Connecticut Medical Assistance Program
New Provider Workshop

Presented by
The Department of Social Services
& HP Enterprise Services
Training Topics

- **www.CTDSSMAP.com Web Portal Overview**
  - **Web Account**
    - Set Up / Capabilities
    - Demographic Maintenance
  - **Clerk Maintenance**
    - Adding/Deleting Clerks, Assigning Roles
  - **Eligibility Verification**
    - Eligibility Searches
    - Service Codes
    - Interpreting Results
    - Benefit Plans
  - **Claim Processing / Submission Information**
    - Claim Inquiry
    - Void
    - Resubmission
    - Search Results
    - Adjustment
    - Submission
    - Copy
    - Prior Authorization Inquiry
  - **Remittance Advice**
  - **(Re)enrollment**
Training Topics

• **Available Resources**
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    - Important Messages
    - Banner Page Announcements
  - **Publications**
    - Provider Bulletins
    - Provider Manual
    - Forms, Newsletters, Etc.
  - **Links**
  - **HIPAA**
  - **Fee Schedule**

• **Wrap Up**
  - **What’s New in 2012?** – EHR Incentive Program
  - **Contacts**
  - **Questions & Comments**
CTDSSMAP.com Web Portal Overview – Section 1.1

WEB ACCOUNT
Welcome Page at www.CTDSSMAP.com
Web Account Set Up

• Secure Your Web Access to www.CTDSSMAP.com

  – Ensure access to the Web portal to utilize the self-service features of interChange.
  
  – If your office/company has security measures blocking your access you will need to contact the individual responsible for your firewall and internet permissions and request access to the Connecticut Medical Assistance Program (CTMAP) Web site.
Web Account Set Up

• Setting Up your Secure Site Account
  – Select **Secure Site** from either the **Provider** panel on the left or the **Provider** drop down menu. Click **setup account**.
Web Account Set Up

• Setting Up your Secure Site Account

– Alternately, click on the Provider icon from the main page then click **Logging in for the first time?** from the Quick Login panel on the right side of the screen.
Web Account Set Up

- **Information Required for Account Set Up**
  
  - As a new Provider or Trading Partner you should receive your logon IDs via your enrollment confirmation; Web and AVRS PINs will arrive under separate cover.
  
  - **New Providers**
    - AVRS/Initial Web User ID
    - Web PIN
    - AVRS PIN
  
  - **New Trading Partners**
    - Initial Web User ID
    - Web PIN

  - You will need to have the Web ID and Web PIN on hand when you first access the secure site.
Web Account Set Up

• Enter the provided Initial Web User ID and PIN in the appropriate fields; click setup account.

Account Setup

Initial Web User ID = 001111111
Personal Identification Number = AB12C3de4

Please note User ID and Personal Identification Number are case sensitive.

Click here to find answers to the most frequently asked questions (FAQs) regarding Web account set up.
Web Account Set Up

• You will be brought to the Account Setup screen.
• Fill in the fields with the appropriate information.

**Before clicking submit, be sure to write down the chosen User ID, Password, and secret question Answer(s) and keep them in a secure location.**
Web Account Set Up

• You have successfully set up your CTDSSMAP.com Secure Site account.

Your password expires in 60 day(s) on 2/21/2012 at 12:00 AM Change Password

Welcome, JOHN_DOE_DENTAL
Provider ID: 1234567890 NPI
Provider AVRS ID: 123456
Zip Code: 06000 - 1111

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

Global Messages

<table>
<thead>
<tr>
<th>Category</th>
<th>Subject</th>
<th>Message</th>
<th>Sent Date</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification</td>
<td>Web Claim Submission</td>
<td>Web claim submission is now...</td>
<td>12/22/2009</td>
<td>12/22/2009</td>
<td>12/31/2099</td>
</tr>
</tbody>
</table>

Secure Mailbox

*** No rows found ***
Web Account Capabilities

• Accessing your secure site provider account allows you to:
  – Set Up clerk accounts to allow multiple users access to specified roles
  – Check client eligibility via the Web
  – Perform claim and prior authorization (PA) inquiries
  – Create, Submit, Resubmit, Adjust, Void, and Copy claims
    • Even those claims submitted through other means (paper, electronic)
      ▪ Professional
      ▪ Dental
      ▪ Institutional
    • HIPAA 5010 compliant since March, 2011
  – Obtain your Remittance Advice (RA)
  – Re-enroll with the CT Medical Assistance Program
  – Update your demographic information (addresses/bank accounts)
  – Retrieve E-Messages sent by HP
Web Account Capabilities

• The CTDSSMAP.com Web site features Online Field Help to assist providers with accessing and submitting information
  – Placing your mouse cursor over a data field name will create a small question mark beside the cursor.

  – Click the left mouse button when the question mark is displayed to open the Online Field Help window relevant to the selected field.
Demographic Maintenance

• The Demographic Maintenance section of the secure site allows you to alter and maintain demographic information:
  – Mail to, Pay to, and Service Location addresses
  – Service Languages
  – EFT (Electronic Funds Transfer) Account
    • Bank account that will receive all CTMAP related reimbursements.

• Access this section by selecting demographic maintenance from either the Account submenu or the Account drop-down menu.
Demographic Maintenance

• The **Demographic Maintenance** page displays the provider information panel as well as a submenu.

<table>
<thead>
<tr>
<th>Provider Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider ID</strong></td>
</tr>
<tr>
<td><strong>Organization</strong></td>
</tr>
<tr>
<td><strong>Usage</strong></td>
</tr>
<tr>
<td><strong>Provider Type</strong></td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>City</strong></td>
</tr>
<tr>
<td><strong>County</strong></td>
</tr>
<tr>
<td><strong>State/Zip</strong></td>
</tr>
</tbody>
</table>

- **Base Information**
  - Ownership
- **Service Location**
  - County, Organization Code
- **Service Language**
  - Language, Effective Date, End Date

• Clicking the submenu options will open a panel with related information:
  - **Base Information**
    - Ownership
  - **Service Location**
    - County, Organization Code
  - **Service Language**
    - Language, Effective Date, End Date
Demographic Maintenance

- The *Location Name Address* panel allows you to specify different mailing, payment, and service locations.

![Location Name Address Panel](image)

- **Usage**
  - **Mail to**: DOE, JOHN
  - **Pay to**: DOE, JOHN
  - **Service Location**: DOE, JOHN

- **Name**: DOE
- **Title**: DDS
- **Address 1**: 15 MAIN STREET, WILLIMANTI, CT, 06614, 4008, (203)555-5555, 5555, Y
- **Address 2**: 250 OAK AVENUE, WILLIMANTI, CT, 06614, 0001, (203)555-5555, 5555, Y
- **Phone**: (203)555-5555, 5555
- **Fax**: (203)555-5550
- **Handicap Accessible?**: Yes
- **EMail**: john_doe_dds@doedental.com
Demographic Maintenance

• To alter address information simply select the applicable row from the provided list (Mail to, Pay to, or Service Location); then click **maintain address**.
  – Select/fill in the appropriate information (address, phone number etc); **click save**.

The following messages were generated:
<table>
<thead>
<tr>
<th>Message Description</th>
<th>Panel</th>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Save was Successful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

– To have the fields automatically filled in with the information from an address already on file, click **select from list** and then click on the address you would like to use.
Demographic Maintenance

• The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CTMAP will be electronically deposited.

  – Click **add**; enter the appropriate information; and click **save**.

**This action will place the provider in a pre-notification status and the provider will once again receive a paper check until a successful pre-notification EFT has been confirmed.**
Demographic Maintenance

• The Language Spoken panel allows you to select the language(s) spoken at your service locations.
• Click **add**; select the appropriate spoken language from the drop-down menu.
• Enter an **Effective and End Date**.
• If more than one language is spoken at your service address, click **add** to select additional languages.

![Service Language Panel]

• Click **save**.
CTDSSMAP.com Web Portal Overview – Section 1.2

CLERK MAINTENANCE
Clerk Maintenance

• Clerk accounts grant Web access to staff members allowing them to perform functions based on their job responsibilities.

• The local administrator is responsible for maintaining clerk accounts within their organization. This includes adding clerks, changing the role(s) for clerks, removing clerks, and resetting passwords.

• Access the Clerk Maintenance section of the secure site by selecting clerk maintenance from either the Account submenu or the Account drop-down menu.
Clerk Maintenance

- To create a new clerk account, click **add clerk**.
- Fill in the fields with the appropriate information.

- Click **submit**.
Clerk Maintenance

• The new clerk account has been added.

• Return to the Clerk Maintenance menu to add additional clerks, reset an existing clerk’s password, or to alter clerks’ Assigned Roles.
Clerk Maintenance

• When a new clerk logs into the secure site for the first time they will be required to change their password from the one created by the account administrator.

• Fill in the fields with the appropriate information.

• Click **change password**.

• The clerk is now ready to perform the job duties allowed under the **Assigned Roles** chosen by the account administrator.
Clerk Maintenance

• Once a clerk is signed in they can update their information by selecting *account maintenance* from either the Account submenu or the Account drop-down menu.

• Fill in the appropriate information.

![Account Maintenance](image)

- Click *Save*. 
Clerk Maintenance

- 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.

![Switch Provider](image)

- 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**.
Clerk Maintenance

• To delete a clerk account – select that account from the list of existing clerks and click on *remove clerk*.

• A window will appear asking to you verify that you want to mark that clerk account for deletion. Click *OK*.

• The *D* indicates that the clerk has been marked for deletion.

• Click *Submit* to finalize the clerk account removal.
CTDSSMAP.com Web Portal Overview – Section 1.3

ELIGIBILITY VERIFICATION
Eligibility Verification

• DSS recommends that providers verify a client’s eligibility on the date of service prior to performing said service.
  – Eligibility can change at any time.

• Eligibility verification can be performed in the following ways:
  – Internet Web site at www.ctdssmap.com
  – Automated Voice Response System (AVRS)
  – Point of Sale (POS) Device
  – Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
  – Via e-Prescribing using Surescripts and the ASC X12N 270/271 transaction
Eligibility Verification

• To verify a CTMAP client’s eligibility through the secure site – click on the **Eligibility** tab on the main menu.

• Enter enough client data to satisfy at least one of the valid search combinations and then click **search**.

• **When entering a client’s full name as part of your search criteria, a middle initial is required if one is present in their CTMAP profile.**
Eligibility Verification

• The *Eligibility Verification Response* window appears with the results of your search.

![Eligibility Verification Response window](image)

– In this specific case – the client’s eligibility cannot be verified for the requested dates (Sept. 1 – 30, 2010). Eligibility verification can only look as far back as one year.

• Changing the dates of the eligibility request to within the allowable one year window nets a different result. In this case, the client was not eligible.

![Eligibility Verification Request and Response](image)
Eligibility Verification

- Eligibility searches cannot span multiple months.
  - Submitting a request that spans multiple months will result in the following error message:

> Eligibility verification requests must not span multiple months.

- Positive eligibility responses provide greater detail...
### Eligibility Verification Response

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

### Client Information

- **Client ID**: 0099999999
- **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

<table>
<thead>
<tr>
<th>Benefit Month Effective Date</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2012</td>
<td>01/11/2012</td>
<td>01/22/2012</td>
</tr>
</tbody>
</table>

### Service Type Codes - HP Services

- **Service Type Code**: 1
  - **Service Type Information**: Medical Care
- **Service Type Code**: 33
  - **Service Type Information**: Chiropractic
- **Service Type Code**: 35
  - **Service Type Information**: Dental Care
- **Service Type Code**: 42
  - **Service Type Information**: Diagnostic Lab
- **Service Type Code**: 45
  - **Service Type Information**: Long Term Care
- **Service Type Code**: 54
  - **Service Type Information**: Medically Related Trans

### Service Type Codes - MCO Services

- ***No rows found***

### TPL

- ***No rows found***

### Managed Care Provider

- ***No rows found***

### Lockin

- ***No rows found***

### Medicare

- ***No rows found***

### Coverage

- Medicare A
Eligibility Verification

• **What does all this information mean?**
  
  – *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](image)

  ![Client Information](image)

  – *Client Information*
    
    • Provides important client information
Eligibility Verification

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

<table>
<thead>
<tr>
<th>Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Information</td>
</tr>
<tr>
<td>Husky C. For Behavioral Health Services, call BHP at 877-552-8247.</td>
</tr>
</tbody>
</table>

**Service Type Codes – HP Services**
- A list of services for which the client was eligible that would be submitted for payment to HP Enterprise Services.

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Service Type Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
</tr>
<tr>
<td>33</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>35</td>
<td>Dental Care</td>
</tr>
<tr>
<td>4</td>
<td>Diagnostic X-Ray</td>
</tr>
<tr>
<td>42</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>45</td>
<td>Hospice</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
</tr>
<tr>
<td>5</td>
<td>Diagnostic Lab</td>
</tr>
<tr>
<td>54</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>56</td>
<td>Medically Related Trans</td>
</tr>
</tbody>
</table>
Eligibility Verification

- **Service Type Codes – MCO Services**
  - A list of services covered for the client that should be submitted for payment to the Managed Care Organization (MCO) with which they were enrolled.
  - Clients on the HUSKY and Charter Oak plans were enrolled with an MCO for dates of service prior to 1/1/2012.

### Service Type Codes - HP Services

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Service Type Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Dental Care</td>
</tr>
<tr>
<td>88</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>RT</td>
<td>Residential Psych Treatment</td>
</tr>
</tbody>
</table>

### Service Type Codes - MCO Services

<table>
<thead>
<tr>
<th>Service Type Code</th>
<th>Service Type Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Care</td>
</tr>
<tr>
<td>33</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>4</td>
<td>Diagnostic X-Ray</td>
</tr>
<tr>
<td>42</td>
<td>Home Health Care</td>
</tr>
<tr>
<td>45</td>
<td>Hospice</td>
</tr>
<tr>
<td>47</td>
<td>Hospital</td>
</tr>
<tr>
<td>5</td>
<td>Diagnostic Lab</td>
</tr>
<tr>
<td>54</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>56</td>
<td>Medically Related Trans</td>
</tr>
<tr>
<td>75</td>
<td>Prosthetic Device</td>
</tr>
</tbody>
</table>
Eligibility Verification

- **TPL (Third Party Liability)**
  - Private insurance plan(s) listed in the client’s CTMAP profile.
  - Due to HIPAA 5010 restrictions CTMAP is unable to disclose the eligibility status or covered services with the private insurance plan(s) via the web portal.
    - The Automated Voice Response System (AVRS) will continue to return TPL information in the client eligibility verification response.
    - Providers can access the AVRS by dialing 1-800-842-8440.
      - Press 1 for Self Service Options; enter your AVRS ID and PIN
      - Press 1 for Eligibility Verification.
    - Otherwise providers are required to initiate a separate request to the other payer or plan to determine the client’s level of coverage.
Eligibility Verification

– Managed Care Provider
  • Identifies the MCO with which the client was enrolled on the date(s) of service requested (if prior to 1/1/2012).

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Phone</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE CARE FAMILY PLAN</td>
<td>(800)554-1707</td>
<td>08/11/2011</td>
<td>08/21/2011</td>
</tr>
</tbody>
</table>

– Lockin
  • Some clients are locked into receiving certain health care services only from specific providers or pharmacies; those providers or pharmacies will be listed here.

<table>
<thead>
<tr>
<th>Lockin Type</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Provider Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>08/05/2011</td>
<td>08/05/2011</td>
<td>(860)555-1234</td>
</tr>
</tbody>
</table>

– Medicare
  • Types of Medicare coverage active for the client on the date(s) of service requested.
Eligibility Verification

- **Service Codes**

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Medical</td>
<td>Medical</td>
<td>54 –</td>
<td>Long Term Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long Term Care</td>
<td>AD – Occupational Therapy</td>
</tr>
<tr>
<td>4 – Diagnostic X-Ray</td>
<td>Diagnostic X-Ray</td>
<td>56 –</td>
<td>Medical Related Transportation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Related Transportation</td>
<td>AF – Speech Therapy</td>
</tr>
<tr>
<td>5 – Diagnostic Lab</td>
<td>Diagnostic Lab</td>
<td>75 –</td>
<td>Prosthetic Device</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prosthetic Device</td>
<td>AL – Vision (Optometry)</td>
</tr>
<tr>
<td>33 – Chiropractic</td>
<td>Chiropractic</td>
<td>82 –</td>
<td>Family Planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Planning</td>
<td>DM – Durable Medical Equipment</td>
</tr>
<tr>
<td>35 – Dental</td>
<td>Dental</td>
<td>86 –</td>
<td>Emergency Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Services</td>
<td>MH – Mental Health</td>
</tr>
<tr>
<td>42 – Home Health Care</td>
<td>Home Health Care</td>
<td>88 –</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacy</td>
<td>PT – Physical Therapy</td>
</tr>
<tr>
<td>45 – Hospice</td>
<td>Hospice</td>
<td>93 –</td>
<td>Podiatry</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Podiatry</td>
<td>RT – Residential Physical Treatment</td>
</tr>
<tr>
<td>47 – Hospital</td>
<td>Hospital</td>
<td>98 –</td>
<td>Professional (Physician) Office Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional (Physician) Office Visit</td>
<td>UC – Urgent Care</td>
</tr>
</tbody>
</table>
Eligibility Verification

• Benefit Plans
  - HUSKY A and HUSKY A, Primary Care Provider
    • Prior to 1/1/2012, HUSKY A clients had an MCO that handled all medical services. Federally Qualified Health Center (FQHC), behavioral health, dental, and pharmacy services were submitted to HP.
      ▪ As of 1/1/2012, claims for all services are billed to HP.
    • HUSKY A Primary Care Provider clients have enrolled with a Primary Care Case Manager (PCCM) rather than an MCO; eligible for all Medicaid services plus behavioral and support services through HP.
  - HUSKY B
    • Medical services obtained through MCO prior to 1/1/2012. Behavioral health, dental, FQHC and pharmacy claims were submitted to HP.
      ▪ As of 1/1/2012, claims for all services are billed to HP.
  - HUSKY C (previously referred to as Medicaid)
  - HUSKY D (previously referred to as Medicaid for Low-Income Adults (MLIA))
Eligibility Verification

- **Limited Behavioral Health Services**
  - Intensive in-home child and adolescent psychiatric services only.

- **Charter Oak**
  - Medical services obtained through MCO prior to 1/1/2012; behavioral health services and pharmacy services submitted to HP.
    - As of 1/1/2012, claims for all services are billed to HP

- **Connecticut AIDS Drug Assistance Program (CADAP)**
  - Pharmacy benefits for FDA-approved HIV/AIDS medications and medications approved to prevent complications associated with HIV/AIDS.

- **Drug coverage only, under the ConnPACE Program**
  - Pharmacy assistance for the Medicare ineligible elderly and disabled.

- **Medicare Covered Services**
  - Benefits are limited to the payment of Medicare coinsurance and deductible amounts if the Medicaid allowed amount is greater than the Medicare paid amount.

- ______ Waiver
  - Provides coverage for non-medical services. Eligibility requirements vary by waiver.
CTDSSMAP.com Web Portal Overview – Section 1.4

CLAIM PROCESSING / SUBMISSION INFORMATION
Claim Processing / Submission Information

• Claims for services rendered to CMAP clients may be submitted in a variety of ways:
  – Internet Web site at www.ctdssmap.com
  – Software utilizing the following HIPAA ASC X12N transactions:
    • 837D – Health Care Claim Dental
    • 837I – Health Care Claim Institutional
    • 837P – Health Care Claim Professional
  – Point of Sale (POS)
  – Paper
  ▪ UB-04 Claim Form
  ▪ CMS-1500 Claim Form
  ▪ ADA-2006 Dental Claim Form
  ▪ NCPDP Universal Pharmacy Claim Form
  • The HP mailing address for claims submission depends upon claim type.
  • Appropriate addresses are in Chapter 1 of the CMAP Provider Manual.
Claim Processing / Submission Information

• When a claim processes through the Connecticut interChange system it is subject to a series of edits that check the validity of claim data such as:
  – The submitted Provider must be actively enrolled on the date of service
  – Client must be eligible on date of service
  – Procedure Code submitted must be valid for the Provider Type

• Each claim then passes through a series of audits
  – The claim is compared to previously paid claims
    • Is the current claim a duplicate of a paid claim?
    • Is the current claim for an inpatient hospital stay with the same date of service as a paid long term care room and board claim?
  – Does the billed procedure code require prior authorization (PA)?
Claim Processing / Submission Information

• Claims submitted to HP are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research.

\[\text{20|12|032|123|456}\]

1 2 3 4 5

- **Claim Region** – Identifies the manner in which the claim was submitted (20 = Electronic Claims with No Attachments)
- **Year of Receipt** – Indicates the year in which the claim was received by HP (12 = 2012)
- **Julian Date of Receipt** – The Julian calendar date of receipt (032 = the thirty-second day of the year; February 1)
- **Batch Number** – An internal number assigned by HP to uniquely identify a batch (123)
- **Claim Number** – A sequential number assigned by HP to uniquely identify a claim within a batch (456)
Claim 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
    
    • Because of this, providers must investigate the possibility of clients having other insurance coverage and pursue payment prior to submitting their claim to HP.
  
  – Claims can potentially deny when a discrepancy in TPL data exists on the client’s state profile
    
    • A *Third Party Liability Information Form* should be sent to Health Management Systems (HMS)
      
      ▪ This form is available on the *Information > Publications* page of ctdssmap.com
  
    • HMS will contact the insurance carrier and notify DSS of any discrepancy
    
    • DSS will update client eligibility
Claim Processing / Submission Information

• **Third Party Liability Information**

  - TPL claims submitted to HP with other insurance payment or denial must include:
    - Carrier’s unique three-digit carrier code
      - Available through eligibility verification (Web, phone, X12N 270/271 Eligibility Benefit Inquiry/Response Transaction) and in Chapter 5 of the CMAP Provider Manual
    - The *Amount Paid* (on a paid claim) or “0.00” for a TPL denial
    - The date of payment or denial from the TPL Explanation of Benefits (EOB)
      - The physical TPL EOB should *not* be submitted with paper claims; the provider must retain this for audit purposes.
Claim Processing / Submission Information

- **Timely Filing Guidelines**
  - Claims for CMAP client must be submitted within one year of the actual date of service
  - EOB 512 “Claim exceeds timely filing limit” is bypassed if:
    - Original claim with no TPL:
      - ICN Julian date is within 366 days of the detail through date of service
    - Client eligibility file update:
      - Client eligibility has been added or updated where the ICN Julian date is within 366 days of the change and the claim date of service is between the effective dates of the change
    - Other Insurance denial:
      - Providers have one year from the date the primary insurance denied the claim, as long as the provider received a response from the private carrier within a year.
      - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny with EOB 512.
Claim Processing / Submission Information

• **Timely Filing Guidelines**
  - **EOB 512** “Claim exceeds timely filing limit” is bypassed if:
    - 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 ICN Julian date of the claim.
        - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny with EOB 512.
    - Medicare denial:
      - If the Medicare (carrier code MPA or MPB) denial date on the claim is within 549 days of the from date of service on the claim and within 366 days of the ICN Julian date.
    - 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 (RCC) or RCC/Procedure code where the ICN Julian date on the current claim is less than or equal to 366 days from the previous claim’s Remittance Advice date and the previous claim did not deny for timely filing.
Claim Processing / Submission Information

• **Timely Filing Guidelines**
  - Claims through CT Behavioral Health Partnership (CTBHP) must be submitted within 120 days of the actual date of service.
  - EOB 555 “Claim is past behavioral health timely filing guidelines” is bypassed if:
    • Original claim:
      - Detail through date(s) of service on the claim is within 120 days prior to the ICN Julian date.
    • Claim History:
      - Adjudicated claim for same Client, Provider, Billed Amount, detail From and Through dates of service, and RCC or RCC/Procedure code where the ICN Julian date on the current claim is less than or equal to 120 days from the previous claim’s Remittance Advice date and the previous claim did not deny for timely filing.
  - Nursing home providers have one year from the Pay Start date if authorization was added after the through date of service.
Claim Processing / Submission Information

• **Medicare Coinsurance and/or Deductible Claim Submission:**
  - Claims for clients covered under Medicare must first be billed to Medicare.
  - Crossover claims are claims that Medicare has considered and made payment on.
  - Only claims paid by Medicare will be electronically submitted to Medicaid.
  - Crossover claims from Medicare will be denied if TPL information is on the client’s eligibility file.
  - Claims that do not cross over from Medicare or are denied by Medicare can be submitted by the provider to HP.
  - Claims submitted on paper do not need the EOMB (Explanation of Medicare Benefits) voucher attached if Medicare denied the service.
Claim Processing / Submission Information

- **Medicare HMO Claims:**
  - Providers are responsible for identifying Medicare HMO enrolled clients
  - Providers must indicate Medicare HMO in the *Insurance Plan* field of the claim form
  - Medicare HMO claims must be sent to:
    - HP
    - P. O. Box 2911
    - Hartford, CT 06104
  - Medicare HMO claims must include a valid Medicare HMO attachment, unless Medicare HMO denied the services
Claim Processing / Submission Information

• Medicare Coinsurance and/or Deductible Reimbursement:
  – Method of Medicaid reimbursement when Medicare is the primary payer:
    • Medicaid will pay up to the Medicaid Allowed Amount minus any Medicare or private insurance payment
    • Medicaid will not pay if the Medicare payment is equal to or exceeds the Medicaid Allowed Amount
  – A provider may not balance-bill the client, financially responsible relative, or representative of the client

• Explanation of Medicare Benefits (EOMB) is required for Medicare (and Medicare HMO) paid claims and must include:
  – Provider Name
  – Client Name
  – Date of Service
  – Billing Amount
Claim Processing / Submission Information

• Claims for certain services and procedures require that a Prior Authorization (PA) be obtained before the service is rendered in order for the provider to receive reimbursement.
  – Prior authorization forms are located on the CTDSSMAP.com Web site
    • Go to Information > Publications > Authorization/Certification Forms
    • PA forms are currently submitted to HP for scanning and submission for clinical review by Community Health Network of Connecticut (CHNCT).
      ▪ In the future, authorization requests will be submitted directly to CHNCT for processing. Providers will be notified in advance when the required destination of PA requests will change.
    • The HP fax number for PA submission depends upon the type of authorization being requested; refer to the form for the correct fax number.
  – Services that require authorization are identified as such on the Provider Fee Schedule
    • Go to Provider > Provider Fee Schedule Download
CTDSSMAP.com Web Portal Overview – Section 1.5

WEB CLAIM INQUIRY/SUBMISSION
Web Claim Inquiry

• To search or submit claims to HP using the CTDSSMAP.com secure site, click on the **Claims** tab on the main menu.

[Image: Claim Search 1234567890 NPI]

• Enter enough information to satisfy at least one of the following criteria:
  – Enter the **ICN**, the **TCN**, the **From** and **Through Dates of Service**, the **From** and **Through Dates of Payment**, **Prescription No.**, or check the **Pending Claims** box.

• Click **search**.
Web Claim Inquiry

• **Search Results**
  – When more than one claim matches the claim inquiry search criteria, a list of claims will appear in the Search Results panel.
  – Search results may be sorted by clicking on the column headings.
  – Click anywhere on a given row to select the claim to view.

<table>
<thead>
<tr>
<th>ICN</th>
<th>Client ID</th>
<th>Client Name</th>
<th>Prescription No</th>
<th>FDOS</th>
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Web Claim Inquiry

• Results searching by FDOS and TDOS (no greater range than 93 days)
Web Claim Inquiry

• *Exclude Adjusted Claims*
  - Removed claims that have been altered since their initial submission.
  - Results in a more accurate representation of your total reimbursement.

### Claim Search

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

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<tr>
<th>ICN</th>
<th>Client ID</th>
<th>Client Name</th>
<th>Prescription No</th>
<th>FDOS</th>
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Web Claim Inquiry

- **Pending Claims**
  - Claims submitted since the last Remittance Advice (RA) was issued.

  - Convenient way to see all claims that will impact your reimbursement for the current cycle.

- Click on any line in the Search Results panel in order to view/alter the corresponding claim.
Web Claim Inquiry

• *Dental Claim* (base information)
  – Panel label and contents are subject to change based on claim type (*dental, institutional, professional*).
  – Provides important, basic information about the claim (provider and client identification, reimbursement).

![Dental Claim Table]

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<th>Field</th>
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<td>AVRS ID</td>
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<td>Last Name</td>
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Web Claim Inquiry

- **Detail**
  - Provides a detailed account of the billed services/procedures.
  - Available/required fields are subject to change based on claim type.
  - Clicking on a detail line will populate the relevant information into the fields below.

![Web Claim Inquiry Details](image)
Web Claim Inquiry

- **Diagnosis**
  - Lists diagnosis codes submitted on the claim.

- **Claim Status Information**
  - Provides important claim status and reimbursement information.
• **EOB (Explanation of Benefits)**

  Codes posted to claims to provide a brief explanation of the reason why claims were either suspended or denied. The EOB codes are also used to explain any discrepancies between amounts billed and amounts paid on paid claims.

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<td>1912</td>
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<td>0621</td>
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<td>1</td>
<td>9996</td>
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Web Claim Inquiry

• **What can I do with these claims?**
  
  – *Paid* claims allow you to:
    - [cancel] Cancel any alterations you have made
    - [adjust] Adjust the claim
    - [void] Void the claim
    - [copy claim] Copy the claim and use it as a template to create a new claim
    - [new claim] Create a new claim from scratch
  
  – *Denied* claims allow you to:
    - [re-submit] Resubmit the claim (with or without making changes)
    - [cancel] Cancel any alterations you have made
    - [new claim] Create a new claim from scratch
  
  – *Suspended* claims allow you to:
    - [new claim] Create a new claim from scratch
Web Claim Submission

• **New Claim Submission**

  • Perform the following steps to easily submit a new claim:
    – Select the appropriate claim type (*Professional, Institutional, Dental*)
    – A blank claim will appear
    – At a minimum, enter data into all required fields (identified by an asterisk after the field name)

    – To enter additional diagnosis codes, claim details, additional NDC’s, or a TPL record, click the *add* button within the panel
    – Click the *submit* button at the bottom of the claim page

• The claim will process immediately and return a status of *Paid, Denied* or *Suspended*. 
Web Claim Submission

• **Void a Claim**

• Perform the following steps to void or completely recoup a *paid* claim:
  – Select *Claim Inquiry*
  – Enter the paid claim ICN (found on your RA) in the ICN field
  – Click the *search* button
  – Once the claim is retrieved, click the *void* button at the bottom of the claim page

• The void will process immediately and return a message that the claim has been successfully adjusted/voided with a new ICN.
Web Claim Submission

• **Claim Adjustment**
  • Perform the following steps to easily adjust a *paid* claim:
    – Select *Claim Inquiry*
    – Enter the paid claim ICN (found on your RA) in the ICN field
    – Click the *search* button
    – Once the claim is retrieved, make any necessary changes to the claim
    – Click the *adjust* button at the bottom of the claim page
  • The adjustment will process immediately and return a status of *Paid, Denied* or *Suspended*. 
Web Claim Submission

• **Claim Copying**
  
  *Paid* claims may be copied and submitted as a new claim. This feature is helpful for reoccurring services.

• Perform the following steps to easily copy a *paid* claim for submission as a new claim:
  
  – Select *Claim Inquiry*
  
  – Enter the paid claim ICN (found on your RA) in the ICN field
  
  – Click the *search* button
  
  – Once the claim is retrieved, click the *copy* button at the bottom of the claim page
  
  – Make the necessary changes to the claim
  
  – Click the *submit* button at the bottom of the claim page

• The new claim will process immediately and return a status of *Paid*, *Denied* or *Suspended*. 
Web Claim Submission

• **Claim Resubmission**
  • Perform the following steps to easily resubmit a *denied* claim:
    – Select *Claim Inquiry*
    – Enter the denied claim ICN (found on your RA) in the ICN field
    – Click the *search* button
    – Once the claim is retrieved, make any necessary changes to the claim
    – Click the *re-submit* button at the bottom of the claim page
  • The claim will process immediately and return a status of *Paid, Denied* or *Suspended*. 
CTDSSMAP.com Web Portal Overview – Section 1.6

REMITTANCE ADVICE
Remittance Advice

• All claims processed by HP are reported to the provider on a bi-monthly Remittance Advice (RA)

• RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider’s claim activity.

• Providers receive RAs electronically via the secure Provider Web site at www.CTDSSMAP.com.

• Available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper version of the RA.

• Only the last 10 RAs are maintained on the HP Web site; it is highly recommended that providers save a copy of their RAs to their local computer system for future access.

• Click Download Remittance Advice from the Quick Link box on account home screen.
Remittance Advice

• The PDF version of the RA is also available and can be accessed by selecting **Download** from the **Trade Files** drop-down menu.

• Select **Remit. Advice (RA) – PDF** from the **Transaction Type** menu; click **Search**.

---

**Remittance Advice**

Providers and Trading Partners can access Remittance Advices (RA) in PDF via the ASC X12N 837 (TA1), Eligibility Response, Claim Payment/Advice, Claim Status Response, Drug Rebate File Transfer. These files are available for download for a period of five (5) months, at which time they will be removed and will no longer be available to authorized users for a period of twelve (12) months, at which time they will become available by such other means.

To receive summary to have them mailed to your current address. You will need your computer to view and/or download the request form.

**Important Note:**

Changes to file retention schedules will be posted on this page.

---

**Remittance Advice**

Providers and Trading Partners can access Remittance Advices (RA) in PDF via the ASC X12N 837 (TA1), Eligibility Response, Claim Payment/Advice, Claim Status Response, Drug Rebate File Transfer. These files are available for download for a period of five (5) months, at which time they will be removed and will no longer be available to authorized users for a period of twelve (12) months, at which time they will become available by such other means.

To receive summary to have them mailed to your current address. You will need your computer to view and/or download the request form.

**Important Note:**

Changes to file retention schedules will be posted on this page.
Remittance Advice

• RAs consist of the following 7 sections:
  – Banner Page
    • Important messages from DSS or HP
  – Claims Information (Paid, Denied, and Adjustments)
    • Sorted by claim type and status; reports up to 20 EOB codes per claim
  – TPL Information
    • The primary insurance that is on file for clients whose services appear on the RA
  – Financial Transactions Processed
    • Payouts, Refunds, Accounts Receivable
  – RA Summary
    • Month-to-day and year-to-day summaries of financial activities, accounts receivable.
  – EOB Code Descriptions
    • Descriptions of the EOB codes that affected claims on the RA
  – Claims in Process
    • Lists claims that are in suspense
Remittance Advice Examples

• Banner Page:

REPORT: CRA-BANN-R
RA#: 5553385

MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
PROVIDER BANNER MESSAGES

John Doe Dental
100 Main Street
Suite 2A
New Haven, CT 06106

Attention All Providers.

Expanded Audience for Provider Bulletin FE11-43: Provider Bulletin 2011-43 “Termination of Medicaid Eligibility for Certain Non-Citizens” has been expanded to include all providers. The purpose of this bulletin is to provide information related to the changes for certain non-citizens’ eligibility for DSS medical assistance programs that went into effect on July 1, 2011.

• Claim Information (Paid, Dental):

REPORT: CRA-DNPD-R
RA#: 5553385

MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
DENTAL CLAIMS PAID

John Doe Dental
100 Main Street
Suite 2A
New Haven, CT 06106

Client Name: Jennifer Smith
Client No: 001234567

201178000555
NPI 1234567890

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Remittance Advice Examples

• Claim Information (Denied, Dental):

REPORT: CRA-DANN-R
R# 5553385

MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
DENTAL CLAIMS DENIED

JOHN DOE DENTAL
100 MAIN STREET
SUITE 2A
NEW HAVEN, CT 06106

--ICN-- RENDERING SERVICE DATES BILLED TPL
-PATIENT NUM- PROVIDER FROM THRU AMOUNT AMOUNT

CLIENT NAME: JENNIFER SMITH CLIENT NO: 001234567

1 2011178000555 NPI 1234567890 062111 062111 903.00 0.00

PL SERV PROC CD TOOTH SURFACE QUAD DATE SYC PERF

11 D2751 30 ODL 062111

• EOB Code Description:

REPORT: CRA-DANN-R
R# 5553385

MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE

JOHN DOE DENTAL
100 MAIN STREET
SUITE 2A
NEW HAVEN, CT 06106

PAYEE ID NPI 1234567890
ISSUE DATE 07/12/2011
TAXONY 1223G0001X
P. AVRS ID 001111111

EOB CODE EOB CODE DESCRIPTION
0261 Tooth number is missing.
0513 Client’s name and number disagree.
2102 CLIENT ELIGIBILITY SYSTEM IS NOT CURRENTLY AVAILABLE.
4211 Tooth number is non-covered for the procedure code billed.
9910 PRICING ADJUSTMENT - MAX FEE PRICING APPLIED

CT interChange MMIS
### Remittance Advice Examples

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--- CLAIMS DATA ---

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<th>YEAR-TO-DATE AMOUNT</th>
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<table>
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<th>CURRENT AMOUNT</th>
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--- OTHER FINANCIAL ---

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<table>
<thead>
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<td>4,259,662.70</td>
<td>4,259,662.70</td>
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</tbody>
</table>

--- END ---
(RE)ENROLLMENT
(Re)enrollment

- **CTDSSMAP.com** allows a majority of providers to complete the re-enrollment process online via the Web portal.
  - A majority of the required information is automatically populated based on the provider’s previous contract information.
  - Online re-enrollment cannot be initialized until an *Application Tracking Number (ATN)* is received from the HP Provider Enrollment Unit.

- To begin the re-enrollment process select *Provider Enrollment* from either the *Provider* box on the left hand side of the home page or the *Provider* drop-down menu.
(Re)enrollment

Online enrollment/re-enrollment is available to all provider groups and provider taxonomies/types/specialties with the exception of the following:

- Nursing Facilities (Long Term Care)
- State Institution - ICF/MRs
- Personal Care Services
- Acquired Brain Injury Fiduciary
- Regional Family Service Coordination Center (RFSCC) (Birth to Three) Billing and Performing Providers
- DMH and DDS Performing Providers
- Employment and Day Support Waiver Performing Providers
- School Corporations
- Private Non-Medical Institution Billing and Performing Providers
- Connecticut Home Care (CHC) Personal Care Assistant (PCA) Fiduciary
- Connecticut Home Care (CHC) Program - Access Agency Performing Providers
- Managed Care Organizations
(Re)enrollment

- Five Year Re-enrollment Period:
  - Most provider types who complete their re-enrollment on or after January 1, 2012 will be required to re-enroll every five years.
  - Providers will receive a reminder letter when they are due for re-enrollment (30 days prior to the end of their previous contract).
- The following providers are excluded and are required to re-enroll every two years:
  - Home Health Agencies – Clinics – DME
  - Dentists/Dentist Groups – Pharmacies – State Institutions
  - Drug and Alcohol Abuse Centers
- Long Term Care providers will still be required to re-enroll every 15 months.
(Re)enrollment

- To check the status of an enrollment/re-enrollment application, select *Enrollment Tracking Search* from either the *Provider* submenu or the *Provider* drop-down menu.

- Enter your ATN and *Business OR Last Name* and click *search*.

- In this example HP is reviewing the application that was submitted by Jonathan Q. Smith on January 23, 2012.
Available Resources – Section 2.1

INFORMATION
Information

- www.CTDSSMAP.com contains a wealth of information for providers.
- **Important Messages**
  - Available on the home page. Also available on the *Information* page.
  - Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes.

<table>
<thead>
<tr>
<th>Important Messages</th>
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</thead>
<tbody>
<tr>
<td>Attention All Providers: System Downtime</td>
</tr>
<tr>
<td>Hospital interChange Issues Updated as of 7/15/2011</td>
</tr>
<tr>
<td>Electronic Health Record (EHR) News: Updated 7/15/2011</td>
</tr>
<tr>
<td>Termination of Medicaid Eligibility for Certain Non-Citizens</td>
</tr>
<tr>
<td>Revised Provider Manual Chapters: Updated 6/30/2011</td>
</tr>
<tr>
<td>Connecticut Behavioral Health Provider (CT BHP) Rate Increase Package Interim Payment Adjustment</td>
</tr>
<tr>
<td>PDL Bulletin (PB11-62) Available Online Only!</td>
</tr>
<tr>
<td>Welcome to the HIPAA 5010 Implementation Information Page Updated 6/16/2011</td>
</tr>
<tr>
<td>Inmate Inpatient Hospital Coverage Delayed</td>
</tr>
</tbody>
</table>
Information

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

<table>
<thead>
<tr>
<th>RA Banner Announcement</th>
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</thead>
<tbody>
<tr>
<td><strong>Banner Effective Date</strong></td>
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<tr>
<td>07/22/2011-07/29/2011</td>
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</table>
A majority of the information available on the CTDSSMAP.com Web site is located on the **Publications** page.

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

• **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**
  - 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 CTMAP claims, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions.
  - The Provider Manual is divided into twelve (12) chapters.
    - Click on the chapter title to open the document (disable pop-up blockers).
    - Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click *View Chapter* to access the chapter.
    - Chapter 11 is claim-type specific.
Chapter 1 – Introduction
• Provides information on the CT Medical Assistance Program, the Department of Social Services’ and Hewlett-Packards’ responsibilities and resources, as well as information about the organization of the Provider Manual.

Chapter 2 – Provider Participation Regulations
• Details the CTMAP regulations for provider participation.

Chapter 3 – Provider Enrollment
• Provides information on provider eligibility in regards to provider enrollment and re-enrollment, as well as specific program enrollment information for the various state-offered health care programs.

Chapter 4 – Client Eligibility
• Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability.
Information

- **Chapter 5 – Claim Submission Information**
  • Provides information on general claims processing and billing requirements.

- **Chapter 6 – EDI Options**
  • Provides information on electronic claim submission and electronic RAs.

- **Chapter 7 – Regulations/Program Policy**
  • This section contains the Medical Services Policy sections that pertain to the chosen provider type.

- **Chapter 8 – Billing Instructions**
  • Provides information on provider specific billing requirements and instructions.

- **Chapter 9 – Prior Authorization**
  • Provides information on how to obtain Prior Authorization for designated services.
– **Chapter 10 – Web Portal/Automated Voice Response System (AVRS)**
  - Provides information on the self service features available to the provider from both the AVRS and the Web Portal functions of interChange. This serves as a standalone self-service manual that describes the comprehensive features available to the provider such as: claims inquiry/submission, prior authorization inquiry, Web enrollment and re-enrollment, etc.

– **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 the most common claim errors and, if applicable, information to resolve the error conditions.
## Provider Manual – Table of Contents

### Chapter 1 - Introduction

1.1 Overview

1.2 Organization of Manual
   - About the Provider Manual

1.3 CMAP Overview
   - Connecticut Medical Assistance Program
   - Responsibilities

1.4 HP Directory
   - HP Telephone Numbers
   - HP Mailing Addresses

1.5 DSS Directory
   - DSS Addresses
   - DSS Phone Numbers

1.6 CMAP Provider Research Request

### Chapter 2 – Provider Participation Policy

2.1 Overview

2.2 Requirements for Provider Enrollment
   - Scope
   - Definitions
   - Provider Participation
   - Termination or Suspension of Agreement
   - General Provider Requirements
   - Needs for Goods or Services
   - Prior Authorization
   - Billing Procedures
   - Payment Rates
   - Payment Limitations
   - Payment for Out-of-State Goods or Services
   - Paid in excess of the authorized schedules of payment or for other reasons of ineligibility for payment.
Provider Manual – Table of Contents

• Chapter 3 – Enrollment/Re-enrollment
  3.1 Overview
    Enrollment/Re-enrollment Responsibilities
  3.2 Taxonomies/Provider Type/Specialties
  3.3 In-State Enrollment/Re-enrollment
    Program Information
  3.4 Re-enrollment Periods
  3.5 Out-of-State Enrollment
    Program Information
    Out-of-State Enrollment Process
  3.6 Provider File Maintenance
  3.7 Specific Program Enrollment Information
    ConnPACE

• Chapter 4 – Client Eligibility
  4.1 Overview
  4.2 CONNECT, Charter Oak, ConnPACE Cards
  4.3 Automated Eligibility Verification System
    Eligibility Dispute Resolution
    Manuals and Additional Information
  4.4 Internet Web Portal Eligibility
    Client Eligibility Verification – Secure Provider Web Site Portal
  4.5 AVRS Eligibility Verification
    Global Message
    Special Function Keys
    General Instructions
    Voice Response
    AVRS-Telephone
  4.6 Availability of AEVS and Pharmacy Point-of-Sale (POS) System
  4.7 Client TPL Update Procedures
    Instructions on Completing the TPL Information Form
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<td>5.2 Paid Claim Adjustment Request</td>
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<td>5.3 Instructions and Form for TPL</td>
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<td>5.4 Client TPL Update Procedures</td>
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<td>Exceptions to the Timely Filing Limit</td>
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<td>RA – Summary</td>
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<td>5.10 Carrier Code List</td>
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<td>5.11 EPSDT Information</td>
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<td>EPSDT Billing Chart</td>
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<td>Immunization Tracking Codes</td>
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• **Chapter 5** (continued)
  - Periodicity Schedule
  - Immunization Schedule
  - Well Care Exam Forms & Anticipatory Guidance
  - Recommendations for Anticipatory Guidance
  - 5.12 Forms – Examination Request for Medical Eligibility Determination
    - Form W-513, W-300, W-300A, W-538
  - 5.13 Forms – Hysterectomy
    - Form W-613 and W-613A
  - 5.14 Forms – Physician’s Certification for Abortion (Title XIX)
    - Form W-484
  - 5.15 Forms – Consent to Sterilization
    - Form W-612
  - 5.16 Forms – Notification of Newborn
    - Form W-416
  - 5.17 e-Prescribing
  - 5.18 Co-pays/Cost Shares

• **Chapter 6 – EDI Options**
  - 6.1 Overview
  - 6.2 EDI Eligibility Verification Options
  - 6.3 Electronic Transmission Submission Options, Procedures, and Forms
  - 6.4 Electronic Remittance Advice
  - 6.5 EDI Unit Services
    - EDI Unit
    - EDI Trading Partner Agreement Form
• Chapter 7 – Specific Policy/Regulation
  **This chapter has a number of provider-specific versions. Content will not be the same from one version to another. Below is an example of the information contained in the Dental version of chapter 7.**

  7.1 Medical Services Policy
  Requirements for Payment of Dental Services
  Dental Services
  Clinics
  Dental Clinics
  Requirements for Payment of Public Health Dental Hygienist Services (Regulations of State Agencies)
  Scope
  Definitions
  Provider Participation
  Eligibility
  Services Covered and Limitations
  Services Not Covered
  Payment Rate and Billing Procedure
  Documentation

• Chapter 8 – Provider Specific Claim Sub.
  **This chapter has a number of provider-specific versions. Content will not be the same from one version to another. Below is an example of the information contained in the Physician version of chapter 8.**

  8.1 Overview
  8.2 Prior Authorization
  8.3 EPSDT Information
  8.4 Behavioral Health Claim Submission
  8.5 Professional Service Claim Submission Instructions for CMS-1500 Claim Form
  8.6 Medical Transportation Modifier List
  8.7 Fee Schedule
Provider Manual – Table of Contents

**Chapter 9 – Prior Authorization**
- 9.1 Overview
- 9.2 Professional and Miscellaneous
- 9.3 Hospital Inpatient Services
- 9.4 Chronic Disease Hospital Services
- 9.5 CT Behavioral Health Partnership
- 9.6 Transportation Services
- 9.7 CT Dental Health Partnership
- 9.8 Pharmacy

**Chapter 10 – Web Portal/AVRS**
- 10.1 Overview
- 10.2 PAC Call Flow Chart
- 10.3 PAC Call Flow Manual
- 10.4 PPAAC Call Flow Manual
- 10.5 Web Portal Features
- 10.6 Publications and Services
- 10.7 Provider Enrollment/Re-enrollment
- 10.8 Trading Partner Enrollment
- 10.9 Web Security Administration
- 10.10 Claims - Submit, Resubmit, Adjust and Inquiry
- 10.11 Client Eligibility Verification
- 10.12 Prior Authorization
- 10.13 Trade Files
- 10.14 Provider Electronic Mail
- 10.15 Provider Demographic Maintenance
- 10.16 Pharmaceutical and Therapeutics (P&T) Committee
- 10.17 Provider Search
- 10.18 Drug Search
- 10.19 Provider Fee Schedule Download
- 10.20 Provider Services
- 10.21/22 Help/Troubleshooting
• Chapter 11 – Other Insurance and Medicare Billing Guides

**This chapter has three claim-specific versions. Content will not be the same from one version to another. Below is an example of the information contained in the Dental version of chapter 11.**

11.1 Introduction
11.2 Determining Other Coverage
11.3 Private Insurance as Primary
11.4 Billing Instructions – Other Ins. Payment
   ADA Dental Claim Form,
   Provider Electronic Solutions (PES) Software
   Web Claim
   ASC X12N 837 D Health Care Claim
11.5 Billing Instructions – Other Ins. Denial
11.6 Billing Instructions – Multiple Other Ins.
11.7 Timely Filing Rules

• Chapter 12 – Claim Resolution Guide

12.1 Overview
12.2 Explanation of Benefit Codes

**This is just a sample of the complete list of EOB codes that are discussed in the Guide**

0226 Referring Provider Name/Number is Missing
0512 Claim Exceeds Timely Filing Limit
0513 Client’s Name and Number Disagree
0550 Electronic Adjustment is Invalid
0570 Header Total Days Less Than Covered Days
0572 Quantity Disagrees with Days Elapsed
0813 Claim Denied After Medical Policy Review
0818 Invalid Processor Control Number
0861 NDC is Missing
1927 Billing Providers NPI is Missing or Invalid
2002 Client Ineligible for Dates of Service
2504 Bill Private Carrier First
2509 Bill Medicare First
2516 Claim Adjustment Reason Code is Invalid
3004 Inpatient Claim Requires Prior Authorization
Information

**Forms**

- Authorization/Certification
- Hospice
- Provider Workshop Invitation
- Well Care Exam (EPSDT)
- Claim and Adjustment
- Provider Enrollment/Maintenance
- Third Party Liability
- Other

---

**Authorization/Certification Forms**

- ConnPACE Recipient Statement Form
- Consent to Sterilization, W-612
- Consentimiento para la esterilizacion, W-612S
- Customized Wheelchair Prescription for Patients in a Nursing Facility or ICF/MR, W-628
- Hysterectomy Information Form, W-613 and Physician Hysterectomy Certification Form Retroactive Eligibility, W-613A
- Medicaid Certification for Admission of Individual Under 21 Years of Age to an Inpatient Psychiatric Facility, W-1686
- Notification of Newborn Form, W-416
- Nursing Home and Long Term Care Pharmacy Prior Authorization Form
- Pharmacy Prior Authorization Form
- Physician’s Certification for Abortion (Title XIX), W-484
- Prior Authorization Request Form
- Salzmann Handicapping Malocclusion Index
- Serostim - Physician Certification Prior Authorization Form
- Synagis Prior Authorization Request Form
- Transmucosal Fentanyl PA Request Form
Information

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

  Provider Newsletters
  - EHR Newsletter: Hospitals May 2011
  - June 2011 interChange Newsletter
  - EHR Newsletter: Professionals April 2011
  - March 2011 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
  - Dental Other Insurance Billing Guide
  - Institutional Other Insurance/Medicare Billing Guide
  - Professional OI/Medicare Billing Guide
  - Hospice Procedure Code Exception List

• **Drug Rebate**

  Drug Rebate
  - Application for ConnPACE Drug Rebate Participation
  - J-Codes on Professional Claims
The *Links* page (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.

**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

**HIPAA Information**
- Centers for Medicare and Medicaid Services: HIPAA page
- Washington Publishing Company: the manuals and implementation guides for new transaction sets
Information

• Information regarding the recent implementation of HIPAA 5010 Transaction and Code Sets is located on the CTDSSMAP.com Web site on the HIPAA page.

• Access the HIPAA page by selecting **HIPAA** from either the Information box on the left hand side of the home page or from the Information drop-down menu.

![Image of information menu with HIPAA highlighted]
Information

• **HIPAA Mandated Transactions**
  - Lists the HIPAA transaction types utilized by DSS and HP
  - Provides links to documents that explain the updates mandated by the implementation of version 5010.

**HIPAA Mandated Transactions**

New HIPAA 5010 Version Updates

- ASC X12N 270/271 Eligibility Benefit Inquiry/Response Transaction
- ASC X12N 835 Health Care Claim Payment/Advice
- ASC X12N 999 Acknowledgement for Health Care Insurance Transactions
- NCPDP D.0 Transaction

HIPAA transactions that DSS and HP utilize for the Connecticut Medical Assistance Program are the:

- ASC X12N 837 Health Care Claim Institutional Transaction - for inpatient, outpatient, home health, Part A crossover, and Part B of A crossover claims
- ASC X12N 837 Health Care Claim Professional - for professional and Part B crossover claims
- ASC X12N 837 Health Care Claim Dental
- ASC X12N 835 Health Care Claim Payment/Advice - for all claim types
- NCPDP 5.1 Transaction
- ASC X12N 270/271 Eligibility Benefit Inquiry/Response Transaction
- ASC X12N 276/277 Claim Inquiry/Response Transaction
- ASC X12N 278 Healthcare Services Review - Requested for Review and Response
- ASC X12N 997 Functional Acknowledgement
Information

- **Frequently Asked Questions**
  - HP and DSS have compiled a list of common HIPAA-related questions and answers.

<table>
<thead>
<tr>
<th>Frequently Asked Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q: I've submitted my transactions but have not received a 997 functional acknowledgement.</td>
</tr>
<tr>
<td>A: This can occur in the following situations:</td>
</tr>
<tr>
<td>- The correct trading partner ID is not included on the ISA or GS records.</td>
</tr>
<tr>
<td>- You have submitted transactions for which you are not authorized based on your trading partner agreement.</td>
</tr>
<tr>
<td>- The website is slow due to the high volume of transactions being submitted.</td>
</tr>
</tbody>
</table>

  | Q: Why is the date on my 835 Remittance Advice (RA) different than my paper RA? What date should I use if I have questions or concerns? |
  | A: The paper RA displays the date the check was issued. The electronic RA displays the date the file was created. Providers should use the date indicated on the paper RA. |

  | Q: How do I print the report before transmitting? |
  | A: Choose "Form Status" and click on "Ready". For an individual client/claim- go into provider type, highlight the client, click on print. For a detailed claim- go to Reports/Detail Forms. |

  | Q: Can providers assign more than one account number per client? |
  | A: The account number can be changed for each claim, but only one account number can be entered per claim. |

- **Glossary Of Terms**

<table>
<thead>
<tr>
<th>Glossary Of Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <a href="#">HIPAA Glossary</a> gives general definitions and explanations of HIPAA-related terms and acronyms</td>
</tr>
</tbody>
</table>
Information

• CTMAP 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 in some cases, specialty)

• Click the corresponding link to download the appropriate fee schedule.
Information

• Example of the *Physician Office and Outpatient Services* fee schedule:

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Proc description</th>
<th>Mod1</th>
<th>Rate Type</th>
<th>Max Fee</th>
<th>Effective Date</th>
<th>End Date</th>
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<td>96004</td>
<td>PHYSICIAN REVIEW AND INTERPRETATION OF C</td>
<td></td>
<td>DEF</td>
<td>67.00</td>
<td>1/1/2008</td>
<td>12/31/2299</td>
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</tr>
<tr>
<td>96020</td>
<td>NEUROFUNCTIONAL TESTING SELECTION AND AD</td>
<td></td>
<td>DEF MP</td>
<td>26</td>
<td>8/18/2010</td>
<td>12/31/2299</td>
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<td>GENETIC COUNSELING 30 MIN</td>
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<td>PSYCHO TESTING BY PSYCH/PHYS</td>
<td></td>
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<td>78.13</td>
<td>1/1/2008</td>
<td>12/31/2299</td>
<td>Y</td>
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<tr>
<td>96102</td>
<td>PSYCHOLOGICAL TESTING (INCLUDES PSYCHODI)</td>
<td></td>
<td>DEF</td>
<td>30.80</td>
<td>1/1/2008</td>
<td>12/31/2299</td>
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<td>96103</td>
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<td>FAMILY (WITHOUT THE PATIENT PRESENT)/HEA</td>
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WHAT’S NEW IN 2012?

Wrap Up – Section 3.1
What’s New in 2012

• Medicaid EHR Incentive Payment Program
  – The Electronic Health Records (EHR) incentive program was established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act of 2009. This program aims to transform the nation’s health care system and improve the quality, safety and efficiency of patient health care through the use of electronic health records.

• EHR Incentive Program Eligibility
  – The following eligible professionals and hospitals may participate in the EHR incentive program:

    – Eligible Professionals
      • Physicians
      • Nurse practitioners
      • Certified nurse-midwives
      • Dentists
      • Physician assistants who are working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant

    – Eligible Hospitals
      • Acute care hospitals (including critical access hospitals and cancer hospitals)
      • Children’s hospitals
What’s New in 2012

• **Incentive Payments – Eligible Professionals**
  - Maximum incentives are $63,750 over six years
  - First year payment is $21,250 if a provider adopts, implements or upgrades certified EHR technology
  - Incentive payments are the same regardless of the starting year
  - Must begin by 2016 to receive incentive payments

• **Incentive Payments – Eligible Hospitals**
  - Hospital incentive payments are based on a formula provided in the statute that can be reviewed on the *EHR Incentive Programs: Hospitals* page and the *Medicaid Hospital Incentive Payment Calculations* document on the CMS Web site (www.cms.hhs.gov).
  - For those providers interested in the CT Medicaid EHR Incentive Program, Connecticut began accepting registrations in July of 2011. For further information, please go to www.ctdssmap.com, under *Provider > EHR Incentive Program*. You may also contact us via a toll free Provider Assistance line or email address with any questions:
    - 1-855-313-6638
    - ctmedicaid-ehr@hp.com
Available Resources – Section 3.2

CONTACTS
Contacts

• **HP Provider Assistance Center (PAC)**
  - Monday through Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
  - 1-800-842-8440 (toll free)

• **HP Pharmacy Prior Authorization Assistance Center (PPAAC)**
  - In the office Monday through Friday, 7:00 AM – 9:00 PM (EST), and Saturday, 9:00 AM – 4:00 PM (EST), on-call service available outside of office hours.
  - 1-866-409-8386 (toll free)

• **HP Electronic Data Interchange (EDI) Help Desk**
  - Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
  - 1-800-688-0503 (toll free)

• **CHNCT Provider Relations** (prior authorizations)
  - Monday through Friday, 9 a.m. to 7 p.m. (EST)
  - 1-800-440-5071 (toll free)

• **www.CTDSSMAP.com**

• **CTDSSMAP-ProviderEmail@hp.com**
Wrap Up – Section 3.3

QUESTIONS & COMMENTS
Thank You For Attending the *CT interChange MMIS New Provider Workshop* Training

All questions and comments regarding this training are welcome. Please fill out the supplied workshop survey:

*Your feedback helps us to improve future workshops*