January 27, 2017

By Hand Delivery
The Honorable Dannel P. Malloy
Governor
State of Connecticut
Capitol Avenue
Hartford, CT 06106

Re: Request for Immediate Intervention in DSS' Rollout of Flawed Electronic Visit Verification (EVV) System without Consulting Stakeholders as Required by Federal Law – Expanded Implementation date Feb. 1, 2017

Dear Governor Malloy:

We are a broad coalition of consumers, advocates, provider organizations (both nonprofit and for-profit), individual providers and representatives for individual home care workers. We come from very different perspectives but all share similar concerns with the Department of Social Services' implementation of a mandatory statewide Electronic Visit Verification (EVV) system for providers of home health care, community and personal care assistance services to individuals covered under the state Medicaid program, including some with severe disabilities. We are all alarmed by both the defects in this new system and its imposition as a mandate, and are deeply troubled by the failure of DSS to seriously engage in the consultative process specifically required by federal law as a prerequisite to the implementation of any state-mandated EVV system.

Consumers and advocates care about all of this to the extent the burdens of the new system drive providers from the Medicaid program, resulting in termination of urgently needed services or of their long-time caregivers. Even if the providers stay in the program, the new system will result in individuals being denied services in community settings. They therefore join the providers in requesting: (1) a moratorium on the mandate to use the Sandata EVV system for all providers, (2) the creation of a dedicated workgroup to work with DSS on developing an EVV requirement that works for everyone, (3) authorization for providers to use their own federal law-compliant EVV systems, and (4) assurance that the EVV system requirement will facilitate access to services in the community.

Providers, consumers, home care workers and other impacted individuals have been sharing specific examples of EVV system and process challenges over the past four months with DSS, its subcontractor Sandata and state legislators, warning of the consequences of DSS's rush to implement on January 1 and Feb. 1, 2017. Our message has been clear. We do not oppose the concept of EVV. In fact, we support it as a method of ensuring Medicaid program integrity and eliminating fraudulent billing or payments. We do, however, have concerns with the no-bid vendor selection process, the implementation process, and the lack of HIPAA compliance by the sole-selected vendor, Sandata, resulting in the defective statewide EVV system. Some of these concerns were aired at an Oct. 17, 2016, LOB public forum televised on CTN and attended by legislators, DSS, home care providers and Sandata, while others have become known as

agencies have started to work with the system. Sandata's EVV system violates federal law and harms both access to care and providers' willingness to participate in the Medicaid program, as well as imposes significant costs on providers that choose to stay in Medicaid.

We greatly appreciate your time in considering the information submitted below, addressing each of the following areas:

1. The Harm Already in Process
2. Our Proposed Solution
3. Support for Medicaid Program Integrity and Elimination of Intentional Fraud
4. Governing Law
5. Status of Roll-out
6. DSS's Stated Goals
7. Rush to Implement Based on Claimed Return on Investment to Connecticut

The Harm Already in Process

Some of the specific problems created by the forced application of this singular defective system have been detailed at length in two letters which have been submitted to DSS or other officials, by the CT Association for Healthcare at Home (December 7, 2016, addressed to Commissioner Bremby), and by the CT Community Non-Profit Alliance (January 16, 2017, addressed to Rep. Catherine Abercrombie), and will not be repeated here. But, basically, the system developed by Sandata, under a subcontract with DSS's contractor HPE, is cumbersome, does not fully interface with the EVV systems already in operation by individual provider agencies, and is too inflexible to allow services to be rendered to individuals outside of the home (the GPS tracking parameters are not set to accommodate this) -- where they must be allowed to go with Medicaid-funded assistance. Even if the interface can be made to work, the providers will have to apply manual processes to produce clean claims for which they can be reimbursed, a time-consuming process.

For agencies which provide licensed services, it is extremely costly to participate because of the need to run redundant EVV systems to comply with their own payroll and compliance requirements and the new DSS requirements at the same time. One provider has estimated an annual new cost of about $500,000 to run these redundant systems. Another large non-profit agency that will provide 30,000 visits per year under the EVV program underwent a full cost analysis and concluded that this program will add at least $2.50 to the cost of each visit because of the additional resources necessary to utilize the Sandata system, which cannot be fully integrated and will not replace its existing system. For some, it is just too costly to participate such that they are leaving the Medicaid program entirely.

As just one example of the absurdities created by the imposition of the defective Sandata system on all home care providers, the licensed providers which, as noted, already have their own fully-functioning DSS-approved EVV systems, will have to require their workers to **log in on two parallel systems every time they start a task and every time they end a task.** For one such agency, its skilled nurses can do their own EVV recording on a tablet and will now also have to call into and out of the DSS system. But

for their certified nurses aides, it is even worse: this requires them to make **two phone calls** at the beginning **and** at the end of each visit - one to the agency's own EVV system, where the task and time necessary to generate accurate payroll are recorded, and then one to DSS's system, to record the in and out time to support the Sandata system. This is a colossal waste of time and effort for home health aides, and creates a high cost for the agencies, which then must manually sync information from the parallel systems.

In the case of services provided under the Acquired Brain Injury waivers, these unnecessary burdens are compounded: It is common under ABI care plans for an individual to receive five or six different types of services in a given 24 hour period, or two services for each shift, and the system requires logging in and out for the provision of each of them—even when provided by the same person. Thus, the same caregiver may have to log in and out a total of 4 times in an 8 hour shift. Multiplied by two for the parallel systems mandated by DSS means workers having to do this 8 or more times per shift, an extreme burden when caregivers are attempting to be responsive to their patients' needs. This directly contradicts DSS's stated goal to "ease caregiver burden."

And each time the worker logs in or out, there can be an "error" for a variety of reasons, such as last minute changes in schedules, the service not being provided in the person's home, caregivers forgetting to switch from one service to another, the EVV mobile app going off-line, etc. Each time such an "error" happens – and they happen routinely -- the agency's office staff must manually enter an "exception" in order to be paid, and each exception requires multiple time-consuming phone calls and conversations to address and reconcile the exception. For an agency with 60 clients on the ABI waiver, they are on average experiencing 200 "exceptions" per day, with inordinate time thus dedicated to addressing each of them under penalty of no payment at all for services rendered as required. While we know that this is not DSS's intention, the result is unsustainable bureaucratic excess.

What also has also been lost in the discussion so far is that the Sandata system, which requires that a worker either call in on the Medicaid enrollee's telephone or use an app tied to GPS to check if the services are being provided at the person's home, is premised upon the erroneous assumption that individuals will get all their services in their own homes. Outside of nursing and therapy services, that is a long-outdated assumption. Today, individuals with severe disabilities, both under the Americans with Disabilities Act and Medicaid law requirements, are **entitled** to go into the community and receive necessary home health aides and PCAs whenever they do, if they desire such community interaction -- from attendance at school to participation in social events, etc. However, the Sandata system will produce an "error" code whenever an individual worker uses the app on his or her cell phone and the GPS function identifies a location **other** than the person's home.

Apart from this routine (and costly to the agency) "error" problem, an aide transporting a Medicaid enrollee has to stop the vehicle to log in during a narrow window of time to report any change of task, if they or their agency want to get paid, in accordance with the Access Agency's orders. The natural result of all of this EVV-induced disruption is that it strongly encourages providers to avoid these problems by

providing services **only** in the home, depriving individuals of their right to community integration, if those providers are not driven from the Medicaid program entirely.

All of these problems with DSS's EVV system should be able to be worked out with a well-designed system. However, that was not possible here, where DSS declined to seriously dialogue as required by federal law with the very stakeholders most knowledgeable about the problems that can be inadvertently created by such a system.

Our Proposed Solution

The following actions would address our broad concerns. DSS needs to take these four basic steps, the first of which needs to be taken **before February 1st:**

1. **Suspend** the application of the new mandate to use the unitary EVV system on providers to which it has already been imposed, and **delay** its implementation on licensed providers as scheduled for February 1st and on PCAs, to allow a thoughtful, inclusive process for developing effective EVV requirements for all providers.
2. **Form** a dedicated, manageable-sized working group to collaborate with DSS in developing the requirements for EVV systems for all home care and PCA providers, composed of knowledgeable individuals from at least each of the following groups as indicated in the federal law concerning "stakeholder" involvement: agencies providing licensed services, agencies providing non-licensed services, representatives of individual providers (including a union representative for PCA workers), Allied or Sunset Shores, consumers/family members of consumers, advocates, and the CT Association for Healthcare at Home, all of whom should be chosen by their respective constituencies.
3. Include the authorization of the use of an individual agency's **own** EVV system, satisfying all federal and DSS requirements, as an alternative to being required to use the statewide system to be developed by this workgroup, such as has been allowed in other states like Illinois.
4. Require that mandated EVV systems be sufficiently flexible to allow for the provision of home care, community supports or PCA services in settings outside the home whenever otherwise authorized by DSS.

We believe that these solutions will allow DSS to implement EVV systems in an effective way but without compromising access to care, driving providers from the program or resulting in inappropriate savings which have nothing to do with the fraud avoidance claimed to be motivating DSS in this area.

Support for Medicaid Program Integrity and Elimination of Intentional Fraud

Every organization signing this letter is in support of the appropriate application of an effective, client-focused EVV system to the provision of home care and personal care services to Medicaid enrollees. While we disagree with the Department's apparent view that there is extensive fraud in the provision of

these services, to the extent this kind of system can help to eliminate any fraud that does still exist in the system, we are fully in support of implementing such systems.

The objection to DSS's statewide system developed by DSS's subcontractor, Sandata, is not because of resistance to EVV systems generally. The majority of agencies providing licensed home care services **already have** robust, fully functional EVV systems that are seamlessly integrated with their existing electronic health record, scheduling and revenue management systems, and which will comply with the requirements set forth in federal law to avoid financial penalties starting in 2023. These agencies have heavily invested in these systems so that they will work effectively for their needs, and many of these systems have been operating for over a decade. In fact, DSS's own Office of Quality Assurance has approved the agencies' EVV systems, and the effectiveness of these systems in ensuring the accuracy of claims submitted to the agency is regularly tested through that office's audit process. Even the non-licensed providers are in the process of contracting with companies which offer robust EVV systems appropriate to their needs.

Governing Law

The requirement of federal law is that, by January 2019 for non-licensed providers, and by January 2023 for licensed providers, there must be "an electronic visit verification system for such services" in effect or the amount of federal reimbursement will be slightly reduced starting on those dates. 42 U.S.C. § 1396b(l)(1)(A) and (B). There is no actual requirement to do EVV at all, and even when the financial penalty for not doing so kicks in, which does not begin to apply for two or six years, there is **no requirement that there be one statewide system used by all providers**.

The Department has suggested that its uniform statewide EVV system is somehow mandated by federal law, which, as noted above, does not provide for any such thing. But it also has ignored **other** governing provisions of federal Medicaid law, including that any EVV system must be crafted so as to "take[ ] into account existing best practices and electronic visit verification systems in use in the State" and must involve "a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders …." 42 U.S.C. § 1396b(l)(2)(A)(ii) and (B).

There also are long-standing requirements of federal law pertaining to the delivery of Medicaid services generally which DSS apparently failed to consider, including the requirement that all Medicaid-covered services be provided with reasonable promptness, and that services be provided so as to maximize independence and self-care of Medicaid enrollees. 42 U.S.C. §§ 1396-1 and 1396a(a)(8). Medicaid services must also be provided consistent with the Americans with Disabilities Act, which requires that services be provided in the most integrated setting appropriate to the needs of individual enrollees, including in community settings. 42 U.S.C. §§ 12132, 12134(a). The "integration regulation" promulgated under the ADA states that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR § 35.130(d*); see also Olmstead v. L.C.*, 527 U.S. 581 (1999). These requirements

have long been interpreted to mean providing services outside of the home where necessary so the individual may maximize their independence by venturing into the community. *See Skubel v. Fuoroli*, 113 F.3d 330, 336-67 (2d Cir. 1997); *Detsel v. Sullivan*, 895 F.2d 58, 64 (2d Cir. 1990).

Status of Roll-out

DSS has already mandated, effective January 1, 2017, the application of its defective statewide system for all non-medical service providers other than PCAs. It also has repeatedly declared that it intends to require the application of the same defective system to all medical service providers on **February 1, 2017**. While it has said that the application to individual PCA workers who technically work for individual Medicaid enrollees, with Allied and Sunset Shores acting as the intermediary, is not mandatory, it has more recently indicated it intends to apply the system to them as well. As a result of the rushed process used by DSS without the collaborative consultation required by federal law, services are already being affected for many Medicaid enrollees.

DSS's Stated Goals

In its updated bulletin issued to all providers on January 24th, DSS stated that "[t]he goal of EVV is to ease caregiver burdens by eliminating the use of manual time sheets, facilitate real-time communications about changes in client health and other status between clients, caregivers and care managers and ensure that the clients receive the services they are authorized to receive." But, as discussed above, the exact opposite result is occurring under DSS's system.

However, based on what DSS representatives have otherwise stated, it appears that a primary motivation is not this but the desire to save money through fraud avoidance. We of course acknowledge that fraud prevention is a worthwhile effort and that there have been a few cases of fraud in Connecticut's home care services system over the years. But the supposed 5 to 10% savings from the imposition of the cumbersome statewide system designed by Sandata are ludicrous as premised on fraud prevention.

Rush to Implement Based on Claimed Return on Investment to Connecticut

In the subcontract between HP and Sandata, at page 47, HPE and Sandata claim that "a conservative 5% savings projection represents a saving impact of over $9.8 M dollars annually for the state" and "[i]n other programs, higher levels of savings have been observed." The contract even includes a chart entitled "RETURN ON INVESTMENT" purporting to show that the large $1.246 M cost of the Sandata system's roll-out plus its $144,000 ongoing monthly cost will be far exceeded by resulting savings, so as "to demonstrate the ROI for the administrative cost for EVV, and how quickly DSS can achieve cost savings for the program." In other words, it appears that these large projected savings are being suggested as justification for the cost of the Sandata subcontract and that, to justify this cost, DSS is insisting on moving forward quickly with a system that is not operational and does not serve even DSS's own identified goals. We fully appreciate the difficult financial times we live in and support prudent

budgeting for our State but we do not believe that this approach is the best way to achieve savings, as it will affect access to care for the state's most vulnerable population.

Savings will result **not** from the avoidance of fraud but from the denial of legitimate claims for services rendered as authorized. This has become evident since the January 1st implementation date for non-medical home care providers. Claims are routinely being rejected as "error," paid only if a supervisor goes in and manually corrects the "error" through a time-consuming "exception" process. This ensures that many legitimate claims will be dropped. While this will save money for the state in the short term by reducing payments to home care agencies, it is an entirely inappropriate way to save money where services have in fact been fully provided as required. Such inappropriate "savings" at the expense of conscientious providers will drive providers out of the Medicaid program. Eventually, it will result in individuals being needlessly institutionalized because of lack of sufficient home care providers, at a greater cost to the state under Medicaid, contradicting the Department's oft-repeated declaration that it is committed to "rebalancing" by getting individuals out of nursing homes.

Conclusion

We stand ready, willing and able to work with DSS in a cooperative fashion to implement our shared commitment to the use of appropriate, fully functioning EVV systems. We request that the Sandata system be put on hold so that all of the problems already identified are not compounded by expanding a broken system to other providers, and all stakeholder groups can thoughtfully work together with DSS toward EVV system requirements that work for everyone and ensure independence in the community for people with disabilities.

Thank you for hearing our concerns and considering our urgent request. If you have any questions, please contact either Tracy Wodatch, V.P. Clinical & Regulatory Services, CT Association for Healthcare at Home wodatch@cthealthcareathome.org or 203-774-4940,or Joelen Gates, Conn. Legal Services, at JGates@connlegalservices.org or (860) 786-6372.

Respectfully yours,

Family Member of Medicaid Consumer

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Advocates

Nancy Alisberg
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Billye Simmers
S&S Consulting, Advocate

Daniela Giordano
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Sheldon V. Toubman
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Conn. Legal Rights Project

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Suzi Craig
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Ellen Andrews
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Deborah Hoyt
CT Association for Healthcare at Home

Marie Allen
CT Association of Area Agencies on Aging

Representatives of Individual Providers

David Pickus, President
New England Health Care Employees Union, District 1199, SEIU

cc: Lt. Governor Nancy Wyman
Vicki Veltri, J.D.
Attorney General George Jepsen
OPM Secretary Benjamin Barnes
Commissioner Roderick Bremby
Kate McEvoy, Medicaid Director
Rep. Catherine Abercrombie
Sen. Marilyn Moore
Sen. Joseph Markley
Sen. Cathy Osten
Sen. Paul Formica
Rep. Toni Walker
Sen. Terry Gerratana
Sen. Heather Somers
Rep. Jonathan Steinberg
Rep. Susan Johnson
Sen. Tony Hwang
Sen. Craig Miner
Rep. Prasad Srinivasin

Hewlett Packard Enterprise

Acquired Brain Injury (ABI)

Billing and Web Claim Submission Workshop

Presented by:
The Department of Social Services & Hewlett Packard Enterprise
for Billing Providers

Training Topics

- *Introduction to ABI Program Changes*
- *Access and Set-up of Secure Web Account*
- *Web Account Capabilities*
  - *Demographic Maintenance*
  - *Clerk Account Maintenance/Set-up*
    - *Switch Provider*
  - *Client Eligibility*
  - *Prior Authorization (PA)*
  - *Claim Inquiry/Submission Guidelines*
- *Common Claim Errors and Resolution*
- *Remittance Advice (RA)*
  - *Access to Claim and Financial Reporting*
    - *Components of RA*
- *Monthly Recoupment/Reprocessing due to Care Plan/PA Changes*
- *Web Information – Resources*
  - *www.ctdssmap.com*
    - *Important Messages*
    - *EVV IM*
    - *Procedure Code Crosswalk*
    - *Fee Schedule*
    - *Banner / IM Archive*
    - *Bulletins*
    - *E-Messaging*
    - *Provider Manuals*
- *Contacts*
- *Questions/Comments*

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***<u>Effective</u> for dates of service, <u>September 1, 2016</u>***

- Organizations and Self Employed Individuals must enroll as **"ABI Service"** providers to be reimbursed by the Department of Social Services (DSS) for performing a wide range of non-medical, home and community based services to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder) in the community, **who do not self direct their own care**, and are eligible for either the **ABI I or ABI II Waiver.**

  - Organizations and Self-Employed Individuals **must be credentialed by Allied Community Resources before their application will be considered complete to send to DSS for approval.**

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***Effective for dates of service, September 1, 2016***

- Providers who are ready, may begin using EVV for both mandated and optional services effective for dates of service **September 1, 2016.**
- Providers who are not ready may bill both EVV mandatory and optional services directly to Hewlett Packard Enterprise until **November 1, 2016.**
- Providers who's services are not mandated or optional must submit all services with dates of service effective **September 1, 2016** directly to Hewlett Packard Enterprise for payment.
- Providers should refer to the EVV Service Code Listing link in the Electronic Visit Verification Implementation Important Message on the www.ctdssmap.com Home page for EVV mandated and optional services.

ABI Billing and Web Claim Submission Workshop

➢Effective for dates of service <u>November 1, 2016:</u>

- Provider's **must utilize the EVV system** for services that are **mandated** by EVV.
- Providers may choose to implement the EVV check-in/check-out process for optional service.
- Services entered into the EVV system will be **submitted directly from the EVV system** to **Hewlett Packard Enterprise**, the Department of Social Services Fiscal Agent, when the **service matches the authorization**.

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ Effective for dates of service September 1, 2016:

- Claims that require correction for services that are **EVV mandated** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **the EVV system.**

- Claims that require correction for services that are **EVV optional** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - can be **resubmitted** via **the EVV system or Hewlett Packard Enterprise.**

- Claims that require correction for services that are **not EVV mandated or optional** that have been **submitted** directly to Hewlett Packard Enterprise by the provider
  - must be **recouped or adjusted** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **Hewlett Packard Enterprise.**

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Introduction to ABI Program Changes cont.

➢ ***Effective for dates of service, September 1, 2016 and Mandated for dates of Service November 1, 2016:***

Self Directed Services

- All claims for CFC services, regardless of the EVV check-in/check-out election, will continue to be billed by Allied Community Resources, the Department of Social Services ABI Fiduciary.
- The EVV check-in/check-out process is either optional or not required for ABI services rendered to clients who self direct their own care through the Community First Choice (CFC) services option.
  - Although CFC services are optional, the client may choose to implement the EVV check-in/check-out process.

Secure Web Account Set-up

www.ctdssmap.com
Secure Web Account

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Secure Web Account Set-up – Access to Secure Web Portal

Providers who have successfully enrolled as ABI Service Providers will receive:

✓An approval letter with their new AVRS/Medicaid ID

✓Additional letter under separate mailing containing their Personal Identification Number (PIN)

– The AVRS ID and PIN allow the provider initial access to the Connecticut Medical Assistance Program Secure Web Portal for the purpose of creating a **secure Web account.**

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Secure Web Account Set-up – Access to Secure Web Portal

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



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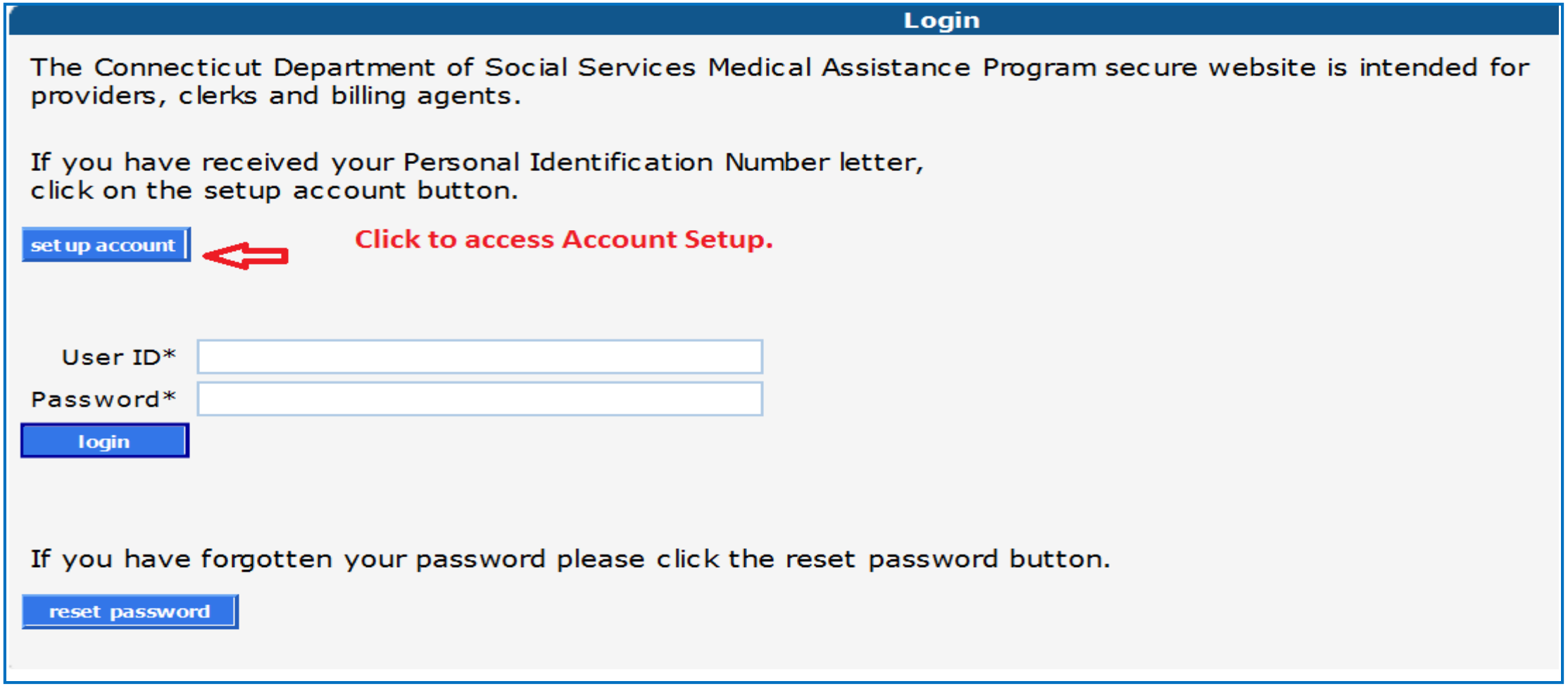
Secure Web Account Set-up – Access to Secure Web Portal

To ensure your access to the www.ctdssmap.com 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 (CMAP) Web site.

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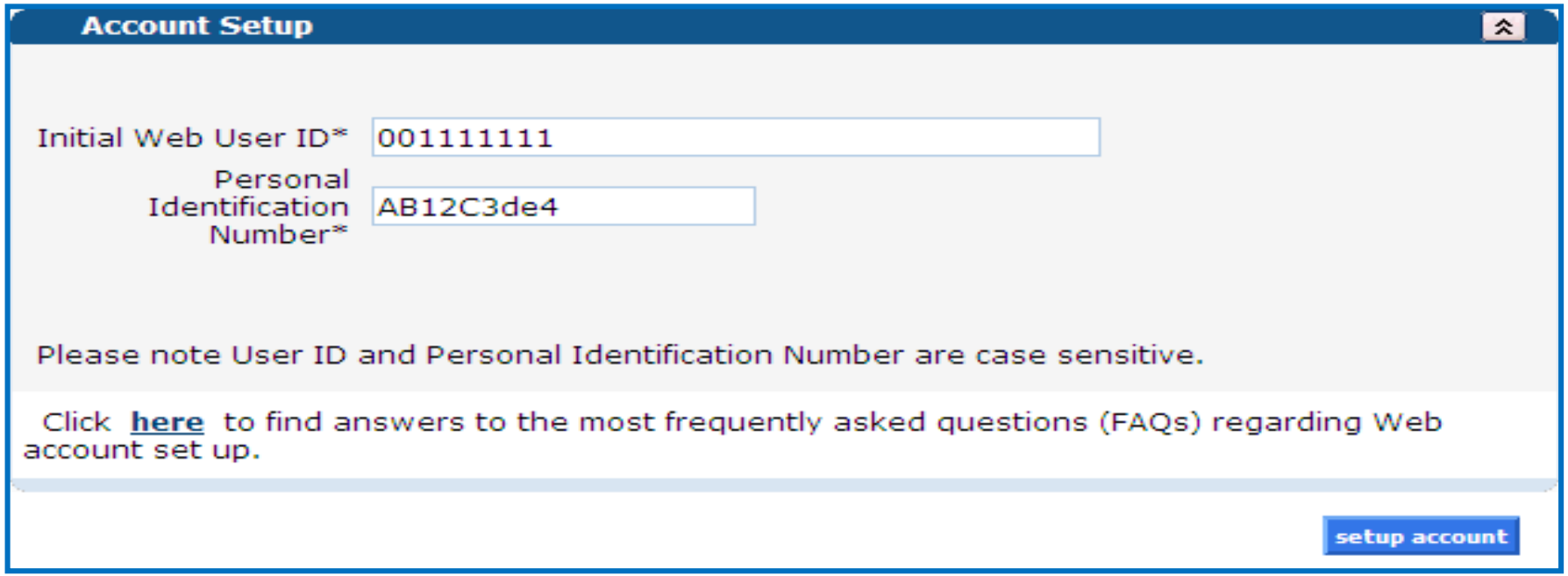
Secure Web Account Set-up – Access to Secure Web Portal



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Secure Web Account Setup

- Account Setup- Allows providers to set up a local administrator user account.
- Enter the provided *Initial Web User ID* and *PIN* (which can be found in the enrollment and PIN letters), in the appropriate fields; click ***setup account***.

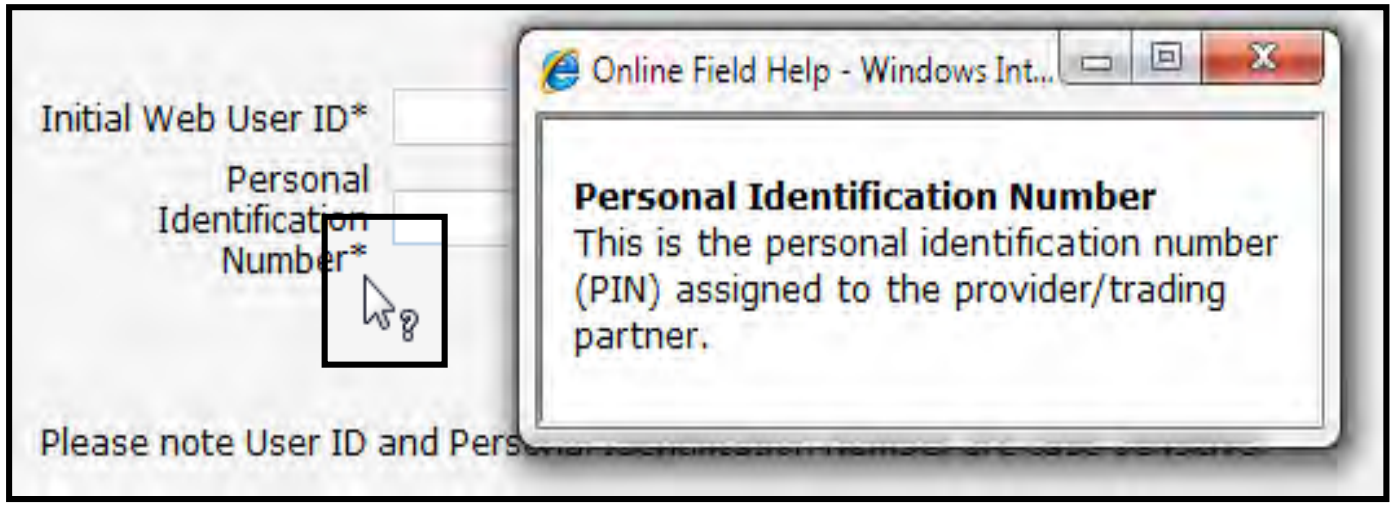


ABI Billing and Web Claim Submission Workshop

Secure Web Account - Online Field Help

– The ctdssmap.com Web site features an ***Online Field Help Window*** to assist providers with accessing and submitting information.

– Placing your mouse 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.



ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

➢Once on the ***Account Setup*** screen, fill in the fields with the appropriate information.

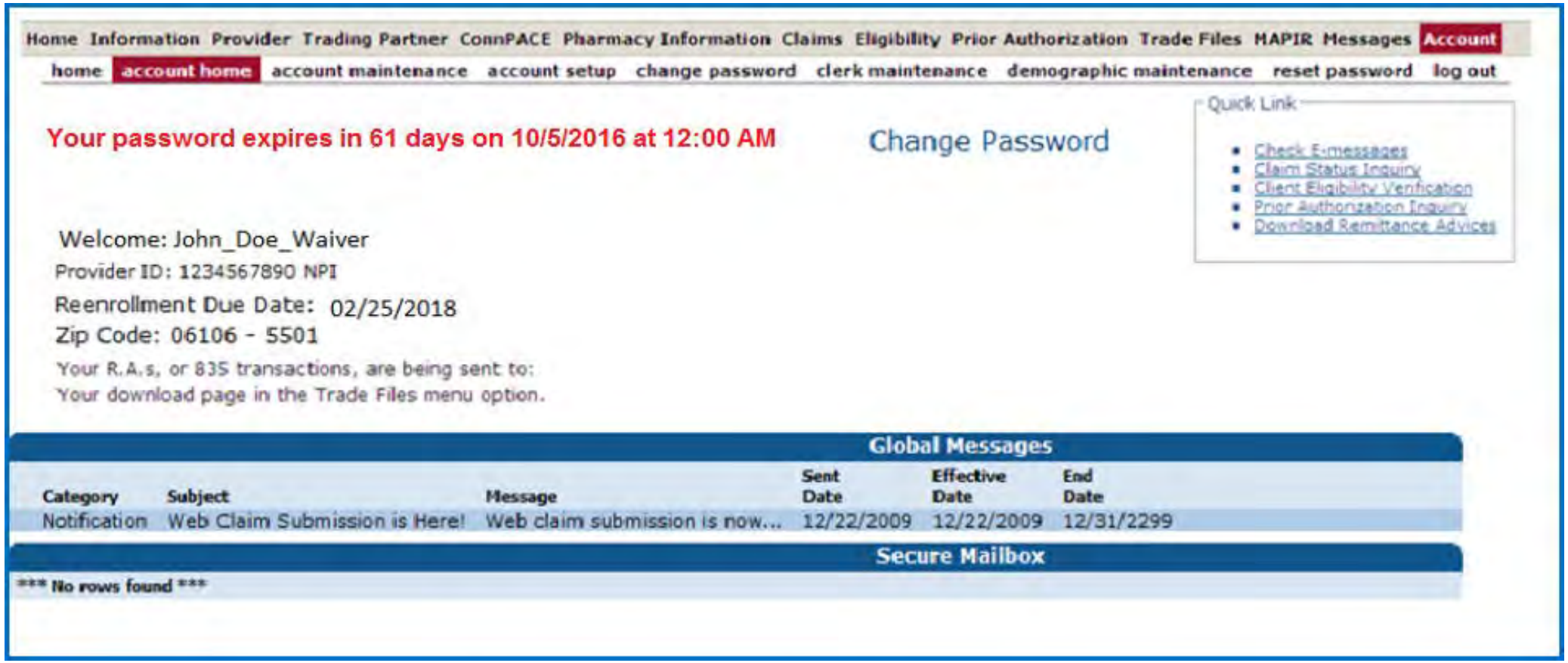


****Before clicking submit, be sure to write down the chosen User ID, Password, and security question/answer(s) and keep them in a secure location.****

ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

– You have successfully set up your ctdssmap.com *Secure Site* account



Web Account Capabilities

www.ctdssmap.com

ABI Billing and Web Claim Submission Workshop

Web Account Capabilities

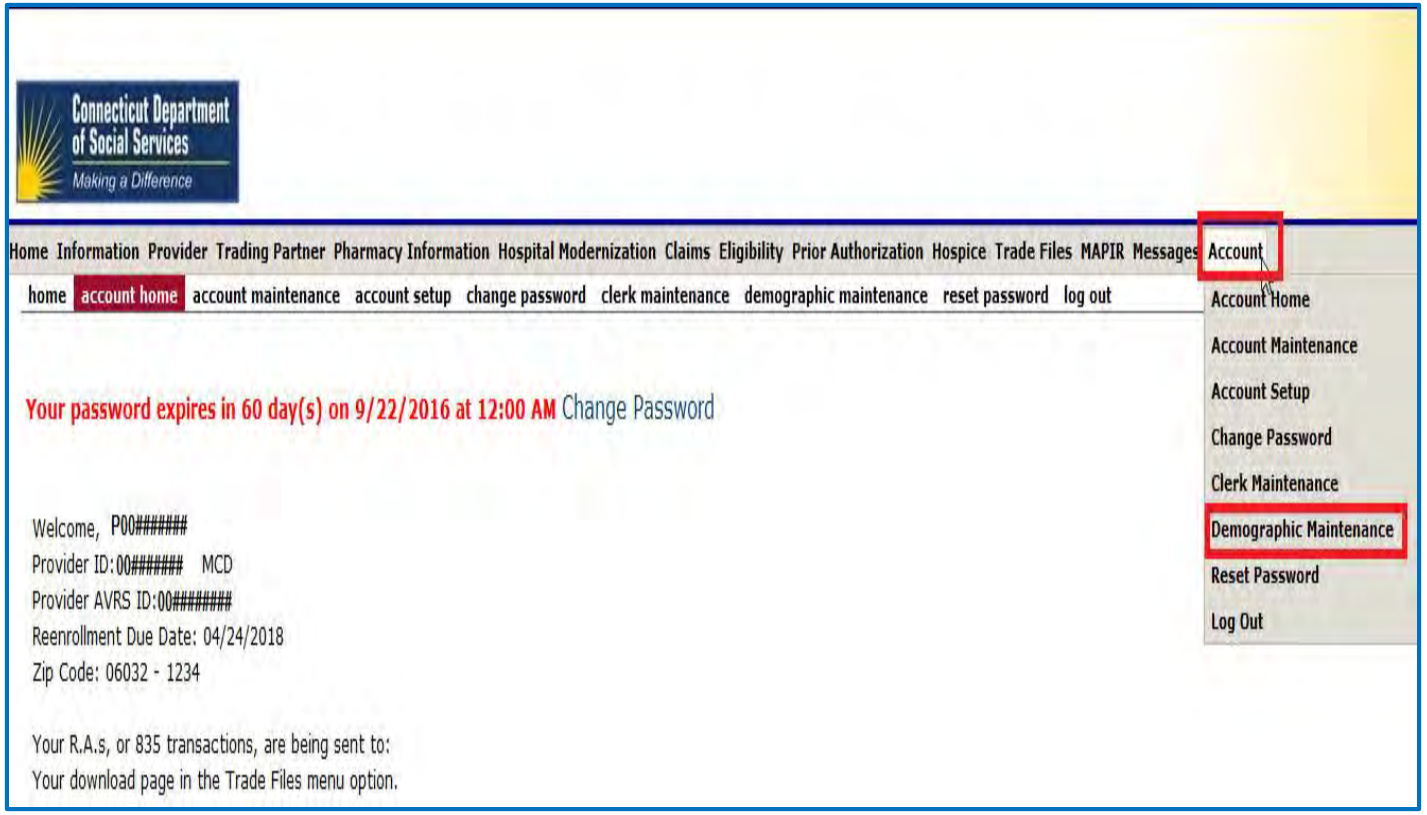
Accessing your Secure Site provider account allows you to:

- Update your demographic information (addresses/phone numbers/bank accounts/organization members)
- Verify re-enrollment due date(s)
- 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 (EVV, electronic, paper)
- Obtain your Remittance Advice (RA)

Demographic Maintenance

ctdssmap.com
Web Account Capabilities

Web Account Capabilities
Demographic Maintenance

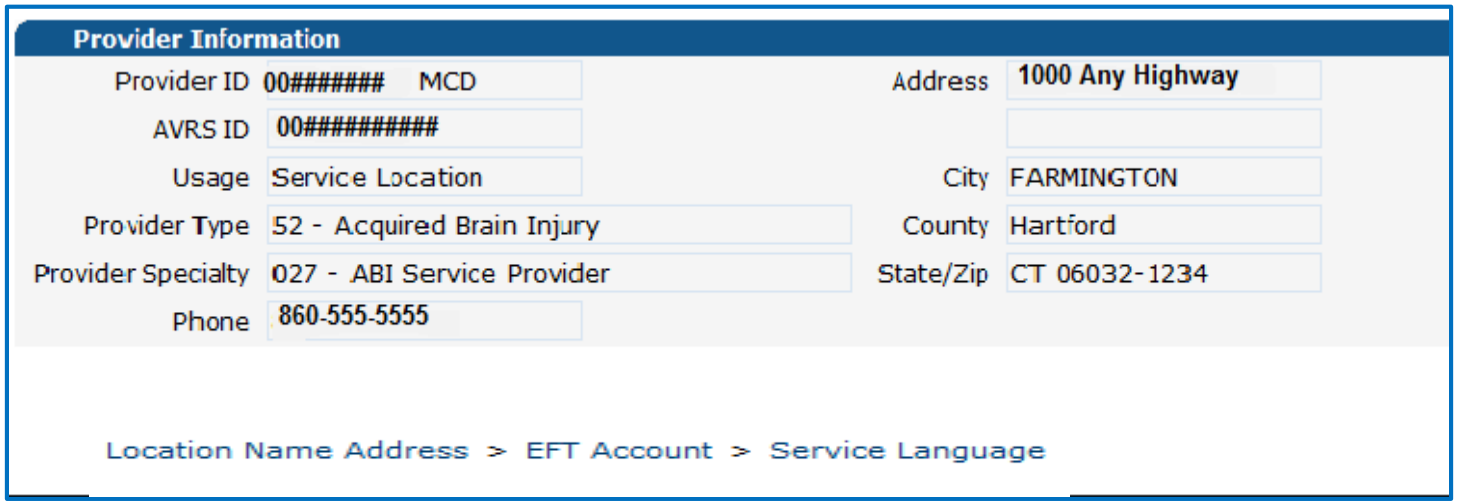


The Demographic Maintenance section of the Secure Site allows you to alter and maintain demographic information:

- Mail to, Pay to, Service Location, and Enrollment addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Service Language

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

Web Account Capabilities
Demographic Maintenance cont.



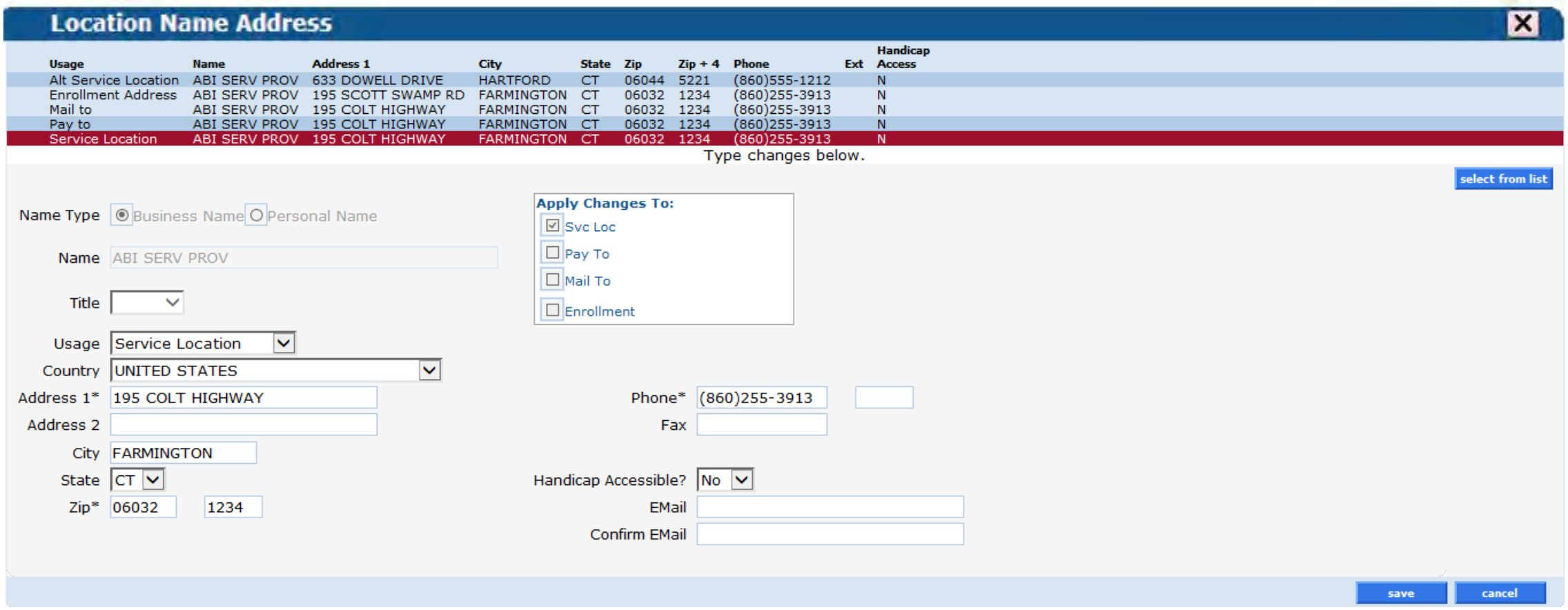
The Demographic Maintenance page displays the provider information panel as well as a submenu

- Clicking the submenu options will open a panel with related information:
- Location Name Address
- Electronic Funds Transfer (EFT Account)
- Service Language - Language, Effective Date, End Date

Web Account Capabilities

Demographic Maintenance cont.

– Specify different mailing, payment, service location and enrollment addresses.



Web Account Capabilities
Demographic Maintenance cont.

– **To alter address information, simply select the applicable row from the provided list (Enrollment Address, Mail to, Pay to, or Service Location); then click maintain address**



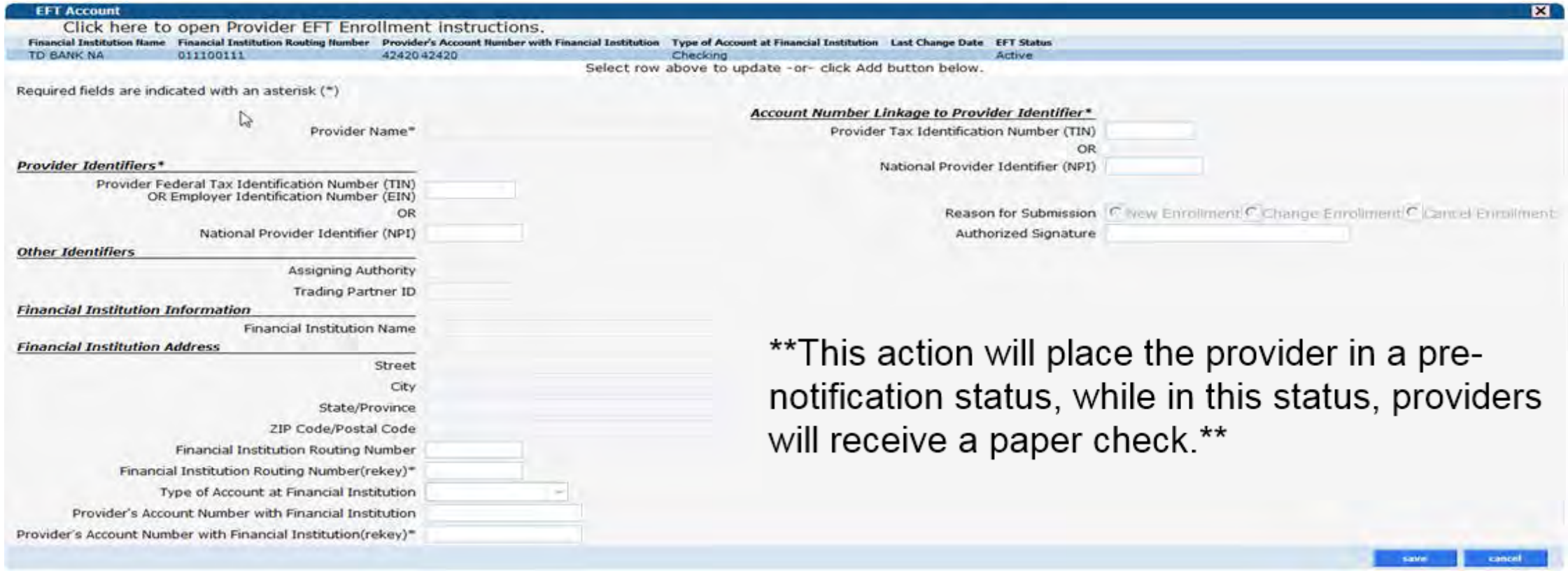
– **Select/fill in the appropriate information (address, phone number, etc); click save**



Web Account Capabilities

Demographic Maintenance cont.

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited. Click add; enter the appropriate information; and click save.



This action will place the provider in a pre-notification status, while in this status, providers will receive a paper check.

Clerk Maintenance

www.ctdssmap.com
Web Account Capabilities

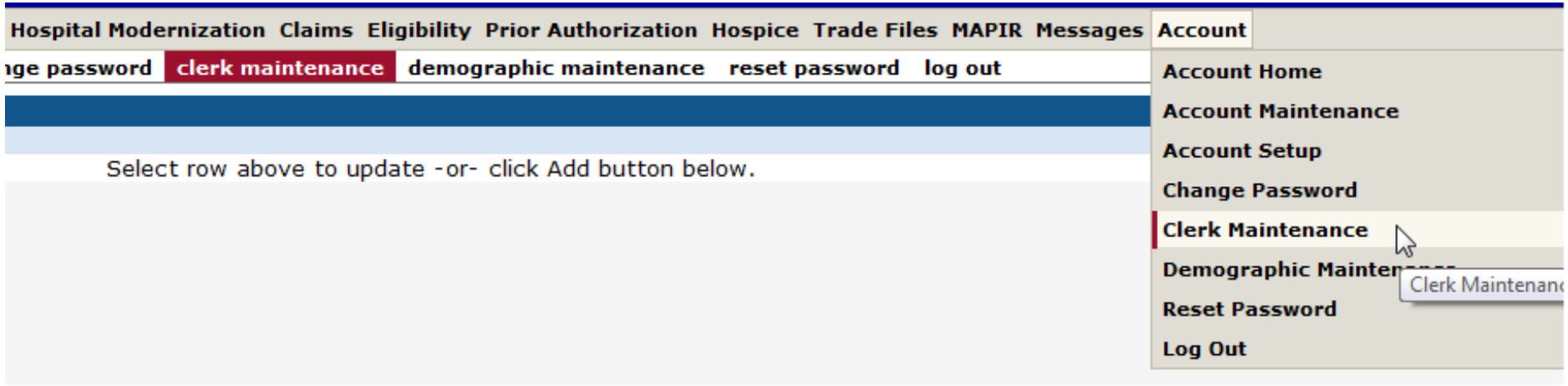
Web Account Capabilities

Clerk Maintenance

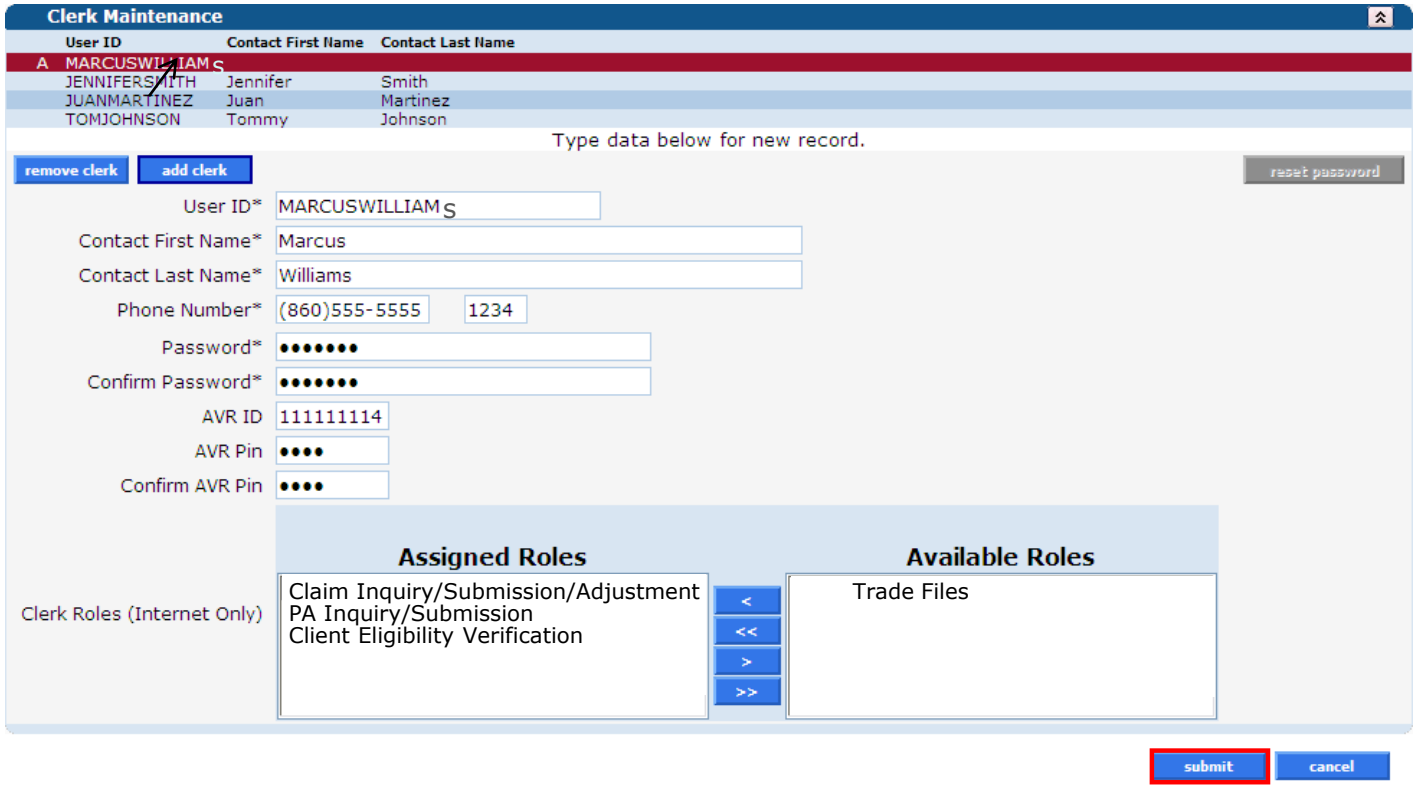
– Clerk accounts grant Web access to staff members allowing them to perform functions based on their job responsibilities

– The main account 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

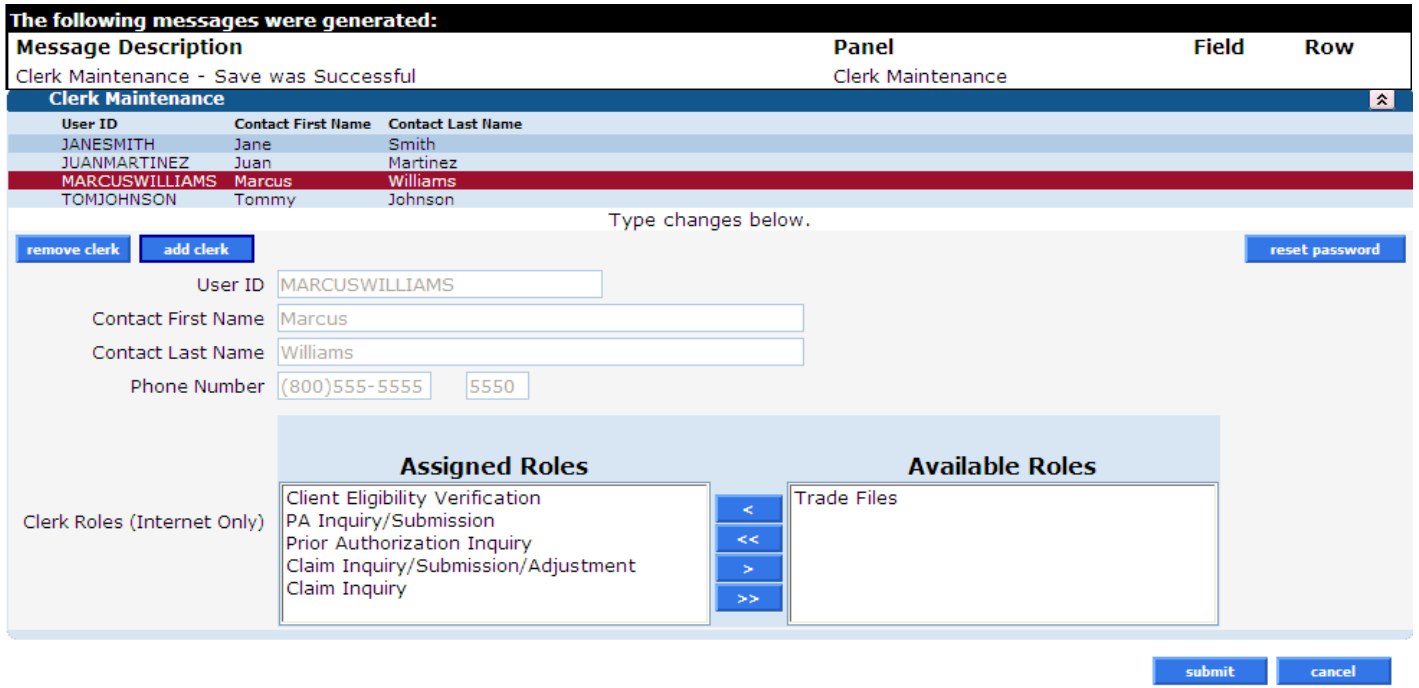


Web Account Capabilities
Clerk Maintenance



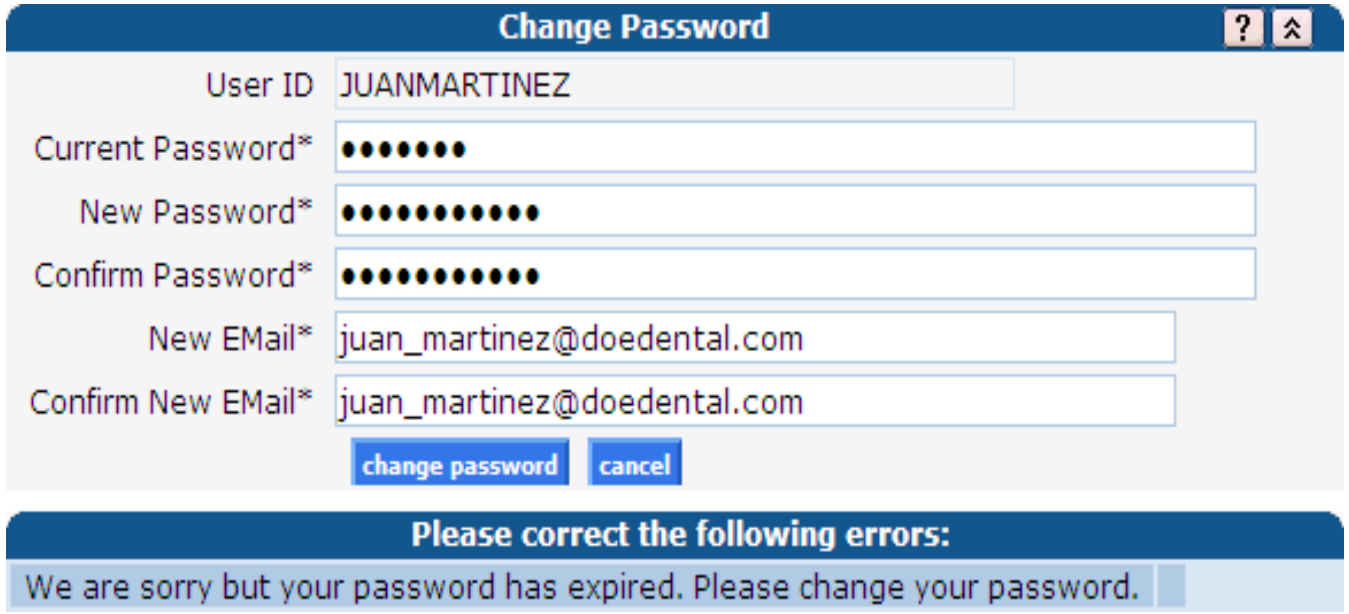
- To create a new clerk account, click add clerk
- Fill in the required fields, click submit

Web Account Capabilities
Clerk Maintenance



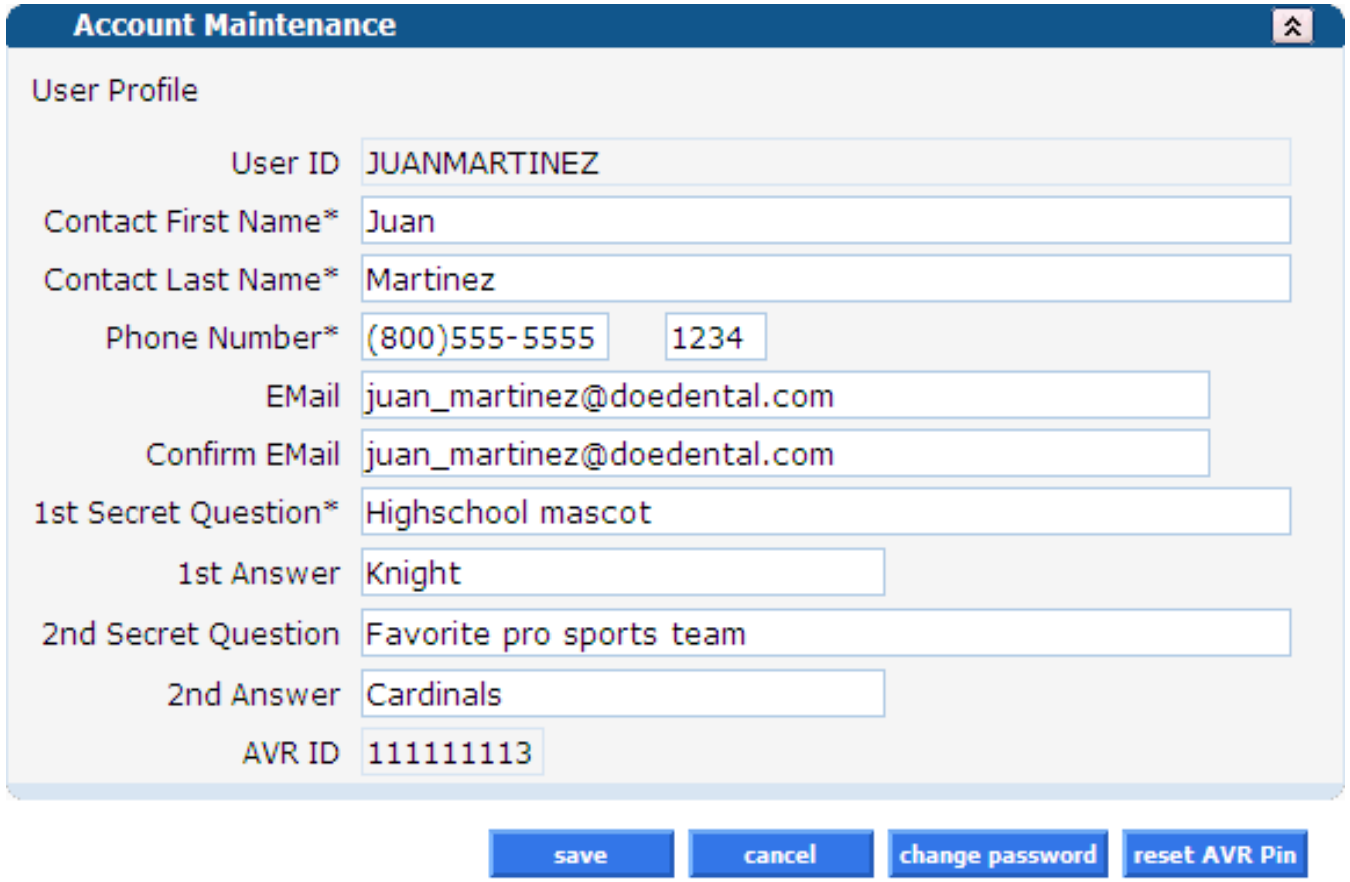
– Return to the Clerk Maintenance menu to add additional clerks, reset an existing clerk's password, or to alter clerks' Assigned Roles

Web Account Capabilities
Clerk Maintenance



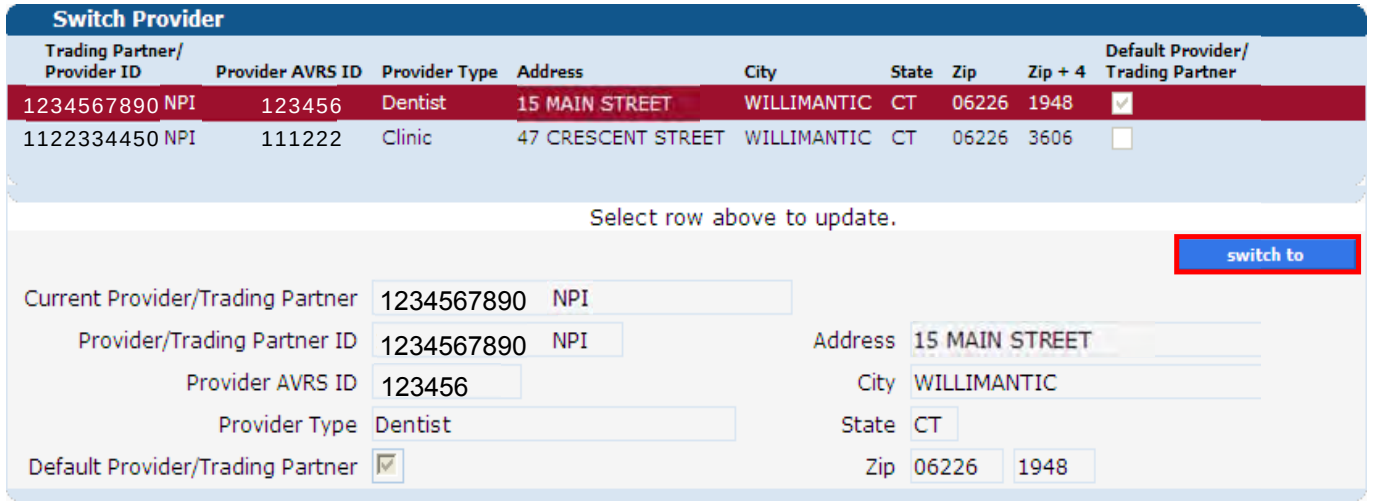
- When a new clerk logs into the Secure Site for the first time, they will be required to change their password from the one created by the account administrator
- Fill in the fields with the appropriate information; click change password
  - The clerk is now ready to perform the job duties allowed under the Assigned Roles chosen by the account administrator

Web Account Capabilities
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; click save

Web Account Capabilities
Clerk Maintenance



- Once a clerk ID is created by the local administrator, the same clerk ID can be added to more than one main account, this will allow the clerk the ability to switch back and forth between submitting online transactions for those providers
- Select switch provider from either the Account submenu or the Account drop-down menu
- Select the appropriate provider; click switch to. A window will appear asking you to verify the switch; click OK

Web Account Capabilities
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 

Clerk Maintenance

	User ID	Contact First Name	Contact Last Name
D	JANESMITH	Jane	Smith
	JUANMARTINEZ	Juan	Martinez
	MARCUSWILLIAMS	Marcus	Williams
	TOMJOHNSON	Tommy	Johnson

The following messages were generated:

Message Description	Panel	Field	Row
Clerk Maintenance - Save was Successful	Clerk Maintenance		

Clerk Maintenance

User ID	Contact First Name	Contact Last Name
JUANMARTINEZ	Juan	Martinez
MARCUSWILLIAMS	Marcus	Williams
TOMJOHNSON	Tommy	Johnson

Eligibility Verification

www.ctdssmap.com
Web Account Capabilities

ELIGIBILITY VERIFICATION

Eligibility Verification Methods

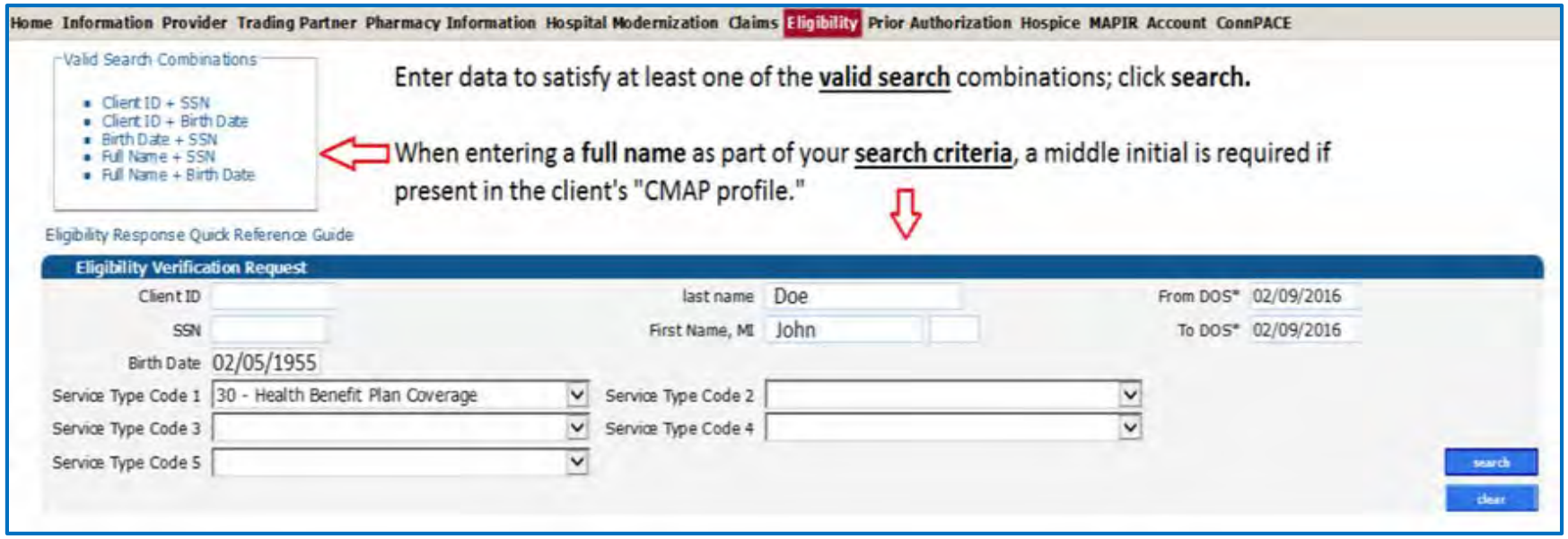
- Receipt of a service order from the Case Management Agency confirms the client is ABI Waiver eligible, however, the client's eligibility file may not yet reflect the client's ABI Waiver eligibility. To avoid unnecessary claim denials such as:
  - The client was not eligible on the date of service.
  - The service provided was not a covered service under the client's benefit plan.

  Verify client eligibility upon receipt of the initial service order.

- 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.
  - Provider Electronic Solutions (PES) software.

Web Account Capabilities
Eligibility Verification

– To verify a CMAP client's eligibility through the Secure Site – click on the Eligibility tab on the main menu



Web Account Capabilities

Eligibility Verification

The Eligibility Verification Response window provides the search results

– In this specific case – the client's eligibility cannot be verified for the requested dates (Sept. 1, 2013) – eligibility verification can only look back one year

– Changing the dates of the eligibility request to within the allowable one year window creates a different result.



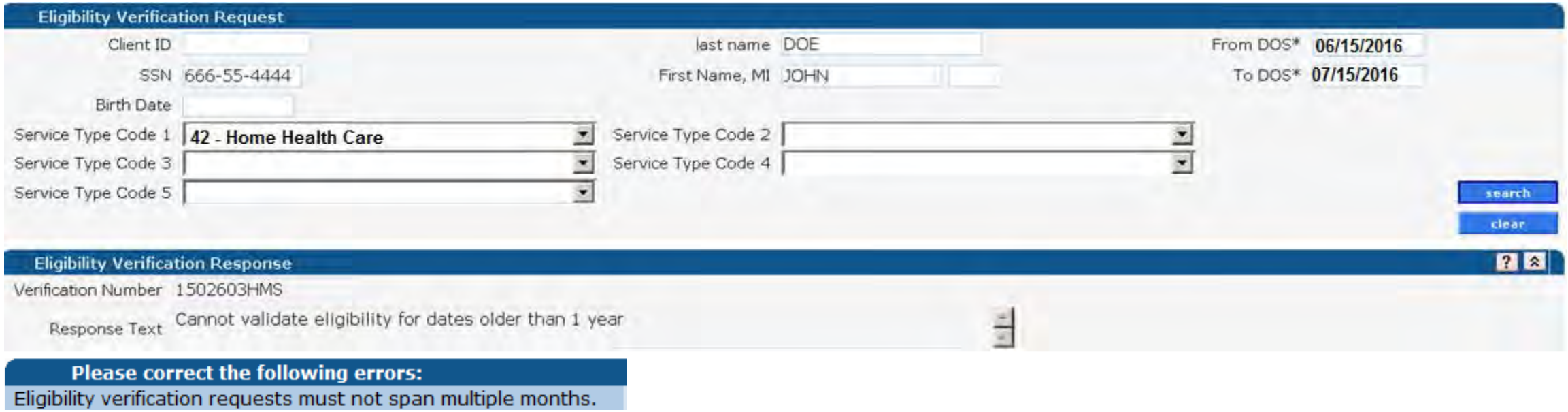
Web Account Capabilities

Eligibility Verification

Eligibility searches cannot span multiple months

– 12/01/2015 – 12/31/2015 is valid, 12/31/2015 – 1/15/2016 is not valid

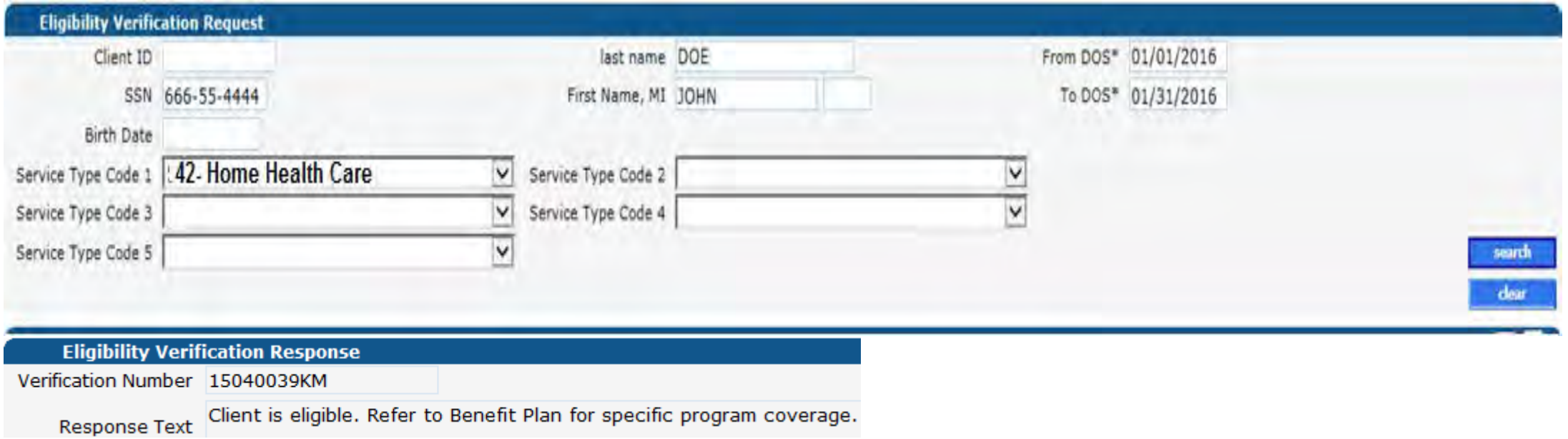
– Submitting a request that spans multiple months will result in an error message.



Web Account Capabilities

Eligibility Verification

Positive eligibility responses provide greater detail…



Web Account Capabilities

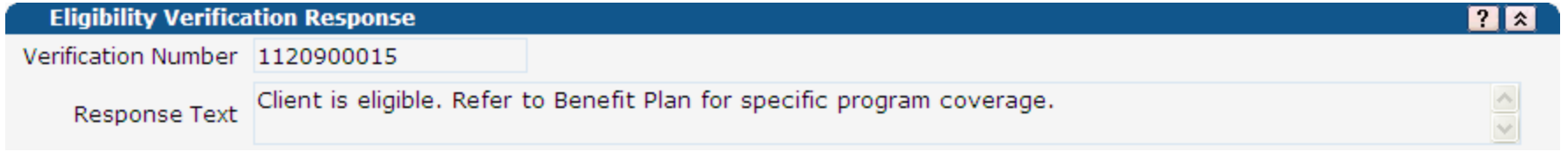
Eligibility Verification

What does all this information mean?

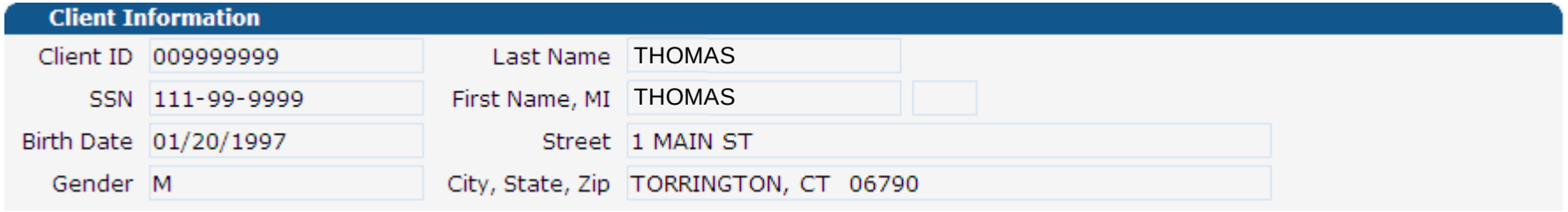
Eligibility Verification Response

– 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



Client Information



Web Account Capabilities

Eligibility Verification

Benefit Plan

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

- The client must have an ABI I or ABI II Waiver benefit plan for the ABI Service provider to be reimbursed for services provided to an ABI client and billed via EVV or directly by the ABI Service provider.
- The client must also have a HUSKY A, C or D benefit for Community First Choice (CFC) services that may be provided to an ABI Self Directed Waiver client by an ABI Service provider. Services are billed and payable to Allied Community Resources who will reimburse the ABI Service provider directly.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

Web Account Capabilities

Eligibility Verification

Service Type Codes – Hewlett Packard Enterprise

– A list of services for which the client was eligible that would be submitted for payment to Hewlett Packard Enterprise

Service Type Codes - HP Services

Service Type Code	Service Type Information	Copay	Coinsurance
1	Medical Care		
33	Chiropractic	$0.00	0%
35	Dental Care		
4	Diagnostic X-Ray	$0.00	0%
42	Home Health Care	$0.00	0%
45	Hospice	$0.00	0%
47	Hospital	$0.00	0%
48	Hospital - Inpatient	$0.00	0%
5	Diagnostic Lab	$0.00	0%
50	Hospital - Outpatient	$0.00	0%

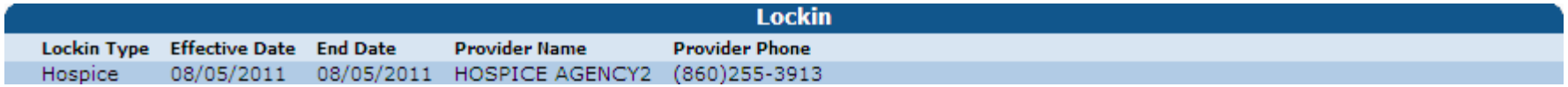
1 2 3 Next >

Web Account Capability

Eligibility Verification

Lockin

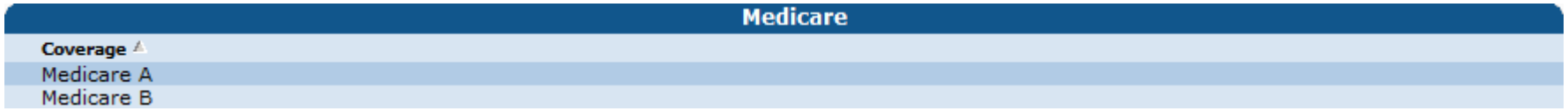
– Some clients are locked into receiving certain health care services only from specific providers or pharmacies; those providers or pharmacies will be listed here



Lockin				
Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	08/05/2011	08/05/2011	HOSPICE AGENCY2	(860)255-3913

Medicare

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

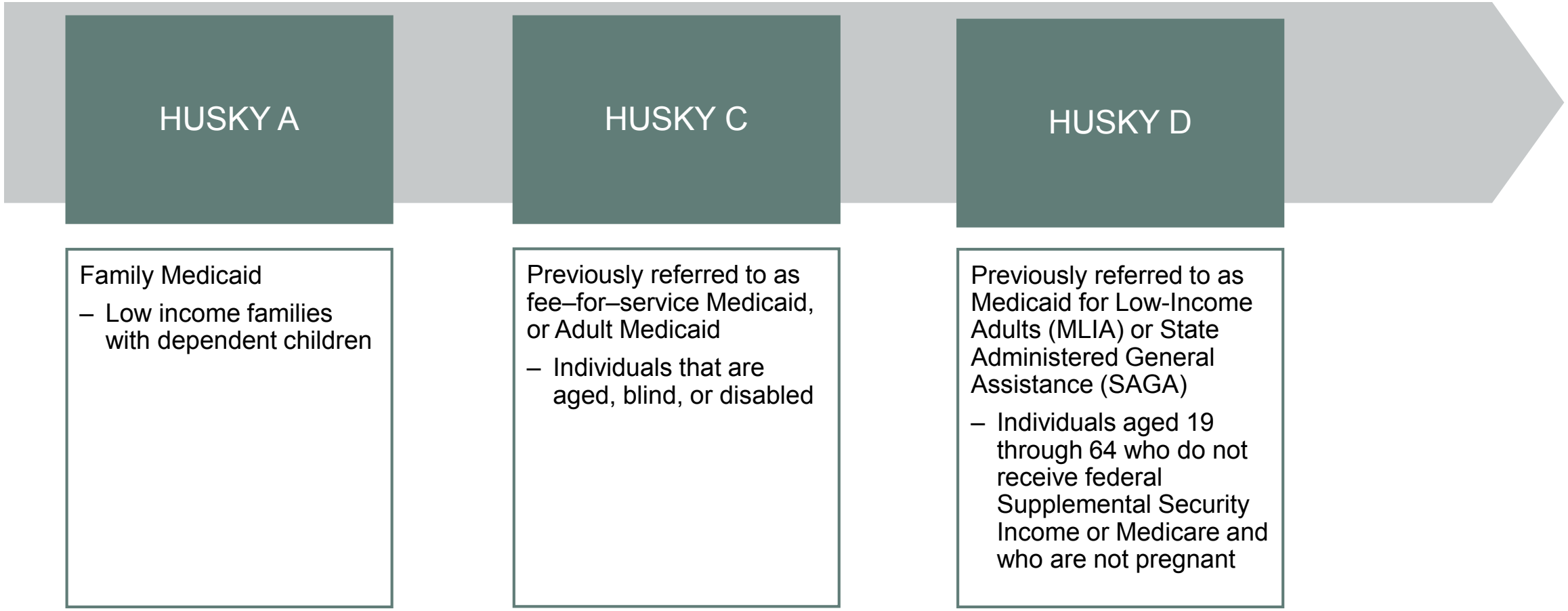


Medicare
Coverage
Medicare A
Medicare B

Web Account Capabilities

Eligibility Verification

Benefit Plans payable for CFC Services



Prior Authorization

www.ctdssmap.com

Web Account Capabilities

Prior Authorization

CARE PLAN ACCESS

Effective September 1, 2016, ABI Service providers *will have access to the care plans of the client's they service via the* ***secure Web portal*** *within the* ***Prior Authorization (PA) subsystem****.*

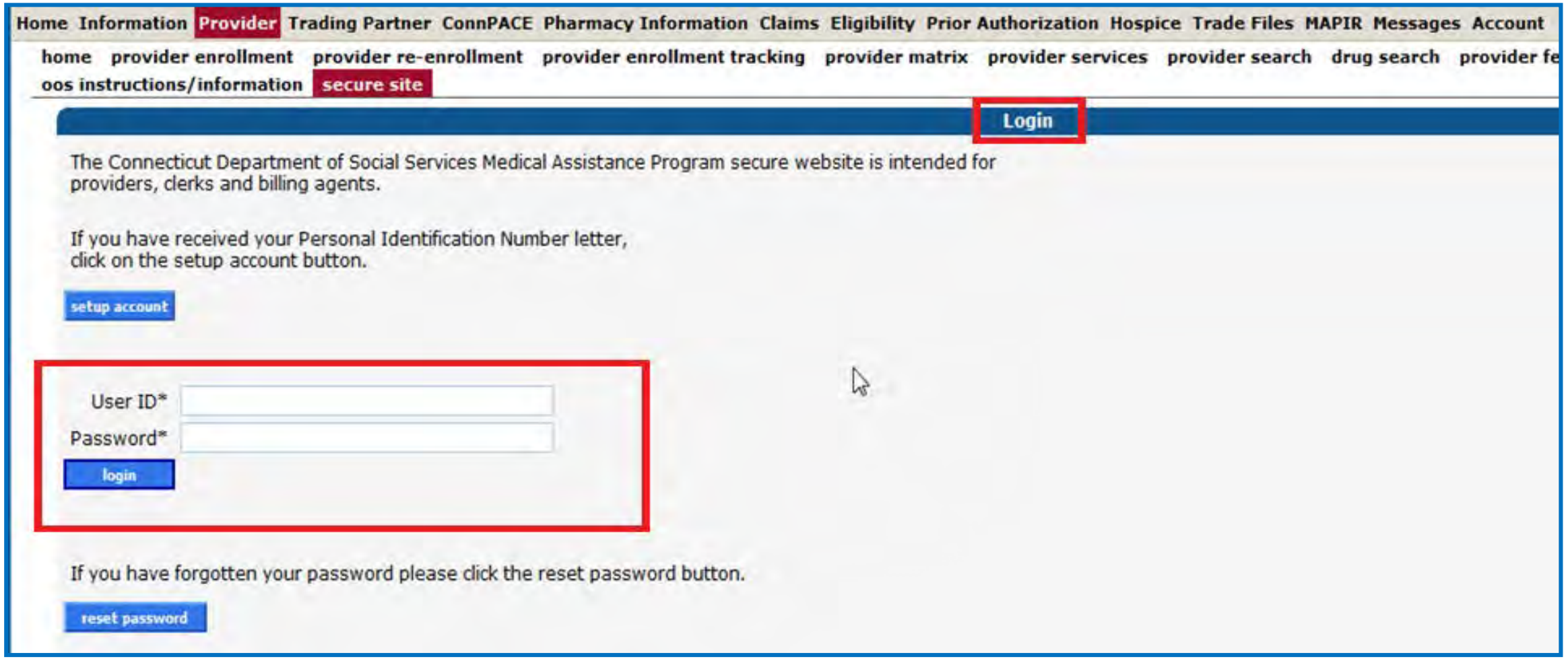
- Each service on the care plan has its own **unique PA#** and **viewable** to the **servicing provider** via a **PA inquiry.**

- All ABI services billed directly by an ABI Service provider ***must be on the care plan*** for the **services** to be ***reimbursed****.*

- All ABI services billed via EVV must have the **client care plan (PA) uploaded** from the PA subsystem that **matches** the caregiver **service check-in/check-out**.

Prior Authorization

Care Plan Access Via Secure Web Portal



Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

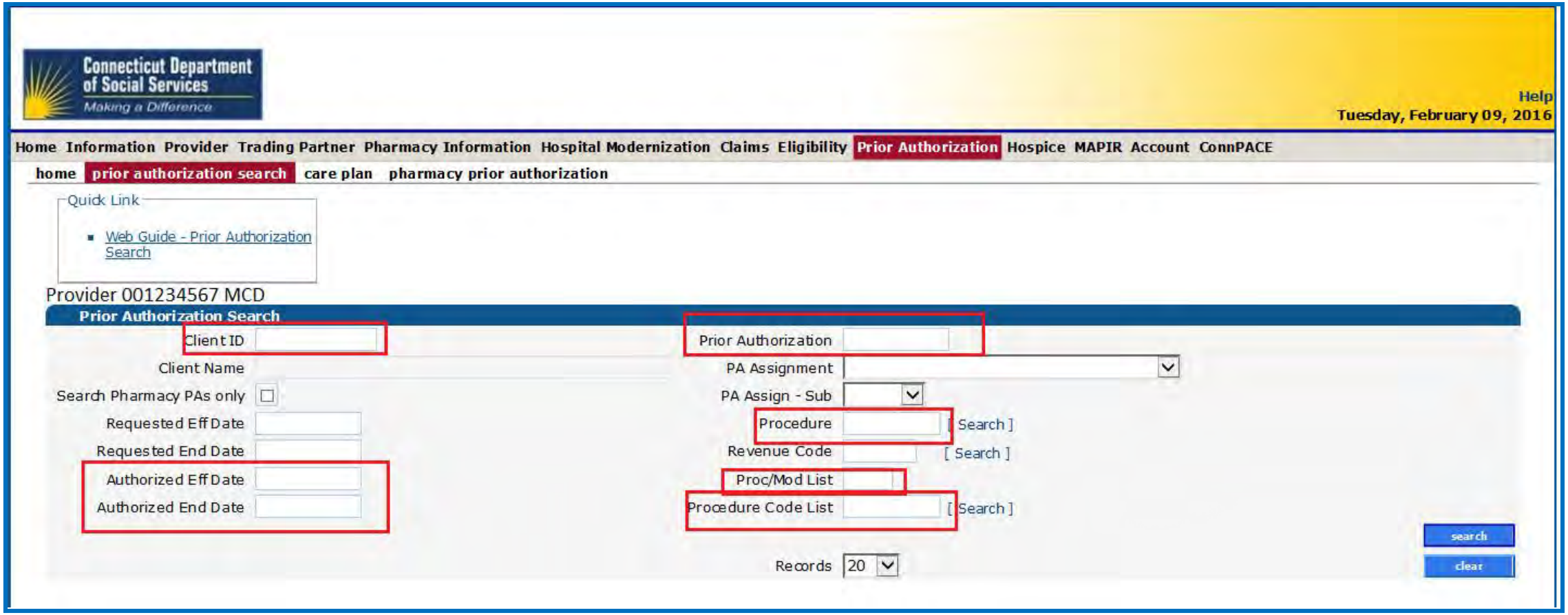
Once on the secure site, click ***Prior Authorization*** > ***Prior Authorization Search.***



Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

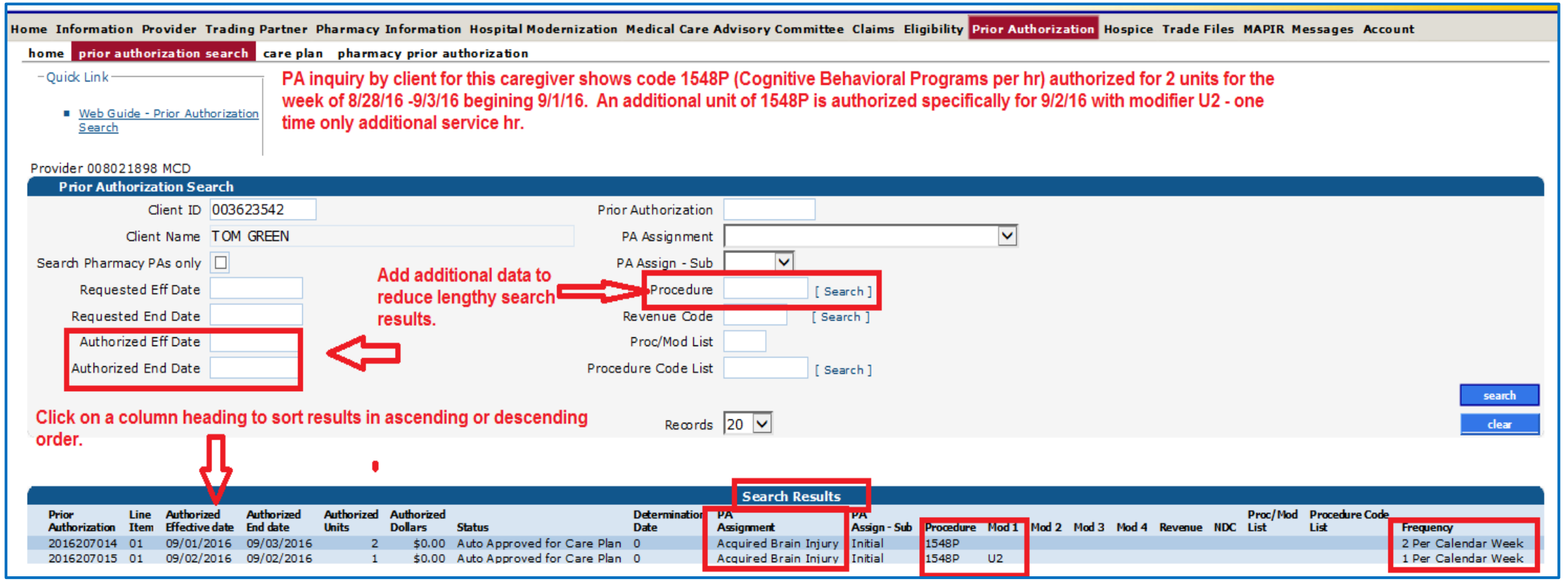
Search by ***Client ID or PA Number***. Further define search by ***date, procedure or list code.***



Prior Authorization

ABI PA Search Results

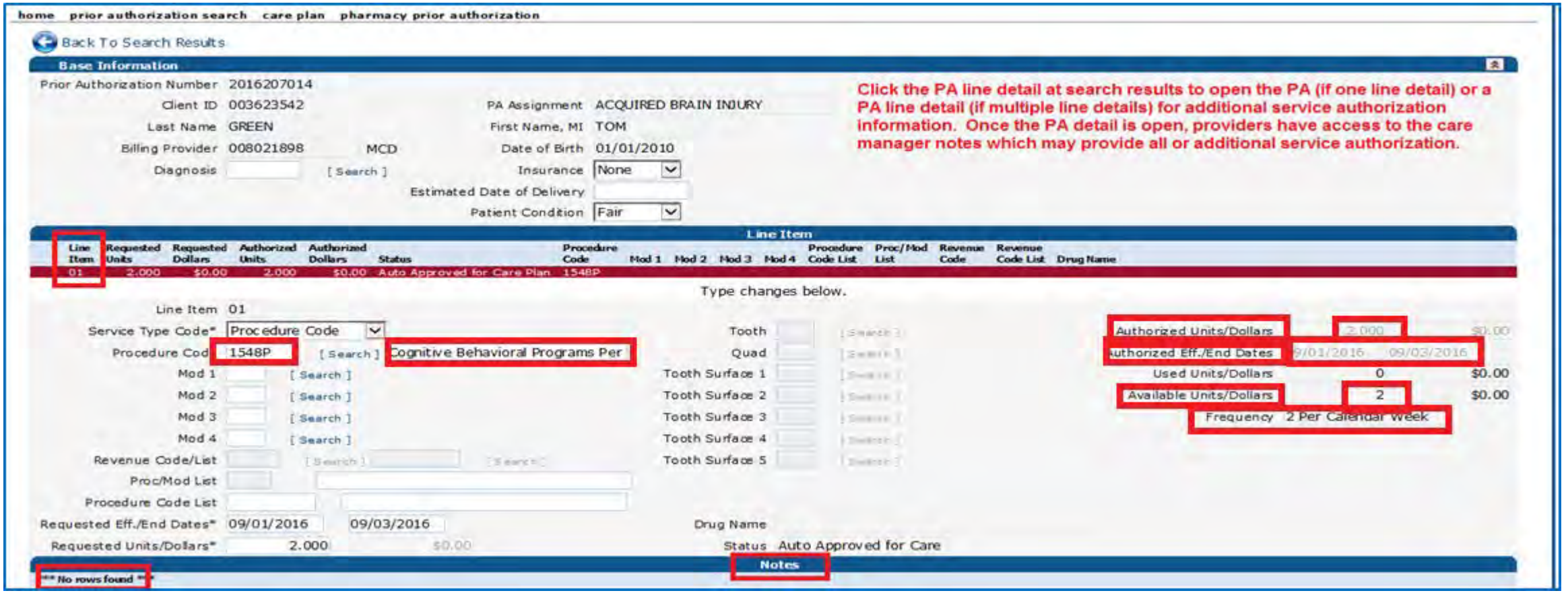
– Search results by client ID provide all PAs authorized for the client under the provider's care. Results can be more defined by increasing the amount of data used in the search.



Prior Authorization

Access to Additional Service Authorization Information

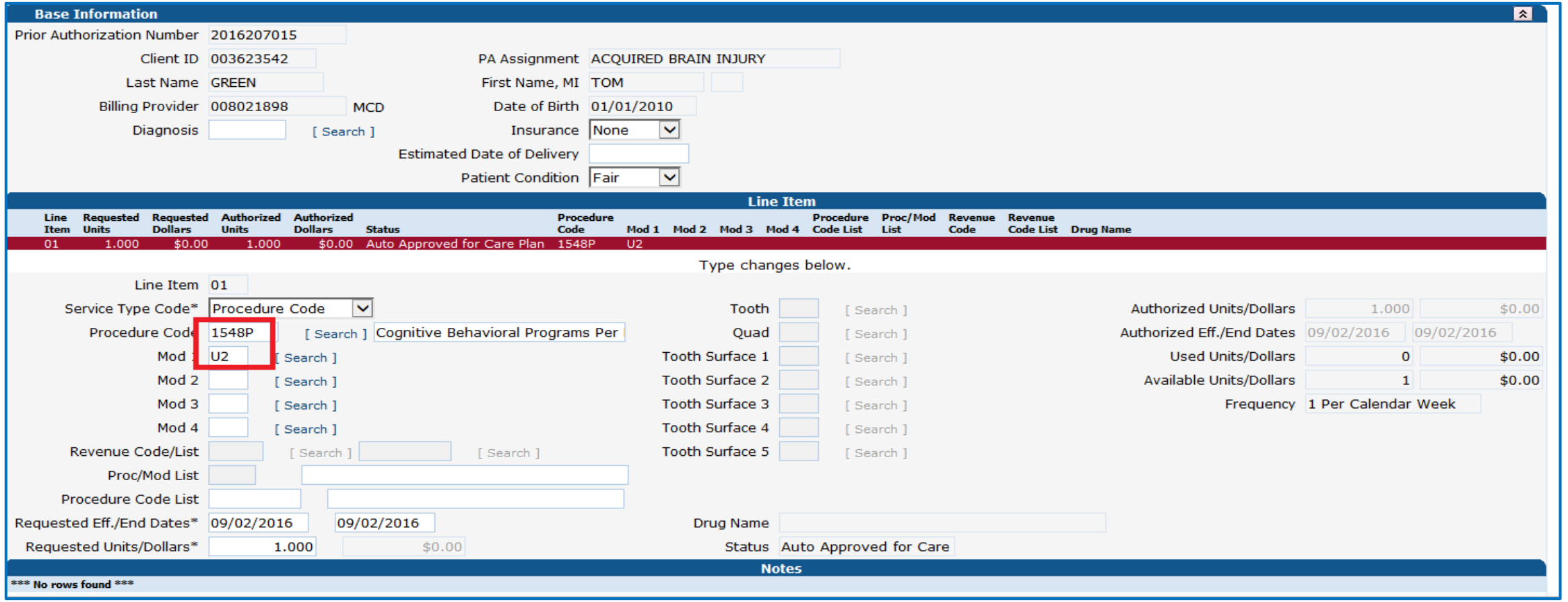
– Additional Care Plan Information can be Viewed by opening a PA from the PA Search Results Inquiry. A one-line detail PA will auto populate when the PA is opened.



Prior Authorization

Access to Additional Service Authorization Information

- ABI Services can be authorized via a procedure code or procedure code with one or more modifiers.



Prior Authorization
Use of Modifiers

- **The following Modifiers may be authorized when ABI Service Provider Services are authorized by Procedure Code:**

  - ✓Modifier **U2 - One Time Only Services** can be used to authorize:

    - Additional units needed on a day an **ABI** service is provided
    - Another day of service in an existing care plan when **Adult Day Health** is provided
    - An additional frequency to an existing service when **additional services are required outside of the existing frequency.**

      −For example: Client receives 1534P – Community Living Support Services(1/2 day) 5 x per week, M-F). Client also receives an additional unit (1/2 day 1 x per month on any given Saturday.

Prior Authorization

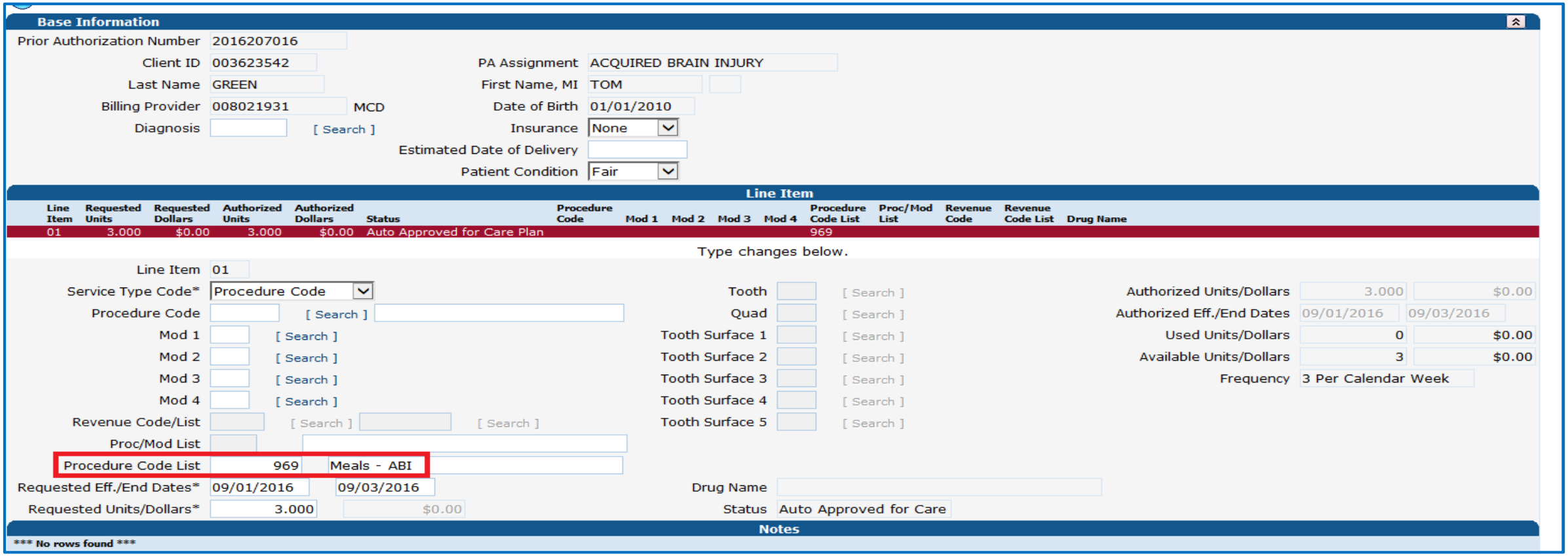
Use of Modifiers

- ✓Modifier **TT** - Subsequent Client, can be used to authorize:
  - –**ABI** services for an additional client residing in the home of a client already receiving the same service.
  - –If the **TT** modifier is authorized, it must be associated to the procedure code on the care plan/PA.
  - –The **TT** modifier reduces the subsequent client payment for service by **50%**.

Prior Authorization

Use of List Codes

– **List Codes may be authorized when ABI services are authorized by a code associated with a list of procedure codes with and/or without modifiers.**



Prior Authorization

Meals Procedure Code list and Procedure Code/Modifier Code List.

Meals	**List Code = 969** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P
Home Delivered Meals Per Day *(double meal)*	1551P
Meals – ***(One Time Only)***	**List Code = AB** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P U2
Home Delivered Meals Per Day *(double meal)*	1551P U2

Prior Authorization

Adult Day Health Procedure Code list and Procedure Code/Modifier Code List.

Adult Day Health	**List Code = 971** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model)	1200Z
Adult Day Health – Full Day (Approved Medical Model)	1201Z
Adult Day Health – Half Day (Less than or equal to 4 hrs.)	1202Z
Adult Day Health – ***(One Time Only)***	**List Code = AD** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model) – *one time only*	1200Z U2
Adult Day Health – Full Day (Approved Medical Model) – *one time only*	1201Z U2
Adult Day Health – Half Day (Less than or equal to 4 hrs.) – *one time only*	1202Z U2

Prior Authorization

Viewing and Understanding the ABI Care Plan – PA Inquiry

Points to remember when viewing the client's Service Order/Prior Authorization on your secure Web Account:

- The procedure code, modifiers, from and through dates of service, units and frequency should match:

  - ✓the service request (via telephone, paper or notes on PA via secure Web account.)

  - ✓the service order noted in the notes section of the PA on your secure Web account (Case Management Agency Upload of Service Orders)

Note: Discrepancies should be reported to the Case Management Agency

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember

- **Codes Authorized on the care plan are not always the codes to be billed on the claim.**
  - Providers should refer to the procedure code crosswalk for billing codes associated to codes authorized on the (PA).

- **If a Procedure Code or Procedure Code Modifier List is authorized, providers should:**
  - Refer to the Procedure Code Crosswalk for billing codes and unit increments associated to the Procedure Code List or Procedure Code Modifier List authorized.
  - Codes associated to the list can be billed interchangeably, based on the service provided, up to the units authorized within the frequency, unless otherwise indicated by the care manager as documented on the service order/PA notes.

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember cont.

– If the procedure code on the **PA**

– is of a **lessor reimbursement** value than the **service being provided** from the code list,

  – the provider must contact the care manager unless otherwise indicated in the external notes on the PA.

Web Claim Submission

www.ctdssmap.com

Web Claim Submission

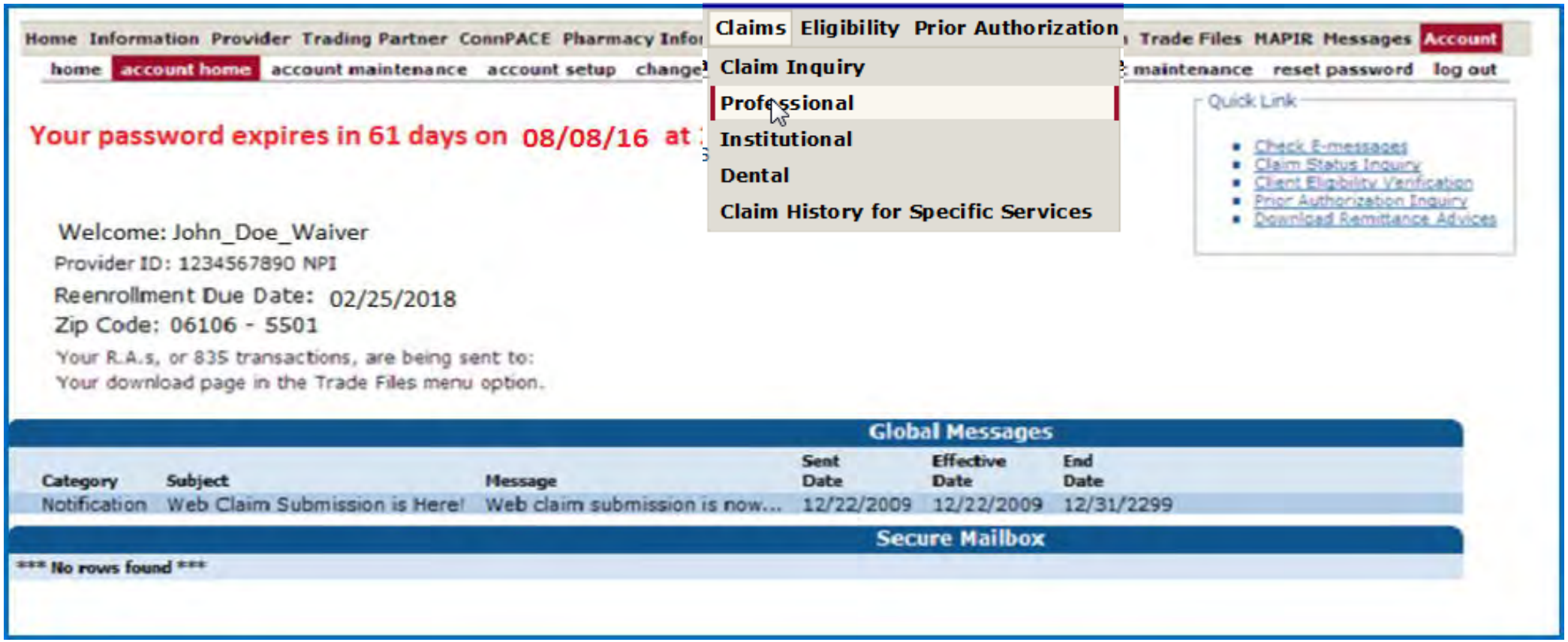
Web Account Capabilities

Web Claim Inquiry/Submission

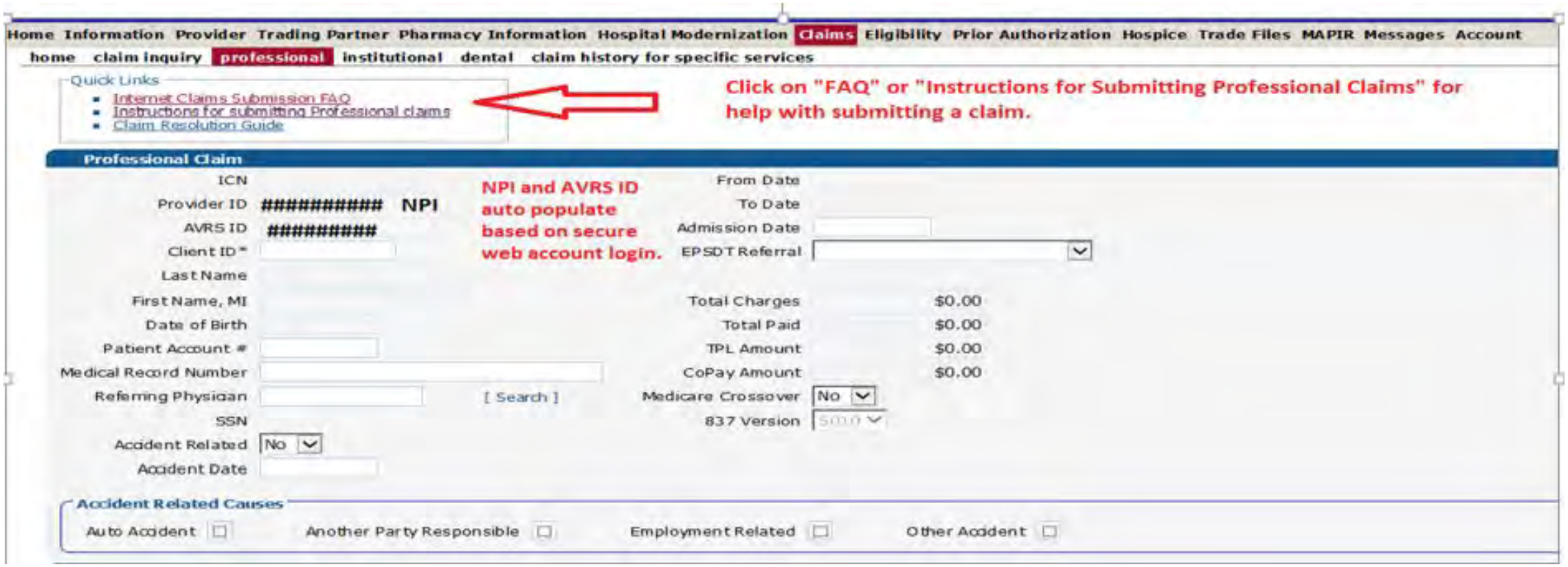
- Internet Web site at www.ctdssmap.com
  - Interactive with ***immediate response*** of claim payment or denial.
  - Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle.***

Web Claim Submission
Access to Claim Format

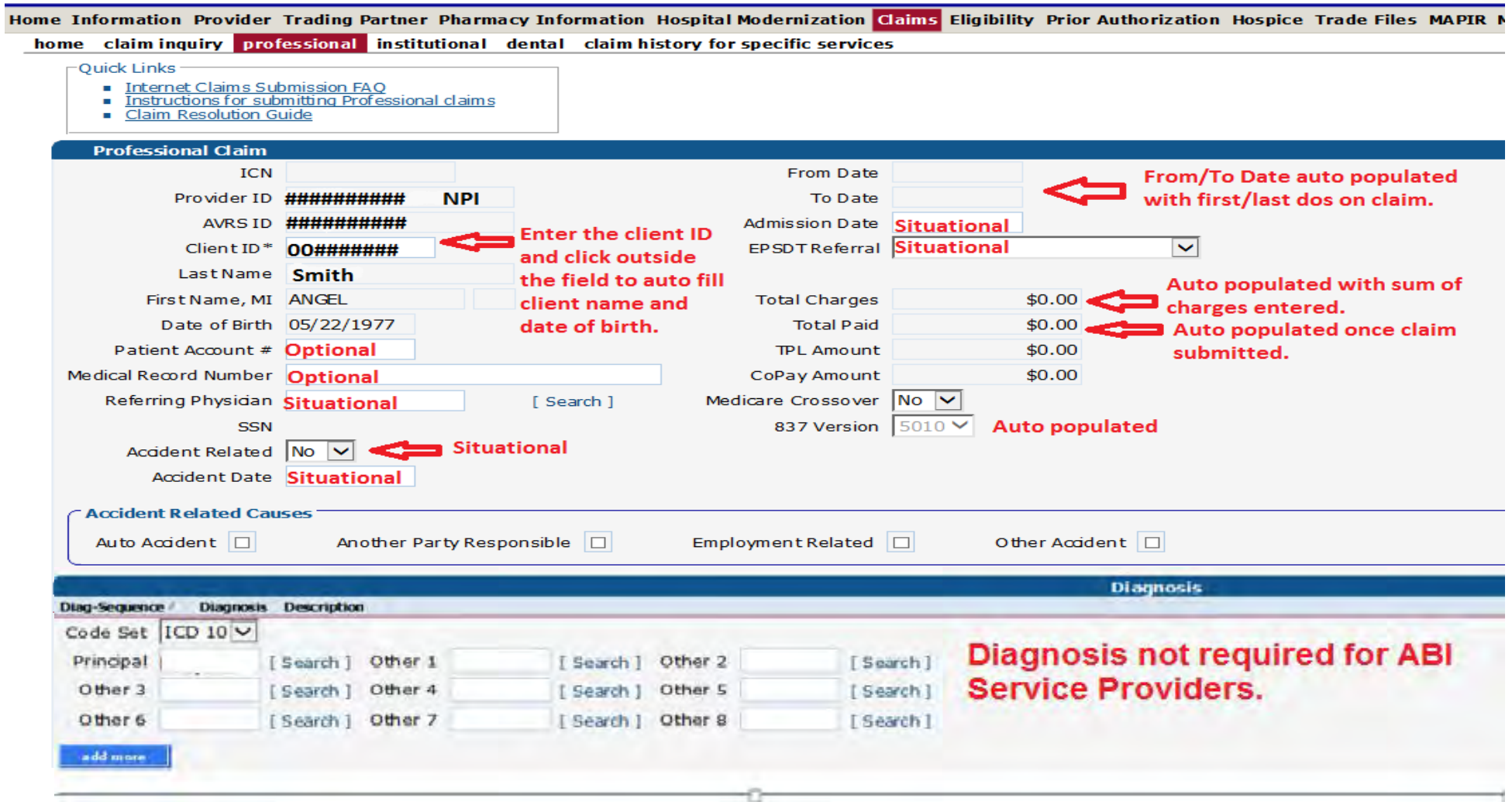
– Click Claims and Select the Professional Format



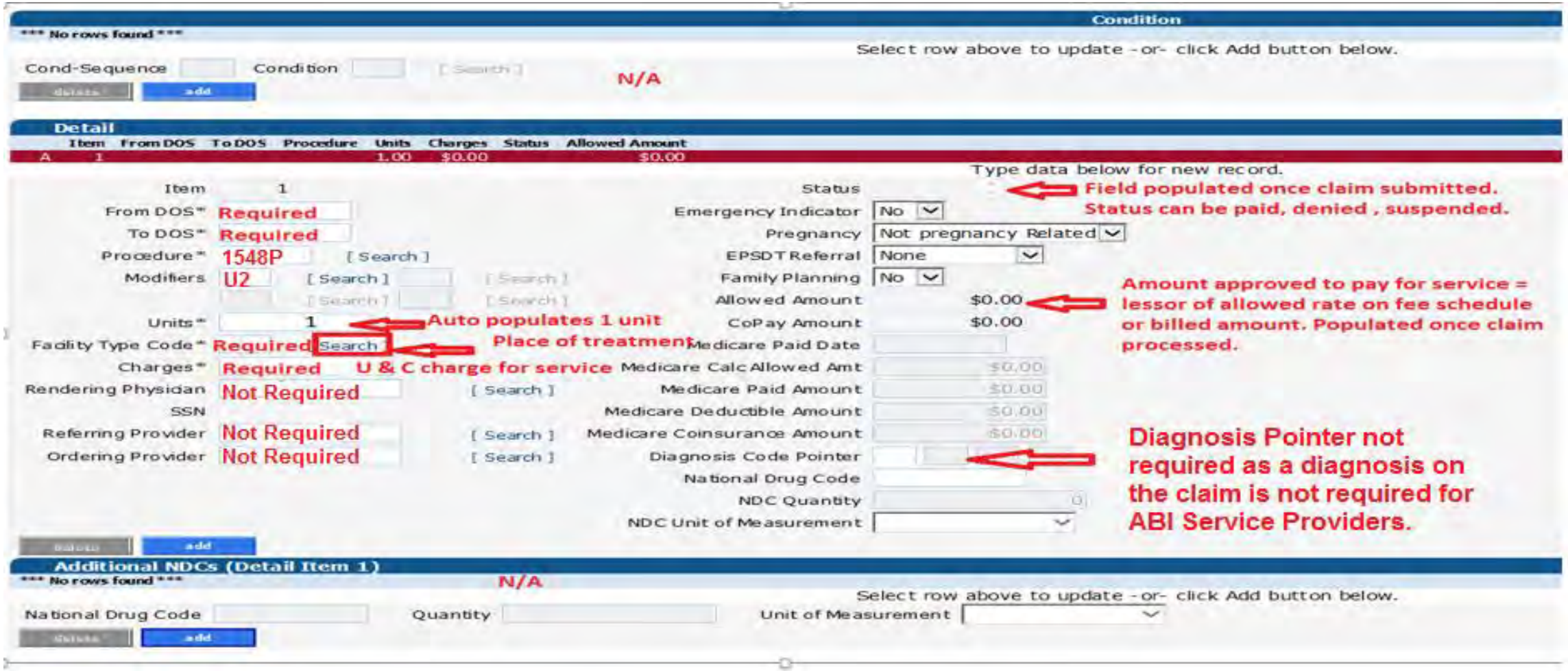
Claims Processing/Submission Information
Claim Submission Resources



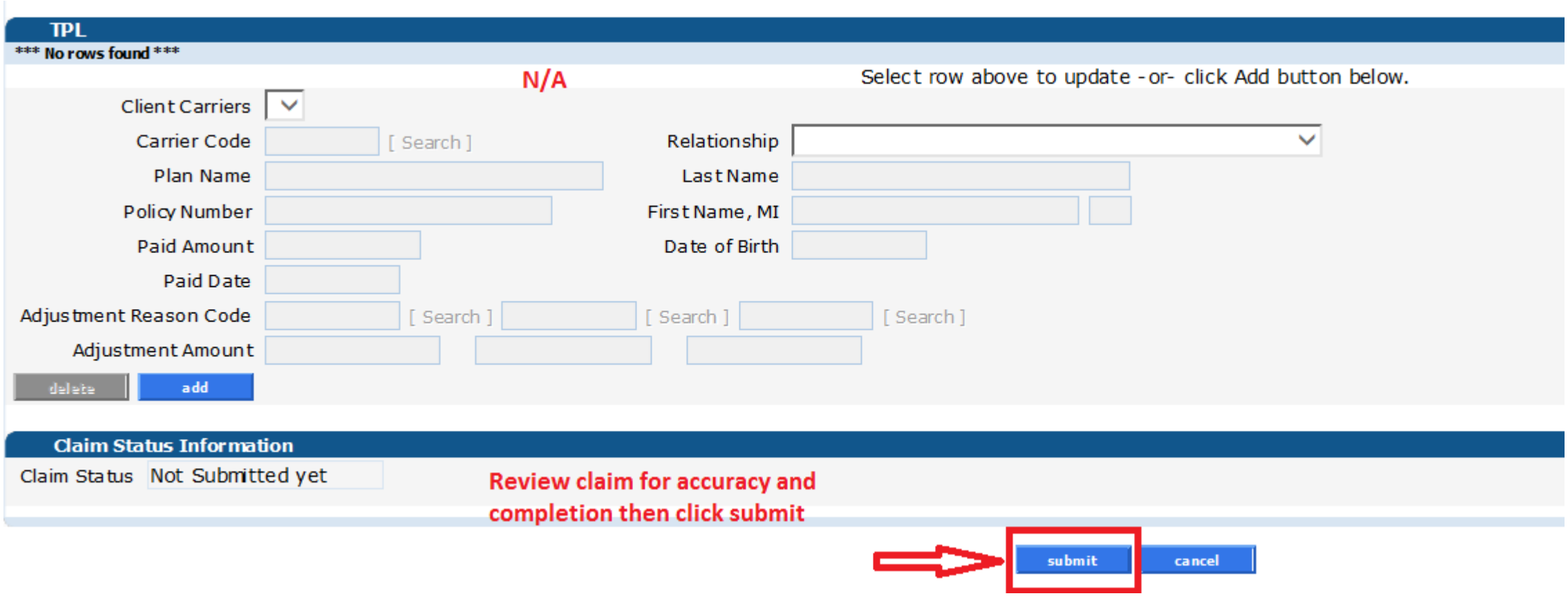
Claims Processing/Submission Information



Claims Processing/Submission Information



Claims Processing/Submission Information



Claims Processing/Submission Information

Claim Status Information

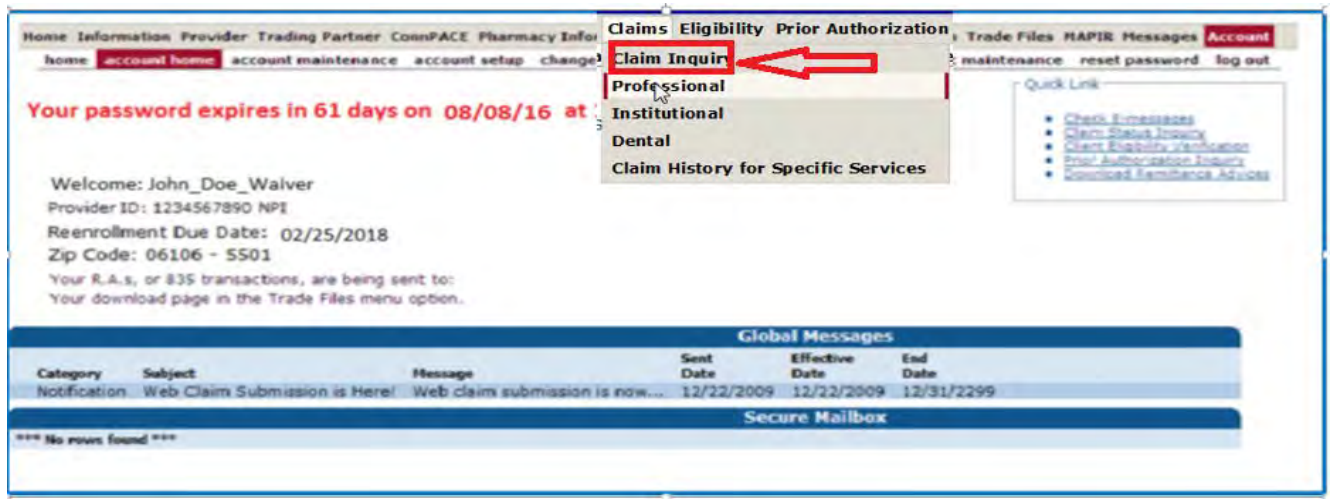
Claim Status	PAID
Claim ICN	2216165600002
Paid Date	
Paid Amount	**$12.00**
Applied Income	$0.00
Client Contribution	$0.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

Paid date of 6/13/16 will populate after the next financial cycle.

EOB Information

Detail Number	Code	Description
0	9997	REFER TO DETAIL EOB
1	9918	PRICNG ADJUSTMENT - MAX FEE PRICING APPLIED

Web Claim Inquiry





- Once you have submitted a claim to Hewlett Packard Enterprise using the ctdssmap.com Secure Site:
  - click on the “Claims” tab on the main menu and select “**Claim Inquiry**”
- Enter enough information to satisfy at least one of the following criteria:
  - ICN
  - Client ID FDOS/TDOS or Fdate Paid/Tdate Paid (spanning 91 days or less)
  - check the Pending Claims box

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

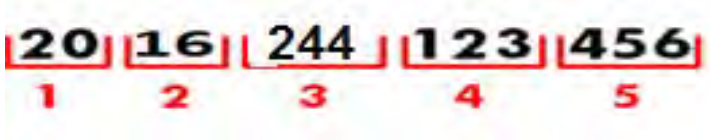
Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016026600026				12/31/2015	01/05/2016	Professional Claims	Paid	01/29/2016	$500.00	$105.73
5616026001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/29/2016	$500.00	$0.00
5616025001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600026				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$100.00
2016022600037				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016022600039				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
5616025002001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600023				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2216019600005				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600004				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600010				09/05/2015	09/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600009				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600008				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600006				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00

Claim Submission Guidelines

Claim Inquiry

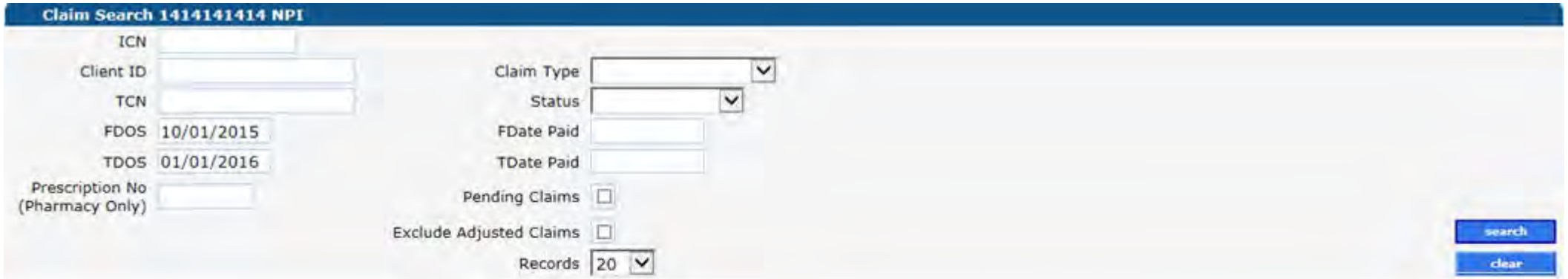
Claims submitted to Hewlett Packard Enterprise are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research.



- **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 Hewlett Packard Enterprise. (**16** = ***2016***)
- **3** *Julian Date of Receipt* – The Julian calendar date of receipt (**244** = *the two hundred forty fourth day of the year = September 1, 2016.*
- **4** *Batch Number* – An internal number assigned by Hewlett Packard Enterprise to uniquely identify a batch. (**123**)
- **5** *Claim Number* – A sequential number assigned to uniquely identify claims within a batch. (**456**)

Web Claim Inquiry

Results searching by FDOS and TDOS (no greater range than 93 days)



Search Results

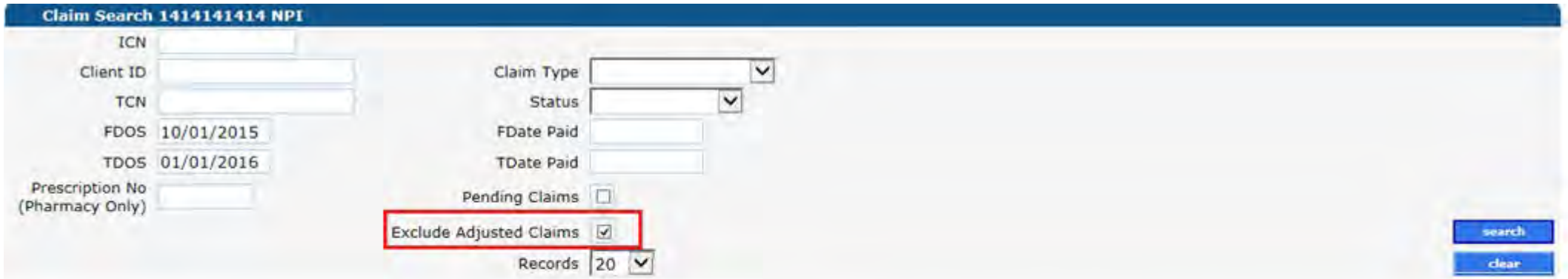
ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Exclude Adjusted Claims

– Removes claims that have been altered since their initial submission

– Results in a more accurate representation of your total reimbursement



Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

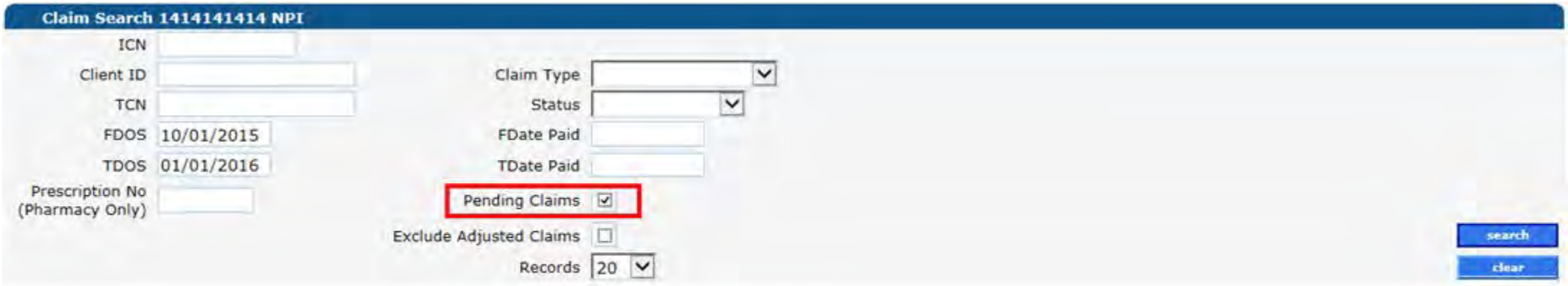
Web Claim Inquiry

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 any line in the Search Results panel to view the corresponding claim



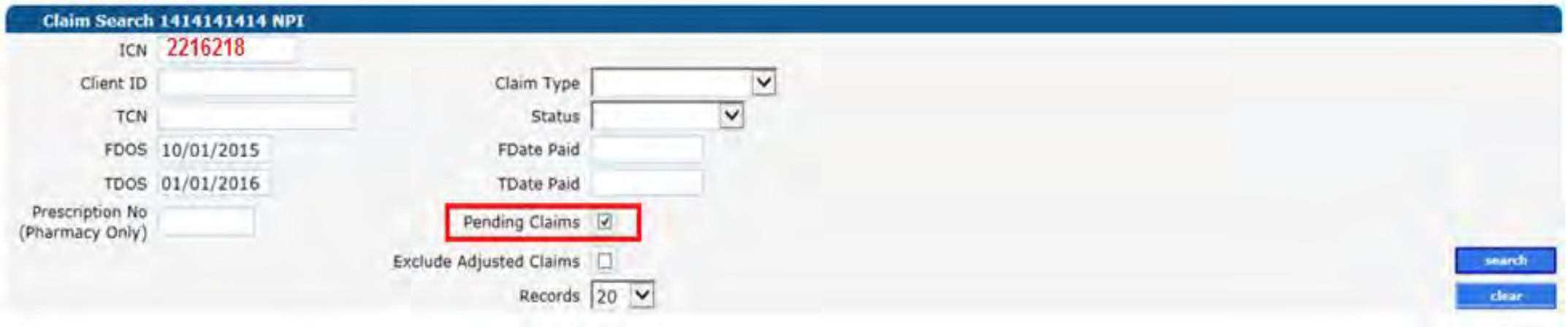
Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Pending Claims

- To narrow search results for pending claims by region on a given date, enter the first 7 digits of the Claim Internal Control Number (ICN).
- This search will provide claims submitted via the Web on August 5, 2016 that have not yet processed through a financial cycle.



Claim Submission Options

www.ctdssmap.com

Web Claim Submission

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 brand new claim

– Denied claims allow you to:

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

– Suspended claims allow you to:

- new claim — Create a brand new claim

Web Claim Submission

Void

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

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

Web claim adjustment limitations

Timely Filing

– Claims that are over the *Timely Filing* guidelines cannot be adjusted, unless the adjustment is submitted to pay the same or less than the original claim; otherwise, claim adjustments outside of the timely filing limit will be fully recouped

Special Handled Claims

– Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by Hewlett Packard Enterprise and are, therefore, not able to be adjusted via the **www.ctdssmap.com** Web site

Web Claim Submission
Copy

Paid claims may be copied and submitted as a new claim

– *This feature is helpful for reoccurring services*

Copy - 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
Resubmit

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*

Claim Submission Methods

ABI Services

Claim Submission Methods

EVV Services

EVV Mandated Services

– Claims for the following services rendered to ABI Waiver I or II clients are **mandated for EVV check-in/check-out** and will be systematically **submitted via Sandata's Santrax Electronic Visit Verification (EVV) System** when the **caregiver's check-in/check-out matches the Prior Authorization (PA)** uploaded from Hewlett Packard Enterprise PA subsystem.

- **1021Z** - Personal Care Services per 15 min
- **1211P** - Recovery Assistant
- **1212P** – Recovery Assistant II
- **1232Z** – Respite Care in the Home per hr. – other
- **1531P** – Community Living Support Services Per ½ Day
- **1532P** – Chore Services Per ¼ hr.
- **1534P** – Community Living Support Services Per ½ Day
- **1536P** – Companion Services per ¼ hr. (18 hr. per day max)
- **1542P** – Homemaker Services Per 1/4/hr.
- 1546P – Independent Living Skill Development Per hr, (agency)

These services must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

EVV Services cont.

EVV Optional Services

– Claims for the following service rendered to ABI Waiver I or II clients are **optional** and will be systematically submitted via the Sandata Santrax Electronic Visit Verification (EVV) System, **should the caregiver choose to check-in/check-out via the EVV system** and the check-in/check-out matches the Prior Authorization (PA) uploaded from Hewlett Packard Enterprise PA subsystem.

- 1**562P** – Respite Care Per hr.

This service must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

Direct ABI Provider Billing

– Claims submitted for ABI Waiver services, directly by ABI Service providers must be submitted via:
  – Internet Web site at www.ctdssmap.com
    –Interactive with ***immediate response*** of claim payment or denial.
    –Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle***.

  – Vendor Software utilizing the following HIPAA ASC X12N transactions:
    –837P – Health Care Claim Professional
    –Requires provider to enroll as a Trading Partner
  – Paper
    –CMS-1500 Claim Form

Effective October 1, 2016 the Department of Social Services (DSS) will no longer accept paper claims for processing. Paper claims submitted on or after October 1, 2016 will be returned to the provider.

Ref: PB 2016-31.

Claim Submission Guidelines

ABI Services

Claim Submission Guidelines

Edits and Audits

- Regardless of the claim submission method, all claims are processed through the Connecticut interChange system and 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*** such as:
  - 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***?

Claim Submission Guidelines

Timely Filing

- Timely Filing Guidelines
  - The timely filing limit, under the ***ABI Waiver Benefit*** plan for the submission of ABI Services by an ABI Service Provider:
    - ***One (1) year*** *from the date of service (initial claim).*
    - ***One (1) year*** *from date of last payment or denial, if not for timely filing.*

Claim Submission Guidelines

Spanning Dates of Service

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

– Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan.

- **For example, if adult day health service is to be provided 6 days per week on consecutive days such as Monday through Saturday for 1 per day for a total of 6 units, the span dates of service must begin on the Monday of the calendar week in which the service was performed and end on the Saturday of the same calendar week for a total of 6 units.**

Claim Submission Guidelines

Spanning Dates of Service

– Spanned dates of service cannot span multiple line details on the care plan.

- **For example, in the example above a onetime only of an additional day of adult day health services on Sunday is needed for the above week. If the additional day on Sunday is added as an additional line detail on the PA, the services for Sunday, even though they are consecutive with the regular weekly services, must be billed on a separate line detail.**

Claim Denials and Resolutions

ABI Services

Claim Denials and Resolution

Claim Denials due to Client Eligibility

Denial Reasons:

- **EOB Code 2003** - Client Ineligible for dates of service
- **EOB Code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have an ABI Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021). Please Note: **The system attempts to process under the HUSKY benefit plan first, if not a covered service it will set 4021 for the HUSKY benefit plan. The system will then attempt to process under the ABI benefit plan. If the claim denies for 00X EOB, the system will attempt to process under any other benefit plan the client may have. It is the 00X EOB that should be acted upon and disregard all 4021 EOB codes**

Resolution:

- Client eligibility file needs to be updated with an ABI Waiver benefit plan or change in the effective dates of eligibility.

Claim Denials and Resolution

Determining and Resolving Eligibility Issues

- The Home and Community Based Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to 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 "ABI Waiver Client Eligibility Issue" in the subject line of the email.
- Providers who identify an eligibility issue upon claim denial should contact the DSS Home and Community Services Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.

Claim Denials and Resolution

Claim Denials due to Care Plan not on File

Denial Reasons:

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

Resolution: A care plan must be created by the ABI Case Management Agency and uploaded to the Hewlett Packard Enterprise system. **Contact the Case Management Agency.**

Claim Denials and Resolution

Claim Denials due to Service not Authorized

Denial Reason:

- **EOB Code 3016** -Service not Authorized on the Care Plan.

Resolution 1: A service denied for not on care plan must be added by the Case Management Agency to the Care plan.

Resolution2: Incorrect Procedure code billed by provider or PA/claim mismatch.

Claim Denials and Resolution

Claim Denials due to Units Billed Exceeding Frequency

Denial Reason:

- **EOB Code 5151**- Units exceed the frequency units authorized on the care plan.

Resolution 1: Units of service must be added to the frequency of an existing PA by the Case Management Agency.

Resolution 2: Units exceeded due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Denial due to PA Exhausted

Claim Denial

- **EOB Code 3003** - Units of service must be added by the Case Management Agency to an existing PA that is currently exhausted.

Resolution 1: Prior Authorization is required for payment of the service (units for the service are exhausted).

Resolution 2: **PA exhausted** may be due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Resources for Care Plan Issues

- Case Mangers create service orders and enter them in the Case Management Agencies Care Management System. **DSS cannot make care plan or prior authorization changes in the portal.**

- The Case Management Agency is responsible for uploading initial care plans and changes to care plans to Hewlett Packard Enterprise, in Prior Authorization format, within seven (7) days of issuing the service order.

- If the provider **has a service order** and a **PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account** within **seven (7) days** of receipt of the service order, the provider should contact the applicable Case Management Agency.

Remittance Advice

www.ctdssmap.com
Web Account Capabilities

Remittance Advice

Access to Claim and Financial Reporting

All claims activity is reported to providers twice a month on a Remittance Advice

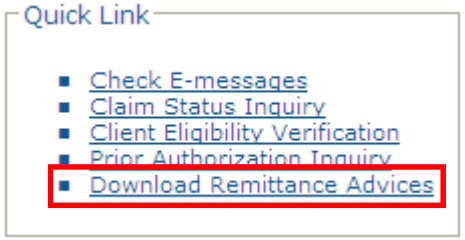
– RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider's claim activity

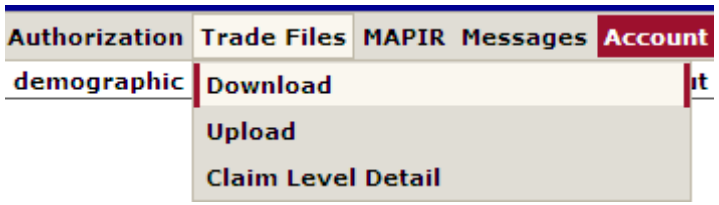
– Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com

– Available in either the ASC X12N 835 Payment/Advice standard transaction format, which is a string of raw data that must be configured by the provider/vendor for download into their system or in the Comma Separated Format (CSV) which provides the paper version of the RA

– Only the last 10 RAs are maintained on the Hewlett Packard Enterprise 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 the account home screen or select Download from the Trade Files drop-down menu:





Remittance Advice

CSV - Comma separated Value

- ABI Service providers will have access to their Remittance Advice (RA) in an excel format. This allows providers to sort the file and search for specific claim approvals and denials. To access the RA, go to our Web site at www.ctdssmap.com and log onto the secure Web portal. Under "Trade Files", choose "Download" from the drop down menu. Select "CSV" from the "Transaction Type" on the File Download Search screen. This will populate the current files available to download. The following provides an example of the data available in this excel format:

Provider ID	Client ID	Client Last Name	Client First Name	Client Acct Number	ICN	Paid Date (MMDDYY)	Detail Num	FDOS(MM DDYY)	TDOS(MM DDYY)	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Billed Amt	Paid Amt	EOB1	EOB2	EOB3	Medical Record Num	Adj Xref ICN
########	########			FFS	5916249001001	09012016	1	08202016	08202016	1021Z					18	8.5	9918	0	0	TC1FORANDIE	201624059045
########	########			FFS	5916244001002	09012016	2	08232016	08232016	1021Z					36	17	9918	0	0	TC1FORANDIE	201624008245
########	########			FFS	5916244001003	09012016	1	08292016	08292016	1021Z	TT				18	8.5	9918	0	0	TC1FORANDIE	2016240082051

Remittance Advice

Components of the RA – 7 Sections

- Banner Page
  - Important messages from DSS or Hewlett Packard Enterprise
- 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, Account Receivables
- RA Summary
  - Month-to-day and year-to-day summaries of financial activities, account receivables
- EOB Code Descriptions
  - Descriptions of the EOB codes that posted to claims on the RA
- Claims in Process
  - Lists claims that were in suspense when the financial cycle was run

Monthly Claims Reprocessing

Care Plan Changes
ABIO Services

Monthly Claims Reprocessing
Care Plan Changes –ABI Services

Systematic Monthly Claims Reprocessing to:

– Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Case Management Agency such as:

– End dating and restarting a care plan due to periods of hospitalization.
– Increasing or decreasing services.
– End dating a care plan when the client leaves the Agency's service.

Monthly Claims Reprocessing cont.

Care Plan Changes ABI Services

Systematic Monthly Reprocessing:

- In the **first cycle of each month**, Hewlett Packard Enterprise will recoup (void) all paid claims impacted by the Case Management Agency changes made two months prior(Region 52 claims = a voided claim).

- In the **same cycle Hewlett Packard Enterprise will reprocess, (deny and/or pay claims)** posting to the correct PA/PA line detail (Region 24 claims = a new day claim).

- For example: changes made to PAs in **Jan. 2017** by the Case Management Agency will result in claims being voided (region 52) and reprocessed (region 24) in the **first cycle of March 2017**.

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

Monthly Claims Reprocessing cont.
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper RA)

– If there is a financial impact (Change in $ amount up or down) between the voided claim (region 52) and the reprocessed claim (region 24):

– Providers will see in the **adjustment section** of their RA:

- The previously paid claim ICN (Region 20, 22, 59, 10 etc.).
- Recouped/Voided claim ICN (Region 52).
- EOB Code 8236 – Claim was recouped due to PA change.

Monthly Claim Reprocessing
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper RA)

– A new claim will be systematically created. Providers will see the new day claim on their RA :

- Claim ICN (Region 24) in the **paid/denied** section of the RA.

- EOB Code 8238 – Claim Systematically Reprocessed Due to a PA/Service Order Change.

NOTE: If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the RA.

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry:

- Region **24 claims** identify a change made to the care plan/PA.

- Region **24 claims** with **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change confirms there has been a change which has:
  - ✓ **Positively** or **negatively** impacted you financially.
  - ✓May continue to impact you financially in the future.

- Providers should investigate reprocessed claims with a **negative** impact to determine if:
  - ✓Providing appropriate level of service currently authorized.
  - ✓Current service order matches the PA on their secure web account. Report discrepancies to the Case Management Agency.

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry cont.

- A PA may show negative units available, if the changes made by the Case Management Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.
  - For example:
  - PA authorized for 7 units per week for 4 weeks = 28 units authorized and available.
  - Claims are paid against the PA = 14 units used
  - Case Management Agency changes the PA to 5 units a week for 2 weeks = 10 units authorized and available.
  - Until claims are recouped and reprocessed, the PA will show 10 units available – 14 used = (4) negative units.

Monthly Claim Reprocessing Due to PA Changes Made by Case Management Agency Claim Recouped

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

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

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

FP --ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
PL SERV PROC CD MODIFIERS	UNITS	SERVICE DATES RENDERING FROM	THRU PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS					

CLIENT NAME: Sally Client — CLIENT NO.: 0000000000

1	2200000000000	060314	061214	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	060314	061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 8236

Monthly Claim Reprocessing Due to PA Changes – Claim Reprocessed and appears on RA (paid amount region 24 claim greater than amount recouped – region 52 claim)

REPORT: CRA-PHPD-R — interChange MMIS — Date: 10/15/2014
RA#: — MEDICAID MANAGEMENT INFORMATION SYSTEM — PAGE: 2
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

Home Care Agency
555 Any ST
Somewhere, CT00000-0000

PAYEE ID MCD
ISSUE DATE 10/15/2014
TAXONOMY ----------
P. AVRS ID

FP	--ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
	CLIENT NAME: Sally Client			CLIENT NO.:								
	2400000000000	060214	061214	116.16	75.00	0.00	0.00	0.00	0.00	0.00	75.00	0
	HEADER EOB 8238											

PL	SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
	12	1542P		20	060214	061214	MCD	116.16	75.00	

Monthly Claims Reprocessing

Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – Claim Inquiry

➢ Regardless of the financial impact (more, less or no $ change):

- All **region 52** and **region 24** claims will appear on the provider's secure web account
- **Region 24** claims with no financial impact (i.e. region 24 claims paid the same as voided region 52 claims) will appear on the web with:
  - **EOB code 8237** – Claim Systematically Reprocessed Due to PA Change-Information Only.

Note: These claims will not appear on the provider's RA

Program Reminders for Successful Claim Submission

www.ctdssmap.com

Information

Program Reminders for Successful Claim Submission
Client Care Plan

- **Check the client's care plan (PA)** to be sure the services you have been requested to provide have been authorized.

  - ✓ Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.

  - ✓ Report discrepancies to the appropriate Case Management Agency immediately.

  - ✓ Review the care plan when you are notified of changes to be sure the services you are being requested to provide are on the care plan/PA.

Program Reminders for Successful Claim Submission

Claim Submission

➢ Claim submission review

- Prior to submitting claims be sure services provided match services authorized and services to be billed.

✓ Identify discrepancies early to avoid over service or potential billing errors which may cause claims to deny such as:

- Exceeding units on a claim frequency.
- Omission of a modifier on a claim detail(s).
- Spanning dates of service across frequencies or PA line details.

Program Reminders for Successful Claim Submission

Claim Submission Review cont.

➢Claim submission review

- Minimize claim submission time by:

✓Submitting claims via 837 batch or interactively via the web. Paper claims submitted on or after 10/1/16 will be returned unless the claim needs special handling.

✓Copying a prior paid claim, especially when billing for like services, minimizes changes needed for resubmission

✓Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces key strokes and the number of details on a claim.

Example: a PCA service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 9/5/16 to 9/7/16 1021Z for 30 units.

Program Reminders for Successful Claim Submission

Claim Resolution

➢ Claims Resolution

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

Information-Resources

www.ctdssmap.com
Information

Information – Important Messages

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

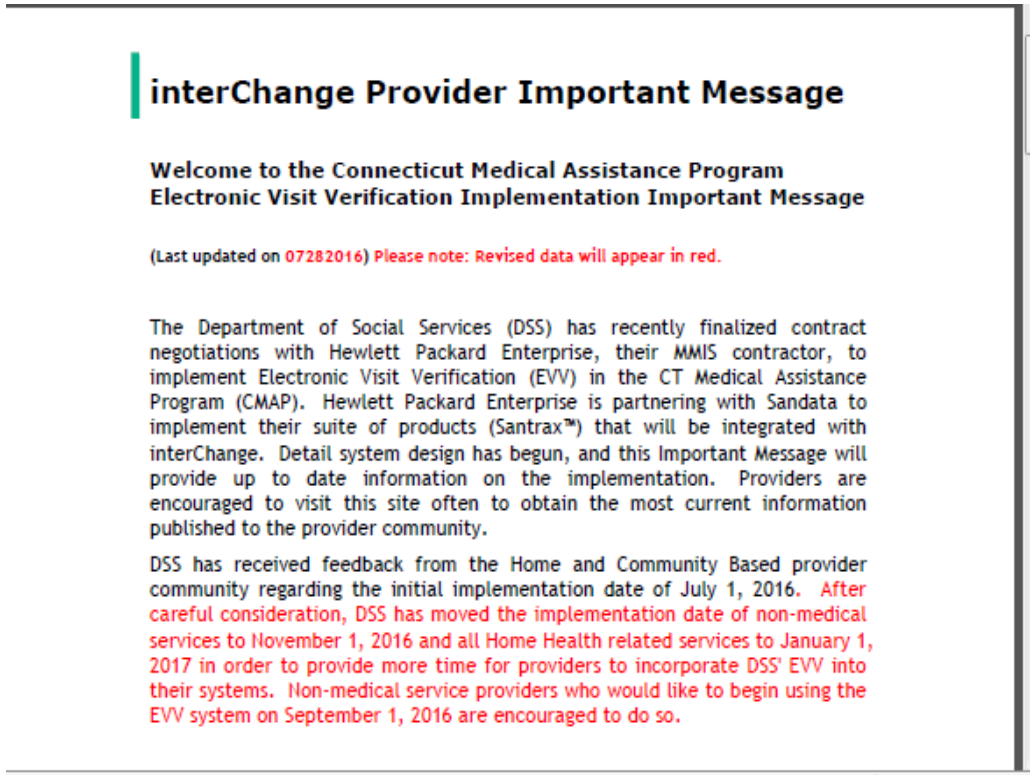


Important Messages

Electronic Visit Verification Implementation (Updated 7/28/16)
CMAP Medicaid Access Monitoring Review Plan (AMRP)
Outpatient Hospitals Prior Authorization Issue (Updated 7/22/16)
Hospital interChange Issues (Updated 7/12/2016)
Revised Provider Manual Chapters (Updated 7/6/16)
Revised Joint Guidance by DSS and CTDOL Regarding USDOL's Home Care Final Rule
Pediatric Dental Fee Schedule Reduction Postponed (Posted 7/6/16)
Provider Bulletin PB-37 New Autism Spectrum Disorder Services Being Rescinded
System Down Time 06/30/2016
Frequently Asked Questions (FAQs) - Provider Bulletin PB16-31
Clarification of Provider Bulletin PB16-33
DSS Issues RFP for Medicaid Quality Improvement and Shared Savings Program
Revised Provider Manual Chapters (Updated 6/7/16)
Attention: Out of State Providers - Where to Send Updated License Information (Updated 5/16/16)
Inpatient Delivery Stays (Updated 5/12/16)
Hospital interChange Issues (Updated 5/11/16)
ABI Individual Provider On-line Enrollment (Effective 5/11/16)

Information- Resources
Important Messages

Electronic EVV Implementation Message



interChange Provider Important Message

Welcome to the Connecticut Medical Assistance Program
Electronic Visit Verification Implementation Important Message

(Last updated on 07282016) Please note: Revised data will appear in red.

The Department of Social Services (DSS) has recently finalized contract negotiations with Hewlett Packard Enterprise, their MMIS contractor, to implement Electronic Visit Verification (EVV) in the CT Medical Assistance Program (CMAP). Hewlett Packard Enterprise is partnering with Sandata to implement their suite of products (Santrax™) that will be integrated with interChange. Detail system design has begun, and this Important Message will provide up to date information on the implementation. Providers are encouraged to visit this site often to obtain the most current information published to the provider community.

DSS has received feedback from the Home and Community Based provider community regarding the initial implementation date of July 1, 2016. After careful consideration, DSS has moved the implementation date of non-medical services to November 1, 2016 and all Home Health related services to January 1, 2017 in order to provide more time for providers to incorporate DSS' EVV into their systems. Non-medical service providers who would like to begin using the EVV system on September 1, 2016 are encouraged to do so.

Important Message References

– Providers can reference links to Important Documentation published regarding EVV as noted below

Important Documentation:
EVV Service Code Listing
Frequently Asked Questions
Proposed Task List
Proposed Reason Code List
CT DSS EVV Interface Specification Data Mapping
CT DSS EVV Interface Testing Process
CT DSS EVV Sandata Standard Interface Specification Schedules
CT DSS EVV Sandata Standard Extract Completed Visits
CT DSS EVV Sandata Standard Extract Payroll

Workshop Presentations:
Introductory Webinar
Introduction to Electronic Visit Verification

Publications:
PB16-44 - Electronic Visit Verification Notification to Clients

Information - Resources

ABI Procedure Code Crosswalk

- **ABI Procedure Code Crosswalk –**A list of non-medical procedure codes, and procedure code modifier lists with associated procedure codes/modifiers that can be authorized under the ABI Waiver Program.
- Providers should access the **ABI Procedure Code Crosswalk** for the following information:
  - ✓A list of procedure codes and procedure code/modifier combinations authorized under a procedure code/modifier list
  - ✓Service descriptions
  - ✓Unit increments
  - ✓Provider who can be authorized to bill the service
  - ✓If service can be spanned when consecutive dates of service are performed (N/A for home health services)
  - ✓Frequency of service
  - ✓Care Plan limitations (When PA is required by DSS or Value Options)
  - ✓Funding Source that covers the service

Information- Resources

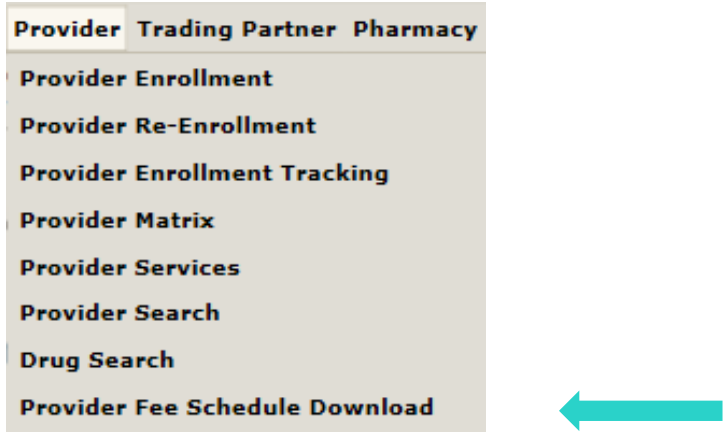
ABI Procedure Code Crosswalk

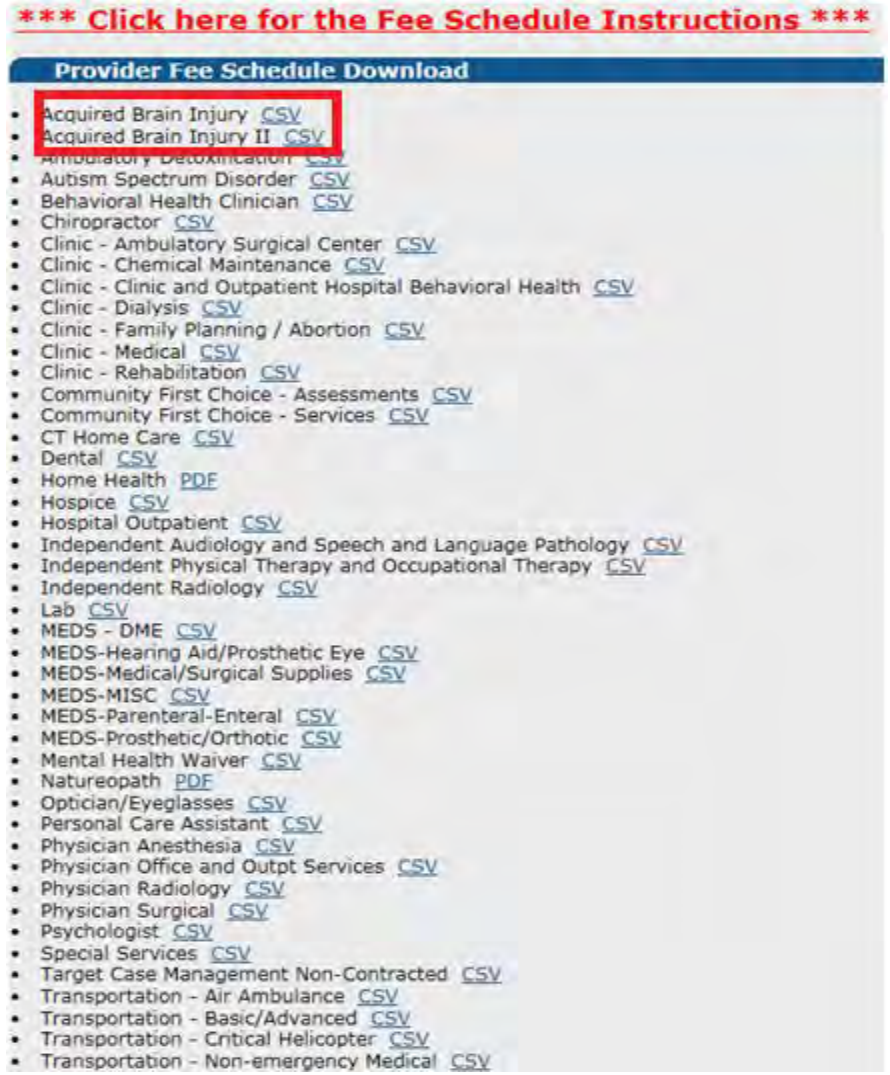
- **ABI Procedure Code Crosswalk –** can be obtained on the www.ctdssmap.com Website.

  - ✓ From the Home page >publications > provider manuals > chapter 8 ABI Provider Manual > Claim Submission Instructions > field 24d.

Information – Resources
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
  – See Information “What is CSV” at the bottom of the Web page for accessing the CSV file





Information – Resources
Banner Page Announcements

- 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

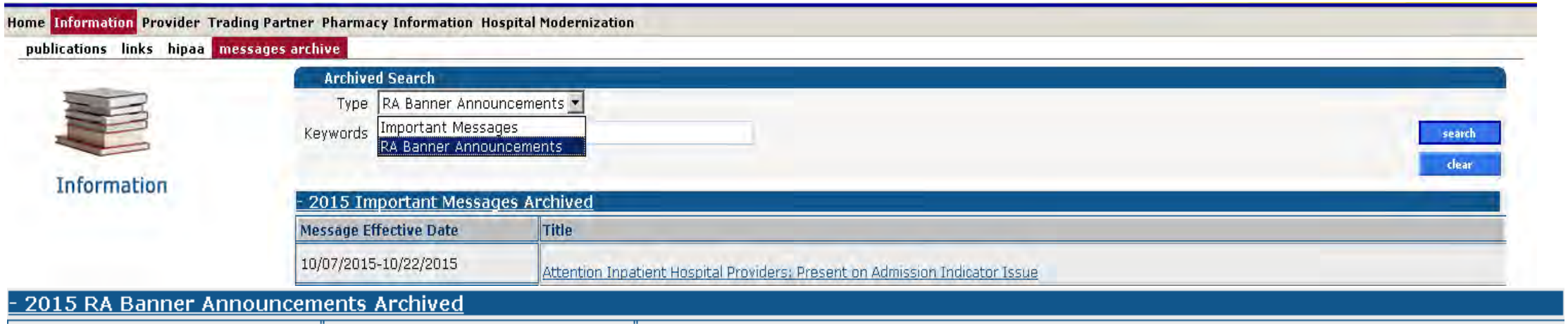
02/05/2016-02/12/2016	Attention Select Providers	Attention Select Providers. CLAIMS PROCESSING ISSUE: Hewlett Packard Enterprise has identified a claims reprocessing issue where claims originally processed with a temporary ID incorrectly denied when they were reprocessed with the client's true (permanent) 9-digit Connect Medical Assistance Program (CMAP) ID. The denied claims have been identified and reprocessed and will appear on the February 9, 2016 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 27.

Information – Resources

Archive Important Messages and Banner Announcements

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

– RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.

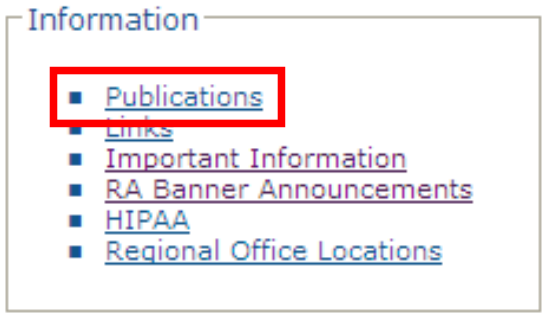


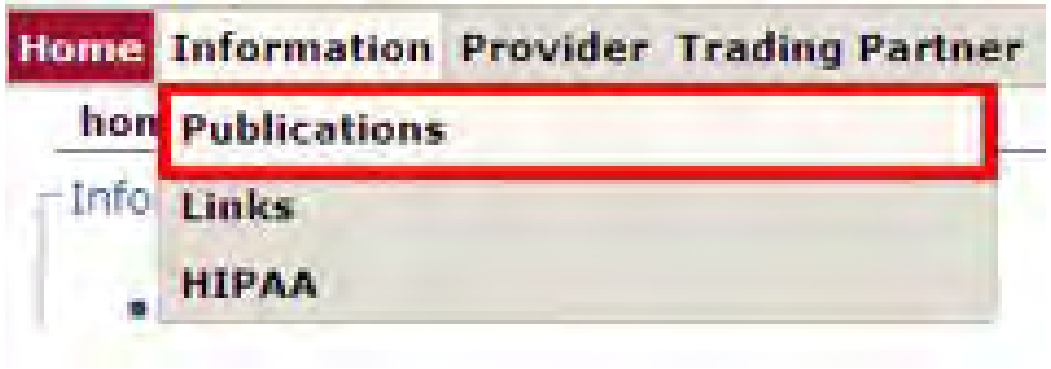
Information - Resources

Publications

– A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page

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





Information – Resources
Provider Bulletins

– Provider Bulletins
  – Publications posted to relevant provider types / specialties documenting changes or updates to the CT Medical Assistance Program
  – Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000



Bulletin Search

Year 15 Provider Type ALL PROVIDER TYPES

Number Title

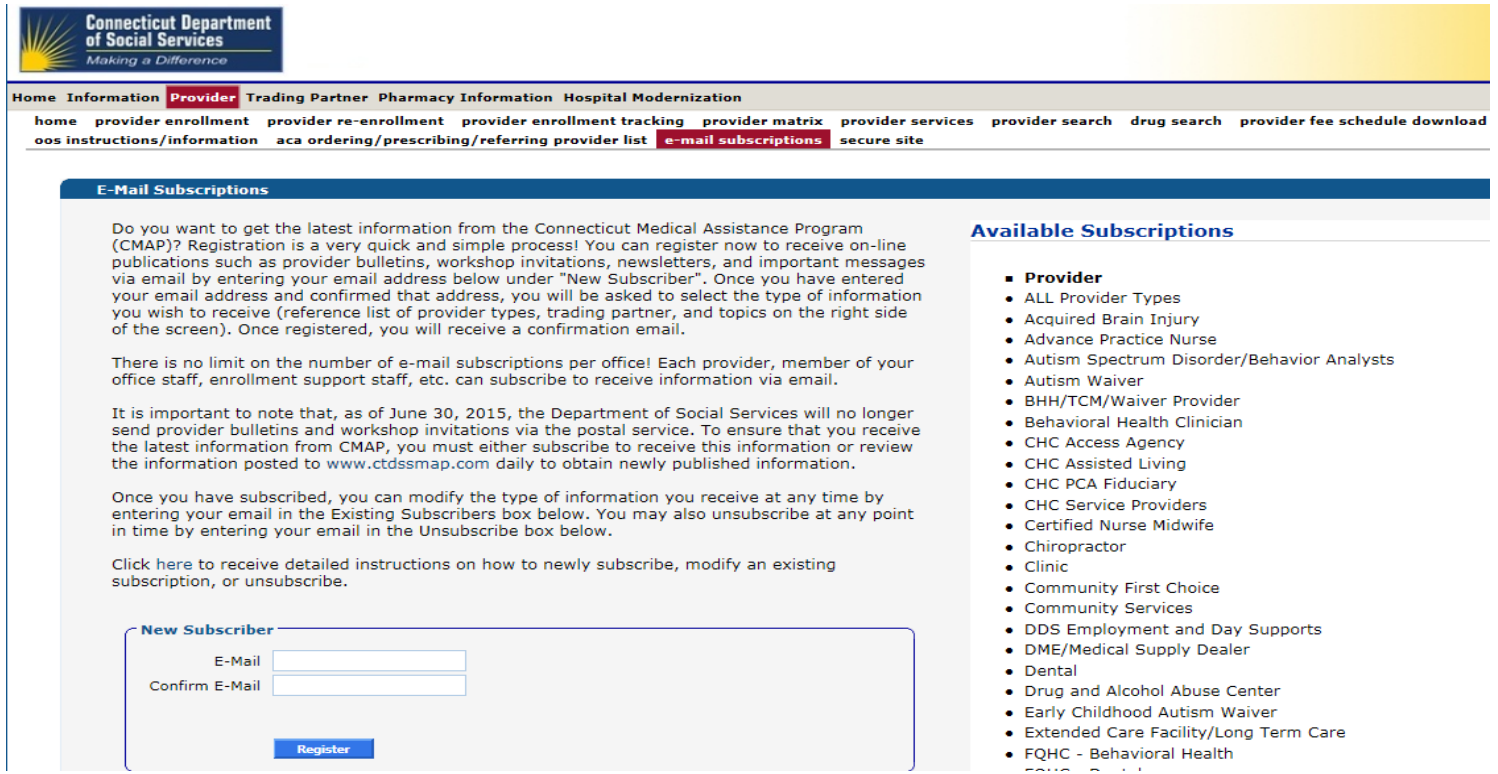
Search Results

Bulletin Number	Title	Published Date
PB15-85	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/08/2015
PB15-61	Claims Processing Guidance for Implementing ICD-10 Codes	08/04/2015
PB15-60	Eligible Clients under the Affordable Care Act Part IV (Temporary ID Update)	07/28/2015
PB15-55	Upcoming Changes to the Automated Voice Response System Menu Options	07/16/2015
PB15-54	Elimination of Mailing Paper Remittance Advices	07/14/2015
PB15-47	Fee Schedule Updates for ICD-10 Diagnosis Codes	06/30/2015
PB15-47	ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assista...	06/30/2015
PB15-50	Payment Error Rate Measurement (PERM) Program Audit Requests	06/30/2015
PB15-45	Billing Procedures for Services Ordered by Residents and Interns	06/22/2015
PB15-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/19/2015
PB15-35	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergenci...	05/05/2015
PB15-23	Implementation of Electronic Messaging - Replacement to the Mailing of Bulletins...	03/10/2015
PB15-05	Billing Clients for Missed Appointments	01/20/2015

Information- Resources
E-mail Subscriptions

Register for E-mail Subscriptions

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



Information – Resources
Provider Manual

– 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 CMAP claims, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions

– The Provider Manual is divided into twelve (12) chapters
  – Click on the chapter title to open the document (disable pop-up blockers)
  – Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter
  – Chapter 11 is claim-type specific

Information – Resources
Provider Manual

- Chapter 1 – Introduction
  - Provides information on the CT Medical Assistance Program, the Department of Social Services' and Hewlett Packard Enterprise's responsibilities and resources
- Chapter 2 – Provider Participation Regulations
  - Details the CMAP regulations for provider participation
- Chapter 3 – Provider Enrollment
  - Provides information on provider eligibility in regards to provider enrollment and re-enrollment
- Chapter 4 – Client Eligibility
  - Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability
- Chapter 5 – Claim Submission Information
  - Provides information on general claims processing and billing requirements
- Chapter 6 – EDI Options
  - Provides information on electronic claim submission and electronic RAs

Information – Resources
Provider Manual

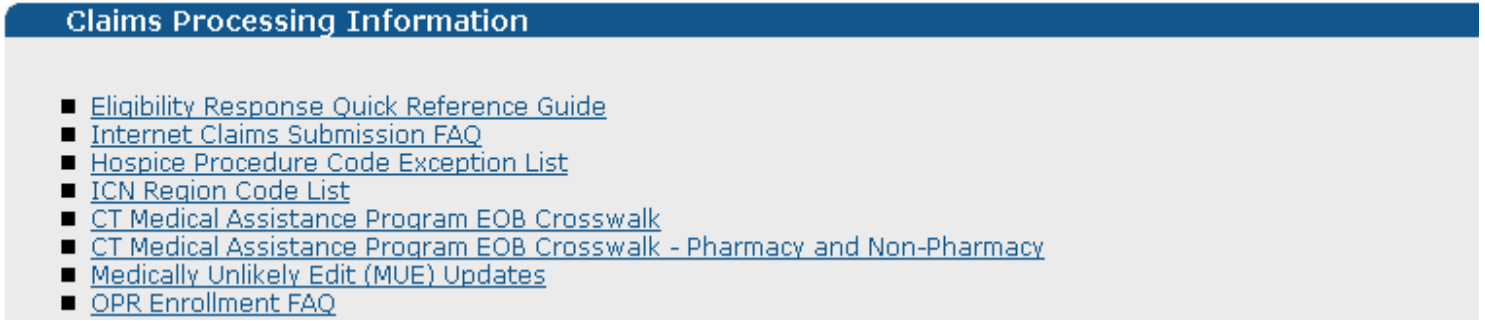
- Chapter 7 – Regulations/Program Policy
  - This section contains the Medical Services Policy sections that pertain to the chosen provider type
- Chapter 8 – Billing Instructions
  - Provides information on provider specific billing requirements and instructions
- Chapter 9 – Prior Authorization
  -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

Information – Resources
Other

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



- Claims Processing Information
  - **Guides and FAQs to assist with billing/claims processing**



Contacts

www.ctdssmap.com
Contacts

Resources
Contacts

- **Hewlett Packard Enterprise Provider Assistance Center (PAC)**
  - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
  - www.ctdssmap.com ctdssmap-ProviderEmail@HPE.com
  - This should be your first call resource to answer all enrollment and billing related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number for future call reference.

- **Hewlett Packard Enterprise Electronic Data Interchange (EDI) Help Desk**
  - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

- **Sandata (EVV) Technologies, LLC (EVV)**
  - Sandata Customer Care:
    - 1-855-399-8050 or ctcustomercare@sandata.com
      Monday thru Friday 8:00 AM – 6:00 PM

Case Management Agency Contact Information

Contacts

➢ **Connecticut Community Care (CCCI)**

- serviceauthissues@ctcommunitycare.org
- **Providers must include the following information when submitting service authorization issues to CCCI:**
  - Provider name, client name, client EMS number, CCCI number, EOB code on rejecting claim at Hewlett Packard Enterprise, from and to dates of service, the type service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day etc.) the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

➢ **South Western Connecticut Area on Aging (SWCAA)**

- **SWCAABillings@swcaa.org.**
- **Please have the following information available when contacting SWCAA:**
  - client name, the client EMS number, the type of service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit.

Case Management Agency Contact Information

Contacts

- **Western Connecticut Area on Aging (WCAA)**
  - **Contact WCAA directly at (203)465-1000**
  - **Please have the following information available when contacting WCAA:**
    - Client name, the client EMS number, type of service (adult family living/foster care, support broker services, CFC or home health services) the dates of service, the frequency of service and the number of units or hours per visit.

–

Questions/Comments

www.ctdssmap.com
Question and Comments

Hewlett Packard
Enterprise

Thank You For Attending

The Connecticut Medical Assistance Program

Acquired Brain Injury (ABI) Web Claim Submission Workshop

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey:

Your feedback helps us to improve future workshops

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
INDIV. SRVS BILLED BY ALLIED COMMUNTY - PROV.TYPE/SPECIALTY 52/029									
1212M	Recovery Assistant, Indiv	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1213P	Recovery Assistant II, Indiv	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1533P	Chore Service Individual	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1535P	Individual Companion Per 1/4 Hour	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	1	Optional
1537P	Companion Individual	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1538P	Environmental Modification Per Unit ($10,100/Yr=Max.)	$S	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
1546P	Independent Living Skill Development (Individual) Per Hour	1 per hour per 15 min-(eff dos 3/1/17)	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1562P	Respite Care Per Hour	1 per hour	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1564P	Specialized Medical Equipment Per Unit ($10,100/Yr = Max.)	$	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
1575P	Transportation - Mileage	Per Mile	Allied	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1578P	Vehicle Modification Per Unit ($10,100/Year = Max.)	$	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
ABI SRVS BILLED BY ABI SERVICE PROVIDERS - PROV. TYPE/SPEC. 52/027									
1021Z	Personal Care Services, Per 15 Minutes	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
33	Personal Care Services, Per 15 Minutes 1021Z, 1021Z TT	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1022Z	Personal Care Services, Overnight	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
34	Personal Care Services, Overnight 1022Z, 1022Z TT	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
3022Z	Personal Care Services, Overnight cannot be completed, prorated hourly	Per hour, up to 11 hours per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1023Z	Personal Care Services, Per Diem	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
35	Personal Care Services, Per Diem 1023Z, 1023Z TT	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1225Z	Personal Care Services, Per Diem cannot be completed, prorated hourly	Per hour, up to 23 hours per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1200Z	Adult Day Health - Full Day (Non-Medical Model Provider)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1201Z	Adult Day Health - Full Day (Approved Medical Model Provider)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1202Z	Adult Day Health - Half Day (Less Than Or Equal To 4 Hrs)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
971	Adult Day Care 1200Z, 1201Z, 1202Z	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
AD	ADULT DAY CARE(1Xonly) 1200Z U2 1201Z U2, 1202Z U2	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	2	N/A
1211P	Recovery Assistant	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1212P	Recovery Assistant II	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1232Z	Respite Care In The Home Per Hour-Other	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1448P	Cognitive behavioral interventions per 15 min not face-to-face	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1548P	Cognitive Behavioral Programs Per 15 min face to face	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
757	Cognitive Behavioral Services 1448P, 1548P	per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1531P	Community Living Support Services	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1532P	Chore Services Per 1/4 Hour	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1534P	Community Living Support Services Per 1/2 Day	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1536P	Companion Services Per 1/4 Hour (18-Hour/Day Max.)	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1538P	Environmental Modification Per Unit ($10,100/Yr=Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized	>$10,100 year, In Process status	WVR only	1&2	N/A
1542P	Homemaker Services Per 1/4 Hour	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1546P	Independent Living Skill Development (agency)	1 per hour per 15 min-(eff dos 3/1/17)	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1547P	Independent Living Skill Development (Group) Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1549P	Consultation Services	1 per year	ABI Srvc Prv only	N	Per year	Auto-approve	WVR only	2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1550P	Home Delivered Meals Per Day (Single Meal)	up to 7 per day/7 per week max	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1551P	Home Delivered Meals Per Day (Double Meals)	up to 7 per day/7 per week max	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
969	Meals 1550P, 1551P	up to 7 per day/7 per wk max any combo with single auths	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
AB	Meals (One time only) 1550P U2 1551P U2	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1556P	Personal Emergency Response System (Installation)	1 per year	ABI Srvc Prv only	N	Per year	Auto-approve	WVR only	1&2	N/A
1557P	Personal Service Emergency Response System (Monthly Service One-Way)	2 per month	ABI Srvc Prv only	N	Per month	Auto-approve	WVR only	1&2	N/A
1558P	Personal Emergency Response Two Way	1 per month	ABI Srvc Prv only	N	Per month	Auto-approve	WVR only	1&2	N/A
1560P	Pre-Vocational Services Per Hour (Max = 40 Hours/Week)	1 per hour	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	Optional
1561P	ABI Group Day	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve max 8 per day	WVR only	1&2	N/A
1562P	Respite Care Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1564P	Specialized Medical Equipment Per Unit ($10,100/Yr = Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized.	>$10,000yr, In-Process status	WVR only	1&2	N/A
1566P	Substance Abuse Program Per Day (56 Days/Yr = Max.)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1567P	Substance Abuse Program Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1572P	Supported Employment Per Hour (40 Hours/Week = Max. Cannot Be Provided With Pre-Voc.)	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1574P	Transportation - One Way Trip Public	Per Trip	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1575P	Transportation - Mileage	Per Mile	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1578P	Vehicle Modification Per Unit ($10,100/Year = Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized.	> $10,100 year, In-Process status	WVR only	1&2	N/A
1580P	Transitional Living Per Day (183 Days/Year = Max.)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1	N/A
H2035	A/d tx program per hour	1 per hour	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1	N/A
H2036	A/d tx program per diem	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1	N/A
T1013	Sign lang/oral interpreter	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1	N/A
CFC SRVS BILLED BY CFC FI - PROVIDER TYPE/SPEC 50/501									
CF	Personal Care Services: Per Diem 1019Z 1019Z TT 1019Z U2 1019Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Personal Care Services: Overnight 1020Z 1020Z TT 1020Z U2 1020Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Single Meal (hot) 1218Z, 1218Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
	Double Meal (One Hot - One Cold) 1220Z 1220Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Kosher Meals Double 1221Z 1221Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Two-Way PERS System (Ongoing Services) 1223Z, 1223Z TT	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	PCA Individual Per Diem (Prorated Hourly) 1227Z, 1227Z TT 1227Z U2, 1227Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	PCA Services 1520P, 1520P TT 1520P U2, 1520P TT U2	$S	CFC FI/PCA Srvc Prv only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Workers Compensation Coverage 1525P	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Personal Emergency Response System (Installation) 1556P, 1556P TT	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Support and Planning Coach, Individual 2042Z, 2042Z TT 2042Z U2, 2042Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Support and Planning Coach, Agency 2043Z, 2043Z TT 2043Z U2, 2043Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
	PCA Individual Overnight Prorated Hourly 3020Z, 3020Z TT 3020Z U2, 3020Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Physical Therapy Coach G0151, G0151 TT G0151 U2, G0151 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Occupational Therapy Coach G0152, G0152 TT G0152 U2, G0152 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Speech Language Therapy Coach G0153, G0153 TT G0153 U2, G0153 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Skilled services LPN/RN (Training/education) G0164, G0164 TT, G0164 U2, G0164 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
HOME HEALTH SRVS BILLED BY HOME HEALTH AGENCIES PROV.TYPE/SPEC 05/050									
H0033	Oral medication administration, direct observation	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
441	Speech therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated
431	Occupational therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated
421	Physical therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
T1001	Nursing Assessment/Evaluation	1 per initial or ROC eval	HOME HEALTH AGENCY ONLY	N	Per Date Span	Greater than 1 per year requires PA	MCD only	1&2	Mandated
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	Auto-approve	MCD only	1&2	Mandated
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	Auto-approve	MCD only	1&2	Mandated
T1004	Services of a qualified nursing aide, up to 15 minutes	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004,&/or NA or NN	MCD only	1&2	Mandated
NA	Srvcs, qualified nursing aid, up to 15 minutes T1004, T1004 TT	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004,&/or NA or NN	MCD only	1&2	Mandated
NN	Services of a qualified nursing aid, up to 15 minutes T1004 U2 T1004 U2 TT	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004&/or NA or NN	MCD only	1&2	Mandated
T1021	MED TECH (Home Health Aide or Certifiied Nurse Assistant)	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
MT	MED TECH (Home Health Aide or Certifiied Nurse Assistant) T1021 T1021 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
MU	MED TECH (Home Health Aide or Certifiied Nurse Assistant) T1021 U2 T1021 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
SN	Skilled Nursing S9123 S9123 TT S9124 S9124 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS,MA,MM	MCD only	1&2	Mandated
MA	Medication Administration T1502 T1502 TT T1503, T1503 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
SS	Skilled Nursing S9123 U2 S9123 U2 TT S9123 S9124 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
MM	Medication Administration T1502 U2 T1502 U2 TT T1503 U2 T1503 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
29	Oral medication admin., direct observation H0033, H0033 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated

EVV **NON-MEDICAL SERVICES** ARE **MANDATED** FOR CHECK-IN/CHECK/OUT **EFFECTIVE 1/1/2017.**									
EVV **MEDICAL SERVICES** ARE **MANDATED** FOR CHECK-IN/CHECK/OUT **EFFECTIVE 4/3/2017**									
NOTE:	ABI Benefit Plan 1=ABI Acquired Brain Injury 2= ABI II Acquired Brain Injury								
FOR NON-MEDICAL SERVICES:									
*** Spanned dates of service cannot span multiple line details on care plan.**									
*** Spanned dates of service cannot exceed the frequency (weekly or monthly) of services on the care plan.**									

Hewlett Packard Enterprise

Acquired Brain Injury (ABI)

Billing and Web Claim Submission Workshop

Presented by:
The Department of Social Services & Hewlett Packard Enterprise
for Billing Providers

Training Topics

- *Introduction to ABI Program Changes*
- *Access and Set-up of Secure Web Account*
- *Web Account Capabilities*
  - *Demographic Maintenance*
  - *Clerk Account Maintenance/Set-up*
    - *Switch Provider*
  - *Client Eligibility*
  - *Prior Authorization (PA)*
  - *Claim Inquiry/Submission Guidelines*
- *Common Claim Errors and Resolution*
- *Remittance Advice (RA)*
  - *Access to Claim and Financial Reporting*
    - *Components of RA*
- *Monthly Recoupment/Reprocessing due to Care Plan/PA Changes*
- *Web Information – Resources*
  - *www.ctdssmap.com*
    - *Important Messages*
    - *EVV IM*
    - *Procedure Code Crosswalk*
    - *Fee Schedule*
    - *Banner / IM Archive*
    - *Bulletins*
    - *E-Messaging*
    - *Provider Manuals*
- *Contacts*
- *Questions/Comments*

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***<u>Effective</u> for dates of service, <u>September 1, 2016</u>***

- Organizations and Self Employed Individuals must enroll as **"ABI Service"** providers to be reimbursed by the Department of Social Services (DSS) for performing a wide range of non-medical, home and community based services to help maintain adults who have an acquired brain injury (not a developmental or degenerative disorder) in the community, **who do not self direct their own care**, and are eligible for either the **ABI I or ABI II Waiver.**

  - Organizations and Self-Employed Individuals **must be credentialed by Allied Community Resources before their application will be considered complete to send to DSS for approval.**

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ ***Effective for dates of service, September 1, 2016***

- Providers who are ready, may begin using EVV for both mandated and optional services effective for dates of service **September 1, 2016.**
- Providers who are not ready may bill both EVV mandatory and optional services directly to Hewlett Packard Enterprise until **November 1, 2016.**
- Providers who's services are not mandated or optional must submit all services with dates of service effective **September 1, 2016** directly to Hewlett Packard Enterprise for payment.
- Providers should refer to the EVV Service Code Listing link in the Electronic Visit Verification Implementation Important Message on the www.ctdssmap.com Home page for EVV mandated and optional services.

ABI Billing and Web Claim Submission Workshop

➢Effective for dates of service <u>November 1, 2016:</u>

- Provider's **must utilize the EVV system** for services that are **mandated** by EVV.
- Providers may choose to implement the EVV check-in/check-out process for optional service.
- Services entered into the EVV system will be **submitted directly from the EVV system** to **Hewlett Packard Enterprise**, the Department of Social Services Fiscal Agent, when the **service matches the authorization**.

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes

➢ Effective for dates of service September 1, 2016:

- Claims that require correction for services that are **EVV mandated** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **the EVV system.**

- Claims that require correction for services that are **EVV optional** that have been **submitted** to Hewlett Packard Enterprise via the **EVV system**:
  - must be **recouped** via **Hewlett Packard Enterprise.**
  - can be **resubmitted** via **the EVV system or Hewlett Packard Enterprise.**

- Claims that require correction for services that are **not EVV mandated or optional** that have been **submitted** directly to Hewlett Packard Enterprise by the provider
  - must be **recouped or adjusted** via **Hewlett Packard Enterprise.**
  - must be **resubmitted** via **Hewlett Packard Enterprise.**

ABI Billing and Web Claim Submission Workshop

Introduction to ABI Program Changes cont.

➢ ***Effective for dates of service, September 1, 2016 and Mandated for dates of Service November 1, 2016:***

Self Directed Services

- All claims for CFC services, regardless of the EVV check-in/check-out election, will continue to be billed by Allied Community Resources, the Department of Social Services ABI Fiduciary.
- The EVV check-in/check-out process is either optional or not required for ABI services rendered to clients who self direct their own care through the Community First Choice (CFC) services option.
  - Although CFC services are optional, the client may choose to implement the EVV check-in/check-out process.

Secure Web Account Set-up

www.ctdssmap.com
Secure Web Account

ABI Billing and Web Claim Submission Workshop

Secure Web Account Set-up – Access to Secure Web Portal

Providers who have successfully enrolled as ABI Service Providers will receive:

✓An approval letter with their new AVRS/Medicaid ID

✓Additional letter under separate mailing containing their Personal Identification Number (PIN)

– The AVRS ID and PIN allow the provider initial access to the Connecticut Medical Assistance Program Secure Web Portal for the purpose of creating a **secure Web account.**

ABI Billing and Web Claim Submission Workshop

Secure Web Account Set-up – Access to Secure Web Portal

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



ABI Billing and Web Claim Submission Workshop

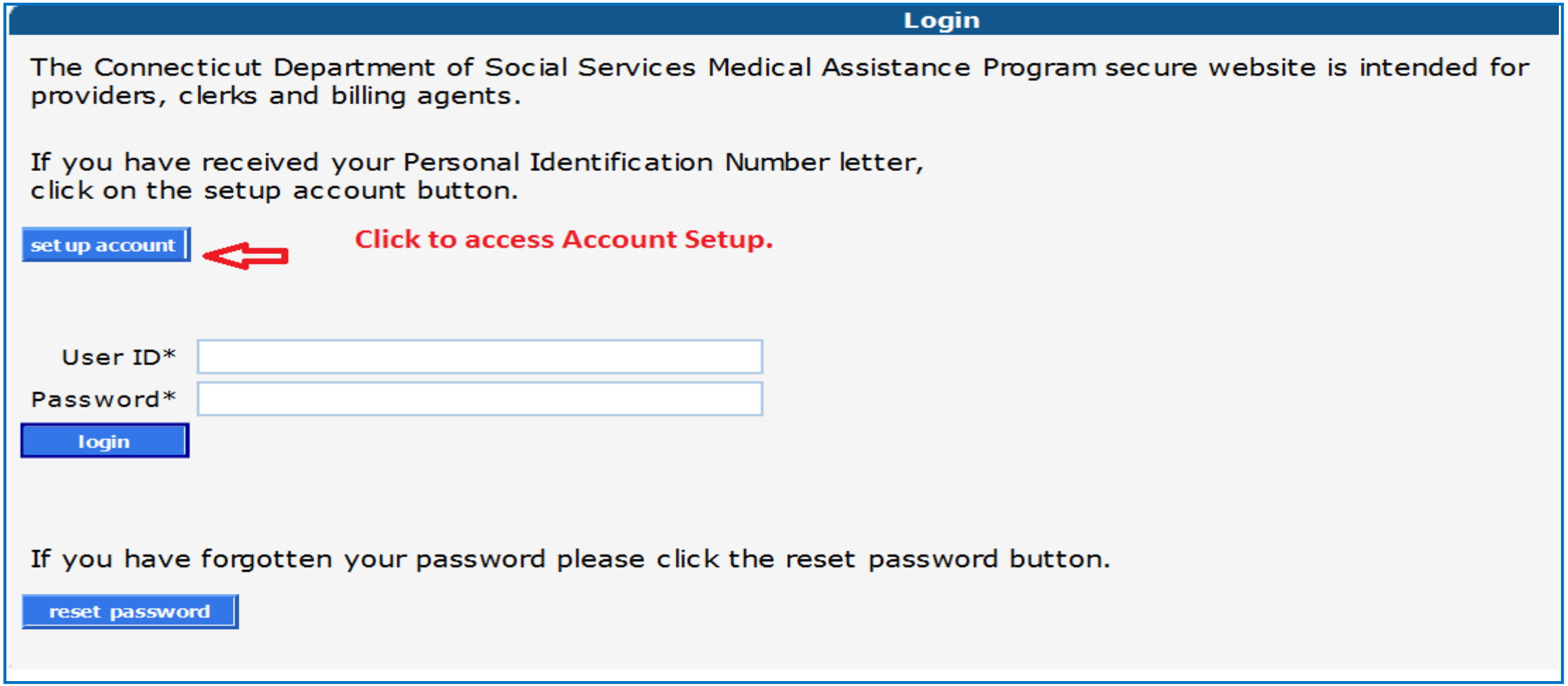
Secure Web Account Set-up – Access to Secure Web Portal

To ensure your access to the www.ctdssmap.com 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 (CMAP) Web site.

ABI Billing and Web Claim Submission Workshop

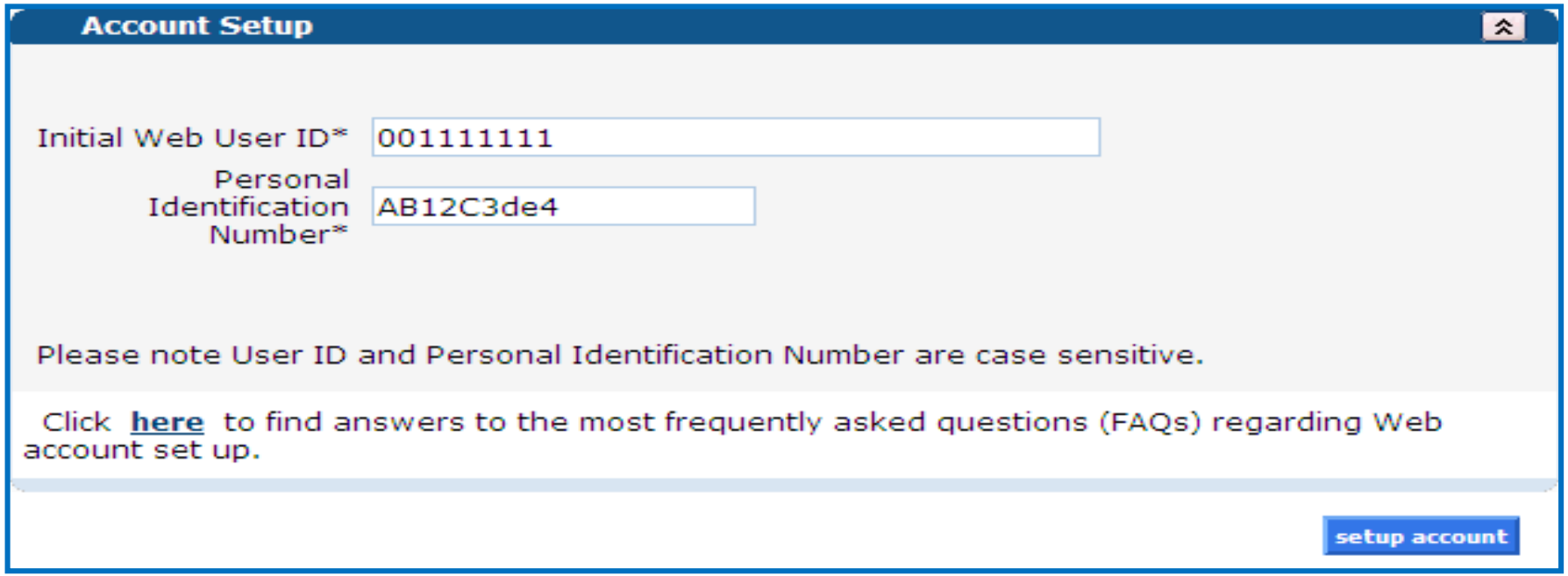
Secure Web Account Set-up – Access to Secure Web Portal



ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

- Account Setup- Allows providers to set up a local administrator user account.
- Enter the provided *Initial Web User ID* and *PIN* (which can be found in the enrollment and PIN letters), in the appropriate fields; click ***setup account***.

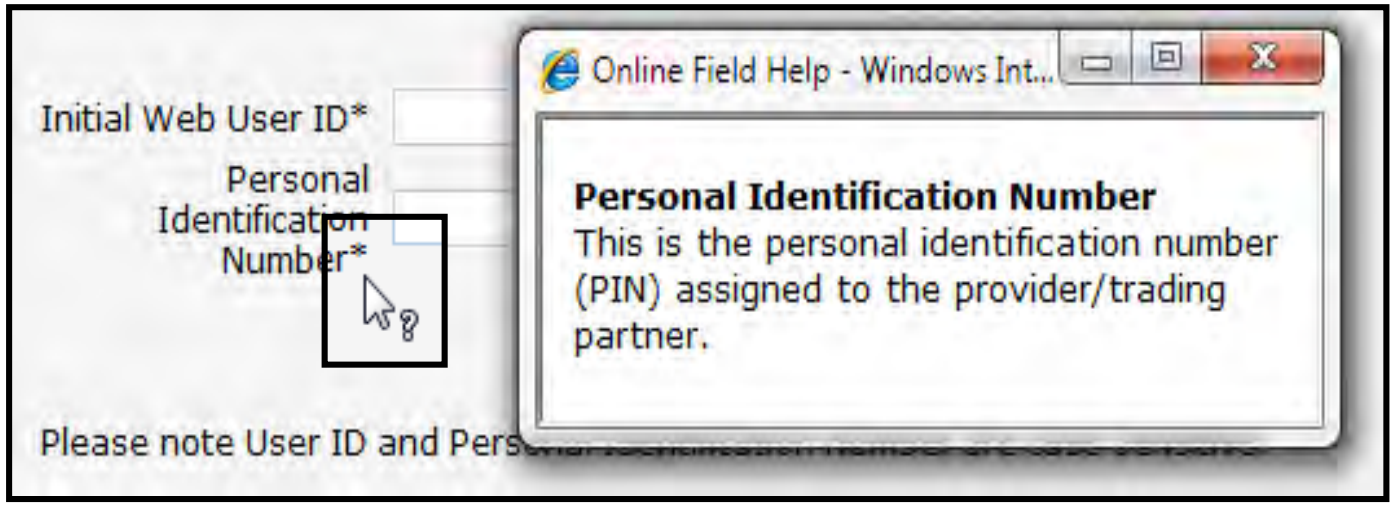


ABI Billing and Web Claim Submission Workshop

Secure Web Account - Online Field Help

– The ctdssmap.com Web site features an ***Online Field Help Window*** to assist providers with accessing and submitting information.

– Placing your mouse 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.



ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

➢Once on the ***Account Setup*** screen, fill in the fields with the appropriate information.

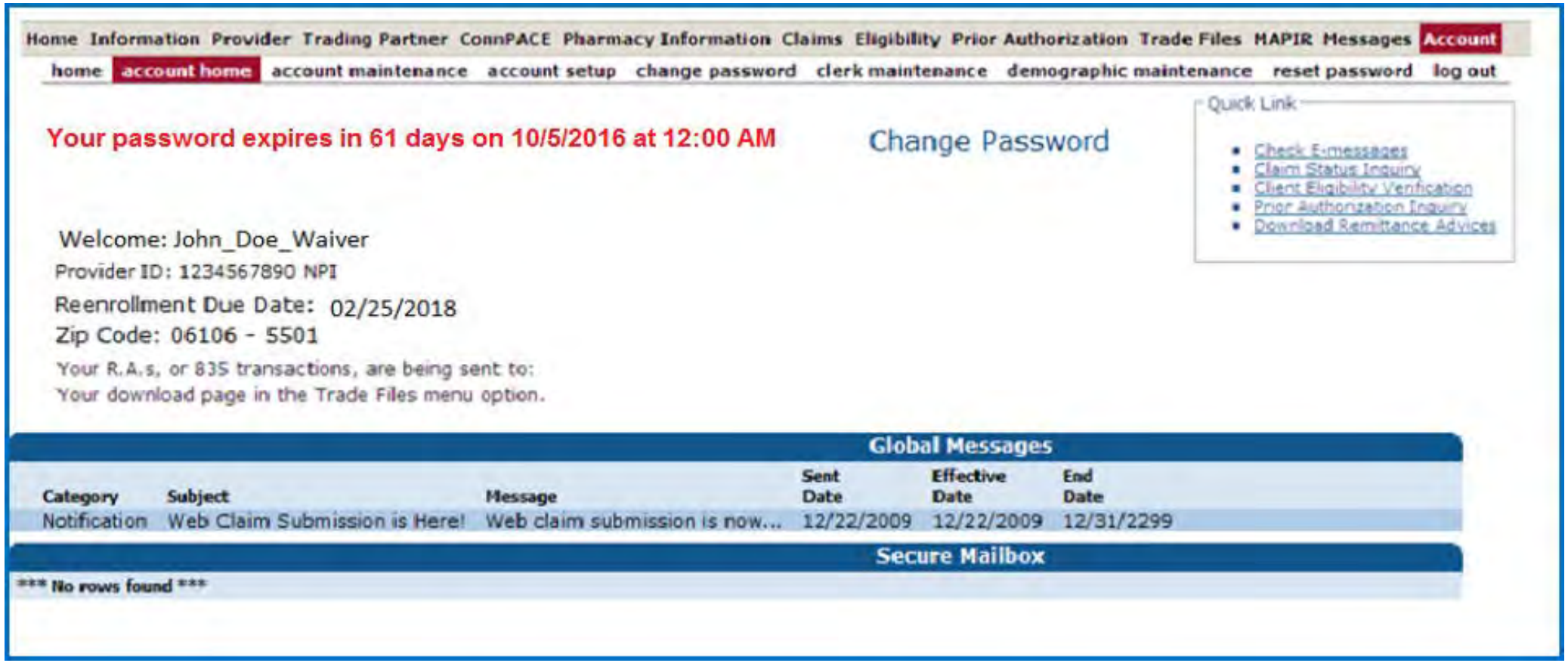


****Before clicking submit, be sure to write down the chosen User ID, Password, and security question/answer(s) and keep them in a secure location.****

ABI Billing and Web Claim Submission Workshop

Secure Web Account Setup

– You have successfully set up your ctdssmap.com *Secure Site* account



Web Account Capabilities

www.ctdssmap.com

ABI Billing and Web Claim Submission Workshop

Web Account Capabilities

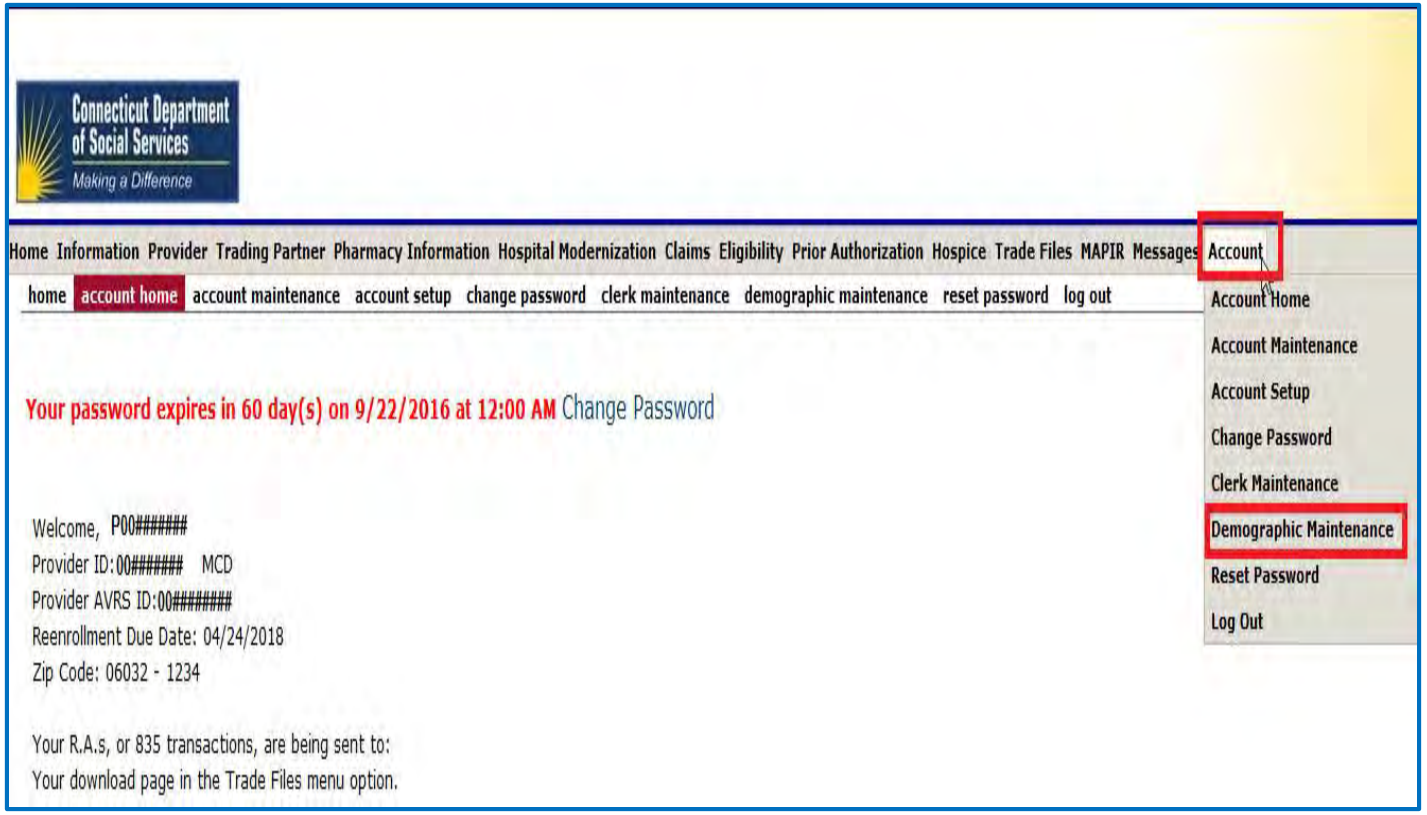
Accessing your Secure Site provider account allows you to:

- Update your demographic information (addresses/phone numbers/bank accounts/organization members)
- Verify re-enrollment due date(s)
- 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 (EVV, electronic, paper)
- Obtain your Remittance Advice (RA)

Demographic Maintenance

ctdssmap.com
Web Account Capabilities

Web Account Capabilities
Demographic Maintenance

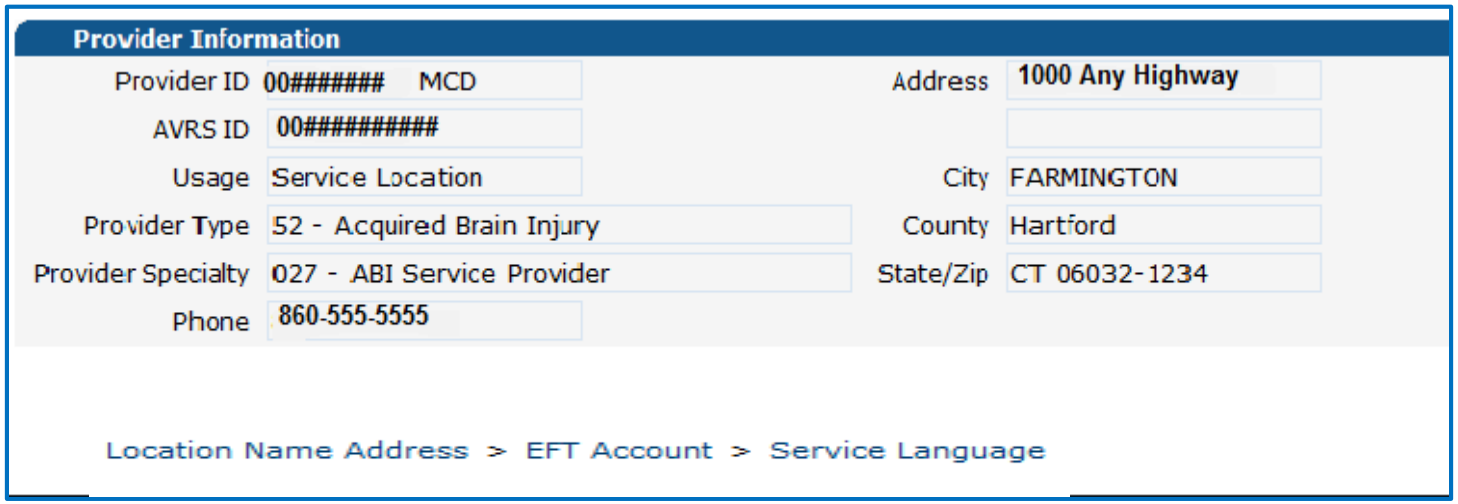


The Demographic Maintenance section of the Secure Site allows you to alter and maintain demographic information:

- Mail to, Pay to, Service Location, and Enrollment addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Service Language

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

Web Account Capabilities
Demographic Maintenance cont.



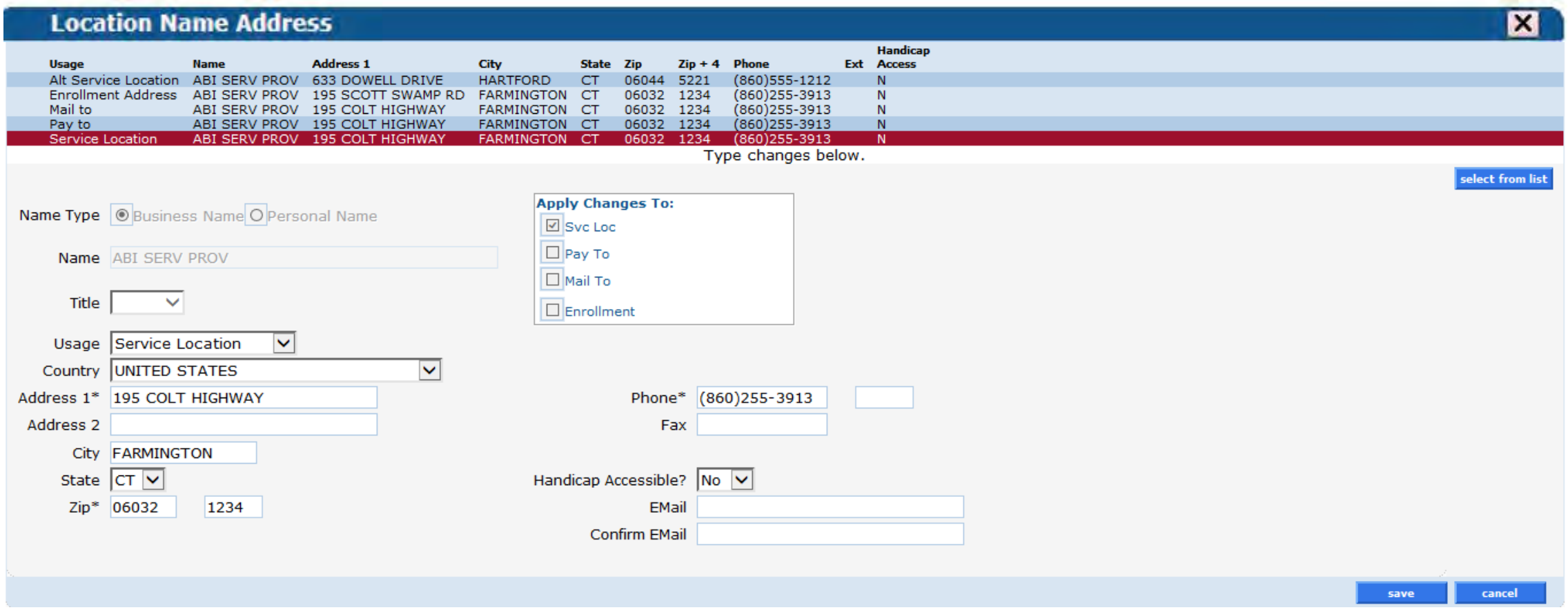
The Demographic Maintenance page displays the provider information panel as well as a submenu

- Clicking the submenu options will open a panel with related information:
- Location Name Address
- Electronic Funds Transfer (EFT Account)
- Service Language - Language, Effective Date, End Date

Web Account Capabilities

Demographic Maintenance cont.

– Specify different mailing, payment, service location and enrollment addresses.



Web Account Capabilities
Demographic Maintenance cont.

– **To alter address information, simply select the applicable row from the provided list (Enrollment Address, Mail to, Pay to, or Service Location); then click maintain address**



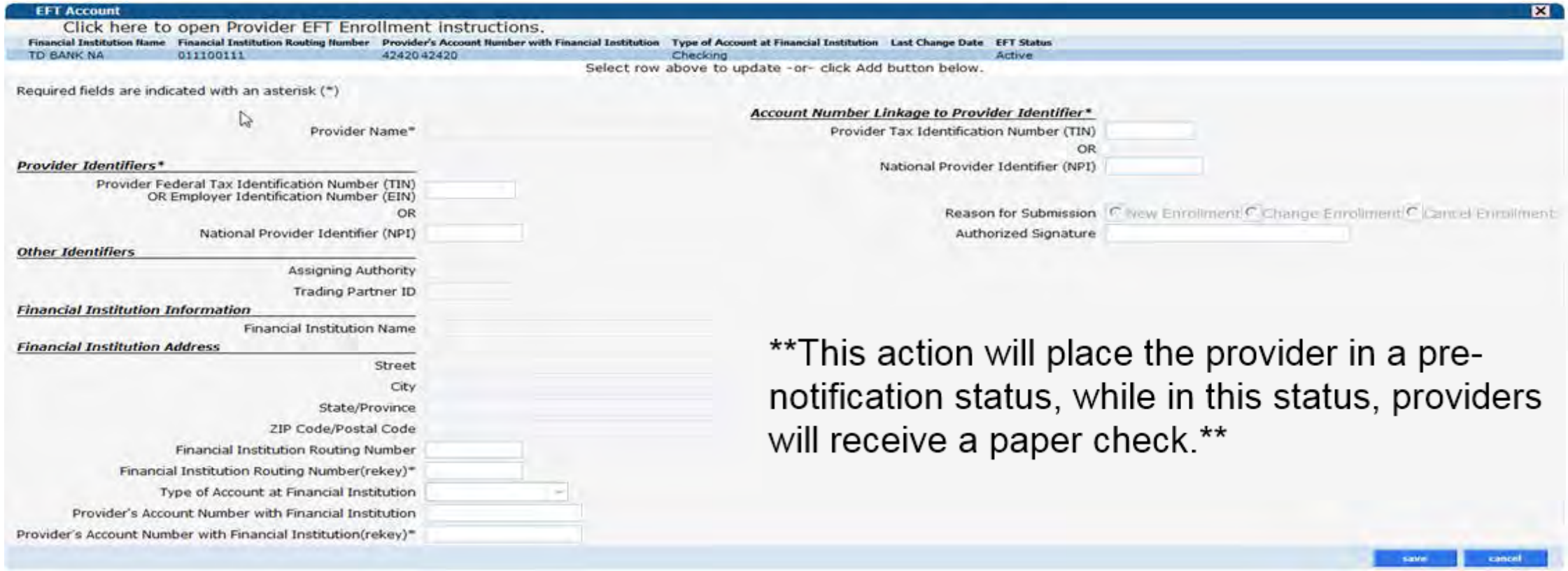
– **Select/fill in the appropriate information (address, phone number, etc); click save**



Web Account Capabilities

Demographic Maintenance cont.

The EFT Account panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited. Click add; enter the appropriate information; and click save.



This action will place the provider in a pre-notification status, while in this status, providers will receive a paper check.

Clerk Maintenance

www.ctdssmap.com
Web Account Capabilities

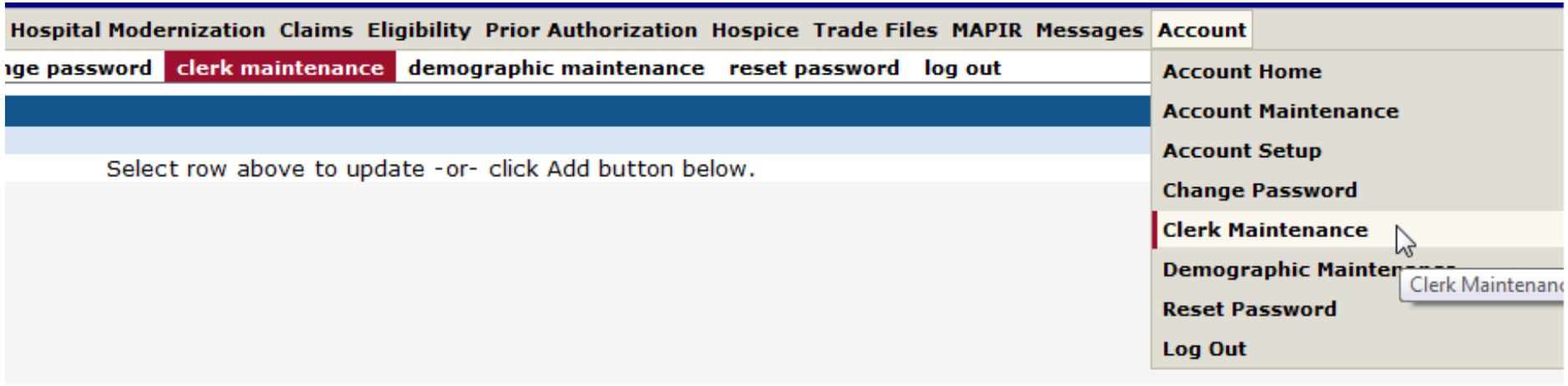
Web Account Capabilities

Clerk Maintenance

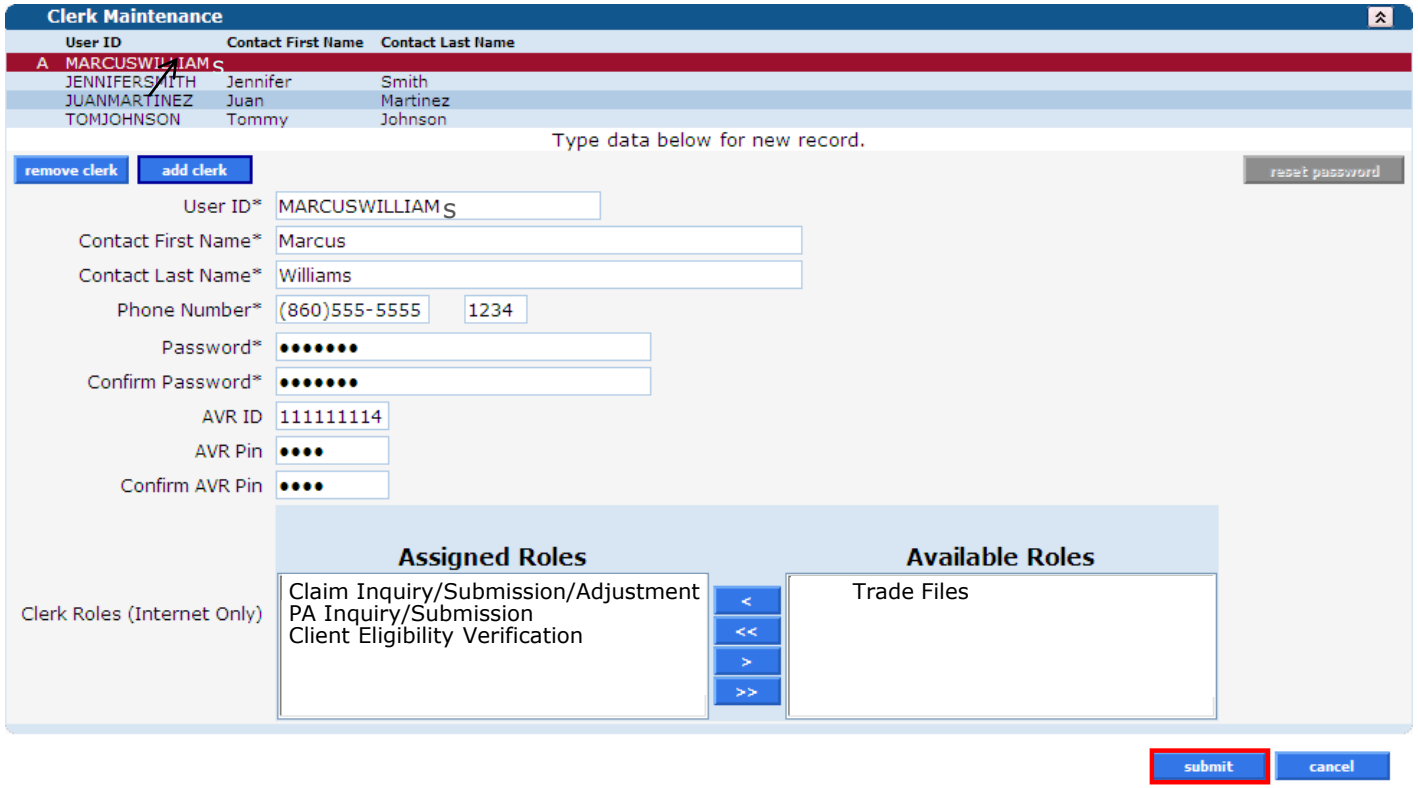
– Clerk accounts grant Web access to staff members allowing them to perform functions based on their job responsibilities

– The main account 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

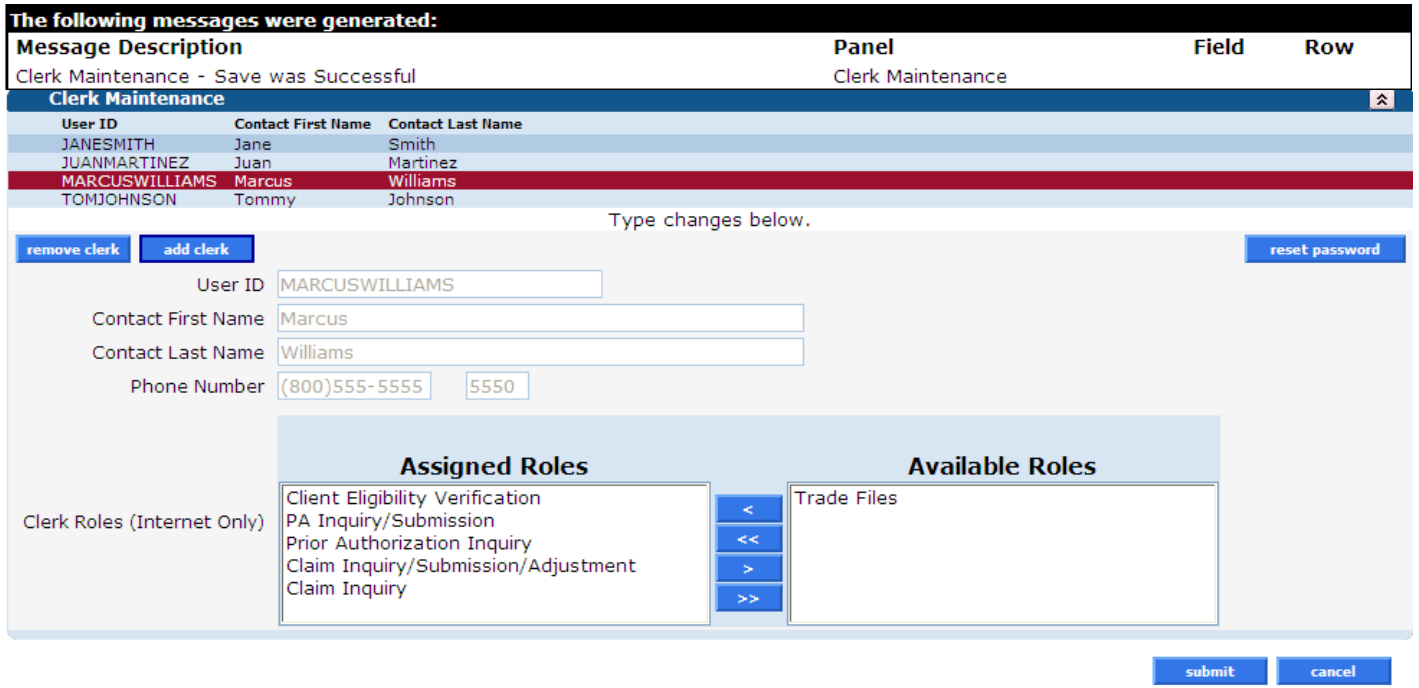


Web Account Capabilities
Clerk Maintenance



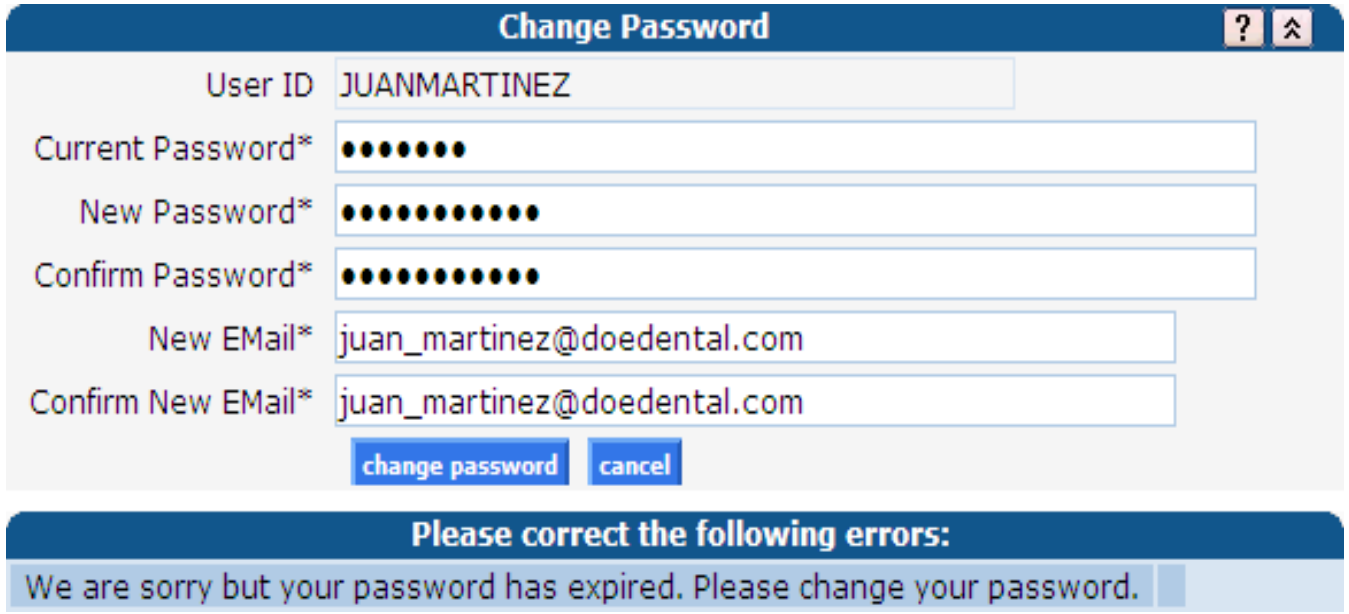
- To create a new clerk account, click add clerk
- Fill in the required fields, click submit

Web Account Capabilities
Clerk Maintenance



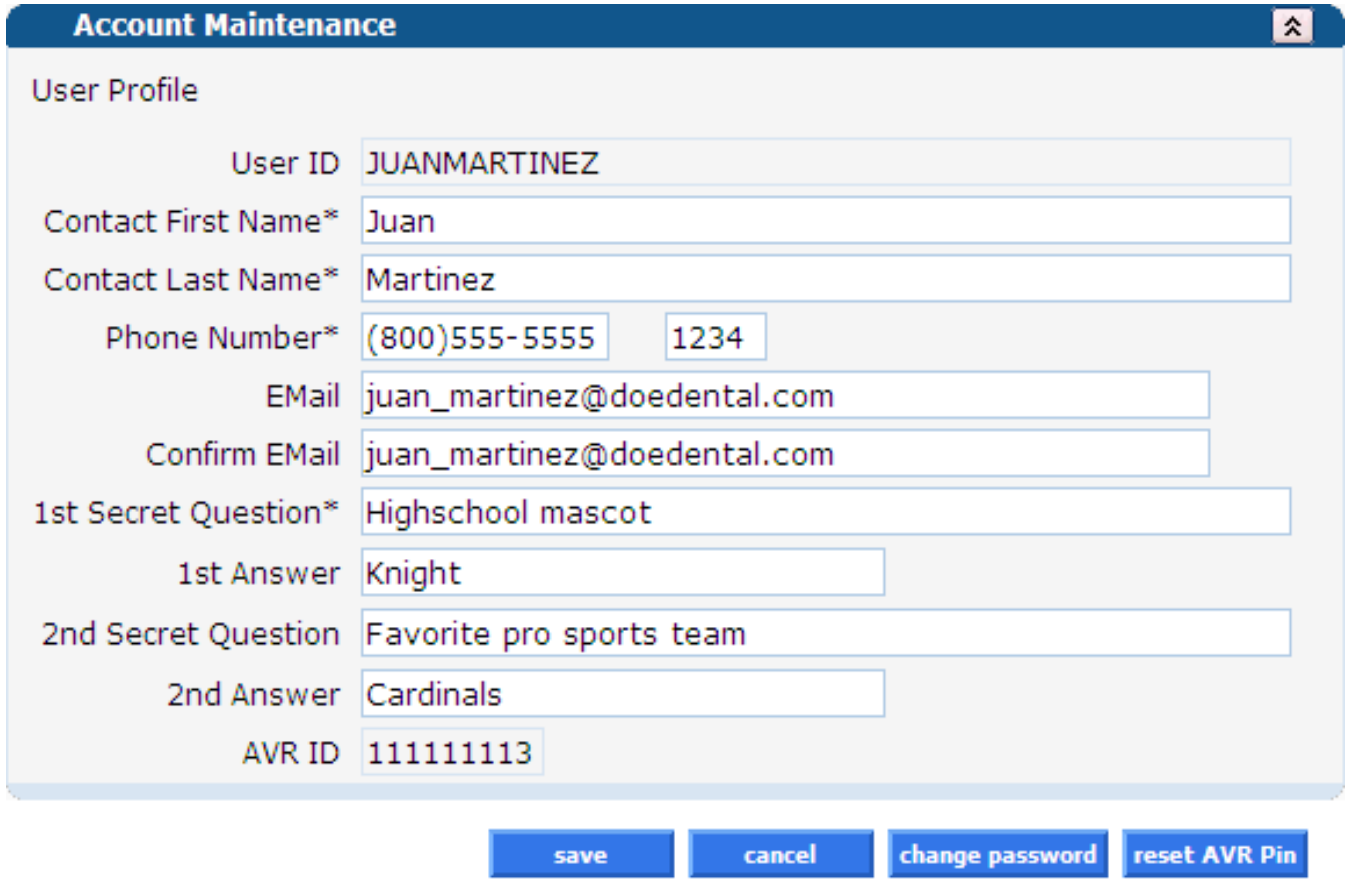
– Return to the Clerk Maintenance menu to add additional clerks, reset an existing clerk's password, or to alter clerks' Assigned Roles

Web Account Capabilities
Clerk Maintenance



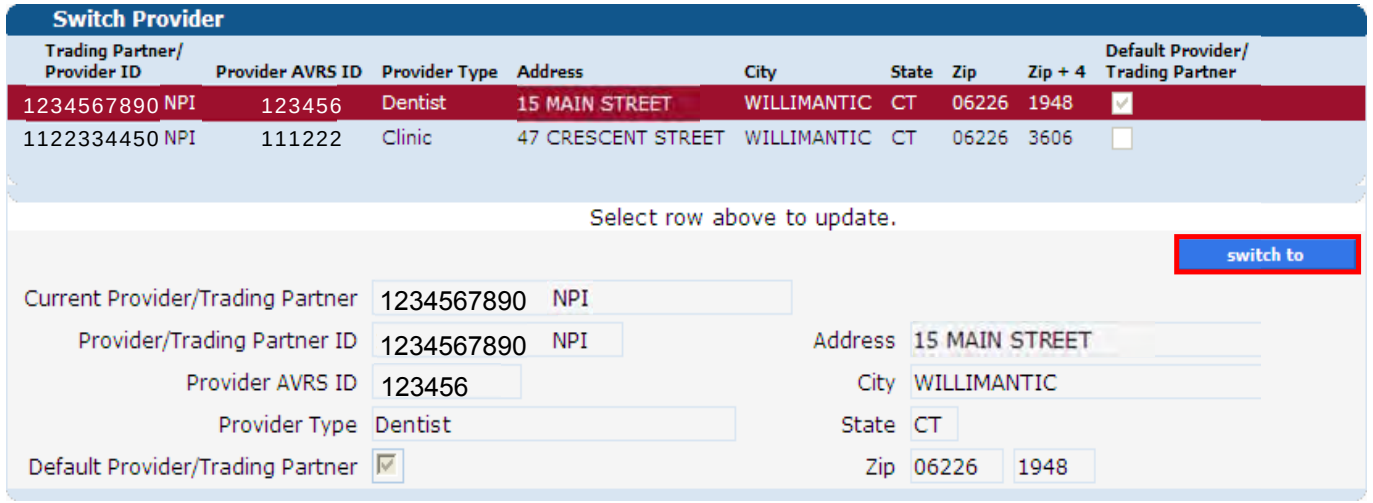
- When a new clerk logs into the Secure Site for the first time, they will be required to change their password from the one created by the account administrator
- Fill in the fields with the appropriate information; click change password
  - The clerk is now ready to perform the job duties allowed under the Assigned Roles chosen by the account administrator

Web Account Capabilities
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; click save

Web Account Capabilities
Clerk Maintenance



- Once a clerk ID is created by the local administrator, the same clerk ID can be added to more than one main account, this will allow the clerk the ability to switch back and forth between submitting online transactions for those providers
- Select switch provider from either the Account submenu or the Account drop-down menu
- Select the appropriate provider; click switch to. A window will appear asking you to verify the switch; click OK

Web Account Capabilities
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 

Clerk Maintenance

	User ID	Contact First Name	Contact Last Name
D	JANESMITH	Jane	Smith
	JUANMARTINEZ	Juan	Martinez
	MARCUSWILLIAMS	Marcus	Williams
	TOMJOHNSON	Tommy	Johnson

The following messages were generated:

Message Description	Panel	Field	Row
Clerk Maintenance - Save was Successful	Clerk Maintenance		

Clerk Maintenance

User ID	Contact First Name	Contact Last Name
JUANMARTINEZ	Juan	Martinez
MARCUSWILLIAMS	Marcus	Williams
TOMJOHNSON	Tommy	Johnson

Eligibility Verification

www.ctdssmap.com
Web Account Capabilities

ELIGIBILITY VERIFICATION

Eligibility Verification Methods

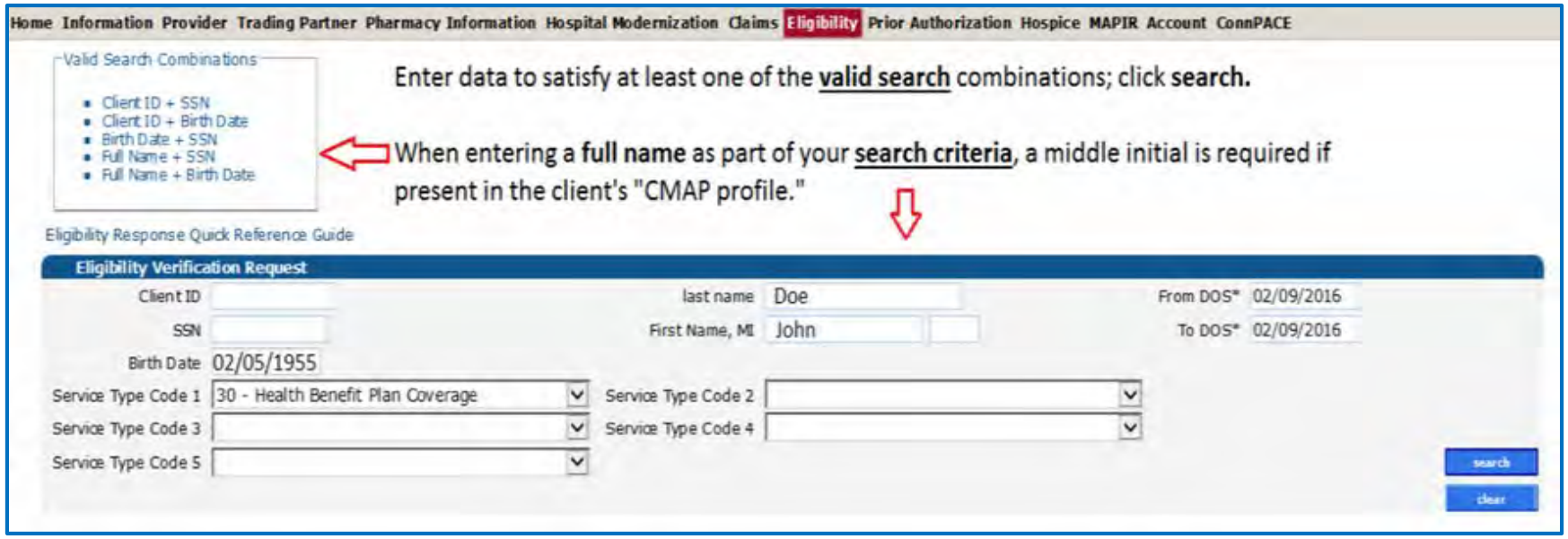
- Receipt of a service order from the Case Management Agency confirms the client is ABI Waiver eligible, however, the client's eligibility file may not yet reflect the client's ABI Waiver eligibility. To avoid unnecessary claim denials such as:
  - The client was not eligible on the date of service.
  - The service provided was not a covered service under the client's benefit plan.

  Verify client eligibility upon receipt of the initial service order.

- 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.
  - Provider Electronic Solutions (PES) software.

Web Account Capabilities
Eligibility Verification

– To verify a CMAP client's eligibility through the Secure Site – click on the Eligibility tab on the main menu



Web Account Capabilities

Eligibility Verification

The Eligibility Verification Response window provides the search results

– In this specific case – the client's eligibility cannot be verified for the requested dates (Sept. 1, 2013) – eligibility verification can only look back one year

– Changing the dates of the eligibility request to within the allowable one year window creates a different result.



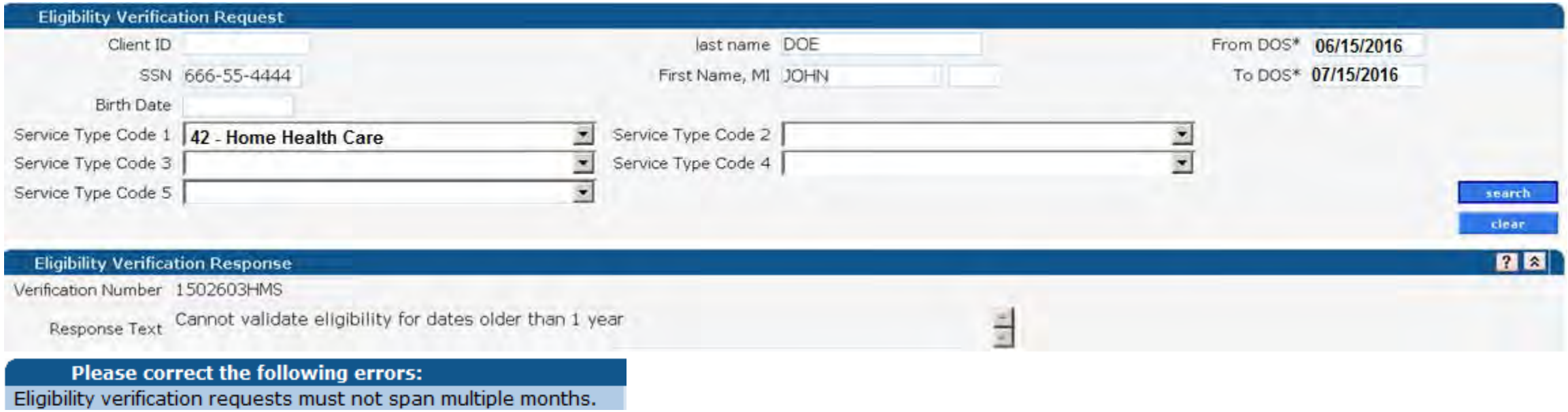
Web Account Capabilities

Eligibility Verification

Eligibility searches cannot span multiple months

– 12/01/2015 – 12/31/2015 is valid, 12/31/2015 – 1/15/2016 is not valid

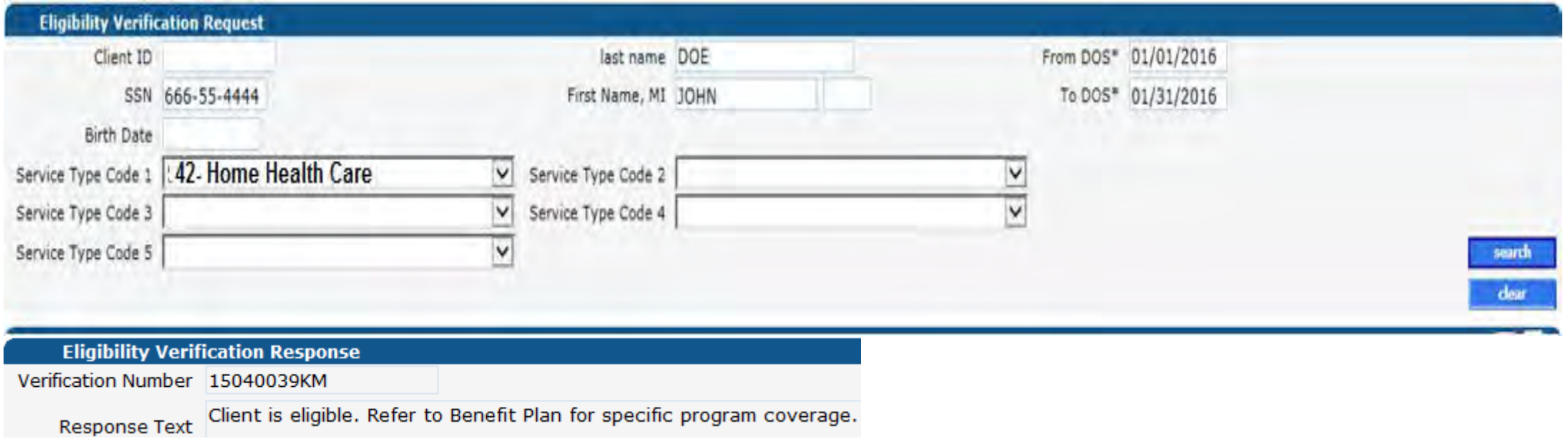
– Submitting a request that spans multiple months will result in an error message.



Web Account Capabilities

Eligibility Verification

Positive eligibility responses provide greater detail…



Web Account Capabilities

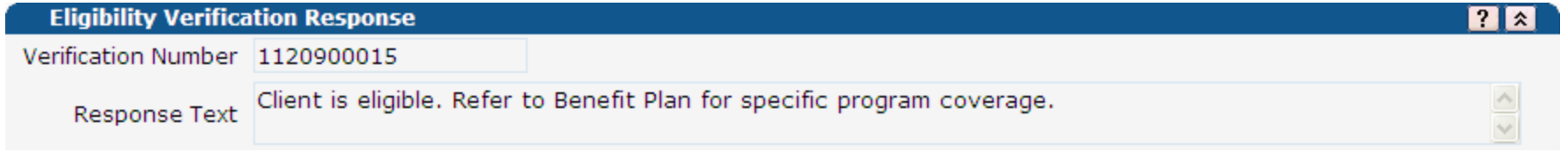
Eligibility Verification

What does all this information mean?

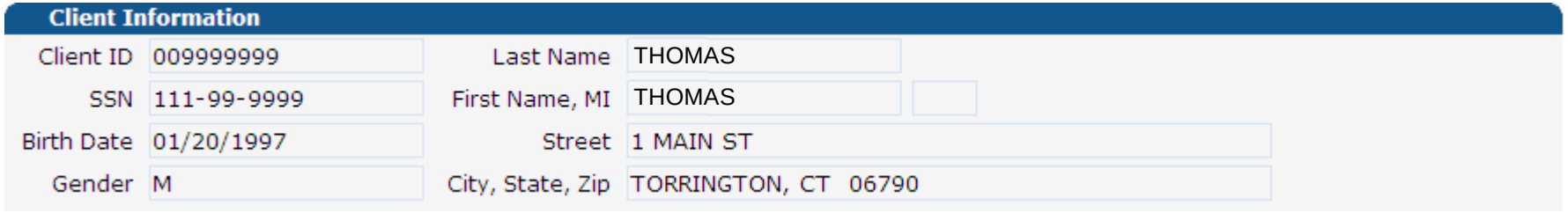
Eligibility Verification Response

– 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



Client Information



Web Account Capabilities

Eligibility Verification

Benefit Plan

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

- The client must have an ABI I or ABI II Waiver benefit plan for the ABI Service provider to be reimbursed for services provided to an ABI client and billed via EVV or directly by the ABI Service provider.
- The client must also have a HUSKY A, C or D benefit for Community First Choice (CFC) services that may be provided to an ABI Self Directed Waiver client by an ABI Service provider. Services are billed and payable to Allied Community Resources who will reimburse the ABI Service provider directly.

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
ABI II Acquired Brain Injury	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	07/01/2016	07/01/2016	07/31/2016	The eligibility response is based on current eligibility and is subject to change. Please validate again on the actual date of service.

Web Account Capabilities

Eligibility Verification

Service Type Codes – Hewlett Packard Enterprise

– A list of services for which the client was eligible that would be submitted for payment to Hewlett Packard Enterprise

Service Type Codes - HP Services

Service Type Code	Service Type Information	Copay	Coinsurance
1	Medical Care		
33	Chiropractic	$0.00	0%
35	Dental Care		
4	Diagnostic X-Ray	$0.00	0%
42	Home Health Care	$0.00	0%
45	Hospice	$0.00	0%
47	Hospital	$0.00	0%
48	Hospital - Inpatient	$0.00	0%
5	Diagnostic Lab	$0.00	0%
50	Hospital - Outpatient	$0.00	0%

1 2 3 Next >

Web Account Capability

Eligibility Verification

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

Lockin

Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	08/05/2011	08/05/2011	HOSPICE AGENCY2	(860)255-3913

Medicare

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

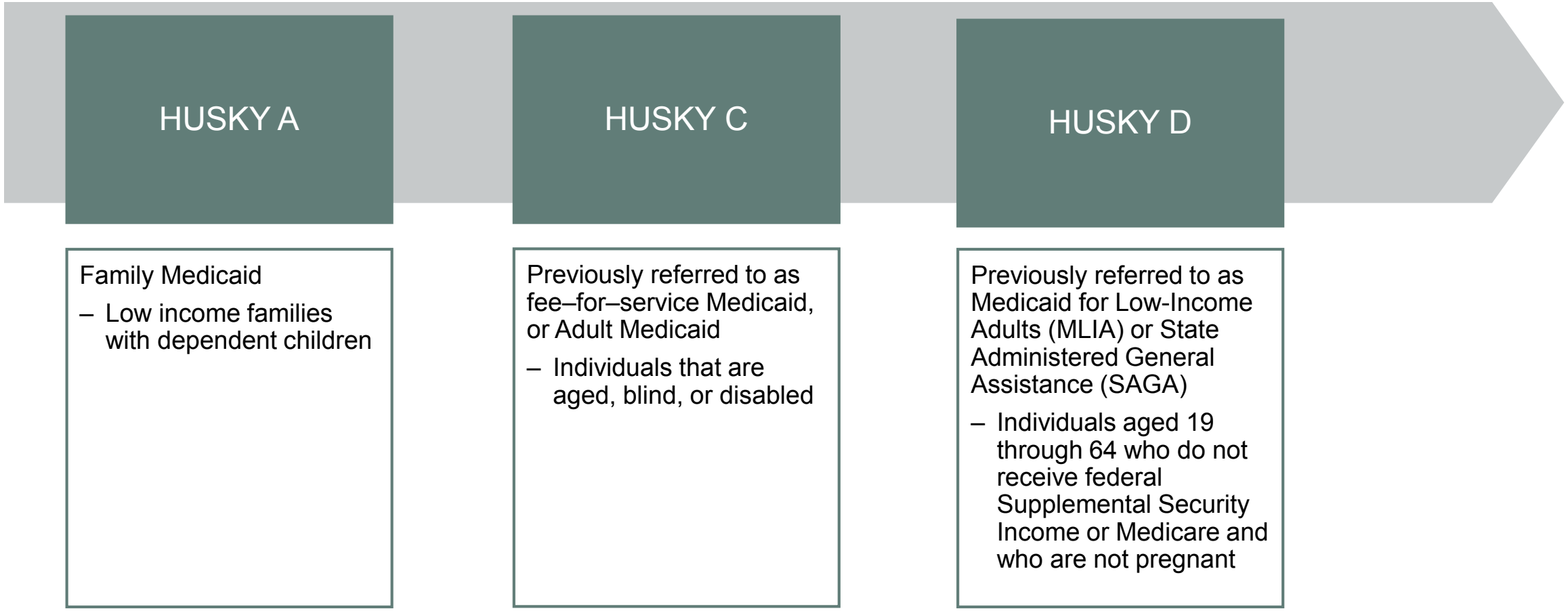
Medicare

Coverage
Medicare A
Medicare B

Web Account Capabilities

Eligibility Verification

Benefit Plans payable for CFC Services



Prior Authorization

www.ctdssmap.com

Web Account Capabilities

Prior Authorization

CARE PLAN ACCESS

Effective September 1, 2016, ABI Service providers *will have access to the care plans of the client's they service via the* ***secure Web portal*** *within the* ***Prior Authorization (PA) subsystem****.*

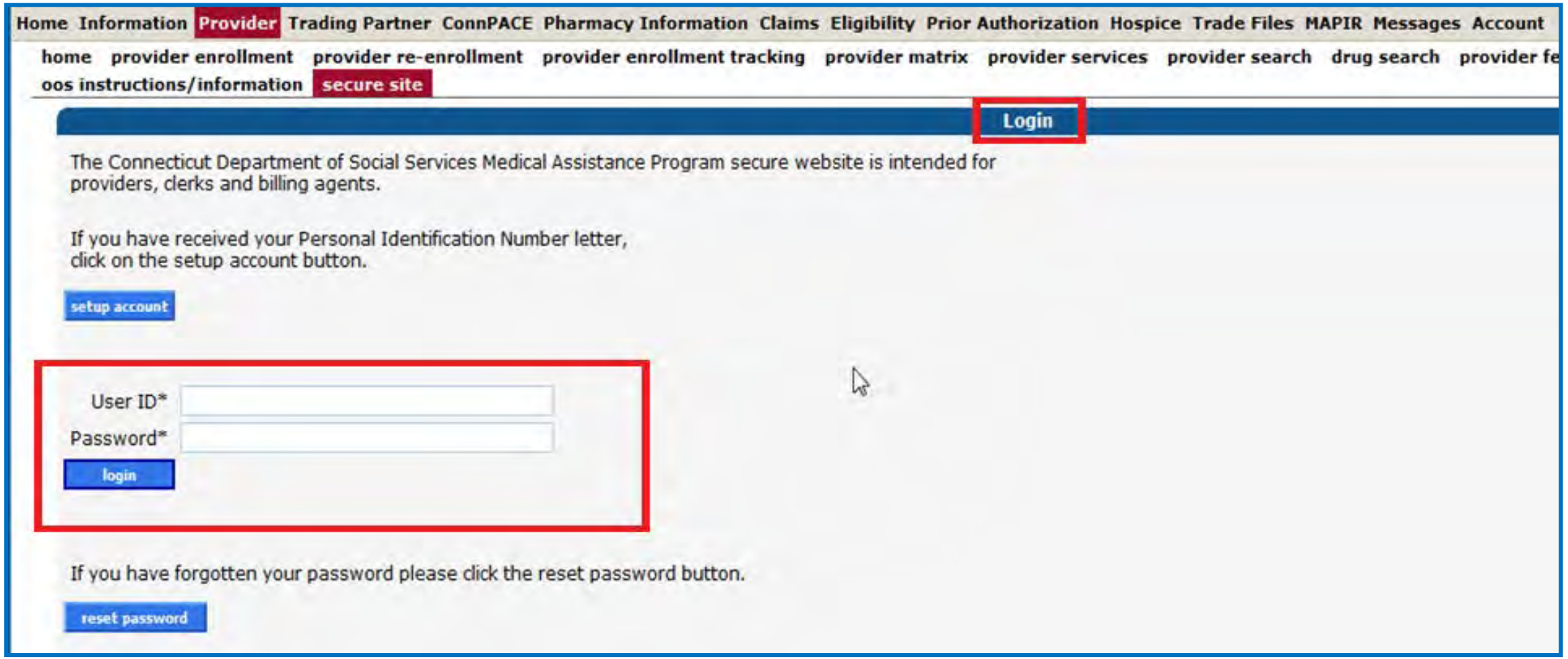
- Each service on the care plan has its own **unique PA#** and **viewable** to the **servicing provider** via a **PA inquiry.**

- All ABI services billed directly by an ABI Service provider ***must be on the care plan*** for the **services** to be ***reimbursed****.*

- All ABI services billed via EVV must have the **client care plan (PA) uploaded** from the PA subsystem that **matches** the caregiver **service check-in/check-out**.

Prior Authorization

Care Plan Access Via Secure Web Portal



Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

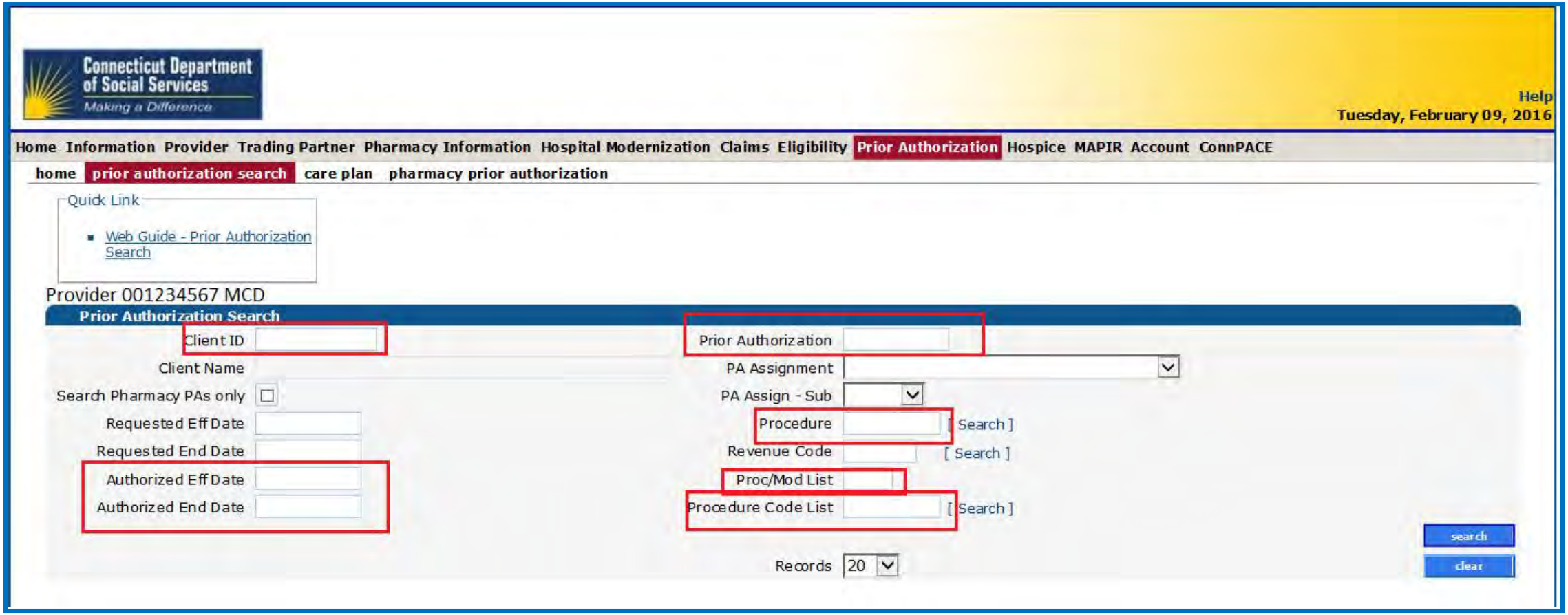
Once on the secure site, click ***Prior Authorization*** > ***Prior Authorization Search.***



Prior Authorization

ABI CARE PLAN ACCESS - (PA) SEARCH

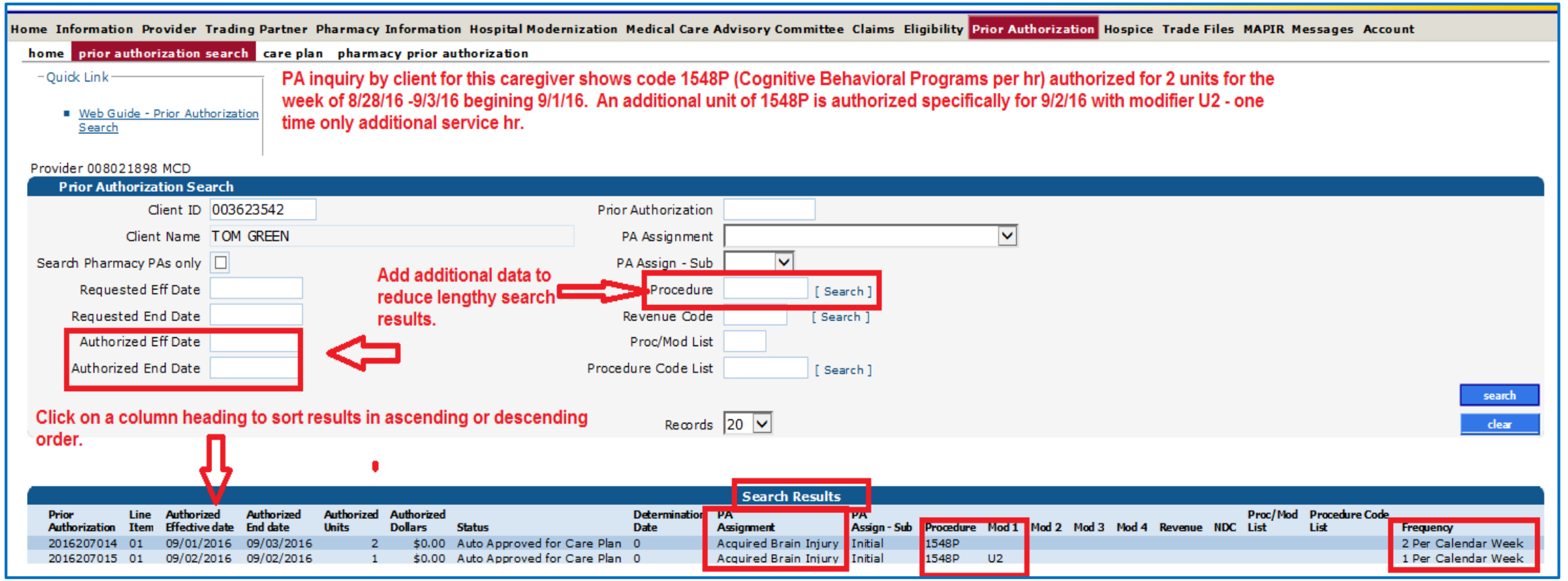
Search by ***Client ID or PA Number***. Further define search by ***date, procedure or list code.***



Prior Authorization

ABI PA Search Results

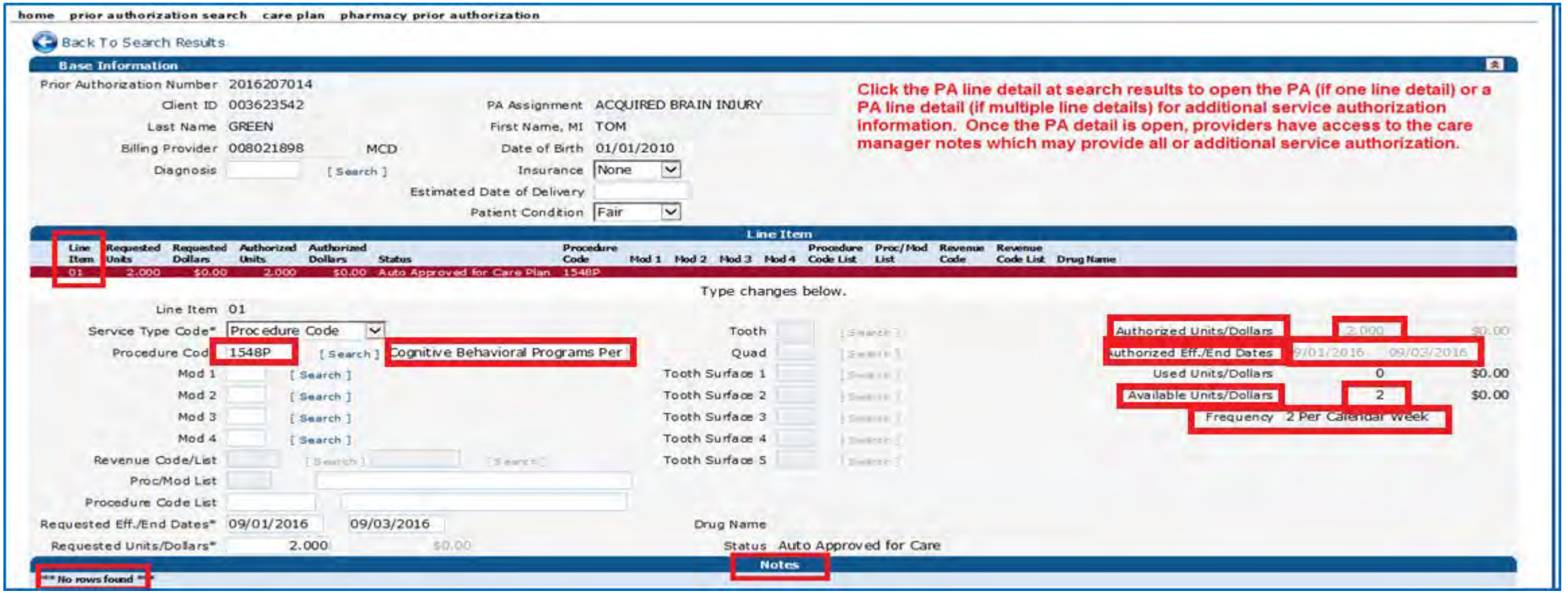
– Search results by client ID provide all PAs authorized for the client under the provider's care. Results can be more defined by increasing the amount of data used in the search.



Prior Authorization

Access to Additional Service Authorization Information

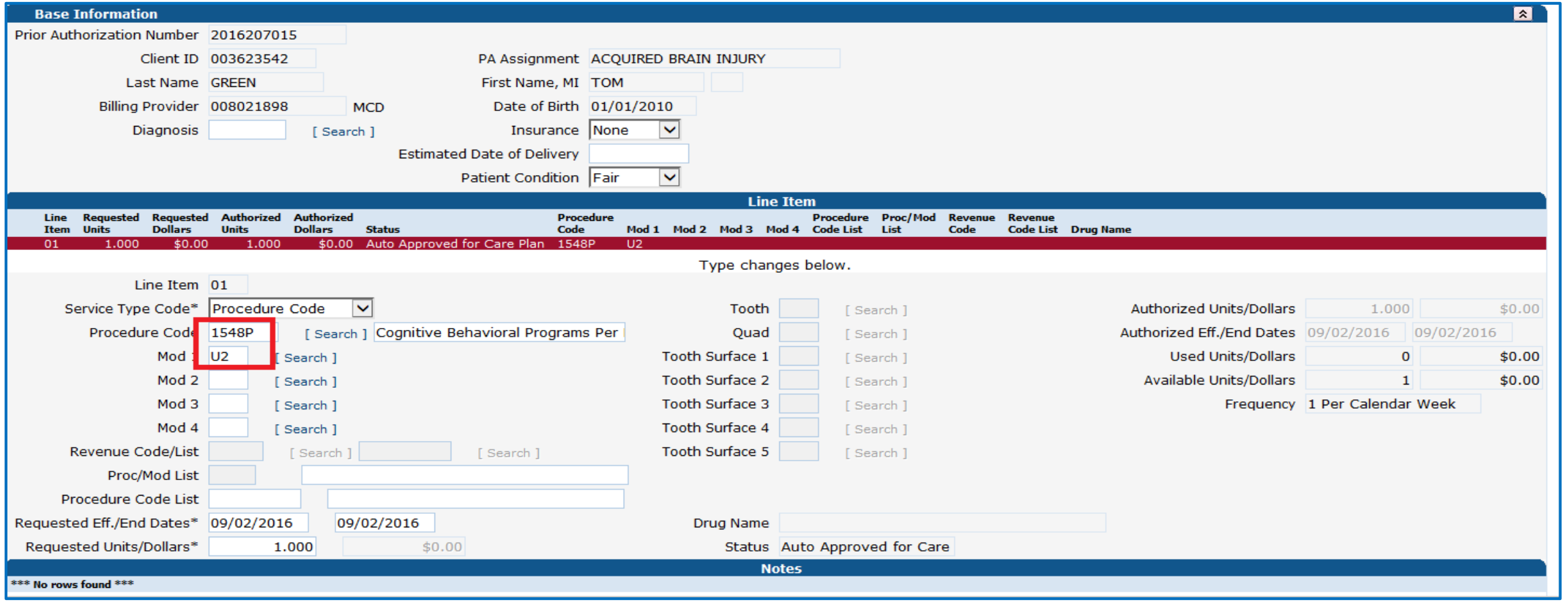
– Additional Care Plan Information can be Viewed by opening a PA from the PA Search Results Inquiry. A one-line detail PA will auto populate when the PA is opened.



Prior Authorization

Access to Additional Service Authorization Information

- ABI Services can be authorized via a procedure code or procedure code with one or more modifiers.



Prior Authorization
Use of Modifiers

➢ **The following Modifiers may be authorized when ABI Service Provider Services are authorized by Procedure Code:**

✓Modifier **U2 - One Time Only Services** can be used to authorize:

- Additional units needed on a day an **ABI** service is provided
- Another day of service in an existing care plan when **Adult Day Health** is provided
- An additional frequency to an existing service when **additional services are required outside of the existing frequency.**

  −For example: Client receives 1534P – Community Living Support Services(1/2 day) 5 x per week, M-F). Client also receives an additional unit (1/2 day 1 x per month on any given Saturday.

Prior Authorization

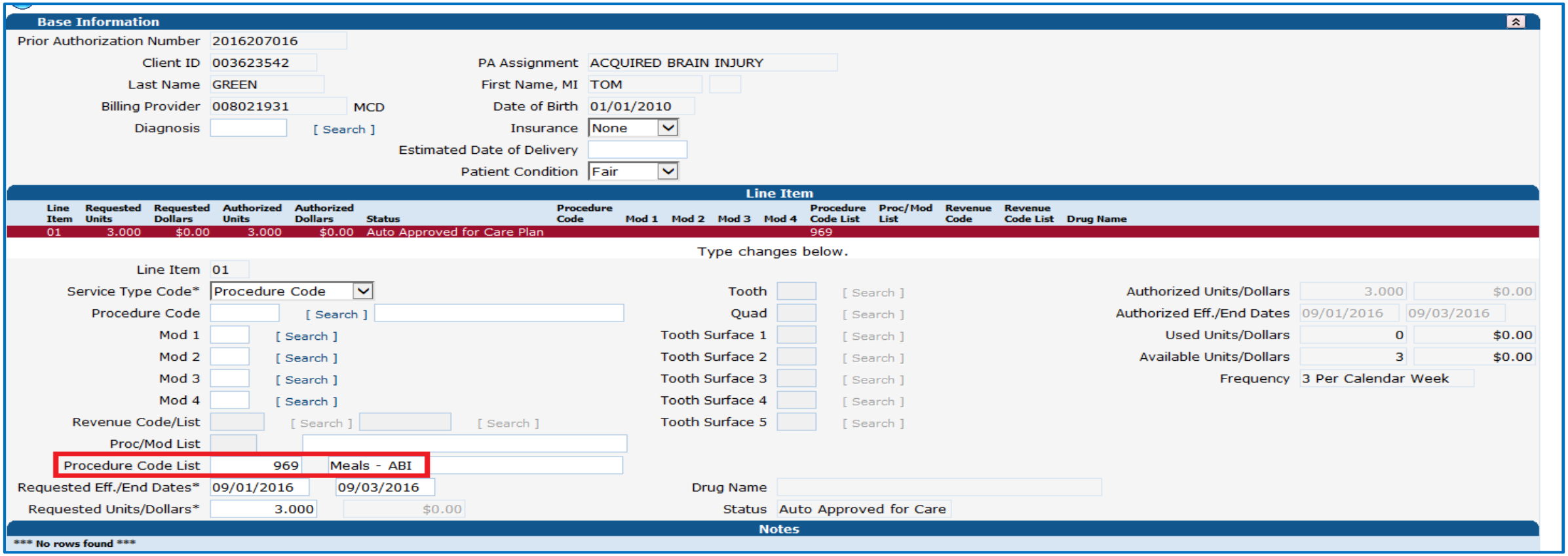
Use of Modifiers

- ✓Modifier **TT** - Subsequent Client, can be used to authorize:
  - –**ABI** services for an additional client residing in the home of a client already receiving the same service.
  - –If the **TT** modifier is authorized, it must be associated to the procedure code on the care plan/PA.
  - –The **TT** modifier reduces the subsequent client payment for service by **50%**.

Prior Authorization

Use of List Codes

– **List Codes may be authorized when ABI services are authorized by a code associated with a list of procedure codes with and/or without modifiers.**



Base Information

Prior Authorization Number 2016207016

Client ID 003623542 — PA Assignment ACQUIRED BRAIN INJURY

Last Name GREEN — First Name, MI TOM

Billing Provider 008021931 MCD — Date of Birth 01/01/2010

Diagnosis [Search] — Insurance None

Estimated Date of Delivery

Patient Condition Fair

Line Item

Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Procedure Code List	Proc/Mod List	Revenue Code	Revenue Code List	Drug Name
01	3.000	$0.00	3.000	$0.00	Auto Approved for Care Plan						969				

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List

Procedure Code List 969 Meals - ABI

Requested Eff./End Dates* 09/01/2016 09/03/2016

Requested Units/Dollars* 3.000 $0.00

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Drug Name

Status Auto Approved for Care

Authorized Units/Dollars 3.000 $0.00

Authorized Eff./End Dates 09/01/2016 09/03/2016

Used Units/Dollars 0 $0.00

Available Units/Dollars 3 $0.00

Frequency 3 Per Calendar Week

Notes

*** No rows found ***

Prior Authorization

Meals Procedure Code list and Procedure Code/Modifier Code List.

Meals	**List Code = 969** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P
Home Delivered Meals Per Day *(double meal)*	1551P
Meals – ***(One Time Only)***	**List Code = AB** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Home Delivered Meals Per Day *(single meal)*	1550P U2
Home Delivered Meals Per Day *(double meal)*	1551P U2

Prior Authorization

Adult Day Health Procedure Code list and Procedure Code/Modifier Code List.

Adult Day Health	**List Code = 971** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model)	1200Z
Adult Day Health – Full Day (Approved Medical Model)	1201Z
Adult Day Health – Half Day (Less than or equal to 4 hrs.)	1202Z
Adult Day Health – ***(One Time Only)***	**List Code = AD** ***(on care plan)***
Description of Service	*Procedure Code* *(on claim)*
Adult Day Health -Full Day (Non-Medical Model) – *one time only*	1200Z U2
Adult Day Health – Full Day (Approved Medical Model) – *one time only*	1201Z U2
Adult Day Health – Half Day (Less than or equal to 4 hrs.) – *one time only*	1202Z U2

Prior Authorization

Viewing and Understanding the ABI Care Plan – PA Inquiry

Points to remember when viewing the client's Service Order/Prior Authorization on your secure Web Account:

- The procedure code, modifiers, from and through dates of service, units and frequency should match:

  - ✓the service request (via telephone, paper or notes on PA via secure Web account.)

  - ✓the service order noted in the notes section of the PA on your secure Web account (Case Management Agency Upload of Service Orders)

Note: Discrepancies should be reported to the Case Management Agency

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember

- **Codes Authorized on the care plan are not always the codes to be billed on the claim.**
  - Providers should refer to the procedure code crosswalk for billing codes associated to codes authorized on the (PA).
- **If a Procedure Code or Procedure Code Modifier List is authorized, providers should:**
  - Refer to the Procedure Code Crosswalk for billing codes and unit increments associated to the Procedure Code List or Procedure Code Modifier List authorized.
  - Codes associated to the list can be billed interchangeably, based on the service provided, up to the units authorized within the frequency, unless otherwise indicated by the care manager as documented on the service order/PA notes.

Prior Authorization

Viewing and Understanding the Care Plan Points to Remember cont.

– If the procedure code on the **PA**

– is of a **lessor reimbursement** value than the **service being provided** from the code list,

  – the provider must contact the care manager unless otherwise indicated in the external notes on the PA.

Web Claim Submission

www.ctdssmap.com

Web Claim Submission

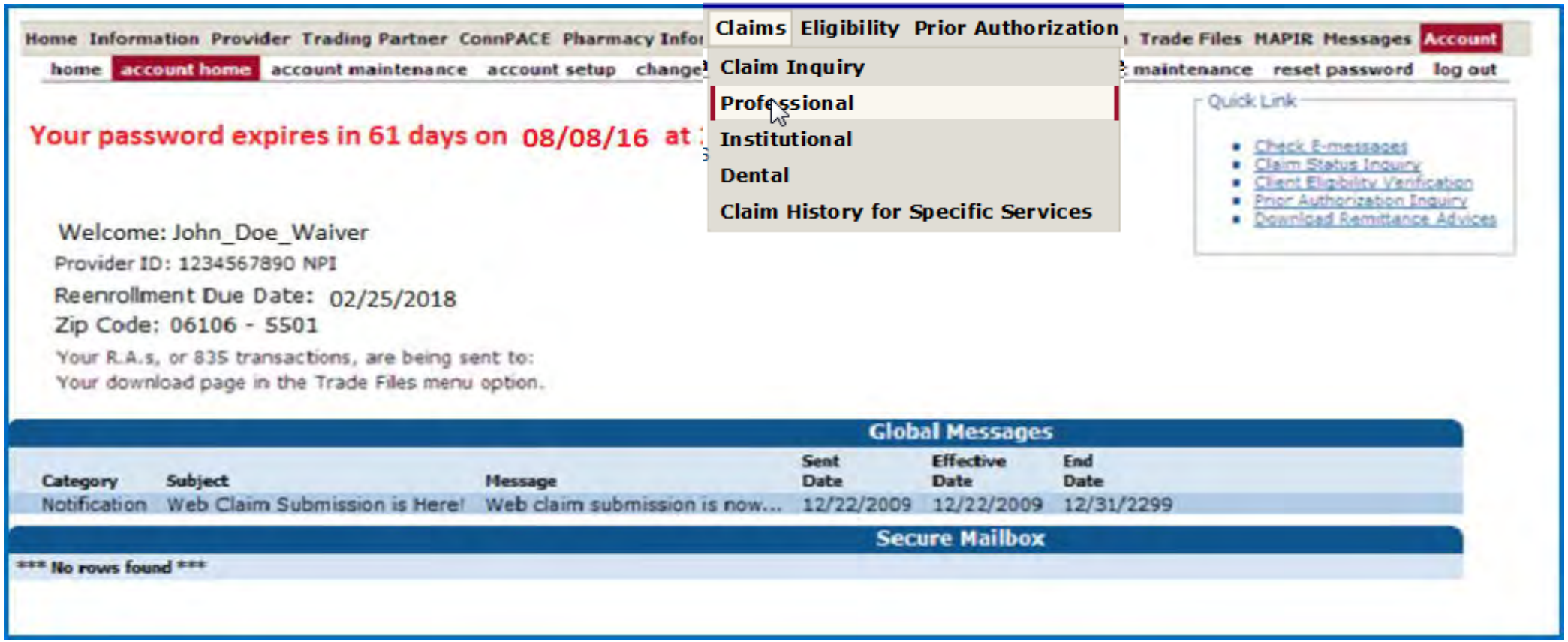
Web Account Capabilities

Web Claim Inquiry/Submission

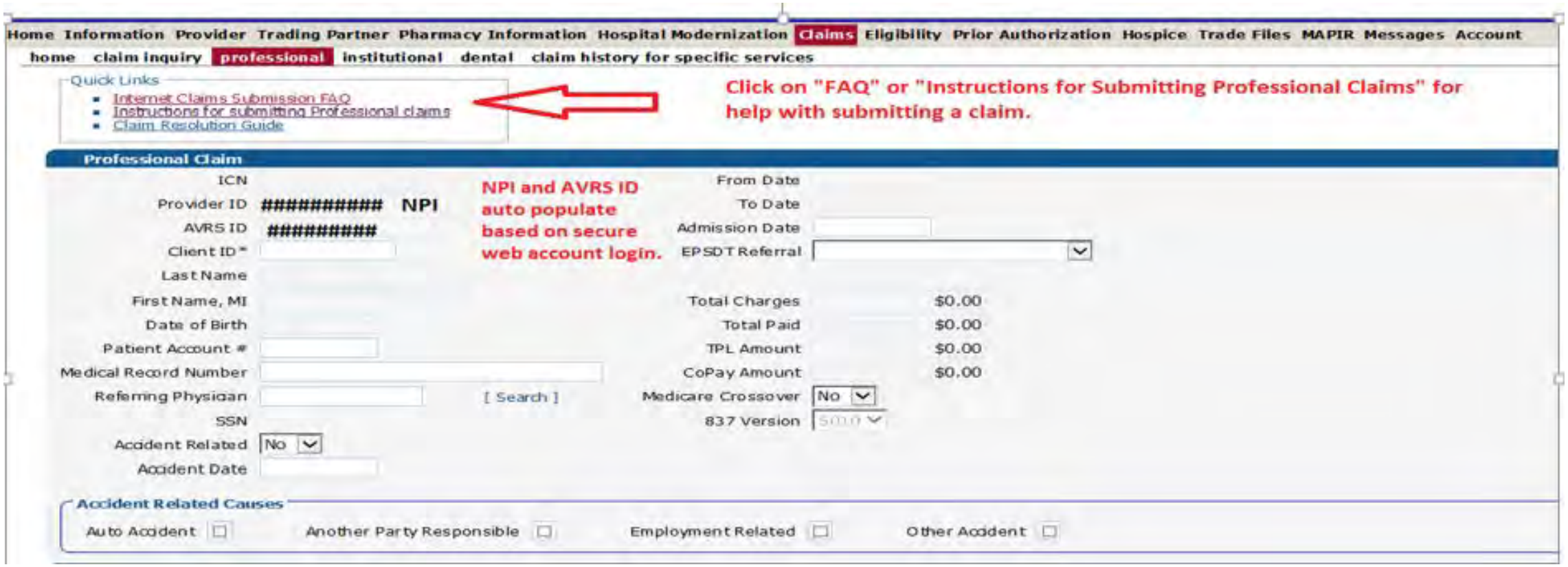
- Internet Web site at www.ctdssmap.com
  - Interactive with ***immediate response*** of claim payment or denial.
  - Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle.***

Web Claim Submission
Access to Claim Format

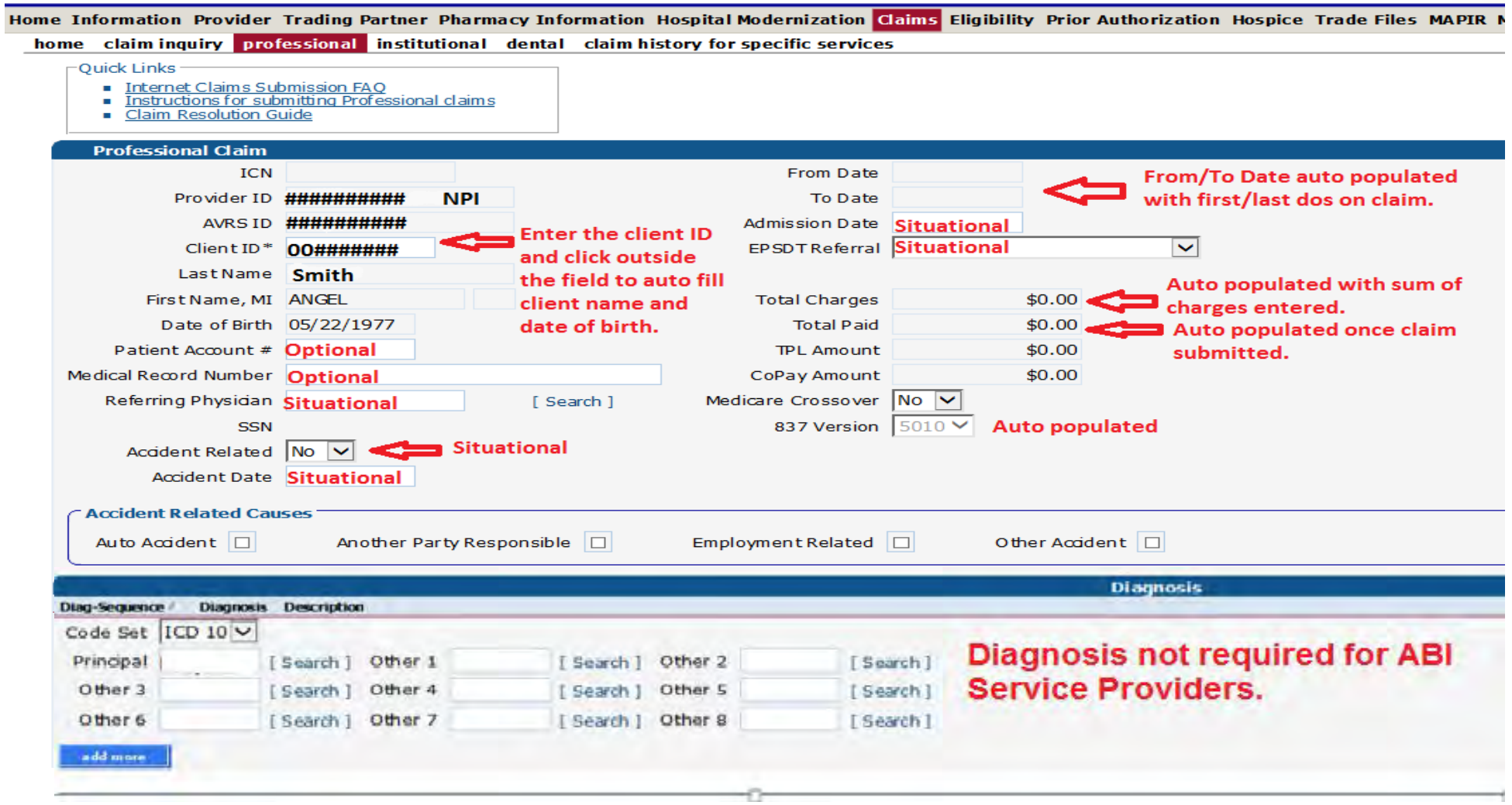
– Click Claims and Select the Professional Format



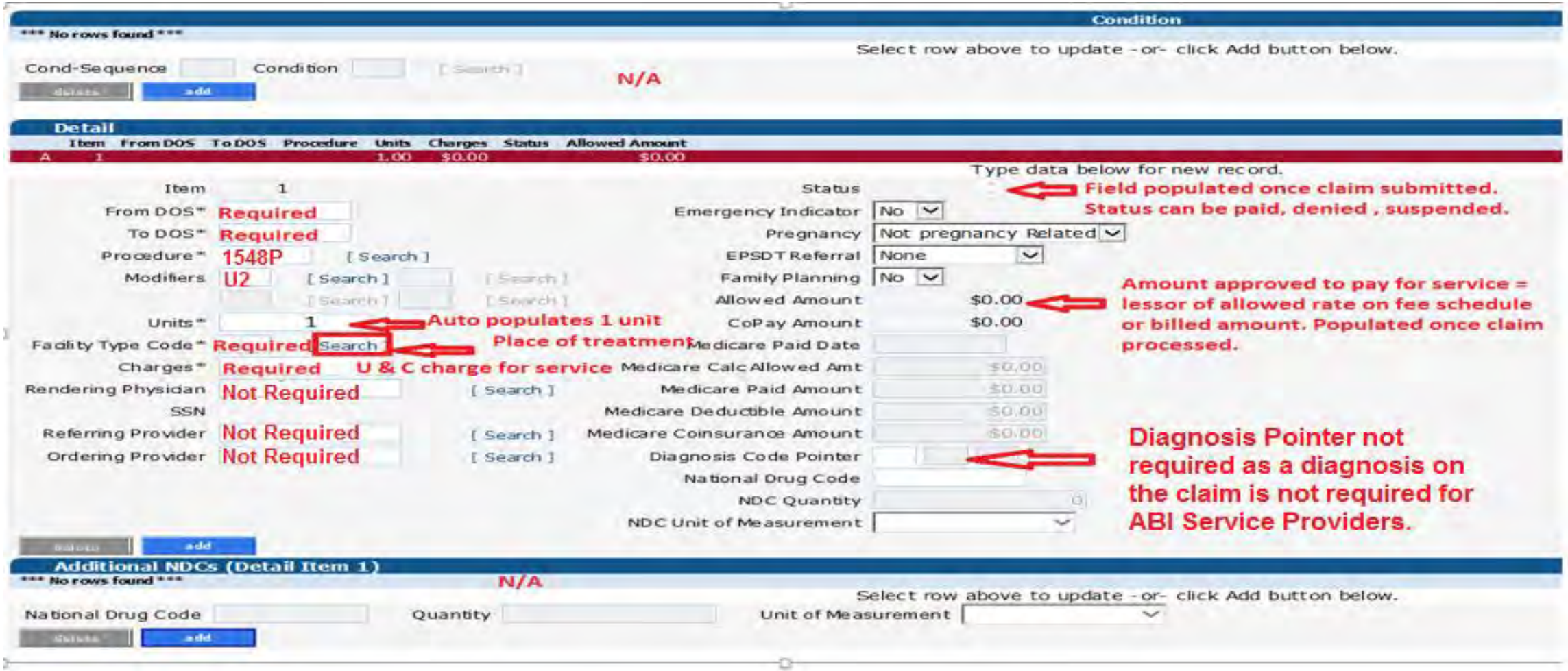
Claims Processing/Submission Information
Claim Submission Resources



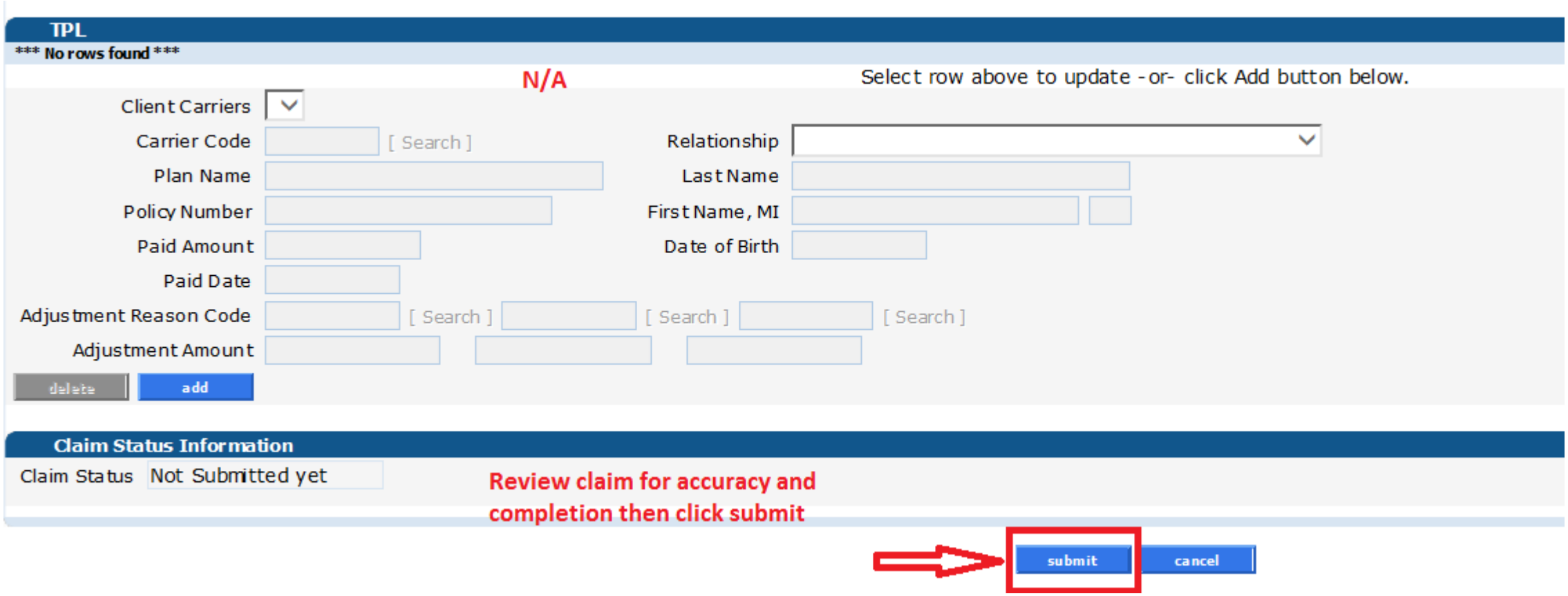
Claims Processing/Submission Information



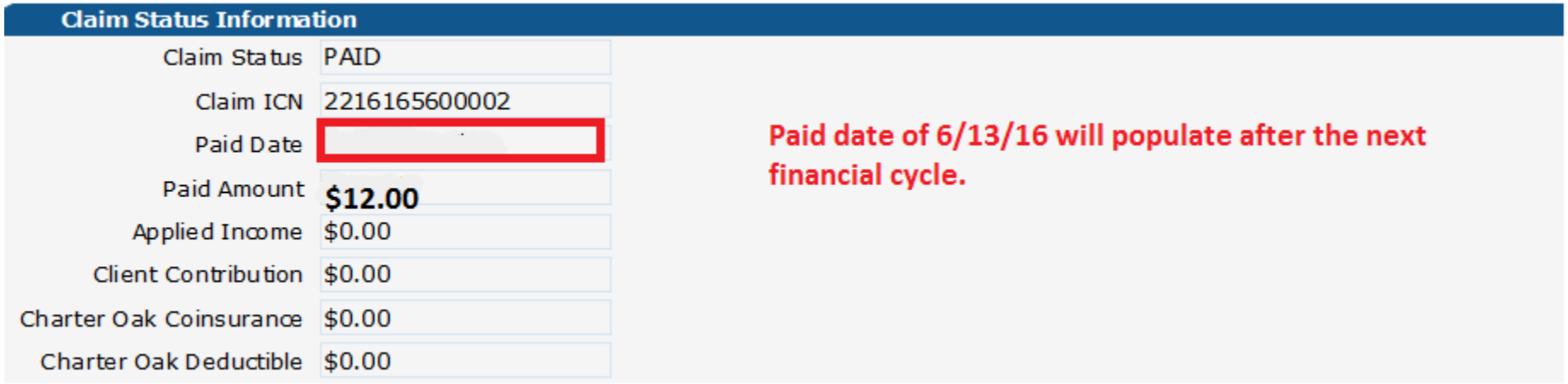
Claims Processing/Submission Information



Claims Processing/Submission Information



Claims Processing/Submission Information



Claim Status Information

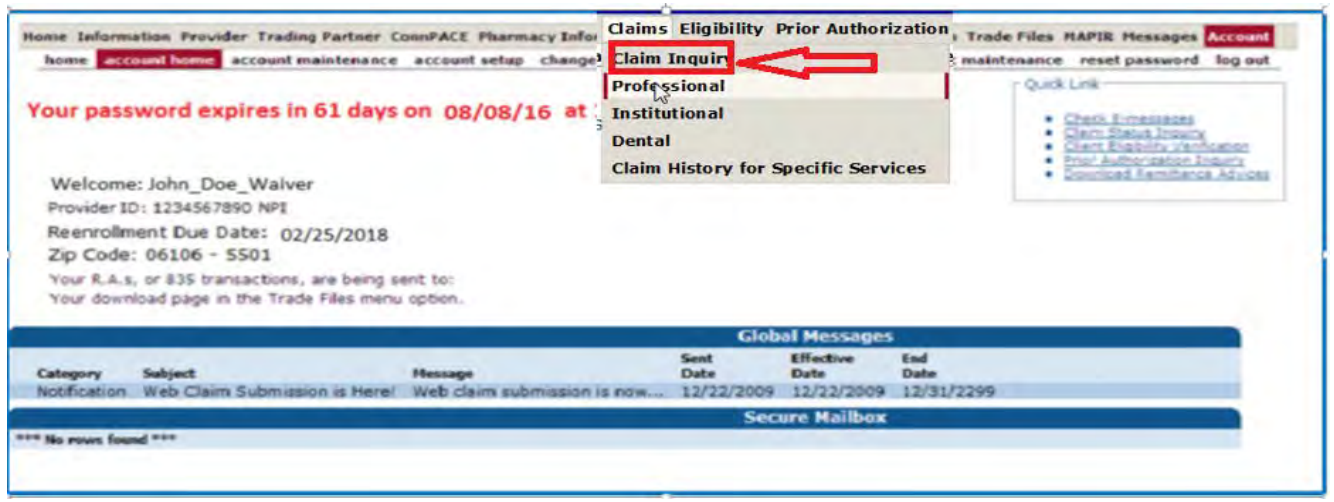
Claim Status	PAID
Claim ICN	2216165600002
Paid Date	
Paid Amount	$12.00
Applied Income	$0.00
Client Contribution	$0.00
Charter Oak Coinsurance	$0.00
Charter Oak Deductible	$0.00

Paid date of 6/13/16 will populate after the next financial cycle.

EOB Information

Detail Number	Code	Description
0	9997	REFER TO DETAIL EOB
1	9918	PRICNG ADJUSTMENT - MAX FEE PRICING APPLIED

Web Claim Inquiry





- Once you have submitted a claim to Hewlett Packard Enterprise using the ctdssmap.com Secure Site:
  - click on the “Claims” tab on the main menu and select “**Claim Inquiry**”
- Enter enough information to satisfy at least one of the following criteria:
  - ICN
  - Client ID FDOS/TDOS or Fdate Paid/Tdate Paid (spanning 91 days or less)
  - check the Pending Claims box

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

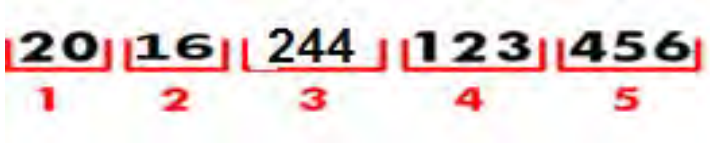
Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016026600026				12/31/2015	01/05/2016	Professional Claims	Paid	01/29/2016	$500.00	$105.73
5616026001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/29/2016	$500.00	$0.00
5616025001001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600026				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$100.00
2016022600037				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016022600039				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
5616025002001				12/31/2015	01/02/2016	Professional Claims	Denied	01/27/2016	$500.00	$0.00
2016025600023				12/31/2015	01/02/2016	Professional Claims	Adj/Voided	01/27/2016	$500.00	$5.73
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2216019600005				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600004				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600010				09/05/2015	09/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600009				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600008				08/05/2015	08/05/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00
2216019600006				08/25/2015	08/25/2015	Professional Claims	Denied	01/21/2016	$150.00	$0.00

Claim Submission Guidelines

Claim Inquiry

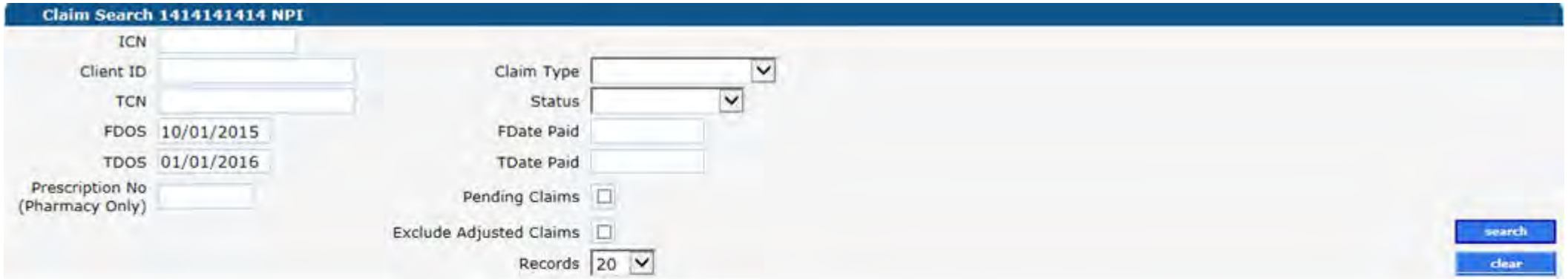
Claims submitted to Hewlett Packard Enterprise are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research.



- **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 Hewlett Packard Enterprise. (**16** = ***2016***)
- **3** *Julian Date of Receipt* – The Julian calendar date of receipt (**244** = *the two hundred forty fourth day of the year = September 1, 2016.*
- **4** *Batch Number* – An internal number assigned by Hewlett Packard Enterprise to uniquely identify a batch. (**123**)
- **5** *Claim Number* – A sequential number assigned to uniquely identify claims within a batch. (**456**)

Web Claim Inquiry

Results searching by FDOS and TDOS (no greater range than 93 days)



Search Results

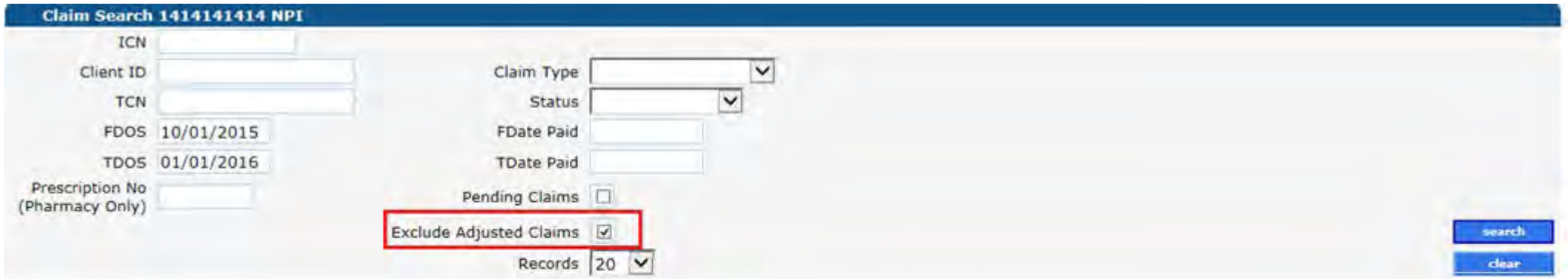
ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Exclude Adjusted Claims

– Removes claims that have been altered since their initial submission

– Results in a more accurate representation of your total reimbursement



Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2216022600004				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2216022600003				10/01/2015	10/01/2015	Professional Claims	Denied	01/27/2016	$98.00	$0.00
2016020600011				12/31/2015	01/01/2016	Professional Claims	Denied	01/22/2016	$300.00	$0.00
2215315600003				11/08/2015	11/08/2015	Professional Claims	Denied	11/18/2015	$85.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

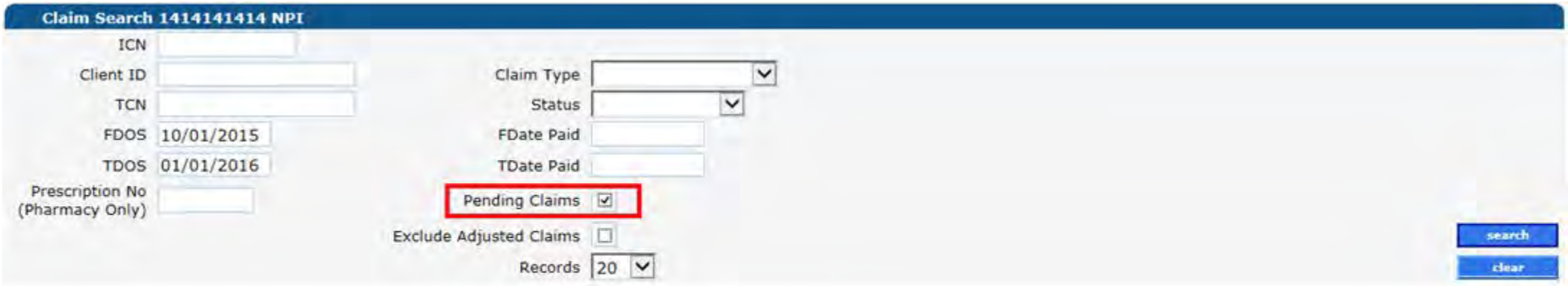
Web Claim Inquiry

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 any line in the Search Results panel to view the corresponding claim



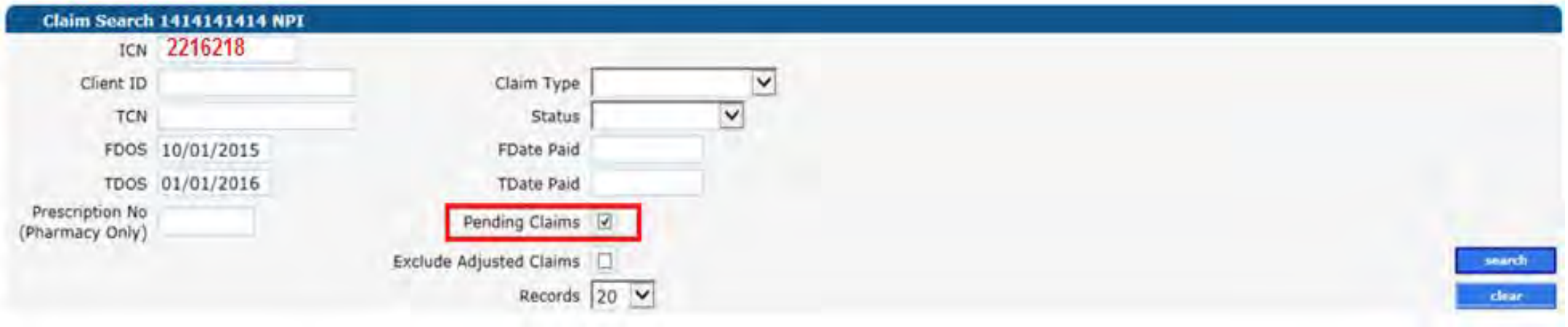
Search Results

ICN	Client ID	Client Name	Prescription No	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
2016019600001				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600003				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00
2016019600002				12/31/2015	01/01/2016	Professional Claims	Denied	0	$300.00	$0.00

Web Claim Inquiry

Pending Claims

- To narrow search results for pending claims by region on a given date, enter the first 7 digits of the Claim Internal Control Number (ICN).
- This search will provide claims submitted via the Web on August 5, 2016 that have not yet processed through a financial cycle.



Claim Submission Options

www.ctdssmap.com

Web Claim Submission

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 brand new claim

– Denied claims allow you to:

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

– Suspended claims allow you to:

- new claim — Create a brand new claim

Web Claim Submission

Void

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

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

Web claim adjustment limitations

Timely Filing

– Claims that are over the *Timely Filing* guidelines cannot be adjusted, unless the adjustment is submitted to pay the same or less than the original claim; otherwise, claim adjustments outside of the timely filing limit will be fully recouped

Special Handled Claims

– Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by Hewlett Packard Enterprise and are, therefore, not able to be adjusted via the **www.ctdssmap.com** Web site

Web Claim Submission
Copy

Paid claims may be copied and submitted as a new claim

– *This feature is helpful for reoccurring services*

Copy - 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
Resubmit

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*

Claim Submission Methods

ABI Services

Claim Submission Methods

EVV Services

EVV Mandated Services

– Claims for the following services rendered to ABI Waiver I or II clients are **mandated for EVV check-in/check-out** and will be systematically **submitted via Sandata's Santrax Electronic Visit Verification (EVV) System** when the **caregiver's check-in/check-out matches the Prior Authorization (PA)** uploaded from Hewlett Packard Enterprise PA subsystem.

- **1021Z** - Personal Care Services per 15 min
- **1211P** - Recovery Assistant
- **1212P** – Recovery Assistant II
- **1232Z** – Respite Care in the Home per hr. – other
- **1531P** – Community Living Support Services Per ½ Day
- **1532P** – Chore Services Per ¼ hr.
- **1534P** – Community Living Support Services Per ½ Day
- **1536P** – Companion Services per ¼ hr. (18 hr. per day max)
- **1542P** – Homemaker Services Per 1/4/hr.
- 1546P – Independent Living Skill Development Per hr, (agency)

These services must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

EVV Services cont.

EVV Optional Services

– Claims for the following service rendered to ABI Waiver I or II clients are **optional** and will be systematically submitted via the Sandata Santrax Electronic Visit Verification (EVV) System, **should the caregiver choose to check-in/check-out via the EVV system** and the check-in/check-out matches the Prior Authorization (PA) uploaded from Hewlett Packard Enterprise PA subsystem.

- 1**562P** – Respite Care Per hr.

This service must first be authorized by the client's case manager, associated to the client's care plan and uploaded by the Case Management Agency, associated to the client, to Hewlett Packard Enterprise.

Claim Submission Methods

Direct ABI Provider Billing

– Claims submitted for ABI Waiver services, directly by ABI Service providers must be submitted via:
  – Internet Web site at www.ctdssmap.com
    – Interactive with ***immediate response*** of claim payment or denial.
    – Allows providers to **query claims** in order to ***adjust, void, or re-submit*** within the ***same claims processing cycle***.

  – Vendor Software utilizing the following HIPAA ASC X12N transactions:
    – 837P – Health Care Claim Professional
    – Requires provider to enroll as a Trading Partner
  – Paper
    – CMS-1500 Claim Form

Effective October 1, 2016 the Department of Social Services (DSS) will no longer accept paper claims for processing. Paper claims submitted on or after October 1, 2016 will be returned to the provider.

Ref: PB 2016-31.

Claim Submission Guidelines

ABI Services

Claim Submission Guidelines

Edits and Audits

- Regardless of the claim submission method, all claims are processed through the Connecticut interChange system and 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*** such as:
  - 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***?

Claim Submission Guidelines

Timely Filing

- Timely Filing Guidelines
  - The timely filing limit, under the ***ABI Waiver Benefit*** plan for the submission of ABI Services by an ABI Service Provider:
    - ***One (1) year*** *from the date of service (initial claim).*
    - ***One (1) year*** *from date of last payment or denial, if not for timely filing.*

Claim Submission Guidelines

Spanning Dates of Service

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

– Spanned dates of service cannot exceed the frequency (weekly or monthly) for the service as noted on the care plan.

- **For example, if adult day health service is to be provided 6 days per week on consecutive days such as Monday through Saturday for 1 per day for a total of 6 units, the span dates of service must begin on the Monday of the calendar week in which the service was performed and end on the Saturday of the same calendar week for a total of 6 units.**

Claim Submission Guidelines

Spanning Dates of Service

– Spanned dates of service cannot span multiple line details on the care plan.

- **For example, in the example above a onetime only of an additional day of adult day health services on Sunday is needed for the above week. If the additional day on Sunday is added as an additional line detail on the PA, the services for Sunday, even though they are consecutive with the regular weekly services, must be billed on a separate line detail.**

Claim Denials and Resolutions

ABI Services

Claim Denials and Resolution

Claim Denials due to Client Eligibility

Denial Reasons:

- **EOB Code 2003** - Client Ineligible for dates of service
- **EOB Code 4021** - Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have an ABI Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021). Please Note: **The system attempts to process under the HUSKY benefit plan first, if not a covered service it will set 4021 for the HUSKY benefit plan. The system will then attempt to process under the ABI benefit plan. If the claim denies for 00X EOB, the system will attempt to process under any other benefit plan the client may have. It is the 00X EOB that should be acted upon and disregard all 4021 EOB codes**

Resolution:

- Client eligibility file needs to be updated with an ABI Waiver benefit plan or change in the effective dates of eligibility.

Claim Denials and Resolution

Determining and Resolving Eligibility Issues

- The Home and Community Based Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to 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 "ABI Waiver Client Eligibility Issue" in the subject line of the email.
- Providers who identify an eligibility issue upon claim denial should contact the DSS Home and Community Services Unit as noted above. To avoid further claim denial, check eligibility before resubmitting claim.

Claim Denials and Resolution

Claim Denials due to Care Plan not on File

Denial Reasons:

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

Resolution: A care plan must be created by the ABI Case Management Agency and uploaded to the Hewlett Packard Enterprise system. **Contact the Case Management Agency.**

Claim Denials and Resolution

Claim Denials due to Service not Authorized

Denial Reason:

- **EOB Code 3016** -Service not Authorized on the Care Plan.

Resolution 1: A service denied for not on care plan must be added by the Case Management Agency to the Care plan.

Resolution2: Incorrect Procedure code billed by provider or PA/claim mismatch.

Claim Denials and Resolution

Claim Denials due to Units Billed Exceeding Frequency

Denial Reason:

- **EOB Code 5151**- Units exceed the frequency units authorized on the care plan.

Resolution 1: Units of service must be added to the frequency of an existing PA by the Case Management Agency.

Resolution 2: Units exceeded due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Denial due to PA Exhausted

Claim Denial

- **EOB Code 3003** - Units of service must be added by the Case Management Agency to an existing PA that is currently exhausted.

Resolution 1: Prior Authorization is required for payment of the service (units for the service are exhausted).

Resolution 2: **PA exhausted** may be due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution

Resources for Care Plan Issues

- Case Mangers create service orders and enter them in the Case Management Agencies Care Management System. **DSS cannot make care plan or prior authorization changes in the portal.**

- The Case Management Agency is responsible for uploading initial care plans and changes to care plans to Hewlett Packard Enterprise, in Prior Authorization format, within seven (7) days of issuing the service order.

- If the provider **has a service order** and a **PA for the service order cannot be found by doing a PA inquiry via the provider's secure Web account** within **seven (7) days** of receipt of the service order, the provider should contact the applicable Case Management Agency.

Remittance Advice

www.ctdssmap.com
Web Account Capabilities

Remittance Advice

Access to Claim and Financial Reporting

All claims activity is reported to providers twice a month on a Remittance Advice

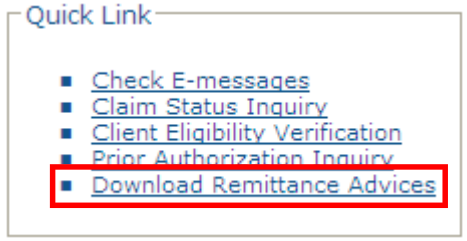
– RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider's claim activity

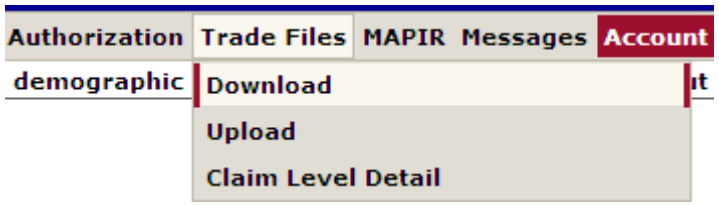
– Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com

– Available in either the ASC X12N 835 Payment/Advice standard transaction format, which is a string of raw data that must be configured by the provider/vendor for download into their system or in the Comma Separated Format (CSV) which provides the paper version of the RA

– Only the last 10 RAs are maintained on the Hewlett Packard Enterprise 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 the account home screen or select Download from the Trade Files drop-down menu:





Remittance Advice

CSV - Comma separated Value

- ABI Service providers will have access to their Remittance Advice (RA) in an excel format. This allows providers to sort the file and search for specific claim approvals and denials. To access the RA, go to our Web site at www.ctdssmap.com and log onto the secure Web portal. Under "Trade Files", choose "Download" from the drop down menu. Select "CSV" from the "Transaction Type" on the File Download Search screen. This will populate the current files available to download. The following provides an example of the data available in this excel format:

Provider ID	Client ID	Client Last Name	Client First Name	Client Acct Number	ICN	Paid Date (MMDDYY)	Detail Num	FDOS(MM DDYY)	TDOS(MM DDYY)	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Billed Amt	Paid Amt	EOB1	EOB2	EOB3	Medical Record Num	Adj Xref ICN
########	########			FFS	5916249001001	09012016	1	08202016	08202016	1021Z					18	8.5	9918	0	0	TC1FORANDIE	201624059045
########	########			FFS	5916244001002	09012016	2	08232016	08232016	1021Z					36	17	9918	0	0	TC1FORANDIE	201624008245
########	########			FFS	5916244001003	09012016	1	08292016	08292016	1021Z	TT				18	8.5	9918	0	0	TC1FORANDIE	2016240082051

Remittance Advice

Components of the RA – 7 Sections

- Banner Page
  - Important messages from DSS or Hewlett Packard Enterprise
- 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, Account Receivables
- RA Summary
  - Month-to-day and year-to-day summaries of financial activities, account receivables
- EOB Code Descriptions
  - Descriptions of the EOB codes that posted to claims on the RA
- Claims in Process
  - Lists claims that were in suspense when the financial cycle was run

Monthly Claims Reprocessing

Care Plan Changes
ABIO Services

Monthly Claims Reprocessing
Care Plan Changes –ABI Services

Systematic Monthly Claims Reprocessing to:

– Sync paid claims to the appropriate PA/PA line detail once care plan changes have been made by the Case Management Agency such as:

– End dating and restarting a care plan due to periods of hospitalization.

– Increasing or decreasing services.

– End dating a care plan when the client leaves the Agency's service.

Monthly Claims Reprocessing cont.

Care Plan Changes ABI Services

Systematic Monthly Reprocessing:

- In the **first cycle of each month**, Hewlett Packard Enterprise will recoup (void) all paid claims impacted by the Case Management Agency changes made two months prior(Region 52 claims = a voided claim).

- In the **same cycle Hewlett Packard Enterprise will reprocess, (deny and/or pay claims)** posting to the correct PA/PA line detail (Region 24 claims = a new day claim).

- For example: changes made to PAs in **Jan. 2017** by the Case Management Agency will result in claims being voided (region 52) and reprocessed (region 24) in the **first cycle of March 2017**.

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

Monthly Claims Reprocessing cont.
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper RA)

– If there is a financial impact (Change in $ amount up or down) between the voided claim (region 52) and the reprocessed claim (region 24):

– Providers will see in the **adjustment section** of their RA:

- The previously paid claim ICN (Region 20, 22, 59, 10 etc.).
- Recouped/Voided claim ICN (Region 52).
- EOB Code 8236 – Claim was recouped due to PA change.

Monthly Claim Reprocessing
Care Plan Changes – ABI Services

Impact to Provider Remittance Advice (Paper RA)

– A new claim will be systematically created. Providers will see the new day claim on their RA :

- Claim ICN (Region 24) in the **paid/denied** section of the RA.

- EOB Code 8238 – Claim Systematically Reprocessed Due to a PA/Service Order Change.

NOTE: If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the RA.

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry:

- Region **24 claims** identify a change made to the care plan/PA.

- Region **24 claims** with **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change confirms there has been a change which has:
  - ✓ **Positively** or **negatively** impacted you financially.
  - ✓May continue to impact you financially in the future.

- Providers should investigate reprocessed claims with a **negative** impact to determine if:
  - ✓Providing appropriate level of service currently authorized.
  - ✓Current service order matches the PA on their secure web account. Report discrepancies to the Case Management Agency.

Monthly Claims Reprocessing
Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – PA Inquiry cont.

- A PA may show negative units available, if the changes made by the Case Management Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.
  - For example:
  - PA authorized for 7 units per week for 4 weeks = 28 units authorized and available.
  - Claims are paid against the PA = 14 units used
  - Case Management Agency changes the PA to 5 units a week for 2 weeks = 10 units authorized and available.
  - Until claims are recouped and reprocessed, the PA will show 10 units available – 14 used = (4) negative units.

Monthly Claim Reprocessing Due to PA Changes Made by Case Management Agency Claim Recouped

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

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

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

FP --ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
PL SERV PROC CD MODIFIERS	UNITS	SERVICE DATES RENDERING FROM	THRU	PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS				

CLIENT NAME: Sally Client — CLIENT NO.: 0000000000

1	2200000000000	060314	061214	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	5200000000000	060314	061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 8236

Monthly Claim Reprocessing Due to PA Changes – Claim Reprocessed and appears on RA (paid amount region 24 claim greater than amount recouped – region 52 claim)

REPORT: CRA-PHPD-R — interChange MMIS — Date: 10/15/2014
RA#: — MEDICAID MANAGEMENT INFORMATION SYSTEM — PAGE: 2
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

Home Care Agency
555 Any ST
Somewhere, CT00000-0000

PAYEE ID MCD
ISSUE DATE 10/15/2014
TAXONOMY ----------
P. AVRS ID

FP	--ICN-- / --PATIENT NUMBER--	SERVICE DATES FROM	THRU	BILLED AMOUNT	ALLOWED AMOUNT	DEDUCT AMOUNT	CO-INS AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	APPLIED INCOME	PAID AMOUNT	CLIENT CONTR.
	CLIENT NAME: Sally Client			CLIENT NO.:								
	2400000000000	060214	061214	116.16	75.00	0.00	0.00	0.00	0.00	0.00	75.00	0
	HEADER EOB 8238											

PL	SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL EOBS
	12	1542P		20	060214	061214	MCD	116.16	75.00	

Monthly Claims Reprocessing

Care Plan Changes – ABI Services

Impact to Provider's Secure Web Portal – Claim Inquiry

➢ Regardless of the financial impact (more, less or no $ change):

- All **region 52** and **region 24** claims will appear on the provider's secure web account
- **Region 24** claims with no financial impact (i.e. region 24 claims paid the same as voided region 52 claims) will appear on the web with:
  - **EOB code 8237** – Claim Systematically Reprocessed Due to PA Change-Information Only.

Note: These claims will not appear on the provider's RA

Program Reminders for Successful Claim Submission

www.ctdssmap.com

Information

Program Reminders for Successful Claim Submission
Client Care Plan

- **Check the client's care plan (PA)** to be sure the services you have been requested to provide have been authorized.

  - ✓ Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.

  - ✓ Report discrepancies to the appropriate Case Management Agency immediately.

  - ✓ Review the care plan when you are notified of changes to be sure the services you are being requested to provide are on the care plan/PA.

Program Reminders for Successful Claim Submission

Claim Submission

➢ Claim submission review

- Prior to submitting claims be sure services provided match services authorized and services to be billed.

✓ Identify discrepancies early to avoid over service or potential billing errors which may cause claims to deny such as:

- Exceeding units on a claim frequency.
- Omission of a modifier on a claim detail(s).
- Spanning dates of service across frequencies or PA line details.

Program Reminders for Successful Claim Submission

Claim Submission Review cont.

➢Claim submission review

- Minimize claim submission time by:

✓Submitting claims via 837 batch or interactively via the web. Paper claims submitted on or after 10/1/16 will be returned unless the claim needs special handling.

✓Copying a prior paid claim, especially when billing for like services, minimizes changes needed for resubmission

✓Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces key strokes and the number of details on a claim.

Example: a PCA service for 10 units on Mon, Tues, Wed can be billed on a single line detail such as 9/5/16 to 9/7/16 1021Z for 30 units.

Program Reminders for Successful Claim Submission

Claim Resolution

➢ Claims Resolution

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

Information-Resources

www.ctdssmap.com
Information

Information – Important Messages

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

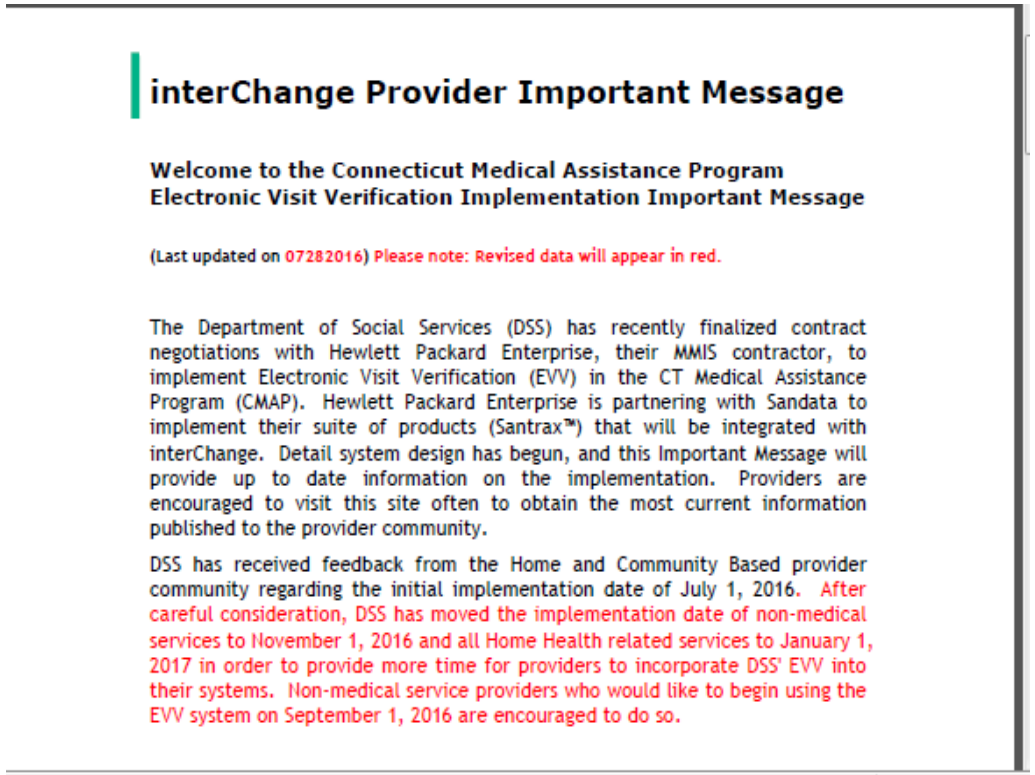


Important Messages

Electronic Visit Verification Implementation (Updated 7/28/16)
CMAP Medicaid Access Monitoring Review Plan (AMRP)
Outpatient Hospitals Prior Authorization Issue (Updated 7/22/16)
Hospital interChange Issues (Updated 7/12/2016)
Revised Provider Manual Chapters (Updated 7/6/16)
Revised Joint Guidance by DSS and CTDOL Regarding USDOL's Home Care Final Rule
Pediatric Dental Fee Schedule Reduction Postponed (Posted 7/6/16)
Provider Bulletin PB-37 New Autism Spectrum Disorder Services Being Rescinded
System Down Time 06/30/2016
Frequently Asked Questions (FAQs) - Provider Bulletin PB16-31
Clarification of Provider Bulletin PB16-33
DSS Issues RFP for Medicaid Quality Improvement and Shared Savings Program
Revised Provider Manual Chapters (Updated 6/7/16)
Attention: Out of State Providers - Where to Send Updated License Information (Updated 5/16/16)
Inpatient Delivery Stays (Updated 5/12/16)
Hospital interChange Issues (Updated 5/11/16)
ABI Individual Provider On-line Enrollment (Effective 5/11/16)

Information- Resources
Important Messages

Electronic EVV Implementation Message



interChange Provider Important Message

Welcome to the Connecticut Medical Assistance Program
Electronic Visit Verification Implementation Important Message

(Last updated on 07282016) Please note: Revised data will appear in red.

The Department of Social Services (DSS) has recently finalized contract negotiations with Hewlett Packard Enterprise, their MMIS contractor, to implement Electronic Visit Verification (EVV) in the CT Medical Assistance Program (CMAP). Hewlett Packard Enterprise is partnering with Sandata to implement their suite of products (Santrax™) that will be integrated with interChange. Detail system design has begun, and this Important Message will provide up to date information on the implementation. Providers are encouraged to visit this site often to obtain the most current information published to the provider community.

DSS has received feedback from the Home and Community Based provider community regarding the initial implementation date of July 1, 2016. After careful consideration, DSS has moved the implementation date of non-medical services to November 1, 2016 and all Home Health related services to January 1, 2017 in order to provide more time for providers to incorporate DSS' EVV into their systems. Non-medical service providers who would like to begin using the EVV system on September 1, 2016 are encouraged to do so.

Important Message References

– Providers can reference links to Important Documentation published regarding EVV as noted below

Important Documentation:
EVV Service Code Listing
Frequently Asked Questions
Proposed Task List
Proposed Reason Code List
CT DSS EVV Interface Specification Data Mapping
CT DSS EVV Interface Testing Process
CT DSS EVV Sandata Standard Interface Specification Schedules
CT DSS EVV Sandata Standard Extract Completed Visits
CT DSS EVV Sandata Standard Extract Payroll

Workshop Presentations:
Introductory Webinar
Introduction to Electronic Visit Verification

Publications:
PB16-44 - Electronic Visit Verification Notification to Clients

Information - Resources

ABI Procedure Code Crosswalk

- **ABI Procedure Code Crosswalk –**A list of non-medical procedure codes, and procedure code modifier lists with associated procedure codes/modifiers that can be authorized under the ABI Waiver Program.
- Providers should access the **ABI Procedure Code Crosswalk** for the following information:
  - ✓A list of procedure codes and procedure code/modifier combinations authorized under a procedure code/modifier list
  - ✓Service descriptions
  - ✓Unit increments
  - ✓Provider who can be authorized to bill the service
  - ✓If service can be spanned when consecutive dates of service are performed (N/A for home health services)
  - ✓Frequency of service
  - ✓Care Plan limitations (When PA is required by DSS or Value Options)
  - ✓Funding Source that covers the service

Information- Resources

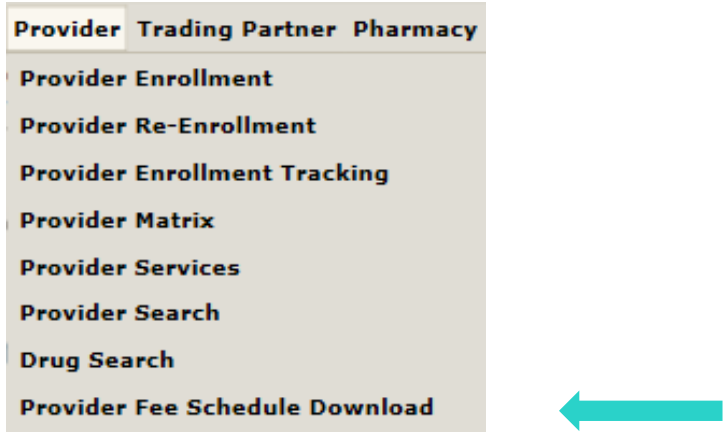
ABI Procedure Code Crosswalk

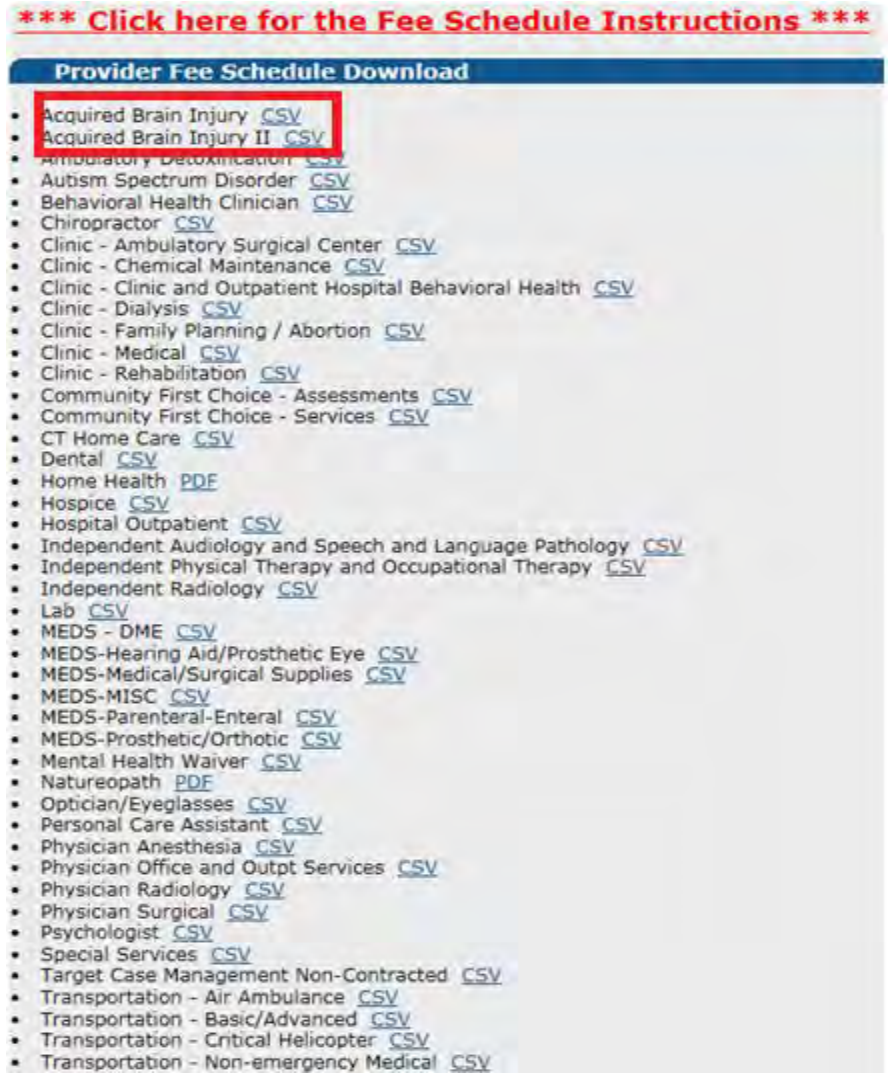
- **ABI Procedure Code Crosswalk –** can be obtained on the www.ctdssmap.com Website.

  - ✓ From the Home page >publications > provider manuals > chapter 8 ABI Provider Manual > Claim Submission Instructions > field 24d.

Information – Resources
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
  – See Information “What is CSV” at the bottom of the Web page for accessing the CSV file





Information – Resources
Banner Page Announcements

- 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

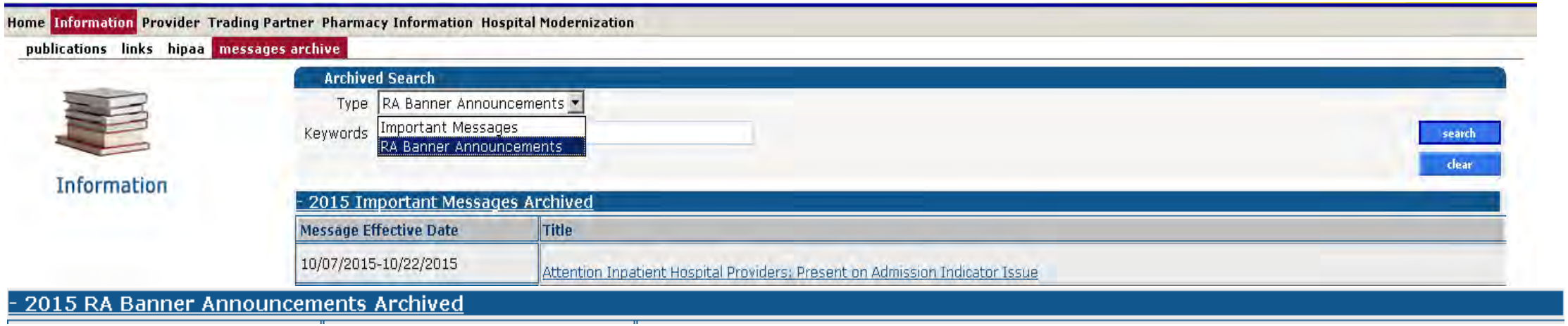
02/05/2016-02/12/2016	Attention Select Providers	Attention Select Providers. CLAIMS PROCESSING ISSUE: Hewlett Packard Enterprise has identified a claims reprocessing issue where claims originally processed with a temporary ID incorrectly denied when they were reprocessed with the client's true (permanent) 9-digit Connect Medical Assistance Program (CMAP) ID. The denied claims have been identified and reprocessed and will appear on the February 9, 2016 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 27.

Information – Resources

Archive Important Messages and Banner Announcements

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

– RA Banner Announcements and Important Messages dated January 1, 2014 and forward are saved on the Web site and are available for review.

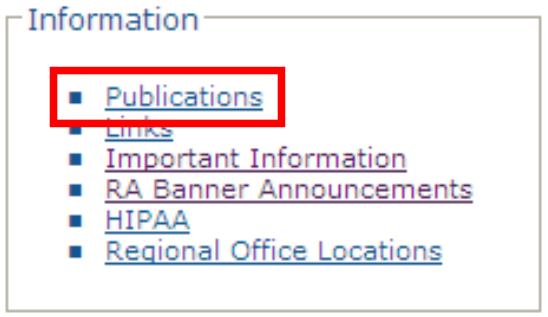


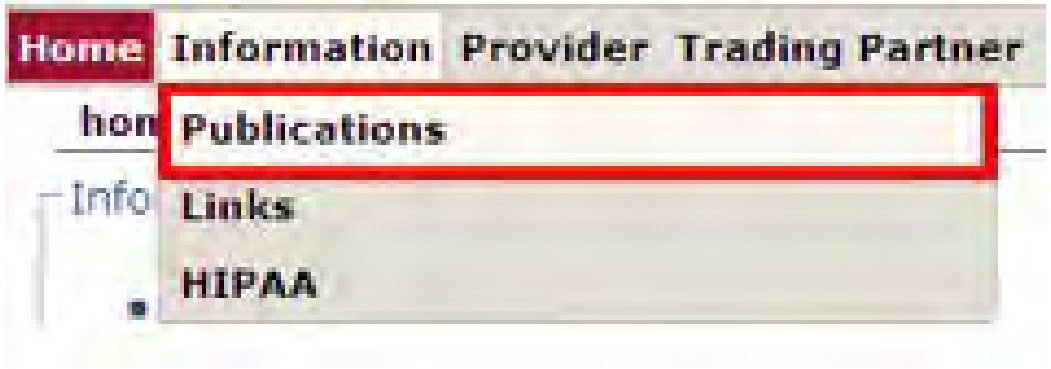
Information - Resources

Publications

– A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page

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





Information – Resources
Provider Bulletins

– Provider Bulletins
  – Publications posted to relevant provider types / specialties documenting changes or updates to the CT Medical Assistance Program
  – Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type. The online database of bulletins goes back to the year 2000



Bulletin Search

Year 15 Provider Type ALL PROVIDER TYPES

Number Title

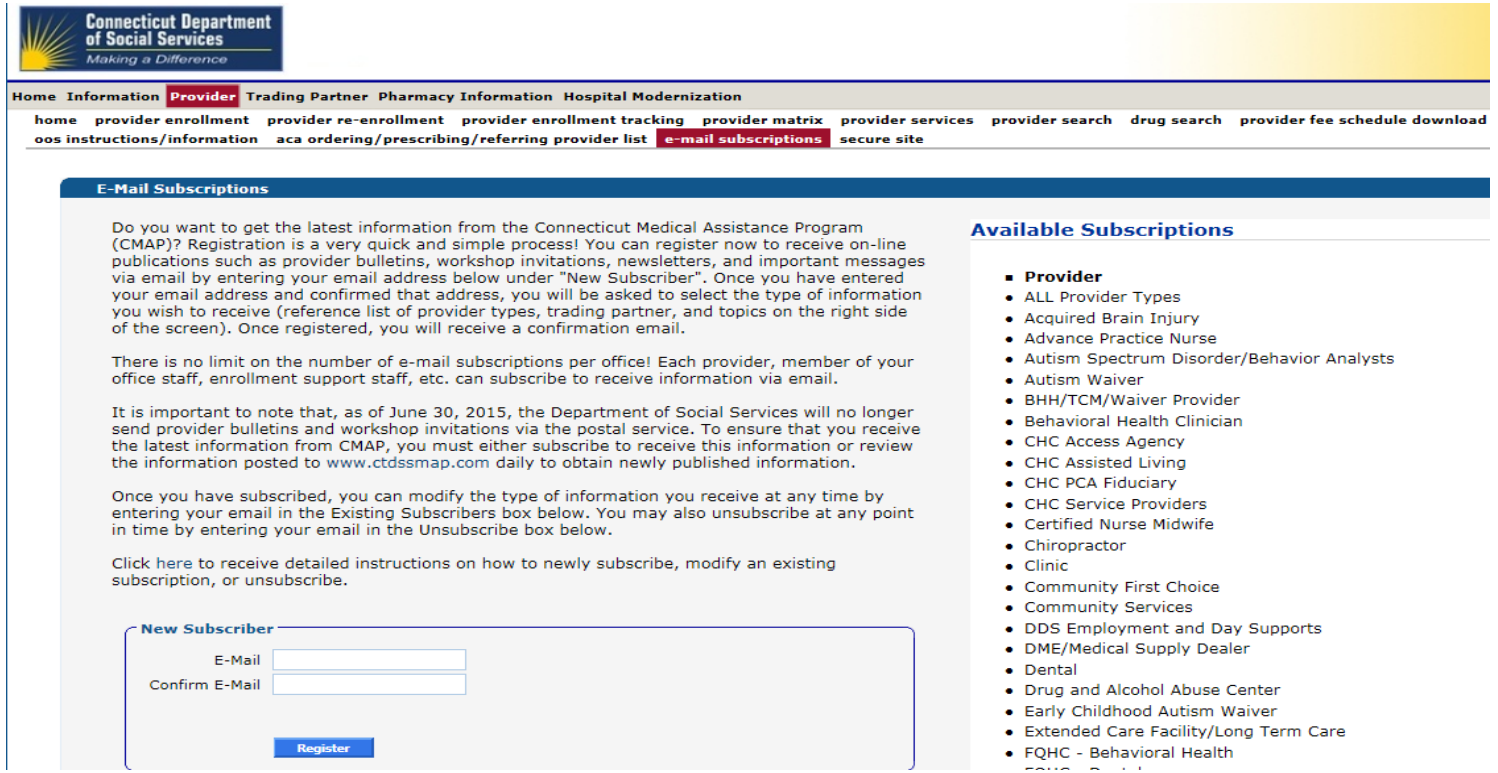
Search Results

Bulletin Number	Title	Published Date
PB15-85	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/08/2015
PB15-61	Claims Processing Guidance for Implementing ICD-10 Codes	08/04/2015
PB15-60	Eligible Clients under the Affordable Care Act Part IV (Temporary ID Update)	07/28/2015
PB15-55	Upcoming Changes to the Automated Voice Response System Menu Options	07/16/2015
PB15-54	Elimination of Mailing Paper Remittance Advices	07/14/2015
PB15-47	Fee Schedule Updates for ICD-10 Diagnosis Codes	06/30/2015
PB15-47	ICD-10 Related Explanation of Benefit (EOB) Codes in Connecticut Medical Assista...	06/30/2015
PB15-50	Payment Error Rate Measurement (PERM) Program Audit Requests	06/30/2015
PB15-45	Billing Procedures for Services Ordered by Residents and Interns	06/22/2015
PB15-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	05/19/2015
PB15-35	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergenci...	05/05/2015
PB15-23	Implementation of Electronic Messaging - Replacement to the Mailing of Bulletins...	03/10/2015
PB15-05	Billing Clients for Missed Appointments	01/20/2015

Information- Resources
E-mail Subscriptions

Register for E-mail Subscriptions

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



Information – Resources
Provider Manual

– 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 CMAP claims, prior authorizations, and other related transactions. This manual contains detailed instructions regarding the Program, and should be your first source of information pertaining to policy and procedural questions

– The Provider Manual is divided into twelve (12) chapters
  – Click on the chapter title to open the document (disable pop-up blockers)
  – Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter
  – Chapter 11 is claim-type specific

Information – Resources
Provider Manual

- Chapter 1 – Introduction
  - Provides information on the CT Medical Assistance Program, the Department of Social Services' and Hewlett Packard Enterprise's responsibilities and resources
- Chapter 2 – Provider Participation Regulations
  - Details the CMAP regulations for provider participation
- Chapter 3 – Provider Enrollment
  - Provides information on provider eligibility in regards to provider enrollment and re-enrollment
- Chapter 4 – Client Eligibility
  - Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability
- Chapter 5 – Claim Submission Information
  - Provides information on general claims processing and billing requirements
- Chapter 6 – EDI Options
  - Provides information on electronic claim submission and electronic RAs

Information – Resources
Provider Manual

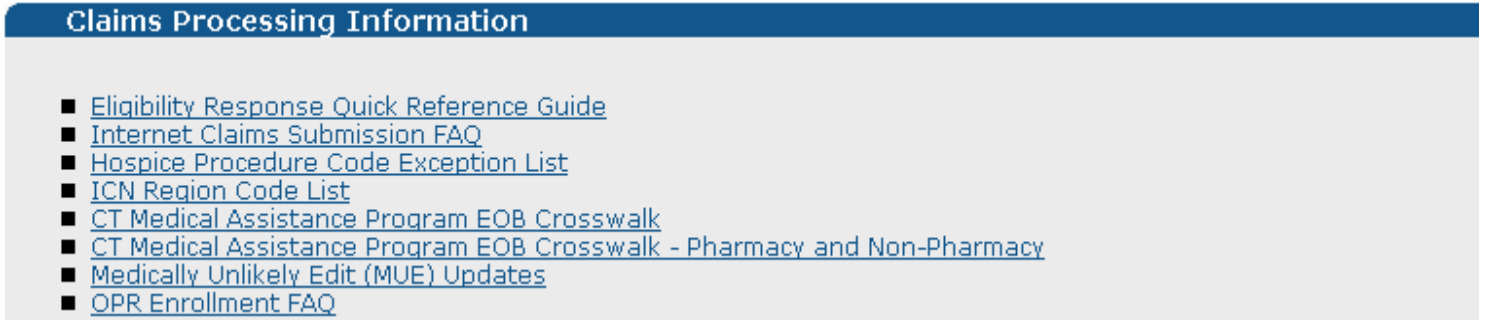
- Chapter 7 – Regulations/Program Policy
  - This section contains the Medical Services Policy sections that pertain to the chosen provider type
- Chapter 8 – Billing Instructions
  - Provides information on provider specific billing requirements and instructions
- Chapter 9 – Prior Authorization
  -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

Information – Resources
Other

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



- Claims Processing Information
  - **Guides and FAQs to assist with billing/claims processing**



Contacts

www.ctdssmap.com
Contacts

Resources
Contacts

- **Hewlett Packard Enterprise Provider Assistance Center (PAC)**
  - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
  - www.ctdssmap.com ctdssmap-ProviderEmail@HPE.com
  - This should be your first call resource to answer all enrollment and billing related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number for future call reference.

- **Hewlett Packard Enterprise Electronic Data Interchange (EDI) Help Desk**
  - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

- **Sandata (EVV) Technologies, LLC (EVV)**
  - Sandata Customer Care:
    - 1-855-399-8050 or ctcustomercare@sandata.com
      Monday thru Friday 8:00 AM – 6:00 PM

Case Management Agency Contact Information

Contacts

➢ **Connecticut Community Care (CCCI)**

- serviceauthissues@ctcommunitycare.org
- **Providers must include the following information when submitting service authorization issues to CCCI:**
  - Provider name, client name, client EMS number, CCCI number, EOB code on rejecting claim at Hewlett Packard Enterprise, from and to dates of service, the type service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day etc.) the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

➢ **South Western Connecticut Area on Aging (SWCAA)**

- **SWCAABillings@swcaa.org.**
- **Please have the following information available when contacting SWCAA:**
  - client name, the client EMS number, the type of service (PCA srvs. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit.

Case Management Agency Contact Information

Contacts

- **Western Connecticut Area on Aging (WCAA)**
  - **Contact WCAA directly at (203)465-1000**
  - **Please have the following information available when contacting WCAA:**
    - Client name, the client EMS number, type of service (adult family living/foster care, support broker services, CFC or home health services) the dates of service, the frequency of service and the number of units or hours per visit.

–

Questions/Comments

www.ctdssmap.com
Question and Comments

Hewlett Packard
Enterprise

Thank You For Attending

The Connecticut Medical Assistance Program

Acquired Brain Injury (ABI) Web Claim Submission Workshop

All questions and comments regarding this training are welcome.

Please fill out the provided workshop survey:

Your feedback helps us to improve future workshops

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
INDIV. SRVS BILLED BY ALLIED COMMUNTY - PROV.TYPE/SPECIALTY 52/029									
1212M	Recovery Assistant, Indiv	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1213P	Recovery Assistant II, Indiv	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1533P	Chore Service Individual	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1535P	Individual Companion Per 1/4 Hour	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	1	Optional
1537P	Companion Individual	Per 15 min	Allied	Y	Per week or per month	Auto-approve	WVR only	2	Optional
1538P	Environmental Modification Per Unit ($10,100/Yr=Max.)	$S	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
1546P	Independent Living Skill Development (Individual) Per Hour	1 per hour per 15 min-(eff dos 3/1/17)	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1562P	Respite Care Per Hour	1 per hour	Allied	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1564P	Specialized Medical Equipment Per Unit ($10,100/Yr = Max.)	$	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
1575P	Transportation - Mileage	Per Mile	Allied	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1578P	Vehicle Modification Per Unit ($10,100/Year = Max.)	$	Allied	N	Frequency N/A dollars authorized	In excess of $10,100 year, In Process status	WVR only	1&2	N/A
ABI SRVS BILLED BY ABI SERVICE PROVIDERS - PROV. TYPE/SPEC. 52/027									
1021Z	Personal Care Services, Per 15 Minutes	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
33	Personal Care Services, Per 15 Minutes 1021Z, 1021Z TT	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1022Z	Personal Care Services, Overnight	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
34	Personal Care Services, Overnight 1022Z, 1022Z TT	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
3022Z	Personal Care Services, Overnight cannot be completed, prorated hourly	Per hour, up to 11 hours per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1023Z	Personal Care Services, Per Diem	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
35	Personal Care Services, Per Diem 1023Z, 1023Z TT	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1225Z	Personal Care Services, Per Diem cannot be completed, prorated hourly	Per hour, up to 23 hours per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1200Z	Adult Day Health - Full Day (Non-Medical Model Provider)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1201Z	Adult Day Health - Full Day (Approved Medical Model Provider)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1202Z	Adult Day Health - Half Day (Less Than Or Equal To 4 Hrs)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
971	Adult Day Care 1200Z, 1201Z, 1202Z	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
AD	ADULT DAY CARE(1Xonly) 1200Z U2 1201Z U2, 1202Z U2	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	2	N/A
1211P	Recovery Assistant	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1212P	Recovery Assistant II	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1232Z	Respite Care In The Home Per Hour-Other	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	Mandated
1448P	Cognitive behavioral interventions per 15 min not face-to-face	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1548P	Cognitive Behavioral Programs Per 15 min face to face	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
757	Cognitive Behavioral Services 1448P, 1548P	per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1531P	Community Living Support Services	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1532P	Chore Services Per 1/4 Hour	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1534P	Community Living Support Services Per 1/2 Day	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1536P	Companion Services Per 1/4 Hour (18-Hour/Day Max.)	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1538P	Environmental Modification Per Unit ($10,100/Yr=Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized	>$10,100 year, In Process status	WVR only	1&2	N/A
1542P	Homemaker Services Per 1/4 Hour	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1546P	Independent Living Skill Development (agency)	1 per hour per 15 min-(eff dos 3/1/17)	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Mandated
1547P	Independent Living Skill Development (Group) Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1549P	Consultation Services	1 per year	ABI Srvc Prv only	N	Per year	Auto-approve	WVR only	2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1550P	Home Delivered Meals Per Day (Single Meal)	up to 7 per day/7 per week max	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
1551P	Home Delivered Meals Per Day (Double Meals)	up to 7 per day/7 per week max	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
969	Meals 1550P, 1551P	up to 7 per day/7 per wk max any combo with single auths	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	N/A
AB	Meals (One time only) 1550P U2 1551P U2	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1556P	Personal Emergency Response System (Installation)	1 per year	ABI Srvc Prv only	N	Per year	Auto-approve	WVR only	1&2	N/A
1557P	Personal Service Emergency Response System (Monthly Service One-Way)	2 per month	ABI Srvc Prv only	N	Per month	Auto-approve	WVR only	1&2	N/A
1558P	Personal Emergency Response Two Way	1 per month	ABI Srvc Prv only	N	Per month	Auto-approve	WVR only	1&2	N/A
1560P	Pre-Vocational Services Per Hour (Max = 40 Hours/Week)	1 per hour	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	Optional
1561P	ABI Group Day	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve max 8 per day	WVR only	1&2	N/A
1562P	Respite Care Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1564P	Specialized Medical Equipment Per Unit ($10,100/Yr = Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized.	>$10,000yr, In-Process status	WVR only	1&2	N/A
1566P	Substance Abuse Program Per Day (56 Days/Yr = Max.)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A
1567P	Substance Abuse Program Per Hour	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
1572P	Supported Employment Per Hour (40 Hours/Week = Max. Cannot Be Provided With Pre-Voc.)	1 per hour	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1&2	Optional
1574P	Transportation - One Way Trip Public	Per Trip	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1575P	Transportation - Mileage	Per Mile	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1&2	N/A
1578P	Vehicle Modification Per Unit ($10,100/Year = Max.)	$S	ABI Srvc Prv only	N	Frequency N/A dollars authorized.	> $10,100 year, In-Process status	WVR only	1&2	N/A
1580P	Transitional Living Per Day (183 Days/Year = Max.)	1 per day	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1	N/A
H2035	A/d tx program per hour	1 per hour	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1	N/A
H2036	A/d tx program per diem	1 per day	ABI Srvc Prv only	N	Per week or per month	Auto-approve	WVR only	1	N/A
T1013	Sign lang/oral interpreter	Per 15 min	ABI Srvc Prv only	Y	Per week or per month	Auto-approve	WVR only	1	N/A
CFC SRVS BILLED BY CFC FI - PROVIDER TYPE/SPEC 50/501									
CF	Personal Care Services: Per Diem 1019Z 1019Z TT 1019Z U2 1019Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Personal Care Services: Overnight 1020Z 1020Z TT 1020Z U2 1020Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Single Meal (hot) 1218Z, 1218Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
	Double Meal (One Hot - One Cold) 1220Z 1220Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Kosher Meals Double 1221Z 1221Z U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Two-Way PERS System (Ongoing Services) 1223Z, 1223Z TT	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	PCA Individual Per Diem (Prorated Hourly) 1227Z, 1227Z TT 1227Z U2, 1227Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	PCA Services 1520P, 1520P TT 1520P U2, 1520P TT U2	$S	CFC FI/PCA Srvc Prv only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Workers Compensation Coverage 1525P	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Personal Emergency Response System (Installation) 1556P, 1556P TT	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	N/A
	Support and Planning Coach, Individual 2042Z, 2042Z TT 2042Z U2, 2042Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Support and Planning Coach, Agency 2043Z, 2043Z TT 2043Z U2, 2043Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
	PCA Individual Overnight Prorated Hourly 3020Z, 3020Z TT 3020Z U2, 3020Z TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Physical Therapy Coach G0151, G0151 TT G0151 U2, G0151 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Occupational Therapy Coach G0152, G0152 TT G0152 U2, G0152 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Speech Language Therapy Coach G0153, G0153 TT G0153 U2, G0153 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
	Skilled services LPN/RN (Training/education) G0164, G0164 TT, G0164 U2, G0164 TT U2	$S	CFC FI/PCA Service Provider only		Frequency N/A dollars authorized.	Auto-approve	MCD with Waiver only	1&2	Optional
HOME HEALTH SRVS BILLED BY HOME HEALTH AGENCIES PROV.TYPE/SPEC 05/050									
H0033	Oral medication administration, direct observation	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
441	Speech therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated
431	Occupational therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated
421	Physical therapy, in the home, per diem	1 per day	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 1 per week or 5 per month	MCD only	1&2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
T1001	Nursing Assessment/Evaluation	1 per initial or ROC eval	HOME HEALTH AGENCY ONLY	N	Per Date Span	Greater than 1 per year requires PA	MCD only	1&2	Mandated
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	Auto-approve	MCD only	1&2	Mandated
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	Auto-approve	MCD only	1&2	Mandated
T1004	Services of a qualified nursing aide, up to 15 minutes	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004,&/or NA or NN	MCD only	1&2	Mandated
NA	Srvcs, qualified nursing aid, up to 15 minutes T1004, T1004 TT	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004,&/or NA or NN	MCD only	1&2	Mandated
NN	Services of a qualified nursing aid, up to 15 minutes T1004 U2 T1004 U2 TT	Per 15 min	HOME HEALTH AGENCY ONLY	N	Per week or per month	In excess of 56 per week or 248 per month any T1004&/or NA or NN	MCD only	1&2	Mandated
T1021	MED TECH (Home Health Aide or Certifiied Nurse Assistant)	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
MT	MED TECH (Home Health Aide or Certifiied Nurse Assistant) T1021 T1021 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated
MU	MED TECH (Home Health Aide or Certifiied Nurse Assistant) T1021 U2 T1021 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated

ABI Procedure Code Crosswalk 05/01/2017

Proc. Code	Description	Unit Increment	Billing Provider	Span DOS Y/N	Valid Frequency	Care Plan limitation	Fund Source	ABI Benefit Plan	EVV Mandate
SN	Skilled Nursing S9123 S9123 TT S9124 S9124 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS,MA,MM	MCD only	1&2	Mandated
MA	Medication Administration T1502 T1502 TT T1503, T1503 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
SS	Skilled Nursing S9123 U2 S9123 U2 TT S9123 S9124 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
MM	Medication Administration T1502 U2 T1502 U2 TT T1503 U2 T1503 U2 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per Date Span	In excess of 2 per week any SN &/or SS, MA, MM	MCD only	1&2	Mandated
29	Oral medication admin., direct observation H0033, H0033 TT	1 per visit	HOME HEALTH AGENCY ONLY	N	Per week or per month	PA Required from first visit	MCD only	1&2	Mandated

EVV **NON-MEDICAL SERVICES** ARE **MANDATED** FOR CHECK-IN/CHECK/OUT **EFFECTIVE 1/1/2017.**									
EVV **MEDICAL SERVICES** ARE **MANDATED** FOR CHECK-IN/CHECK/OUT **EFFECTIVE 4/3/2017**									
NOTE:	ABI Benefit Plan 1=ABI Acquired Brain Injury 2= ABI II Acquired Brain Injury								
FOR NON-MEDICAL SERVICES:									
*** Spanned dates of service cannot span multiple line details on care plan.**									
*** Spanned dates of service cannot exceed the frequency (weekly or monthly) of services on the care plan.**									

Connecticut Medical Assistance Program Workshops

For Non-Medical Home and Community Based Services Agencies

Enrolled as Acquired Brain Injury (ABI) Waiver Service Providers

Presented by the Department of Social Services (DSS) and Hewlett Packard Enterprise

The following workshops are being offered to assist **enrolled ABI Service Providers and those providers who expect to continue their practice, as of September 1, 2016,** delivering non-medical, home and community based services to both ABI I and ABI II Waiver clients, with the transition to becoming a successful billing provider. This workshop will also assist ABI providers with the understanding of how Electronic Visit Verification (EVV) integrates with the Connecticut Medical Assistance Program and the services they provide. ABI Service Providers should access the "Service Code Listing" in the "Electronic Visit Verification Implementation" Important Message on the www.ctdssmap.com home page to determine if the services they provide are mandated, optional or are not required for EVV prior to attending this workshop.

This ABI Billing and Web Claim Submission workshop will review the components of successful claim submission for timely and maximum reimbursement of both **non-mandated and mandated EVV services.** Topics of discussion will include a review of secure Web account set-up and capabilities, determining client eligibility, verification of services on the client care plan, common claim errors and resolution, claim activity reporting/reconciliation and billing resources. The workshop will also include a review of the Web based claim submission functionality, Web claim submission options and time for questions.

Please follow the registration instructions below to register for the workshop of your choice. If you have any questions concerning this information, please contact the Provider Assistance Center at 1-800-842-8440. You are strongly encouraged to attend. To better accommodate the needs of our providers, we are offering three sessions of the workshop to ensure all can attend. We look forward to your attendance at one of the workshops offered to ensure your success as a billing provider of ABI services.

WORKSHOP LOCATIONS, DATES, AND TIMES

Workshop locations, dates, and times for **ABI Service Providers** are listed below. The registration links are listed beneath the date of the workshop. To register for a workshop, select the appropriate link and register online. Please refer to the "How to Register for a Workshop" instructions below if you require further assistance with the registration process.

ABI SERVICE PROVIDER Billing and Web Claim Submission WORKSHOP

Workshop Location, Date and Time:	**Registration Due Date:**
Connecticut Hospital Association, Wallingford, CT	
Friday, August 5, 2016 9:00 am – 1:00 pm	**Tuesday, August 2, 2016**

https://www.surveymonkey.com/r/ABIBillingWebClaimSubmission08052016

HP MyRoom Virtual Classroom Training

Monday, August 8, 2016 1:00 pm – 5:00 pm **Wednesday, August 3, 2016**

https://www.surveymonkey.com/r/ABIBillingWebClaimsSubmission08082016

HP MyRoom Virtual Classroom Training

Tuesday, August 16, 2016 1:00 pm – 5:00 pm **Thursday, August 11, 2016**

https://www.surveymonkey.com/r/ABIBillingWebClaimSubmission081616

HOW TO REGISTER FOR A WORKSHOP

To register for these workshops, visit the **www.ctdssmap.com** Web site and go to Information, then Publications and scroll down to Provider Workshop Invitation Forms. Select the ABI Billing/Web Claim Submission Workshop you wish to attend and click on the Registration Link.

Once you click "Register Now" at the bottom of your registration page, you will be provided a workshop confirmation number. Please retain this number for your records should you need to discuss your registration with Hewlett Packard Enteprises. If you do not receive a confirmation number, you have not successfully registered for this workshop.

Please be sure to include all of the registration information indicated below to ensure timely and accurate attendance registration.

HP MyRoom Virtual Classroom Training

Hewlett Packard Enterprise utilizes internet virtual classrooms that allow class participants to attend a workshop without leaving their office. Participants will be provided a key to an internet classroom to attend the **ABI Workshop**. We have replaced HP Virtual Room with HP MyRoom. As a result, providers who previously attended Virtual Room Workshops for other Connecticut Medical Assistance programs will need to download HP MyRoom and set up an account in order to attend the virtual classroom training. In addition, participants will also dial into a conference call and have an opportunity to ask questions. Providers who register for this training will receive an email with directions on how to attend this training. **For this reason, it is critical that providers enter a valid email address at the time of registration.** If this email is not received 3 days prior to the training, please contact the Provider Assistance Center toll free at 1-800-842-8440.

Please supply the following information when registering for a workshop:

- Provider Name
- NPI Number or AVRS ID, if enrolled as an ABI Service Provider, or current application status
- Contact Name
- Telephone Number (including Area Code)
- Email Address
- Name of Attendee

Once you click "Register Now" at the bottom of your registration page, you will be provided a workshop confirmation number. Please retain this number for your records should you need to discuss your registration with

Hewlett Packard Enterprise. If you do not receive a confirmation number, you have not successfully registered for this workshop.

IMPORTANT NOTICES:

Copy of Workshop Presentation

The workshop presentation will be available on the www.ctdssmap.com Web site. To access a presentation, from the www.ctdssmap.com Web site Home page, select Provider Services. Under Provider Training, click the "here" link. Under "Materials", click the "ABI Service Provider Workshops" link to select the workshop(s) you wish to view and/or download.

Inclement Weather

Should inclement weather occur on the date of a workshop, resulting in a late opening or closure, Hewlett Packard Enterprise will post a notice of workshop delay or cancellation at **1-844-225-1164, extension 2154000.**

DIRECTIONS

Connecticut Hospital Association
110 Barnes Road, Wallingford, CT 06492 (203) 265-7611

- **1-91 NORTHBOUND**: Take Exit 15. At the end of the Exit ramp, turn LEFT onto ROUTE 68 WEST. Proceed approx. 1.8 miles on ROUTE 68 to the *7th traffic light; Turn RIGHT onto BARNES INDUSTRIAL PARK ROAD NORTH; at the traffic light, turn LEFT onto BARNES ROAD; and take FIRST RIGHT into CHA driveway.

- **I-91 SOUTHBOUND:** Take Exit 15. At the end of the Exit ramp, turn RIGHT onto ROUTE 68 WEST. Proceed approx. 1.8 miles on ROUTE 68 to the *6th traffic light; Turn RIGHT onto BARNES INDUSTRIAL PARK ROAD NORTH; at the traffic light, turn LEFT onto BARNES ROAD; and take FIRST RIGHT into CHA driveway.

- **Wilbur Cross (Route 15) NORTHBOUND:** Take Exit 66. At the end of the Exit ramp, turn LEFT onto ROUTE 5 SOUTH. Proceed approx. 1/4 mile to *4th traffic light. Turn LEFT up short hill to next traffic light. Turn LEFT onto ROUTE 68 EAST. At FIRST traffic light; turn LEFT onto NORTH MAIN STREET EXTENSION. Take first RIGHT onto BARNES ROAD. CHA is the SECOND BUILDING ON THE LEFT.

- **Wilbur Cross (Route 15) SOUTHBOUND:** Take Exit 66. At the end of the exit ramp, turn LEFT onto ROUTE 5 SOUTH. Proceed approx. 1/4 mile to *5th traffic light. Turn LEFT up short hill to next traffic light. Turn LEFT onto ROUTE 68 EAST. At FIRST traffic light; turn LEFT onto NORTH MAIN STREET EXTENSION. Take first RIGHT onto BARNES ROAD. CHA is the SECOND BUILDING ON THE LEFT.

- **I-84 EASTBOUND:** Take Exit 27. Proceed onto Route 691 East. Follow to the WILBUR CROSS PARKWAY SOUTHBOUND. Take Exit 66. At the end of the exit ramp, turn LEFT onto ROUTE 5 SOUTH. Proceed approx. 1/4 mile to *5th traffic light. Turn LEFT up short hill to next traffic light. Turn LEFT onto ROUTE 68 EAST. At FIRST traffic light; turn LEFT onto NORTH MAIN STREET EXTENSION. Take first RIGHT onto BARNES ROAD. CHA is the SECOND BUILDING ON THE LEFT.

***IMPORTANT ~ Traffic light count includes light at the end of ramp**

IMPORTANT NOTICES:

CHA is a smoke-free campus.

******* NO SMOKING ALLOWED*******

The use of tobacco products is prohibited on the grounds, sidewalks, delivery areas, and parking lots.

Refreshments will **not** be served.

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE • HARTFORD, CONNECTICUT 06105

October 2, 2017

Dr. Tariq Abdulaziz
Neurostrategies, Inc.
23 Kate Way
Windsor Locks, CT 06096
Via email: tariqabdulaziz@neurostrategies.info

Dear Dr. Abdulaziz,

Please consider this a response to your two letters sent via e-mail on September 20 and 21, 2017.

With respect to the five requests contained in your September 20, 2017 correspondence, the Department responds as follows:

1) 42 CFR 455.410, in addition to other relevant state and federal provisions.

2) The Department has not waived the requirements of section 17b-260a-14 of the ABI Waiver Operating Policy. Rather, the Department has temporarily suspended the deadline for a sub-set of providers, specifically individual (non-agency) Personal Care Assistants ("PCAs") and household employees, to sign and return a provider enrollment agreement.

3) There is no statute or other law requiring audit protocols for ABI Waiver providers.

4) Medicaid claim submission trainings for ABI Waiver providers were held on August 5, 8 and 16, 2017. The invitation you received to sign up for the workshop is attached. Department records show that you registered for the August 16, 2016 ABI Billing Web Claim Submission Workshop. The training materials are attached, and are also available on the Department's Medical Assistance Program (CTMAP) website, www.ctdssmap. Finally, there is no statute or other law requiring that claims submission trainings be offered prior to February 1, 2015. Public Act 17-135, which you cite in your correspondence, actually removed a prior (and unrelated) deadline of February 1, 2015 from C.G.S. 17b-99.

5) In accordance with C.G.S. 17b-10, the Department notified the Legislative Regulation Review Committee on November 10, 2016 that the Department would not be able to submit the proposed regulations on or before 180 days after their adoption.

With respect to your September 21, 2017 correspondence, Neurostrategies, Inc. remains classified as an ABI Waiver agency provider, and you remain classified as an agency employee. Both you and Neurostrategies, Inc. must comply with all rules, requirements and agreements applicable to such providers. To the extent that the Department referred to you and Neurostrategies, Inc. as "self-employed providers…who have chosen to participate in the state's Medicaid program" in the June 22, 2016 Declaratory Ruling, the Department was simply distinguishing between private entities such as you and Neurostrategies, Inc. on one hand, and state or public employees on the other. This was in response to certain portions of your Request for Declaratory Ruling in which you sought a determination that you and Neurostrategies, Inc. should be reclassified as employees of the State of Connecticut, eligible for, among other things, state health insurance and retirement benefits.

Sincerely,

Patricia McCooey
Staff Attorney

From:	Porter, Richard
To:	DeMattia, Tanya; Salton, Henry
Subject:	RE: [arrest] Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas [CTAG-CTAG.FID1652598]
Date:	Wednesday, August 28, 2019 2:17:50 PM

Thank you.

Richard M. Porter
Assistant Attorney General
Antitrust and Government Program Fraud Department
Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06106

Phone: 860.808.5040
Fax: 860.808.5391
Email: Rick.Porter@ct.gov
URL: http://ct.gov/ag/

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From: DeMattia, Tanya
Sent: Wednesday, August 28, 2019 2:14 PM
To: Salton, Henry; Porter, Richard
Subject: FW: [arrest] Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas [CTAG-CTAG.FID1652598]

Tanya Feliciano DeMattia

Assistant Attorney General
Office of the Attorney General
55 Elm Street
P.O. Box 120
Hartford, CT 06106

Phone: 860.808.5210
Fax: 860.808.5385
Email: tanya.demattia@ct.gov
URL: http://ct.gov/ag/

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please notify us immediately by replying to the message so that we can take appropriate action immediately and see to it that this mistake is rectified.

From: Slitt, Michael
Sent: Wednesday, August 28, 2019 1:07 PM
To: DeMattia, Tanya; Salton, Henry
Subject: Fw: [arrest] FW: Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas

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From: Dearborn, David S.
Sent: Wednesday, August 28, 2019 12:56:47 PM
To: Gifford, Deidre; Brennan, Kathleen M.; Simpson, Janel; Ferron-Poole, Astread O.; McEvoy, Kate; Bruni, Kathy A. (DSS); Lambert, Dawn B.; Worrell-Asare, Sonia; Zavoski, Robert W.; Slitt, Michael; Filippini, Laurie R.; Chamberlin, George; Long, Dorian J.; Wilson, Alvin; Seifel, David; Chase, Paul; Gilbert, Michael J.; Venditto, Nicholas
Cc: McCormick, John F.; Markowski, Stephen J.
Subject: [arrest] FW: Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas

Chief State's Attorney's Office release cites DSS Quality Assurance.

From: list [mailto:OTG_PIOs@LIST.CT.GOV] **On Behalf Of** ConnDCJ
Sent: Wednesday, August 28, 2019 12:41 PM
To: OTG_PIOs@LIST.CT.GOV
Subject: Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas

FOR IMMEDIATE RELEASE
August 28, 2019

Medicaid Provider Charged with Billing for Work in Connecticut When He Was in Texas

A Windsor Locks man was arrested today and charged with billing the Medicaid program for face-to-face treatment of acquired and traumatic brain injury (ABI) patients in Connecticut when instead he was actually in Texas.

TARIK M. ABDULAZIZ, age 50, of Kate Way, Windsor Locks, was arrested by Inspectors from the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney and charged with one count each of Larceny in the First Degree by Defrauding a Public Community and Health Insurance Fraud.

According to the arrest warrant affidavit, Abdulaziz was an enrolled provider in the state's ABI waiver program, which is a federal and state funded Medicaid program that develops and delivers treatment to individuals with acquired and traumatic brain injury.

Between June 2018 and January 2019, Abdulaziz submitted 113 claims for face-to-

face treatment of ABI patients in Connecticut when he was actually in Texas. He was paid about $13,650 for these false claims, the warrant alleges.

Abdulaziz was released on a $25,000 non-surety bond and is scheduled to appear in Hartford Superior Court, G.A. No. 14, on September 5, 2019. The charges are merely accusations and he is presumed innocent until and unless proven guilty.

Larceny in the First Degree By Defrauding a Public Community is a class B felony punishable by up to 20 years in prison. Health Insurance Fraud is an unclassified felony punishable by up to 5 years in prison.

The case will be prosecuted by the Medicaid Fraud Control Unit. The Unit is grateful for the assistance it received in this investigation from the state Department of Social Services Office of Quality Assurance, Office of the Attorney General and the Rocky Hill Police Department.

Media Contact: Mark Dupuis, Communications Officer (860) 258-5997

From:	McCormick, John F.
To:	Brennan, Kathleen M.; McEvoy, Kate; Bruni, Kathy A. (DSS); Worrell-Asare, Sonia; Slitt, Michael; Hyman, Phyllis; DeMattia, Tanya; Salton, Henry
Subject:	Fw: Sleep: ABI Waiver
Date:	Friday, August 16, 2019 6:45:52 AM

FYI

From: Tariq Abdulaziz Ph.D MS MS MBA LPC. LADC AADC <abdulaziz.ns@protonmail.com>
Sent: Thursday, August 15, 2019 4:15 PM
To: McCormick, John F.; Bruni, Kathy A. (DSS); Dumont, Amy E; Danielle Gabor; Luisa DiNino-Jones
Subject: Sleep: ABI Waiver

Attention Mr. McCormick

This is a reminder regarding my email from yesterday requesting guidance from Bruni regarding sleeping.

Again, this request was originally sent to Dumont in early July. She failed to respond.

CCCI through DSS has forced a minority business owner to adhere to the policy of “no sleep” while majority business owners are not held to the same standard.

I have requested guidance from Bruni regarding this matter with a deadline of tomorrow end of business.

If I do not receive clear guidance I will assume that the appearance of disparate treatment of minority business owners was an error and that the department has and had every intention of not being biased when disseminating guidance.

As a result, I will disseminate the guidance on behalf of each of you and the department.

Thank you

Tariq Abdulaziz

Sent from ProtonMail Mobile