 *and* the paid date is within 366 days of the claim submission date.
      - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny.

CLAIMS PROCESSING / SUBMISSION INFORMATION

- Situations that allow the timely filing limit to be bypassed (cont.):
  - *Me*dicare or Other Insurance (TPL) denial:
    - » The claim submission date is within range of when the primary insurance denied the claim (provided that denial was not due to timely filing).
    - » If multiple carriers exist and if any one does not meet the above criteria, the claim will deny.
  - Prior claim history:
    - » When a claim in history with the same *Client*, *Provider*, *Billed Amount*, detail *From* and *Through dates of service,* and *Revenue Center Code* or *Procedure Code* where the claim submission date is within range of the previous claim's Remittance Advice date *and* the previous claim did not deny for timely filing.

CLAIM DENIALS AND RESOLUTION

The Access Agencies have been working diligently to upload their care plans to the Web Portal. As most care plans have now been uploaded to the Web portal, effective ***<u>November 1, 2013</u>****, claims previously held in suspense that contain the following EOB messages will deny.*

**** This information can be found under Homepage> Information> Publications> Provider Manuals> Chapter 12-Claim Resolution Guide** located at **www.ctdssmap.com.**

- **3015**- **<u>CHC care plan required</u>**

  <u>Cause:</u>

  – 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.

  <u>Resolution:</u>

  – 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.

CLAIM DENIALS AND RESOLUTION

- **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 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.

CLAIM DENIALS AND RESOLUTION

- **5151**- **Units exceed frequency units on CHC care plan**

  Cause:

  - The claim was submitted with units that exceed the frequency 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.

CLAIM DENIALS AND RESOLUTION

- **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.

CLAIM DENIALS AND RESOLUTION

- **2504-<u>Bill private carrier first</u>**

Cause

- The Connecticut Medical Assistance Program is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage, the benefits of these policies must be fully exhausted prior to submitting the claim to HP. This EOB will post to the claim when a private insurance policy is present on the client's file which contains a type of coverage that may cover the claim and the claim was submitted without the response from this specific insurance carrier.

Resolution

- Perform a client eligibility verification transaction for the date of service on the claim to determine the other insurance carrier to which the claim should be billed.

- Bill the claim to the other insurance carrier.

- Once a response has been received from the carrier, resubmit the claim to HP, indicating either the payment or denial from the insurance carrier, using the same three digit carrier code returned in the client eligibility verification response. These claims can be submitted electronically and the other insurance EOB should not be submitted to HP. For complete instructions for submitting claims with other insurance, refer to **Chapter 11** of the Provider Manual located at www.ctdssmap.com .

CLAIM DENIALS AND RESOLUTION

- **2522-Bill Medicare first or provide appropriate adjustment reason code and date of HHABN or NOMNC.**

Cause

- Medicaid is payer of last resort. The client's eligibility file indicates that the client has Medicare coverage and the Home Health claim was submitted without reference to a Medicare payment, Medicare denial or the reason a Home Health Advanced Beneficiary Notice (HHABN) or MCO Notice of Medicare Non-Coverage (NOMNC) was issued.

Resolution

- The claim must either be billed to Medicare, or the HHABN or NOMNC must be issued to the client indicating the reason the client's care does not meet Medicare coverage criteria.
- The claim must then be resubmitted to HP indicating either Medicare made a payment or denied the claim. If the denial is due to a HHABN or NOMNC, the appropriate claim adjustment reason code must be entered to identify the reason the HHABN or NOMNC was issued.
- Further billing instructions are located in **Chapter 11** of the Provider Manual, the Institutional Other Insurance/Medicare Billing Guide found on www.ctdssmap.com.

CLAIM DENIALS AND RESOLUTION

- **4021**- **<u>The procedure billed is not a covered service under the client's benefit plan</u>**

  <u>Cause:</u>

  - 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.

  <u>Resolution:</u>

  - 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.

CARE PLAN ISSUES RESOLUTION

Providers are reminded to review the client's care plan, which can be found under "PA Inquiry" on their secure Web account to identify omissions or discrepancies in service authorizations which are causing claims to deny effective November 1, 2013.

If omissions or discrepancies are found, providers are encouraged to contact the Access Agency who issued the service order directly as noted below:

- **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

****Please include the following information when submitting care plan issues: client name, the client EMS number, the type of service (SN, Therapy Services, Home Health Aide .), the dates of service, the frequency of service (Spanned/Weekly/ Monthly) and the number of units or hours per visit.****

2013 - AFFORDABLE CARE ACT (ACA) CLAIM SUBMISSION REQUIREMENTS AT www.ctdssmap.com

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 pro health care providers about the Connecticut Medical Assistance Program. This site contains a wealth of resources for providers including enrollme program regulations, plus information on Electronic Data Interchange and the Automated Eligibility Verification System. The site also provides Medical ability to search for enrolled healthcare providers in their area. ConnPACE clients can access enrollment and reenrollment information at this site also.

Information

Provider

Trading Partner

ConnPACE

Important Messages

ICD-10 Implementation Information (Updated 11/1/13)

Electronic Health Record (EHR) News: Updated 10/31/2013

Revised Provider Manual Chapters: Updated 10/30/13

2013/2014 Primary Care Physician Rate Increase - Updated 10/28/2013

Fee Schedule Instructions Update for Hospitals 11/04/2013

Ordering, Prescribing, and Referring (OPR) Claims Edits Information Page (Updated 10/22/2013)

NEW CLAIM SUBMISSION REQUIREMENTS

- The Affordable Care Act (ACA) sections 6401 and 6501 mandate that ordering, prescribing and referring (OPR) providers who render services to HUSKY clients be enrolled in the Connecticut Medical Assistance Program (CMAP).

- Effective, beginning with claim dates of service May 1, 2013, DSS implemented the following new claim edits to validate that attending, referring, and rendering providers submitted on Institutional claims are enrolled in the CMAP:

  – EOB 1033 "Informational Only - Attending physician not enrolled on date of service."
  – EOB 1034 "Informational Only - Rendering provider not enrolled on date of service."
  – EOB 1035 "Informational Only – Referring provider not enrolled on date of service.

NEW CLAIM SUBMISSION (OPR) REQUIREMENTS

- Effective with claim dates of service 9/1/2013 and forward, Home Health claims must be submitted with the attending provider on the claim.

  – **Edit 381 “Attending provider number is missing”**

    - This EOB will post on the provider’s RA and pay for dates of service through 11/30/2013.

    - This edit will begin to deny with dates of service on or after 12/1/2013.

NEW CLAIM SUBMISSION (OPR) REQUIREMENTS CONT.

- Effective with claim dates of service **12/1/2013** and forward
  - **Edit 1033 "Attending physician not enrolled on date of service"** will begin to deny. **(HUSKY or HUSKY with CHC benefit only clients)**
    - If the referring provider is not submitted on the claim and the attending provider is not enrolled in the CMAP.
  - **Edit 1035 "Referring provider not enrolled on date of service"** will begin to deny if the referring provider is not enrolled in the CMAP. **(HUSKY or HUSKY with CHC benefit only clients)**
    - The referring provider is only required when different from the attending provider.
    - This edit will only set if there is a provider number in the referring provider field and the provider is not enrolled on the date of service.

OTHER ACA (OPR) REQUIREMENTS

- Beginning **12/1/2013** Prior Authorization (PA) requests for Home Health Services for **<u>HUSKY or HUSKY with a CHC benefit only clients</u>** where the ordering, prescribing or referring provider is not enrolled in the CTMAP will no longer be accepted.
- Home Health services for **<u>HUSKY or HUSKY with a CHC benefit only clients</u>** performed on or after **12/1/2013** where the ordering, prescribing or referring provider is not enrolled in the CMAP will result in a claim denial for the rendering agency.
  - This includes services that were authorized **<u>prior</u>** to December 1, 2013.
  - Prior authorization forms have been updated and now include mandatory fields for the CMAP ID numbers of both the rendering and ordering providers.
  - Forms submitted without these fields completed will be returned.

OTHER ACA (OPR) RESOURCES

- Log-on to the www.ctdssmap Website > Publications > Provider Bulletins
  - PB 2013-24
  - PB 2013-57
  - PB 2013-68

  For more information regarding:
  - OPR Edits
  - How to obtain revised PA forms
  - How to confirm full provider enrollment or OPR status
  - How to enroll as a CMAP provider

COMING IN 2014 - ICD-10

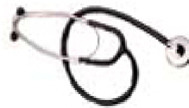
Logon to the www.ctdssmap.com Web site

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 HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS A WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROL PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM. THE SITE ALSO PROVIDES MEDIC ABILITY TO SEARCH FOR ENROLLED HEALTHCARE PROVIDERS IN THEIR AREA. CONNPACE CLIENTS CAN ACCESS ENROLLMENT AND REENROLLMENT INFORMATION AT THIS SITE ALS

Information



Provider

Trading Partner

ConnPACE

Important Messages

ICD-10 Implementation Information (Updated 11/1/13)

INFORMATION RESOURCES AT WWW.CTDSSMAP.COM IMPORTANT MESSAGES

"Important Messages" contains ***urgent messages*** that require immediate communication to the provider community as well as links to important information regarding recent or upcoming system changes. Be sure to review the ***CHC Implementation IM*** on a regular basis to keep informed about the upcoming CHC Program changes.

Important Messages

- ICD-10 Implementation Information (Updated 11/1/13)
- Electronic Health Record (EHR) News: Updated 10/31/2013
- Revised Provider Manual Chapters: Updated 10/30/13
- 2013/2014 Primary Care Physician Rate Increase - Updated 10/28/2013
- Fee Schedule Instructions Update for Hospitals 11/04/2013
- Ordering, Prescribing, and Referring (OPR) Claims Edits Information Page (Updated 10/22/2013)
- Provider FAQ for Provider Enrollment and/or Re-Enrollment (Updated 10/16/2013)
- Attention All Providers
- Attention: School Based Child Health Providers
- Hospital interChange Issues Updated as of 10/9/13
- New Influenza Virus Vaccines Updated 10/08/13
- Welcome to the CT Home Care Program Implementation (Updated 10/3/13)

The **CHC Program Frequently Asked Questions can also be found in the **CHC Implementation Important Message. Home page> Important Messages.****

INFORMATION – RA BANNER PAGE MESSAGES

- ***RA Banner Announcements***
  - Available by going to the **Homepage> Information> RA Banner Announcement** located at www.ctdssmap.com.
    - 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 regards to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected.

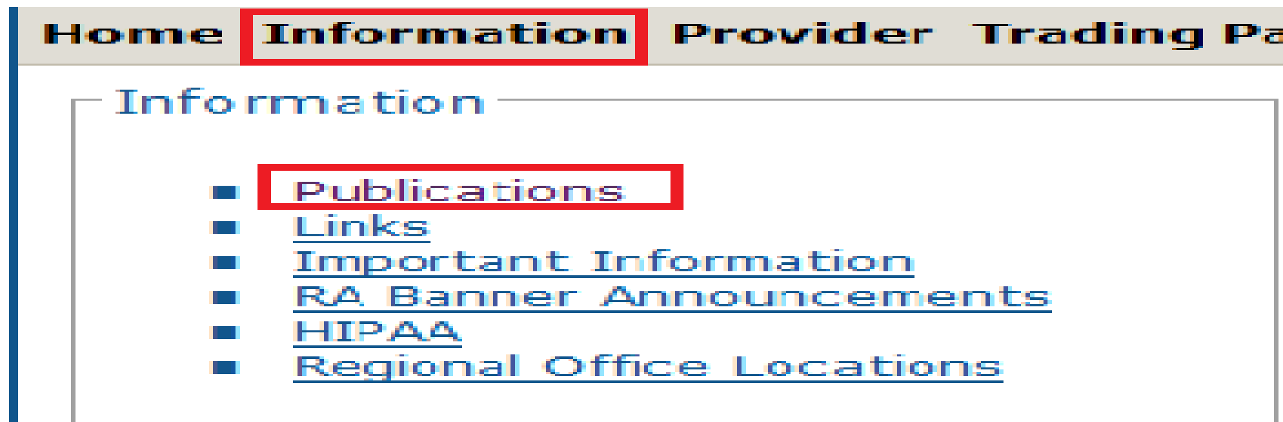
RA Banner Announcement

Banner Effective Date	Providers	Banner Page Announcement
10/18/2013-10/25/2013	Attention Connecticut Home Care (CHC) Service Providers and Home Health Providers Servicing CHC Clients	Attention Connecticut Home Care (CHC) Service Providers and Home Health Providers Servicing CHC Clients. CHC CLAIMS THAT DISPLAY EXPLANATION OF BENEFIT (EOB) CODES: 3015 CHC care plan required, 3016 Service not covered under CHC care plan, or 5151 Units exceed frequency units on CHC care plan, are currently in a suspended status. The Department of Social Services (DSS) has maintained these edits in a suspended status while the Access Agencies continue to make progress in both adding and updating the care plans. Effective November 1, 2013, claims that contain these EOB messages will begin to deny. Please refer to provider bulletin PB13-63 which contains detail surrounding these claim denials, claims resolution and future billing change requirements. This bulletin can be accessed by going to the Connecticut Medical Assistance Program's Web site: www.ctdssmap.com. From this web page, go to Information, then to Publications, then enter Year 13 and Number 63, then click search.

INFORMATION – PUBLICATIONS

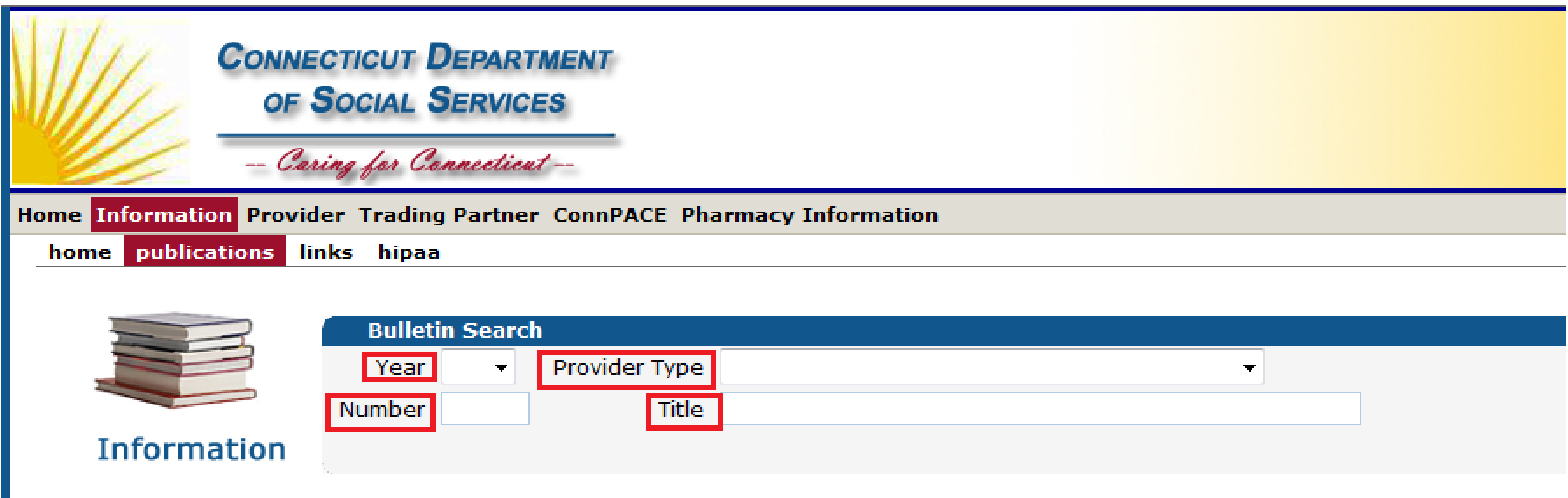
The ***<u>Publications</u>*** page on the www.ctdssmap.com web site is a ***<u>primary</u>* <u>resource</u>** for information available regarding the Connecticut Medical Assistance Program.

Access the *Publications* page by selecting ***<u>Publications</u>*** from either the ***<u>Information</u>*** box on the left hand side of the home page or from the *Information* drop-down menu.



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.



INFORMATION – PROVIDER MANUAL

- ***<u>Provider Manual</u>***
  - 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-Packards' 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

- ***<u>Chapter 5 – Claim Submission Information</u>***
  - Provides information on general claims processing and billing requirements.
- ***<u>Chapter 6 – EDI Options</u>***
  - Provides information on electronic claim submission and electronic Remittance Advices.
- ***<u>Chapter 7- Regulations/Program Policy</u>***
  - This section contains the Medical Section Policy section that pertains to the chosen provider type.
- ***<u>Chapter 8 – Billing Instructions</u>***
  - 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.

(Provider Manual) Homepage> Information> Publications> Provider Manuals located at www.ctdssmap.com.

INFORMATION – FORMS

Forms

– Claim and Adjustment Forms

– Enrollment Maintenance Forms

– Provider Workshop Invitations

– Third Party Liability Forms

– Other Forms

** www.ctdssmap.com

Homepage> Information> Publications> Forms

INFORMATION - OTHER

- ***Provider Newsletters***
  - Quarterly publications to providers on a wide range of topics.

Provider Newsletters

- April 2013 interChange Newsletter
- December 2012 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
- ICN Region Code List
- Medical Assistance Program EOB Crosswalk
- CHC Procedure Code Frequency Crosswalk
- Medically Unlikely Edit (MUE) Updates
- PCMH Billing Instructions
  - Physician, Nurse Practitioner and Physician Assistants PCMH Billing Instructions
  - Outpatient PCMH Billing Instructions
  - FQHC PCMH Billing Instructions

The **CHC Procedure Code/Frequency Crosswalk can be found here by going to www.ctdssmap.com **Homepage> Information> Claims Processing Information.****

INFORMATION – LINKS

The **Links page** is accessible by selecting ***Links*** from either the ***Information*** box on the left hand side of the home page or (from the *Information* drop-down menu) provides Web ***links*** to ***various relevant sites and resources*.**

Information

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

Home | Information | Provider | Trading Partner | ConnPACE | Pharmacy Information

- Publications
- Links
- HIPAA

State Government Sites

- State of Connecticut Department of Social Services
- HUSKY Health - Healthcare for Uninsured Kids and Youth
- ConnPACE - Connecticut Pharmaceutical Assistance Contract for the Elderly and Disabled

Federal Government Sites

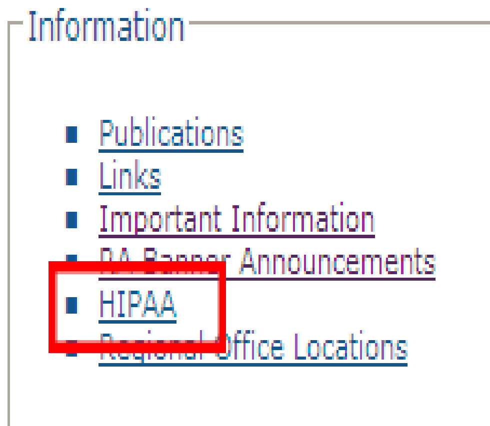
- Centers for Medicare and Medicaid Services
- Department of Health and Human Services
- National Institute of Health

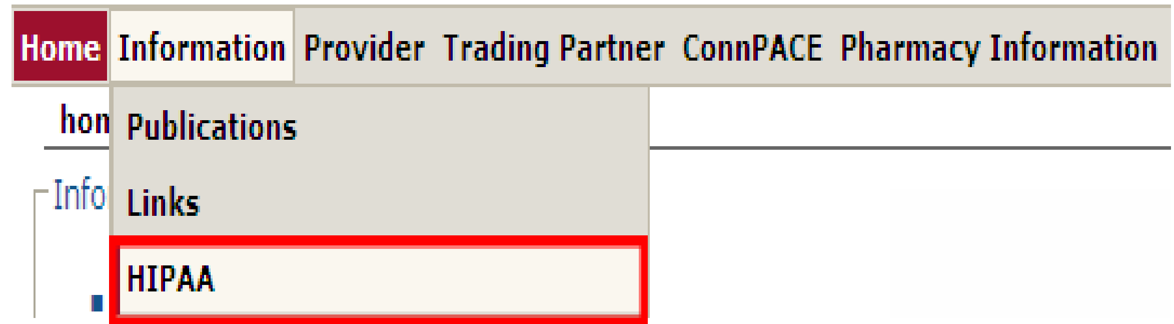
Health Care Provider Organizations

- American Dental Association
- American Academy of Pediatrics
- American Medical Association

INFORMATION – HIPAA

- The **HIPAA information page** is accessible by selecting ***HIPAA*** from either the ***Information*** box on the left hand side of the home page or from the *Information* drop-down menu.

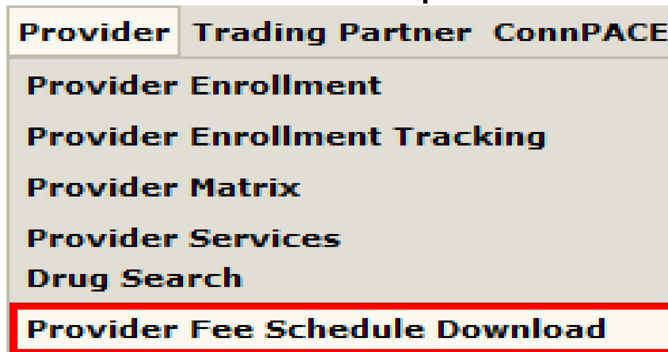




- ***HIPAA Mandated Transactions***
- ***Frequently Asked Questions***
  - HP and DSS have compiled a list of common HIPAA-related questions and answers.
- ***Glossary Of Terms***
  - General definitions and explanations of HIPAA-related terms and acronyms.

INFORMATION – FEE SCHEDULES

- CMAP *fee schedules* are available for download from the Web site.
  – Select *Provider Fee Schedule Download* from the *Provider* drop-down menu.



- You must read and accept the ***End User License Agreement*** prior to downloading the fee schedule; ***click I Accept.***
  – Provider Fee Schedules are **listed** by provider type and specialty.
  – Hold down the ***control key*** and ***click*** the ***corresponding link*** to download the appropriate fee schedule.

Provider Fee Schedule Download

- Acquired Brain Injury CSV
- Air Ambulance CSV
- Alcohol Treatment CSV
- Audiology CSV
- Basic/Advanced Transportation CSV
- Behavioral Health Partnership PDF
- Chiropractor CSV
- Clinic - Ambulatory Surgical Center CSV
- Clinic - Dialysis CSV
- Clinic - Family Planning / Abortion CSV
- Clinic - Medical CSV
- Clinic - Mental Health CSV
- Clinic - Rehabilitation CSV
- Clinic - Substance Abuse CSV
- Critical Helicopter CSV
- CT Home Care CSV
- Dental PDF CSV
- Home Health PDF
- Hospice CSV
- Independent Radiology CSV
- Lab CSV
- MEDS - DME CSV
- MEDS-Hearing Aid/Prosthetic Eye CSV
- MEDS-Medical/Surgical Supplies CSV
- MEDS-MISC PDF
- MEDS-Parenteral-Enteral CSV
- MEDS-Prosthetic/Orthotic CSV
- Mental Health Waiver CSV
- Natureopath PDF
- Optician CSV
- Personal Care Assistant CSV
- Physical Therapy CSV
- Physician Anesthesia CSV
- Physician Office and Outpt Services CSV
- Physician Radiology CSV
- Physician Surgical CSV
- Psychologist PDF
- Special Services CSV
- Travel Agent CSV

PROVIDER WORKSHOPS

- This provider workshop and past presentations can be found by going to www.ctdssmap.com. **Homepage> Provider> Provider Services> Provider Training.**

Provider Training

HP Provider Relations offers free provider training on a bi-monthly basis. If you are a newly enrolled provider in the Connecticut Medical Assistance Program, have new office staff, or simply want to brush up on billing basics, please join us at these scheduled events. For more information on covered topics, the bi-monthly training session schedule, or to obtain a registration form or directions to the facility where the workshop will be held, click here.

CONTACTS

- **HP Provider Assistance Center (PAC)**
  - 1-800-842-8440 – Monday thru Friday, 8:00 a.m. – 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
- **CHNCT Provider Relations (HUSKY Medical Prior Authorizations)**
  - 1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)
- **CTBHP ASO (HUSKY Behavioral Health Prior Authorizations with diagnosis range between 291-319)**
  - 1-877-552-8247

CONTACTS CONT.

- **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.huskyhealth.com
www.ctdssmap.com

CHC BILLING WORKSHOP

Time for Questions

CHC BILLING WORKSHOP

Thank You For Attending
The Connecticut Medical Assistance Program
CHC Billing Workshop!

All questions and comments regarding this training are welcome!

Please fill out the supplied workshop survey, your feedback helps us to improve future workshops!