Connecticut interChange MMIS

Provider Manual

Chapter 8 – Waiver Programs and Special Services Claim Submission Instructions

July 10, 2023

Connecticut Department of Social Services (DSS)
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gainwell

Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	01/01/2008	Initial Release	All	All
1.1	07/10/2009	Updates made to clarify prior authorization overview, updates made to Medicare coinsurance and deductible billing instructions; added additional place of service value; updated procedure code lists; updated fee schedule instructions; added new Mental Health Waiver.	8.1 8.4 8.5 8.11 8.12 8.13 8.14 8.15	2 7-13 14-15 27-28 30 32, 34-36, 38, 40-44 46-47 49
1.2	10/14/2009	Added Hospice claim submission instructions; updated other insurance/Medicare billing instructions.	8.1 8.13	2 32, 34, 36, 42-43
1.3	01/14/2010	Added information on the State Funded Pilot Connecticut Home Care Program for the Disabled (CHCPD) and CHC Cost Sharing, added additional PA instructions.	8.4 8.12	8, 13-14 31
1.4	02/18/2010	Updated Medicare reconsideration requirements to include ABN issue date, updated EDS references to HP.	8.12	31
1.5	08/03/2010	Replaced references to OI/Medicare Billing Guide links with Chapter 11; added references to Medicaid LIA program; added CHC PCA Fiduciary; updated CHC Cost Sharing; revised fee schedule instructions.	8.1 8.4 8.6 8.10 8.12 8.13 8.14	2 8-10, 14 19 27 31 35, 37, 43, 44 47
1.6	10/04/2010	Incorporated changes to add Personal Care Assistance Services and Assistive Technology to the Connecticut Home Care Program.	8.4 8.7 8.13	8, 13-14 21 44

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Version	Version Date	Reason for Revision	Section	Page(s)
1.7	04/27/2011	Updated as a result of PPACA Hospice clarifications for children under the age of 21, the Behavioral Health Expansion Project, and the HIPAA 5010 implementation,	8.1 8.6 8.11 8.12 8.13 8.15	2 20 30 32 44-46 51
1.8	06/23/2011	Updated as a result of new Employment and Day Supports Waiver, and CHC cost sharing change.	8.1 8.4 8.6 8.13 8.14	2 14-15 19-20 47-48 50-52
1.9	06/05/2012	Updates made as a result of ASO transition and implementation of TB Waiver.	All	All
2.0	05/08/2013	Updates made to FTCs in Field 24B for Targeted Case Management.	8.15	46
2.1	09/09/2013	Updates made as result of CHC changes and the implementation of the Autism Waiver.	All	All
2.2	12/31/2013	Updates made as a result of ordering, prescribing, referring implementation. Updated to include new version of CMS 1500 form and billing instructions. Also updated to reflect shut down of Charter Oak program, effective January 1, 2014.	8.1 8.16 8.18	2 44-6, 50 & 58-9 63
2.3	02/24/2014	Deleted section that contained billing instructions for the old version of the CMS 1500 form (08/05). Instructions for the new version of the form (02/12) confirm that claims submitted in the CMS-1500 old version of the form on or after April 1, 2014 will be returned to the provider.	8.16	45-58 & 60
2.4	04/28/2014	Updated with CHC changes as well as added Early Childhood Autism Waiver. Updated to reflect delay in ICD-10 implementation.	8.1 8.5 8.7 8.17	2 19-21 26-27 54, 58 & 60
2.5	09/04/2014	Updated to reflect new DSS address/logo. Removed references to Charter Oak. Misc additional updates.	8.1 8.5	2 15-17
2.6	02/06/2015	Updated to include ABI II program.	8.1 8.3	2 6

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Version	Version Date	Reason for Revision	Section	Page(s)
			8.18 8.20	56, 61, 62 73
2.7	04/22/2015	Added procedure codes for IFS and Comprehensive Waiver, as well as Employment and Day Supports Waiver. Replaced references to DSS Alternate Care Unit with Home and Community Based Services Unit.	8.6 8.7 8.20	12-13 25 67, 70
2.8	06/25/2015	Updated to include Community First Choice Program.	8.1 8.6 8.7 8.18 8.19 8.20 8.21	2 12 25 48 56-57, 63 67 75
2.9	09/21/2015	Updated as a result of ICD-10 implementation.	8.7 8.8 8.16 8.19	20, 25 28 44 57, 62
3.0	11/01/2015	Updated to replace HP references/logo with Hewlett Packard Enterprise references/logo, as well as added reference to School Based Child Health (SBCH) not requiring diagnosis codes on claims and added a FTC for assisted living.	All	All
3.1	01/04/2016	Updated as a result of removing procedure code 9753A from DSS Procedure Code List.	8.20	70
3.2	03/04/2016	Updated the current Place of Service (POS) code set by adding new POS code 19 and revising POS code 22. Updated as a result of the PCA Care Plan changes. Additionally updated waiver procedure code list.	8.12 8.19 8.20	37 59, 62 69, 72
3.3	12/01/2016	Updated to replace ValueOptions with Beacon Health Options. Updated to reflect changes to the non-contracted TCM, TCM, BHH ABI/ABI II, CHC, and PCA waiver programs. Also updated as a result of the elimination of paper claims. Removed references to ICD-9-CM.	All	All
3.4	02/17/2017	Updated Dates for EVV	8.2 8.3	6 12

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Version	Version Date	Reason for Revision	Section	Page(s)
			8.7 8.12	33 47
3.5	06/02/2017	Added procedure code 2021T for DDS Waiver programs, and updated Birth to Three program information. Also, updated ABI, CHC, and PCA Crosswalks. Hewlett Packard Enterprise to DXC Technology updates.	8.2 8.3 8.7 8.12 8.20 All	6 12 34,35 48 77, 78 All
3.6	10/01/2017	Moved Birth to Three billing instructions to a new Chapter 8.	All	All
3.7	1/31/18	Update to Tuberculosis (TB) Benefit, as well as Autisum Waiver information.	8.5 8.16	17-19 61
3.8	02/28/2018	Updates to School Based Child Health Training Materials.	8.13	55
3.9	02/04/2019	Addition of DDS Special Services for Nursing Home Facility Residents. Updated Autism to include EVV implementation effective 2/1/19 with mandate of 3/3/19. Updated ABI, CHC and PCA to include Alternate Claim Solution for EVV mandated servcies.	8.7 8.4 8.2,8.3,8.6, 8.12	41, 75-90, 95 18-20, 7,13,37, 54
4.0	04/03/2019	Updated language for Claims Processing instruction.	8.20	92
4.1	05/02/2019	Updated procedure codes under DDS Waiver programs. Additional updates to include references to EVV Web page.	All	All
4.2	06/07/2019	Updated procedure codes and to the cited provider bulletin number listed under the Tuberculosis (TB) Waiver. Removed references to the Early Childhood Autism Waiver.	All	64 & 65
4.3	09/25/2019	Revisions to Claim submission instructions for DDS Specialized services, as well as revisions to Mental Health Waiver program information and claim submission instructions. Added upcoming new services for PCA waiver effective 10/1/19.	All	All
4.4	01/28/2020	Added references for Local Health Departments. Updated implementation date for Mental Health Waiver. Updated DDS Waiver Procedure Code List. Misc additional updates.	All	All

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4.5	10/01/2020	Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	All	All
4.6	04/28/2021	Updated diagnosis descriptions, added EVV information for MHW, misc additional updates.	All	All
4.7	09/03/2021	Updated CHC Cost Share amount. Added CHESS program. Updated the PA process for Home Health services relating to a behavioral health diagnosis for CHCPE and CHC Waiver clients. Misc additional updates.	All	All
4.8	N/A	N/A	N/A	N/A
4.9	08/08/2022	Added Community First Choice (CFC) Support and Planning (S&P) Coach Provider Services	8.1 8.22 8.23 8.24	2 77-80 82 91, 92, 95
5.0	07/10/2023	Billing provider exception for CFC Support and Planning Coach agency- based services.	8.5	20

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Table of Contents

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8.1 Overview

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Chapter 8 contains claim and fee schedule information for the following Waiver Programs and Special Services:

- Acquired Brain Injury (ABI) Waiver
- Acquired Brain Injury II (ABI II) Waiver
- Autism Waiver
- Community First Choice
- Community First Choice Support & Planning Coach Services
- Community Services
- Connecticut Home Care (CHC) Program for Elders
- Department of Developmental Services (DDS) Specialized Services for Nursing Facility Residents
- Department of Developmental Services (DDS) Waiver
- Employment and Day Supports Waiver
- Local Health Departments
- Mental Health Group Home
- Personal Care Assistance (PCA) Waiver
- Private Non-Medical Institution
- Psychiatric Residential Treatment Facility (PRTF)
- School Based Child Health
- Targeted Case Management (TCM)
- Behavioral Health Home (BHH)
- Tuberculosis (TB) Benefit
- Mental Health (MH) Waiver
- Connecticut Housing Engagement and Support Services (CHESS)

This chapter covers claim submission information and procedures important to all Waiver Programs and Special Services, and specific paper claim submission instructions. It is important to note, however, that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers.

Providers should refer to Chapter 6, Electronic Data InterChange Options for electronic claim submission information. Providers interested in submitting claims through the internet should refer to Chapter 10 for internet claim submission instructions. Claim Submission Help Text for the internet claim submission feature is also located on the claim submission panel by clicking on the Quick Links in the upper left corner of the Web page, and/or by clicking on HELP in the upper right corner of the Web page.

A list of procedure codes for each waiver and special services program is also included in this chapter. Each provider receives a rate letter from the Department of Social Services which constitutes their fee schedule. A procedure code listing is included in Section 8.23.

Hospice

A Hospice benefit is available for all HUSKY Health Program (HUSKY A, HUSKY B, HUSKY C – previously referred to as Medicaid, and HUSKY D – previously referred to as Medicaid LIA) clients. For specific information about the Hospice benefit, providers can access the Chapter 8 Hospice Services Manual located at www.ctdssmap.com, by selecting Information, Publications and Hospice from the Chapter 8 drop down box.

Effective March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) amended the definition of “hospice” and provides that election of hospice by a child under the age of 21 shall not constitute a waiver of payment for treatment of the condition for which the terminal diagnosis has been made. This same change was made to the Children’s Health Insurance Program and allows children to receive hospice services concurrently with treatment of the child’s condition. Note that these changes

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apply only to children defined as those under the age of 21 for HUSKY A, HUSKY C, and HUSKY D, clients, and under the age of 19 for HUSKY B clients.

Detailed billing instructions for professional claims billed for a Hospice client where services are not related to the hospice client's terminal illness can be found in Section 8.22, Claim Submission Instructions for CMS-1500 Claim Form.

For information on obtaining Hospice client eligibility information, refer to Chapter 4, also located at www.ctdssmap.com, by selecting Information, Publications.

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8.2 Acquired Brain Injury (ABI)

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Overview

Acquired Brain Injury (ABI)

The ABI program covers an array of non-medical, home and community-based services to eligible individuals who, without such services, would need to be placed in, or remain in, institutional care.

The goal of the ABI waiver program is:

- To allow individuals who sustain acquired brain injuries to live in the community of their choice, rather than in institutions.

Acquired Brain Injury services are provided to eligible persons who meet all of the following criteria:

- Applicants are between the ages of 18 and 64, inclusive.
- Have an acquired brain injury.
- Meet the level of care criteria.
- Meet the eligibility requirements of the Connecticut Medical Assistance Program Home and Community-Based Services waiver coverage group.
- Are able to participate in the development of a cost-effective plan that offers an alternative to institutionalization.

Following an initial assessment that shows that the individual meets the eligibility criteria described above, a Department of Social Services social worker convenes an interdisciplinary team to work on the development of a service plan that will allow the client to live in the community. The interdisciplinary team includes the client, the client's conservator, the DSS social worker, a neuropsychologist familiar with the client's case, other clinical disciplines as needed, and any other persons that the client chooses.

In this client-centered model, the individual client is the essential participant in determining the services required in order to live safely in the community. The plan to deliver the services is reviewed periodically to assess its effectiveness in achieving the client's goals.

The services available under the ABI waiver program are non-medical in nature. Since these services are delivered within the individual's home community, they are categorized **as home and community-based services**.

Program Changes

Effective 5/1/2016, Case Management Agencies are responsible for establishing and managing the Care Plan of ABI clients who do not self-direct their own care.

Effective 9/1/2016, non-medical providers servicing ABI clients who do not self-direct their own care are required to be enrolled in the Connecticut Medical Assistance Program as ABI Service Providers in order to be reimbursed for the services they provide. Non-medical ABI Waiver services for clients who self-direct their own care, including those services available through Community First Choice, will continue to be billed by the Department of Social Services' (DSS) ABI Fiduciary, Allied Community Resources. Medical Services will continue to be billed by the Home Health Agency.

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	Effective 9/1/2016, all non-medical and medical home and community based services provided to the ABI client, except case management services provided by the Case Management Agency, are required to be on the client's care plan. The care plan services must be uploaded via batch or entered via the Web portal directly into the claims processing system by the Case Management Agency. Once uploaded, services to be provided to the ABI client are viewable to the rendering provider via their secure Web account with granted permission to view their service authorizations by selecting Prior Authorization Search from the Prior Authorization menu. All non-medical and medical ABI services must be on the ABI Care Plan and uploaded to the portal for provider claims to be paid.
Prior Authorization	ABI Service Authorizations uploaded to the Web portal will auto approve unless otherwise indicated under the Care Plan Limitation column of the ABI Procedure Code Crosswalk. Services in excess of the limitation will remain in an in-process status until approved by DSS.
Electronic Visit Verification (EVV) Overview	Effective 9/1/2016, DSS, under contract with Gainwell Technologies, implemented Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata Technologies to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page located on the www.ctdssmap.com Home page for more information on EVV including Interface Specifications, training documentation and videos, publications and a Frequently Asked Questions (FAQ) document located under General Program Information and FAQ's tab. As a result of the EVV implementation, a number of ABI services are EVV mandated or EVV optional while others are not applicable for EVV. Providers should click on the ABI Procedure Code Crosswalk link for EVV Mandated and Optional services. Effective for dates of service 1/1/2017 and forward, providers who deliver non-medical services to ABI clients that are EVV mandated are required to implement DSS's EVV system for the purposes of scheduling and visit verification. Providers must complete the mandatory training in order to receive and be able to use their Welcome Kits. Providers are also encouraged to use EVV for the services they provide that are EVV optional. **Home Health Agencies** who render services to ABI clients are required to implement DSS's EVV system effective for dates of service **4/1/2017.**
EVV Implementation	In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. After verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Web page, accessed from the Home page of the www.ctdssmap.com Web site, for information on registering for mandatory training, what to do when you get your Welcome Kit, training publications and videos.
Claim Submission - EVV Mandated Services	Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account.

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Once voided, providers should refer to the training video in the Electronic Visit Verification Web page as to how to resubmit mandated services via EVV.

Effective for dates of service **1/1/2018 and forward**, EVV service providers have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a *confirmed* visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

Claim Submission - EVV Optional Services

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file, when providers choose to use EVV for their optional services. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit optional services via EVV. Providers who choose not to use EVV for optional services must submit their claims directly to Gainwell Technologies:

- via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction.

Claim Submission - EVV Non-applicable Services

Providers whose services are not mandated or optional for EVV must submit all services with dates of service 9/1/2016 and forward directly to Gainwell Technologies for payment using one of the following methods:

- Web claim submission via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction.

Contact Information – Enrollment and Billing Issues

Gainwell Technologies 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@dxc.com
- This should be your first 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.

Contact Information – Electronic Claim Submission Issues

Gainwell Technologies Electronic Data InterChange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8 AM to 5 PM (EST), excluding holidays

Contact Information – EVV Related Issues

For Fixed Visit Verification (FVV) Requests, Prior Authorization or Claims issues, contact:

ctevv@dxc.com or the Provider Assistance Center at 1-800-842-8440

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Contact Information – Santrax Software

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

Contact Information – Care Plan Related Issues

- **Connecticut Community Care (CCCI) at:**
  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 Gainwell Technologies, from and to dates of service, the type service (PCA services 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) at:**
  SWCAABillings@swcaa.org

  Providers must include the following information when submitting service authorization issues to SWCAA:

  Client name, the client EMS number, the type of service (PCA services. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit. Providers should go to www.swcaa.org for a directory of care managers by zip code, frequently asked questions and SWCAA's provider inquiry form.

- **Western Connecticut Area on Aging (WCAA) 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.

Contact Information – Medicaid Waiver Client Eligibility Issues

The Home and Community Based Services Unit at DSS at the following email address: Waiver.DSS@ct.gov. The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "ABI Client Eligibility Issue" in the subject line of the email.

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8.3 Acquired Brain Injury II (ABI II)

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Overview

Acquired Brain Injury II (ABI II)

Effective November 1, 2014, the ABI II Waiver program, like the ABI Waiver program, covers an array of non-medical, home and community-based services for eligible individuals who, without such services, would need to be placed in, or remain in, institutional care. The ABI II Waiver, however, provides an additional cost limit and services beyond the ABI Waiver.

The goal of the ABI II waiver program is:

- To allow individuals who sustain acquired brain injuries to live in the community of their choice, rather than in institutions.

Acquired Brain Injury services are provided to eligible persons who meet all of the following criteria:

- Applicants are between the ages of 18 and 64, inclusive.
- Have an acquired brain injury.
- Meet the level of care criteria.
- Meet the eligibility requirements of the Connecticut Medical Assistance Program Home and Community-Based Services waiver coverage group as enrolled HUSKY A or HUSKY C clients.
- Are able to participate in the development of a cost-effective plan that offers an alternative to institutionalization.

Following an initial assessment that shows that the individual meets the eligibility criteria described above, a Department of Social Services social worker convenes an interdisciplinary team to work on the development of a service plan that will allow the client to live in the community. The interdisciplinary team includes the client, the client's conservator, the DSS social worker, a neuropsychologist familiar with the client's case, other clinical disciplines as needed, and any other persons that the client chooses.

In this client-centered model, the individual client is the essential participant in determining the services required in order to live safely in the community. The plan to deliver the services is reviewed periodically to assess its effectiveness in achieving the client's goals.

The services available under the ABI II waiver program are non-medical in nature. Since these services are delivered within the individual's home community, they are categorized as home and community-based services.

Allied Community Resources, the ABI II Fiduciary, will be the enrolled billing provider. Although servicing providers will not be required to enroll as ABI performing providers in the Connecticut Medical Assistance Program, Allied will perform credentialing and enrollment activities that mirror the ABI Waiver.

Program Changes

Effective 5/1/2016, Case Management Agencies are responsible for establishing and managing the Care Plan of ABI II clients who do not self-direct their own care.

Effective 9/1/2016, non-medical providers servicing ABI clients who do not self-direct their own care are required to be enrolled in the Connecticut Medical Assistance Program as ABI Service Providers in order to be reimbursed for the services they provide. Non-medical ABI Waiver services

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	for clients who self-direct their own care, including those services available through Community First Choice, will continue to be billed by the Department of Social Services' (DSS) ABI Fiduciary, Allied Community Resources. Medical Services will continue to be billed by the Home Health Agency. Effective 9/1/2016, all non-medical and medical home and community based services provided to an ABI II client, except case management services provided by the Case Management Agency, are required to be on the client's care plan. The care plan services must be uploaded via batch or entered via the Web portal directly into the claims processing system by the Case Management Agency. Once uploaded, services to be provided to the ABI II client are viewable to the rendering provider via their secure Web account with granted permission to view their service authorizations by selecting Prior Authorization Search from the Prior Authorization menu. All non-medical and medical ABI services must be on the ABI Care Plan and uploaded to the portal for provider claims to be paid.
Prior Authorization	ABI II Service Authorizations uploaded to the Web portal will auto approve unless otherwise indicated under the Care Plan Limitation column of the ABI Procedure Code Crosswalk. Services in excess of the limitation will remain in an in-process status until approved by DSS.
Electronic Visit Verification (EVV) Overview	Effective 9/1/2016, DSS, under contract with Gainwell Technologies, implemented Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page, accessed from the www.ctdssmap.com Home page, for more information on EVV including Interface Specifications, training documents and videos, publications and a Frequently Asked Questions (FAQ) document located under General Program Information and FAQ's tab. As a result of the EVV implementation, a number of ABI II services are EVV mandated or EVV optional while others are not applicable for EVV. Providers should click on the ABI Procedure Code Crosswalk link to identify EVV Mandated and Optional services. Effective for dates of service **1/1/2017**, providers who deliver non-medical services to ABI II clients that are EVV mandated are required to implement DSS's EVV system for the purposes of scheduling and visit verification. Providers are also encouraged to use EVV for the services they provide that are EVV optional.
EVV Implementation	In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. Upon verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Web page located on the Home page of the www.ctdssmap.com for information on registering for mandatory training, what to do when you get your Welcome Kit, training publications and videos. **Home Health Agencies** who render services to ABI clients are required to implement DSS's EVV system effective for dates of service **4/1/2017**.
Claim Submission - EVV Mandated Services	Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account.

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Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit mandated services via EVV.

Effective for dates of service **1/1/2018**, EVV service providers have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a *confirmed* visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

Claim Submission - EVV Optional Services

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file, when providers choose to use EVV optional services. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit optional services via EVV. Providers who choose not to use EVV for optional services must submit their claims directly to Gainwell Technologies:

- Via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction

Claim Submission - EVV Non-applicable Services

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- Web claim submission via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC X12N 837P – Health Care Claim Professional transaction

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  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 Gainwell Technologies, from and to dates of service, the type service (PCA services 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) at:**
  SWCAABillings@swcaa.org

  Providers must include the following information when submitting service authorization issues to SWCAA:

  Client name, the client EMS number, the type of service (PCA services. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit. Providers should go to www.swcaa.org for a directory of care managers by zip code, frequently asked questions and SWCAA's provider inquiry form.

- **Western Connecticut Area on Aging (WCAA) 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.

Contact Information – Medicaid Waiver Client Eligibility Issues

The Home and Community Based Services Unit at DSS at the following email address: Waiver.DSS@ct.gov

- The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "ABI Client Eligibility Issue" in the subject line of the email.

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8.4 Autism Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Autism Waiver

The Autism Waiver is a Connecticut Home and Community Supports Waiver for Persons with Autism who are at least three years of age with a diagnosis of autism spectrum disorder who live in a family, caregiver's, or one's own home or a Community Companion Home (formerly Community Training Home).

Although these individuals will not have the diagnosis of intellectual disabilities, they have substantial functional limitations which negatively impact their ability to live independently. These individuals and their caregivers need flexible and necessary supports and services to live safe and productive lives. This waiver will support and encourage the use of consumer-direction to maximize choice as well as control and efficient uses of state and federal resources. Waiver services will be provided face to face, in the participant's home or in other community settings. An individualized assessment, individual service plan development and service delivery will emphasize participant strengths and assets, utilization of natural supports and community integration. The waiver is operated and administered by the Department of Social Services (DSS).

Services will be delivered by an array of private service vendors through a fee for service system, and/or through the use of consumer-direction with waiver participants serving as the employer of record. Fiscal Intermediary organizations will be used to support participants who choose consumer-direction.

Participants in the program can be Medicare and Medicaid (HUSKY A or C) eligible and those who are moving from institutions under Money Follows the Person and transferring to the Autism waiver after 365 days in the community. Program participants can also be Children in the Voluntary Services Program with a diagnosis of Autism Spectrum Disorder as well as emotional, behavioral or substance abuse disorders that result in the functional impairment of the child which substantially interferes with functioning in the family home and/or community.

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Program Changes	Effective January 1, 2018, the DSS Community Options Autism Waiver Case Managers are responsible for establishing and managing the Care Plan of Autism Waiver clients who do not self-direct their own care. Beginning October 1, 2017, non-medical providers who continue to service Autism Waiver clients, on or after January 1, 2018, who do not self-direct their own care are required to be enrolled in the Connecticut Medical Assistance Program as Autism Waiver Service Providers in order to be reimbursed for the services they provide. Non-medical Autism Waiver services for clients who self-direct their own care, including those services available through Community First Choice, will continue to be billed by the Department of Social Services' (DSS) Autism Waiver Fiduciary, Allied Community Resources. Medical Services will continue to be billed by the Home Health Agency. Effective January 1, 2018, all non-medical and medical home and community based services provided to the Autism Waiver client are required to be on the client's care plan. The Care Plan will be entered via the Web portal directly into the claims processing system by the DSS Autism Waiver Case Managers. Once entered, services to be provided to the Autism Waiver client are viewable to the rendering provider via their secure Web account with granted permission to view their service authorizations by selecting Prior Authorization Search from the Prior Authorization menu. All non-medical and medical Autism Waiver services must be on the Autism Care Plan and entered via the Web portal for provider claims to be paid.
Prior Authorization	Autism Service authorizations uploaded to the Web portal will auto approve unless otherwise indicated under the Care Plan Limitation column of the Autism Waiver Procedure Code Crosswalk. Services in excess of the limitation will remain in an in-process status until approved by DSS.
Other Insurance	Billing providers of non-medical Autism Waiver services are not required to bill other insurance or Medicare and will be excluded from both Other Insurance and Medicare Cost Avoidance.
Claim Submission	**Effective January 1, 2018**, Autism Waiver Service Providers will submit their claims for Autism Waiver Services directly to Gainwell Technologies for payment. Claims may be submitted via: − The internet Web site at www.ctdssmap.com − Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction
Electronic Visit Verification (EVV) Overview	**Effective 3/3/2019**, DSS, under contract with Gainwell Technologies, implemented the Autism Waiver in Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page, accessed from the www.ctdssmap.com Home page, for more information on EVV including access to the mandatory training videos and documents, Interface Specifications, and a Frequently Asked Questions (FAQ) document located under the General Program Information and FAQ's tab. As a result of the EVV implementation, a few Autism Waiver services are EVV mandated while all others are not applicable for EVV. Providers should click on the Autism Waiver Procedure Code Crosswalk link for EVV Mandated and Optional services. Effective for dates of service **3/3/2019 and forward**, providers who deliver non-

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	medical services to Autism Waiver clients that are EVV mandated are required to implement DSS's EVV system for the purposes of scheduling and visit verification. **Home Health Agencies** who render services to **Autism Waiver** clients are also required to implement the DSS EVV system, if they have not already done so for the service of ABI, CHC or PCA Waiver clients.
EVV Implementation	In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. Upon verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Web page, accessed from the Home page of the www.ctdssmap.com Web site, for information on registering for mandatory training, what to do when you get your Welcome Kit, training publications and videos.
Claim Submission EVV Alternate Claim Solution	Effective for dates of service **3/3/19 and forward**, Autism service providers have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a *confirmed* visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).
Contact Information – Enrollment and Billing Issues	**Gainwell Technologies 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@dxc.com – This should be your first 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.
Contact Information – Electronic Claim Submission Issues	**Gainwell Technologies Electronic Data InterChange (EDI) Help Desk** – 1-800-688-0503 – Monday through Friday, 8 AM to 5 PM (EST), excluding holidays
Contact Information – EVV Related Issues	For Fixed Visit Verification (FVV) Requests, Prior Authorization or Claims issues, contact: ctevv@dxc.com or the Provider Assistance Center at 1-800-842-8440
Contact Information – Santrax Software	**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
Contact Information – Autism Waiver	**Department of Social Services Community Options Unit** **DSS Community Options mailbox** – AutismCaseManagement.DSS@ct.gov

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Care Plan Service Authorizaiton Issues

Assistance for provider inquires relating to a client's care plan, should the client's case manager not be available:

Alison Hummel – Case Manager – (860) 424-5518 or Alison.hummel@ct.gov

Amy James – Case Manager (860) 424-5445 or amy.james@ct.gov

Mike Olesen – Case Manager (860) 424-5853 or michael.olesen@ct.gov

Michael J. Blaszko - Supv. Case Management - (860) 424-5381 or Michael.Blaszko@ct.gov

Amy Dumont, LCSW – Manager – (860) 424-5173 or amy.dumont@ct.gov

Contact Information – Medicaid Waiver Client Eligibility Issues

The Home and Community Based Services Unit at DSS at the following email address: Waiver.DSS@ct.gov.

- The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "Autism Waiver Client Eligibility Issue" in the subject line of the email.

Other Resources

Providers are encouraged to review the Provider Workshop Training Presentations located on the www.ctdssmap.com Web site. Training Page:

Autism Waiver Provider Training

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8.5 Community First Choice

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Overview

Community First Choice

Section 1915(k) allows States to provide home and community based attendant services and supports through a State plan amendment. This option is referred to as Community First Choice (CFC). Effective July 1, 2015, this option is available to anyone who is eligible for HUSKY A, C or D benefit plans and who meets the institutional level of care. CFC makes available home and community based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living and health related tasks through hands-on assistance, supervision, and/or cueing. CFC includes Attendant Care, Home Delivered Meals, Assistive Technology, Environmental Accessibility, Transitional Services, and Coaching Services. Allied is the billing provider for the CFC services with the exception of CFC Support and Planning Coach agency- based services. Please refer to section 8.22 Community First Choice Support and Planning Coach Services for additional information. The Connecticut Home Care (CHC) Access Agencies are the billing providers for the CFC assessments.

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8.6 Community Services

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Overview

Community Services

Individuals or Agencies who are enrolled as Community Service providers are those who have been servicing Department of Children and Family Services (DCF) clients and/or who provide specialized behavioral health services that are not within the credentialing requirements of existing enrolled providers in the Connecticut Medical Assistance Program (CMAP). The behavioral health services provided by these professionals meet the unique needs of clients who would otherwise not be able to remain in the community.

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8.7 Connecticut Home Care (CHC) Program for Elders Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Connecticut Home Care Program for Elders (CHC)

The Connecticut Home Care (CHC) Program for Elders and the State Funded Pilot Connecticut Home Care Program for Disabled Adults (CHCPDA) cover services to eligible Connecticut residents to prevent unnecessary institutionalization. The CHC Program for Elders is a comprehensive home care program designed to enable older persons at risk of institutionalization to receive the support they need to remain living at home. CHC services are made available to clients age 65 or older who may not be otherwise eligible for HUSKY Health Program. CHC-eligible clients are either state-funded or HUSKY C-eligible. CHC services include a wide range of home health, medical services and community based, non-medical services.

The Connecticut Home Care Program for Disabled Adults (CHCPDA) Pilot Program covers a package of home based services for persons age 18-64, inclusive, with degenerative neurological conditions who are not eligible for other programs.

Personal Care Services

For information about HUSKY Health Program covered home health services, providers should refer to the Connecticut Medical Assistance Program Home Health Services Provider Manual.

The purpose of the CHC Program for Elders and the State Funded Pilot Home Care Program for Disabled Adults (CHCPDA) is to:

- assess whether cost-effective home care services can be offered to elders or those who are disabled who are at risk of institutionalization;
- determine, prior to admission to a nursing facility, whether the client does or does not need nursing facility services; Ascend Management Innovations (Ascend), under contract with the Connecticut Department of Social Services, is responsible for authorizing admissions and payment to nursing facilities;
- authorize department payment for client's home care if appropriate; and
- provide a full range of home care services to eligible individuals who choose to remain in the community, if such services are appropriate, available, and cost effective.

Referrals of clients for CHC program services are typically generated by hospitals, long term care facilities, home care providers, town caseworkers, family members and clients themselves. To obtain more information about the CHC Program or to make a referral, call the Department of Social Services (DSS) at 1-800-445-5394 or 860-424-4904 locally in the Harford area.

The DSS Home and Community Based Services Unit administers the CHC Program. The Home and Community Based Services Unit screens applicants for the CHC Program, approves care plans, monitors agency compliance with program procedures, determines eligibility or works with the DSS regional office to determine eligibility, and monitors clients who are in

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the Self Directed Care component.

In order to become eligible, all applicants must be screened by the Home and Community Based Services Unit to determine whether they are likely to qualify for services under the CHC Program. The Home and Community Based Services Unit refers applicants who meet the functional and financial screening criteria to an access agency for an independent, comprehensive assessment. This initial assessment defines the applicant's physical, cognitive and functional needs and determines if a plan of care can be developed which will safely and cost-effectively meet the client's needs with home-based services.

The initial assessment includes an assessment of the appropriateness of Self Directed Care. The access agency forwards the plan of care to the Home and Community Based Services Unit for review. The Home and Community Based Services Unit review of the plan of care takes into account the client's financial eligibility as well as their functional needs.

The Self Directed Care component of the Connecticut Home Care Program for Elders is a program where clients receive home care services without the ongoing supervision of a care manager. In these instances the home care agency (or other DSS authorized agency) works directly with the client and/or their family to coordinate the client's care. If Self Directed Care is not feasible, ongoing care management is provided by the access agency.

CHC Program Definitions

The list that follows provides definitions for key terms that are used in this provider manual. Providers should review these definitions carefully.

Access Agency	An "Access Agency" is an organization that assists clients to receive medically necessary home health services and non-medical community based services. The access agency staff conducts assessments, develops a plan of care tailored to the needs of each individual, and arranges care delivery with service providers. If needed by the client, the access agency provides ongoing care management and monitors the quality of the services being provided. The access agency is not a provider of services, other than providing care management to clients for whom the agency has conducted the initial assessment.
Adult Family Living	Adult Family Living/Foster Care is Personal care and supportive services, (homemaker, chore, attendant services, meal preparation) that are furnished to CHCPE and PCA participants who reside in a private home by a principal caregiver who lives in the home.
Assisted Living	"Assisted Living" is a combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living. Supportive services are available to meet scheduled needs in a way that promotes maximum dignity and independence for each resident, and involves the resident's family, neighbors, and friends.
Assisted Living Service Agency	An "Assisted Living Service Agency" is an agency licensed by the Connecticut Department of Public Health (DPH) that provides home care services to residents living in managed residential communities approved by DPH.

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Client	A “client” is an individual who has met the requirements for eligibility and is enrolled in the CHC Program. These clients are referred to in this chapter as being CHC-eligible. CHC-eligible clients are either state-funded or HUSKY C-eligible. Clients receiving CHC services who are HUSKY C-eligible receive CHC services under what is known as a “CHC waiver”.
Community Based Service Agency	A “Community Based Service Agency” enrolled in the CHC Program is an agency that provides non-medical services. The services provided by a community based service agency include adult day health services, chore services, companion services, personal care assistance, home delivered meals, homemaker services, mental health counseling, respite care, transportation, and personal emergency response systems.
Home Care Services	The use of the term “Home Care Services” in the CHC Provider Manual means any combination of community based services and home health services that enables clients to live in non-institutional settings. Such services may be provided to elders living in private homes, congregate housing, homes for the aged and other community living situations as long as the services needed are not considered a regular component of the services already being provided in the community living setting.
Home Health Services	“Home Health Services” are defined in the same way in the CHC Program and the HUSKY Health Program. Home health services are medically necessary services provided by a licensed home health agency on a part-time or intermittent basis in the client’s home for the purpose of enabling the client to remain in their own home or to provide a less costly alternative to institutional care. The home health services include skilled nursing, physical therapy, occupational therapy, speech therapy, and home health aide.
PCA CHC Fiduciary	Allied Community Resources is the Department of Social Services PCA Fiduciary responsible for the administration and billing of individual PCA services to CHCP eligible clients.
Plan of Care	A “Plan of Care” is a written individualized plan of home care services that specifies the type and frequency of all services required to maintain the individual in the community, the names of the service providers, and the cost of the services. The type and frequency of services contained in the plan of care must be based upon the needs documented in the client’s assessment. Each service must be necessary to avoid institutional placement.
Risk of Institutionalization	“Risk of Institutionalization” means that the individual is in danger of hospitalization or nursing facility placement due to their medical, functional or cognitive status, but would be able to remain at home, without the creation of unacceptable risk to the safety of the individual or others, if home care services were provided. This definition includes individuals who are currently institutionalized and who are at risk of continued institutionalization unless home care services are provided upon discharge.

Services Provided by Agency Type

There are five types of agencies that can be enrolled in the CHC Program for Elders. These include the CHC PCA Fiduciary, access agencies, home health agencies, community-based service agencies, and assisted living

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service agencies. Each agency can provide specific services defined by Connecticut Medical Assistance Program regulation. While one umbrella company might consist of several different types of CHC-enrolled agencies, the correct NPI/non-medical provider identifier for the agency which provided the services must be entered on the claim submitted.

CHC Access Agency

An access agency uses the same NPI/non-medical provider identifier whether submitting claims for assessments, care management provided by the access agency, or for dates of service prior to July 1, 2013 when submitting claims for home health and community based services arranged with subcontracted performing providers and on behalf of CHC providers for self-directed medical or non-medical community based services. In this latter instance the CHC performing provider must submit their claims to the access agency, and the access agency in turn submits the claims to Gainwell Technologies indicating the CHC performing NPI/non-medical provider identifier on the CMS-1500 in Field 24J.

Access Agencies provide the following services:

- Initial, independent comprehensive assessment
- Development of the plan of care
- Initial care management to arrange for client services
- Ongoing care management to monitor and coordinate home care services

CHC Home Health Agency

For dates of service prior to July 1, 2013, a CHC agency providing home health services may have two CHC NPI/non-medical provider identifiers: a performing NPI/non-medical provider identifier when services are billed through an Access Agency and a billing NPI/non-medical provider identifier used for self-directed CHC clients only when billing CHC services directly to Gainwell Technologies.

When submitting dates of service prior to July 1, 2013 for self-directed **CHC program eligible medical services,** the CHC billing provider submits these services in the professional electronic HIPAA format or on a CMS-1500 claim form with their CHC billing NPI/non-medical provider identifier in Field 33 directly to Gainwell Technologies.

When submitting claims for **HUSKY Health program eligible medical services** for a client who is CHC waiver eligible, the billing provider submits these services in the out-patient institutional electronic format or on a UB-04 claim form with their home health provider NPI in Field 56 directly to Gainwell Technologies.
The list below includes the home health (medical) services provided by a home health agency as part of the CHC Program:

- Medication Administration
- Medication Administration by a Certified Home Health Aid

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- Occupational Therapy
- Physical Therapy
- Skilled Nursing
- Speech Therapy
- Home Health Aide

CHC Community Based Services Agency

For dates of service prior to July 1, 2013, the CHC community based service agency utilizes one NPI/non-medical provider identifier; this identifier is a performing NPI/non-medical provider identifier. The CHC community based service agency submits all claims with dates of service prior to July 1, 2013 for all services to CHC clients to the access agency under which they subcontract. The access agency submits the claims to Gainwell Technologies, entering the community based service performing NPI/non-medical provider identifier in Field 24J and the access agency NPI/non-medical provider identifier in Field 33 of the CMS-1500.

The following are the community-based, non-medical services provided through the CHC Program for Elders:

- Adult day health
- Adult Family Living/Foster Care*
- Chore, companion, and homemaker services
- Personal Care Assistance*
- Highly skilled chore
- Meals
- Mental health counseling
- Minor home modification
- Assistive Technology*
- Personal emergency response systems
- Respite care
- Transportation
- Care Transitions
- Bill Payer
- Chronic Disease Self-Management

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- Environmental Accessibility Adaptations
- Support Broker

*Adult Family Living/Foster Care includes personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to CHCPE and PCA participants who reside in a private home by a principal caregiver who lives in the home. Adult Family Living/Foster Care is furnished to adults who receive these services while living at home in conjunction with residing in the home.

Separate payment will not be made for homemaker or chore services furnished to an individual receiving Adult Family Living/Foster Care services, since these are integral to and inherent in the provision of Adult Family Living/Foster Care services. Therefore, homemaker or chore services cannot be billed when Adult Family Living/Foster Care is in place as a service.

The agency that provides the Adult Family Living/Foster Care service is responsible for supervising the supports delivered by the direct care provider. This service may be provided in the home of either the care provider or the participant, whichever is preferable to the participant. The direct provider may be a relative of the participant as long as he or she is not a legally liable relative. Adult Family Living/Foster Care is limited to no more than 3 participants in a home.

Four levels of Adult Family Living/Foster Care service are available under the programs. The reimbursement rate does not include room and board. The costs of room and board are negotiated between the direct service provider and the CHCPE or PCA participant.

*PCA, and Assistive Technology Services are included in the CHC Program. Although Respite PCA services have been reimbursable to providers in the past under the regular PCA codes, specific Respite, Agency PCA procedure codes have been added to the CHC Fee Schedule effective July 1, 2014. The Access Agencies were responsible for submitting Agency PCA and Assistive Technology services directly to Gainwell Technologies for dates of service through June 30, 2013.

For PCA per diem and overnight services billed by an Access Agency, form W-1532 must be completed by the Care Manager and retained in the clients file. These forms are no longer required to be submitted to the Home and Community Based Services Unit. Form W-1532 may be obtained by contacting the Home and Community Based Services Unit.

PCA CHC FIDUCIARY – PCA services are included in the CHC program. Allied Community Resources, the DSS PCA CHC Fiduciary, provides individual / Respite PCA services to CHC Clients. Specific Respite Individual PCA procedure codes are found on the CHC fee schedule. Claims for these individual PCA services are billed by Allied directly to Gainwell Technologies for reimbursement.

PCA services performed by individual care givers and billed by Allied

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Community Resources for CHC case managed waiver and CHC self-directed waiver clients are available to the client under the Community First Choice Benefit. As the CFC Fiscal Intermediary for PCA services, Allied Community Resources is the billing provider for the submission of Individual PCA services to Gainwell Technologies. Individual PCA services for 1915i, CHC Program for Disabled Adults Community Based (CBCMD), and Sate Funded clients continue to be covered under the CHC program.

For PCA per diem and overnight services billed by the CHC Personal Care Assistance Fiduciary, form W-1532 must be completed by the Care Manager and retained in the clients' file, these forms are no longer required to be submitted to the Home and Community Based Services Unit. Form W-1532 may be obtained by contacting the Home and Community Based Services Unit.

CHC Assisted Living Services Agency (ALSA)

The CHC assisted living service agency utilizes one NPI/non-medical provider identifier for all claim submissions for services to CHC clients.

The following list includes services provided and/or arranged by the Assisted Living Services Agency:

Core services which include:

- Housekeeping
- Laundry
- Meal preparation
- Coordination of Services

Personal Care Services. Personal care services involve hands-on care including adult day health services.

- Occasional
- Limited
- Moderate
- Extensive
- Comprehensive

Mental Health Counseling

Personal Response System

CHC Cost Sharing

Connecticut Home Care Program clients under a state funded Case Managed, Self-Directed, Assisted Living Intermediate or Limited Waiver benefit plan that are not HUSKY C (Medicaid) eligible for the date of service, are required to contribute towards the net cost of their care plan. Since some clients do not always receive all the services in their care plan

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in any given month, the following cost sharing calculations based on the dates of service will be calculated and reported to Allied community Resources, the Department of Social Services' (DSS) CHC Fiduciary. Allied Community Resources is responsible for collecting the calculated cost share amounts on processed claims directly from the CHC client.

Effective Dates	Cost Share
7/1/2021 – Present	4.5%
7/1/2015 – 6/30/2021	9%

For clients who currently pay Applied Income (AI), the cost sharing is in addition to the amount of AI. Cost Sharing is based on the service costs after the AI is deducted. For example, if the allowed amount of the claim is $1,000 and AI equals $100, the cost sharing percentage amount, depending on the date(s) of service on the claim, will be deducted from $900, which equals the allowed amount of the claim – the AI amount.

Example: $1000 claim allowed amount (date of service June 2021) - $100 Applied Income = $900 x 9% (% cost share for claims with dates of service 7/1/15 to 6/30/21 = $ 81.00 (clients cost share for paid claim for dates of service 6/2021)

When a client's other insurance makes a payment, the cost share is applied to the net amount of the claim. For example, if the allowed amount of the claim for date of service 7/1/2021 is $1,000 minus other insurance payment of $200, the applicable percentage, based on the date of service, is calculated and deducted against the net amount of $800.

Example: $1000 allowable amount – insurance payment of $200 = $800 x 4.5% = $36.

Should the client also have AI of $100, the applicable percentage, based on the date of service, would be applied to the new net amount of $700 and would be deducted from the claim.

Example: $1000 allowable amount of claim – insurance payment of $200 = $800 – AI of $100 = $700 x 4.5% cost share (% based on the 7/1/2021 dates of service on the claim as noted above).

The cost sharing applies to Connecticut Home Care and Assisted Living Procedure codes as noted below:

1019Z, 1020Z, 1021Z, 1022Z, 1023Z, 1200Z, 1201Z, 1202Z, 1206Z, 1208Z, 1209Z, 1210Z, 1214Z, 1217Z, 1218Z, 1220Z, 1221Z, 1222Z, 1223Z, 1226Z, 1228Z, 1230Z, 1232Z, 1234Z, 1236Z, 1240Z, 1244Z, 1247Z, 1256Z, 1260Z, 1262Z, 1264Z, 1266Z, 1286Z, 1397Z, 1430Z, 1431Z, 1432Z, 1433Z, 1434Z, S9123, S9124, S9128, S9129, S9131, T1001, T1002, T1003, T1004, T1019, T1502

The following Assisted Living (Demonstration Project) procedure codes are excluded from the cost sharing:

1435Z, 1436Z, 1437Z, 1438Z, 1439Z

The cost sharing does not apply to claims that include at least one of the above excluded procedure codes.

The following procedure codes are retroactively excluded from cost sharing

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as noted below:

1288Z, 1291Z, 1292Z, 1293Z, 1295Z, 1300Z

Procedure code 1286Z, case management, is not excluded from cost sharing. As a result, this code cannot be billed with any other procedure code to ensure that cost sharing is applied.

Providers performing a claim inquiry on the web can find the applicable cost sharing amount in the “Client Contribution” field located in the lower left portion of the claim.

The following procedure codes are retroactively excluded form applied income as noted below:

1288Z, 1291Z, 1292Z, 1293Z, 1300Z

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CHC Program Changes Effective July 1, 2013

Effective for dates of service July 1, 2013 and forward, the Department of Social Services (DSS) made significant changes to the administration of the Connecticut Home Care (CHC) program.

Access Agencies

The following Access Agencies have contracted with DSS to assist clients to receive medically necessary home health services and non-medical community based services, with Western CT Area Agency on Aging being a new Access Agency added to the program, to provide service to Waterbury area CHC clients transferred from Connecticut Community Care Inc.

- Southwestern CT Agency on Aging
- Connecticut Community Care Inc.
- Agency on Aging of South Central CT Inc.
- Western CT Area Agency on Aging

The CHC program changes are outlined in the sections below.

Access Agency Responsibilities

The Access Agencies have the following responsibilities:

- Provide Assessments/Re-Assessments to determine program eligibility.
- Create Initial care plans and ongoing care plan maintenance related to changes in client home and community based service needs.
- Provide daily case management to assure continuity of care plan services and response to changes in client services as needed.
- Upload care plan service authorizations to Gainwell Technologies which allow for the payment of claims submitted for services authorized.

Please note: The Access Agency Care Manager no longer obtains prior authorization for CHC clients with a behavioral health diagnosis. The Home Health Agency provider is responsible for submitting a Prior Authorization (PA) request to Beacon Health Options, after receiving confirmation of service from the Access Agency Care Manager. Once authorization is received from Beacon Health Options, the provider must contact the Access Agency Care Manager with the Beacon Health Options PA number so it can be linked to the client's care plan.

Effective April 1, 2019, Beacon Health Options no longer authorizes Home Health services with a behavioral health related diagnosis for clients covered under the CT Home Care Program for Elders (CHCPE) and CHC Waiver benefit plan. Home Health services for these clients will be uploaded via batch or submitted interactively to Gainwell Technologies by the Access Agency case managing the client. Services exceeding standard benefit, will remain in an "In-Process" status until authorized by DSS.

Provider Credentialing

The following provides information on provider credentialing:

- Allied Community Resources, the DSS CHC Fiduciary, is responsible for the credentialing of CHC service providers.
- Providers are able to declare, as part of the credentialing process, the area(s) of the state they wish to service.
- Access Agencies in turn are provided a list of all CHC credentialed providers in the State of CT from which they can request service.

Provider Enrollment

The following provides information on provider enrollment:

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- Providers of non-medical services, defined as those services that are not skilled nursing, medication administration, home health aide, occupational, physical or speech therapy performed by a home health agency, must enroll as a CHC Service Provider. Please refer to Chapter 3 and Chapter 10 for instructions on accessing and completing the on-line enrollment application via the Web portal enrollment Wizard.

Care Plan Access

The following provides information on accessing a client's care plan:

- Providers can access the client's care plan for the service(s) they will be providing on their secure Web account via "Prior Authorization Search" under the Prior Authorization tab. Please refer to Chapter 10 for instructions on accessing the care plan via the Secure Web portal.
- All CHC services must be on the client's plan of care, including services provided through Community First Choice, in order to be reimbursed, with the exception of initial assessments, re-evaluations, reassessments and status reviews.
- Units of service billed that exceed the number of units allowed within the service frequency will be cut back and pay up to the number of units allowed within the frequency time frame.

Client Eligibility

The following provides information on client eligibility:

- The CHC program has been expanded to include the addition of those clients covered under the 1915i State Plan Home and Community Based Service Option.
- The CHC Benefit plans indicated provide both medical and non-medical community based services coverage to elder and disabled clients in the CHC Program:

  1915C CHC 1915i Case Managed Clients

  1915S CHC 1915i Self Directed Clients

  CBCMD CHC Program for Disabled Adults Community Based

  CBCMF CHC Community Based Case Managed Waiver

  CBCMS CHC Community Based Case Managed State Funded

  SDIRF CHC Self Directed Waiver

  SDIRS CHC Self Directed State Funded
- The following HUSKY clients may also be eligible for one of the above CHC Waiver benefit plans:

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

  HUSKY C – (Medical services for individuals who are aged, blind or disabled).

  The Department of Social Services has added two new e-mail boxes noted below specifically for provider notification of client ineligibility when the provider has taken on a client for service who does not yet have a CHC benefit plan on their eligibility file that will

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reimburse them for the services ordered. Please direct only these types of eligibility issues to these mailboxes. Providers should send an encrypted e-mail containing the clients name, client ID and the start of care or dates of service that remain unpaid to the e-mailbox indicated below. The subject line of the e-mail should indicate "CHC Eligibility Issue".

Medicaid Waiver Client eligibility Issues- Clients with a HUSKY A or HUSKY C benefit plan and one of the following CHC benefit plans:

CBCMF CHC Community Based Case Managed Waiver

SDIRF CHC Self Directed Waiver

Send eligibility issues to: Waiver.DSS@ct.gov

State Funded CT Home Care Program only Client Eligibility Issues with one of the following CHC benefit plans:

CBCMS - Connecticut Home Care Community-Based Care Managed State Funded

CBCMD - CT Home Care Case Managed Disabled

SDIRS – Self Directed State Funded CT Home Care

Send eligibility issues for these clients to:

ACUFinancial.DSS@ct.gov

Within the Electronic Visit Verification system, if a client is unable to be setup in Gainwell Technologies due to eligibility issues and the caregiver is unable to enter a service authorization, a check-in/check-out can still occur. However, an exception in the EVV system will occur indicating an unknown client and unscheduled visit occurred. The Community Options Unit at DSS should be notified of an eligibility issue when a client begins service so action can be taken to resolve the eligibility issue as soon as possible. Providers who identify an eligibility issue at the time of service should send an encrypted email to one of the following e-mailboxes:

for Medicaid Waiver client eligibility related issues:

Waiver.DSS@ct.gov

For CT Home Care state-funded only client eligibility issues:

ACUFinancial.DSS@ct.gov

The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC Waiver Client Eligibility Issue" in the subject line of the email.

Claim Submission

A list of procedure codes, along with billing frequency, ability to span dates of service and allowed billing provider can be found by selecting the following link: CHC Procedure Code Crosswalk.

The following provides additional claim submission information:

Non-Medical Claims

- Providers must be enrolled as a CHC Service Provider and submit their non-medical claims directly to Gainwell Technologies using their CHC Service provider number.

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- Non-medical CHC claims may be submitted to Gainwell Technologies in one or more of the following claim submission methods:
    - Electronically using vendor software in the ASC 837 Professional 5010 format. Providers or their vendors should access the www.ctdssmap.com Web site and select Trading Partner > EDI > scroll to EDI Documents. Providers or their vendors must purchase the Implementation Guide, as the 837 specifications are not proprietary to Gainwell Technologies. For access to the CMS Implementation guide for 837 format specifications click on the ASC X12N link to the WPC Home page.
    - Via the Web using the Professional claim format. Providers should refer to the "Instructions for Submitting Professional Claims" link under the Professional claim submission tab on their secure Web account. Providers may also refer to Chapter 10, Section 10, Web Claim Submission, of the provider manual.
    - On paper via an original red CMS 1500 claim form. Providers should refer to the claim submission instructions in Section 8.22 of this chapter for further details. As noted in this chapter's overview, paper claims are only allowed from Out of State (OOS) providers as well as special handled claims.

    - **NOTE:** Non-Medical and CFC providers are not required to bill with diagnosis codes. However, if diagnosis codes are billed, providers will be subject to ICD-10 billing requirements.

Medical Claims

- Providers must be an enrolled Home Health Agency and submit their CHC medical claims directly to Gainwell Technologies using their Home Health Agency provider number used for submitting HUSKY claims to Gainwell Technologies.
- Medical CHC claims may be submitted to Gainwell Technologies in one or more of the following claim submission methods:
    - Electronically using vendor software in the ASC 837 Institutional 5010 format
    - Via the Web using the Institutional claim format
    - On paper via an original red UB-04 claim form. As noted in this chapter's overview, paper claims are only allowed from Out of State (OOS) providers as well as special handled claims.
- CHC medical claims follow home health claim submission guidelines, unless otherwise indicated in the Home Health claim submission instructions. Providers should refer to Chapter 8 of their Home Health Agency Provider Manual for further claim submission instructions on submitting CHC medical claims.

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Applied Income/Cost Share

The following provides information on applied income/cost share:

- Allied Community Resources, the DSS CHC Fiduciary, collects Applied Income and Cost Share directly from the clients.

Electronic Visit Verification (EVV) Overview

Effective 9/1/2016, DSS, under contract with Gainwell Technologies, implemented Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page, accessed from the www.ctdssmap.com Home page, for more information on EVV including Interface Specifications, training documents and videos, publications and a Frequently Asked Questions (FAQ) document located under General Program Information and FAQ's tab.

As a result of the EVV implementation, a number of CHC services are EVV mandated or EVV optional while others are not applicable for EVV. Providers should click on the CHC Procedure Code Crosswalk link for EVV Mandated and Optional services.

Effective for dates of service **1/1/2017**, providers who deliver non-medical services to CHC clients that are EVV mandated are required to implement the DSS new EVV system for the purposes of scheduling and visit verification. Providers are also encouraged to use EVV for the services they provide that are EVV optional.

EVV Implementation

In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. Upon verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Web page, accessed from the Home page of the www.ctdssmap.com Web site, for information on registering for mandatory training and what to do when you get your Welcome Kit, training publications and videos.

Home Health Agencies who render services to CHC clients are required to implement the DSS EVV system effective for dates of service **4/1/2017**.

Claim Submission - EVV Mandated Services

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit mandated services via EVV.

Effective for dates of service **1/1/2018**, EVV service providers have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a *confirmed* visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

Claim Submission - EVV

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file, when

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Optional Services

providers choose to use EVV optional services. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Implementation Web page as to how to resubmit optional services via EVV. Providers who choose not to use EVV for optional services, must submit their claims directly to Gainwell Technologies:

- Via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC X12N 837P – Health Care Claim Professional transaction

Claim Submission - EVV Non-applicable Services

Providers whose services are not mandated or optional for EVV must submit all services with dates of service 9/1/2016 and forward directly to Gainwell Technologies for payment using one of the following methods:

- Web claim submission via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC 837P – Health Care Claim Professional transaction

Contact Information – Enrollment and Billing Issues

Gainwell Technologies 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@dxc.com
- This should be your first 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.

Contact Information – Electronic Claim Submission Issues

Gainwell Technologies Electronic Data InterChange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8 AM to 5 PM (EST), excluding holidays

Contact Information – EVV Related Issues

For Fixed Visit Verification (FVV) Requests, Prior Authorization or Claims issues, contact:

ctevv@dxc.com or the Provider Assistance Center at 1-800-842-8440

Contact Information – Santrax Software

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

Contact Information – Care Plan Related Issues

- **Connecticut Community Care (CCCI) at:** 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 Gainwell Technologies, from and to dates of service, the type service (PCA services 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.

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- Agency on Aging of South Central CT (AASCC)
  chcbilling@aoascc.org (secure emails only)

  Agencies without secure e-mail, please fax service order inquiries to AASCC at: (203) 528-0455. All other provider information may be faxed to (203) 752-3064.

  Providers must include, on an Excel spreadsheet, the applicable following information when contacting AASCC regarding service authorization inquiries: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

- **South Western Connecticut Area on Aging (SWCAA) at:**
  SWCAABillings@swcaa.org

  Providers must include the following information when submitting service authorization issues to SWCAA:

  Client name, the client EMS number, the type of service (PCA services. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit. Providers should go to www.swcaa.org for a directory of care managers by zip code, frequently asked questions and SWCAA's provider inquiry form.

- **Western Connecticut Area on Aging (WCAA) 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.

Contact Information – Medicaid Waiver Client Eligibility Issues

The Home and Community Based Services Unit at DSS at the following email address:

For clients with a HUSKY A or C benefit plan and CT Home Care Waiver:

Waiver.DSS@ct.gov

State Funded CT Home Care only Eligibilty Issues

For State Funded CT Home Care only client eligibility issues:

ACUFinancial.DSS@ct.gov

The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "CHC Client Eligibility Issue" in the subject line of the email.

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8.8 Department of Developmental Services (DDS) Specialized Services for Nursing Facility Residents

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

The Department of Developmental Services (DDS) provides an array of Specialized Services to Connecticut Medical Assistance Program **clients with intellectual disabilities who reside in a Nursing Facility.**

Providers servicing these clients may be **Individuals or Agencies** and **must be enrolled in the Connecticut Medical Assistance Program with a Provider Type of Specialized Services and Specialty of Intellectual Disability.** Services provided under the DDS Specialized Services Program include the following:

- Community or Work Reintegration Training
- Day Habilitation Waiver Services
- Therapeutic Behavioral Services
- Medical Nutrition Therapy Reassessment and Intervention

Providers should refer to the Procedure Code Listing, Section 8.23 for DDS Specialized Services for Nursing Facility clients billing codes and restrictions and Fee Schedule, Section 8.24 of this chapter for access to the DDS Specialized Services Nursing Facility (NF) Fee Schedule.

Client Eligibility

Clients receiving DDS Specialized services while in a Nursing Facility **must be 21 years of age with an active HUSKY C or HUSKY D benefit plan.** Providers should verify client eligibility prior to submitting claims to avoid claim denial. Methods of client eligibility verification include:

- 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

Providers should refer to chapter 4 for Automated Voice Response System (AVRS) methods, chapter 6 for software methods and chapter 10 for internet methods of eligibility verification.

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Prior Authorization (PA) Requirements

All services require prior authorization from DDS in order to be reimbursed from the Department of Social Services (DSS). **DDS will send DXC a PA transaction file.** Each service authorized will have its own unique PA number beginning with the letter D and will be **authorized for a period of one (1) year.**

PAs will be available to the provider via their secure Web account Home page from the Prior Authorization Menu. Staff requiring access to service authorizations via the provider's secure Web account, must be set up with a clerk account with an assigned role of "Prior Authorization Inquiry" by the provider's primary account holder in order to view PAs via their secure Web account.

To prevent unnecessary claim denials, providers should determine if service authorization has been received for the start date of service prior to submitting claims.

Claim Submission

Effective for dates of service February 1, 2019, DDS Specialized Services Providers must be enrolled to submit claims, for DDS Specialized Services to clients residing in a Nursing Facility, directly to Gainwell Technologies for payment. Claims may be submitted via:

- The internet secure Web site at www.ctdssmap.com
    - Providers may submit and query claims via their secure Web account when clerks are assigned a Claim inquiry, Submission and Adjustment role by their agency's primary account holder. Providers should refer to Chapter 10 of the provider manual for further information regarding internet claim submission
- Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction (refer to chapter 6 of the provider manual)

For further claim submission information, please refer to the Claim Submission Instructions in Section 8.22 of this chapter.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.9 Department of Developmental Services (DDS) Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Department of Developmental Services (DDS) Waiver

Under the DDS Waiver Program, the Department of Developmental Services provides home and community-based services for persons with intellectual disabilities, who would otherwise receive care in an intermediate care facility.

DDS waiver clients are entitled to all other state plan, non-waiver HUSKY Health Program services, reimbursable according to applicable Department of Social Services (DSS) regulation.

Services offered through the DDS waiver include:

- Day Habilitative Services
- Residential Habilitative Services
- Environmental Modification Services
- Family Training Services
- Respite Care Services
- Supported Employment
- Pre-vocational Services
- Specialized Medical Equipment and Supplies
- Health Care Coordination
- Consultative Services
- Adult Day Health
- Personal Support
- Adult Companion
- Assisted Living
- Transportation
- Personal Emergency Response System
- Clinical Behavioral Support Services

For a complete list of services covered under this waiver, please see the procedure code listing at the end of this chapter.

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Diagnosis Codes

DDS providers are required to use the following ICD-10-CM diagnosis codes for describing the condition of the client.

CODE	DESCRIPTION
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F79	Unspecified intellectual disabilities
F840	Autistic disorder
Q87.1	Congenital malformation syndromes predominantly associated with short stature

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.10 Employment and Day Supports Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Employment and Day Supports

The Employment and Day Supports waiver is designed to support individuals who live with family or in their own homes and have a strong natural support system. This includes children under the age of 21 with complex medical needs who would otherwise require institutional placement and individuals over the age of 18 who require career development, supported employment or community based day supports, respite and/or behavioral supports to remain in their own or their family home.

Services are delivered through an array of private service vendors via contract, or through a fee for service system by the Department of Developmental Services (DDS) directly and through the use of consumer-direction with waiver participants serving as the employer of record, or through the selection of an Agency with Choice model. DDS utilizes Fiscal Intermediary organizations to support participants who choose consumer-direction and offers support brokers as part of expanded DDS case management services through the waiver.

The Department of Social Services (DSS) oversees this waiver operated by DDS. DDS is also responsible for the credentialing of performing providers,and is responsible for overseeing completion of enrollment forms and their submission to Gainwell Technologies.

The Department of Administrative Services (DAS) is the sole billing provider responsible for submitting Employment and Day Supports Waiver service claims directly to Gainwell Technologies. Allowed procedure codes billable under this waiver can be found in the Procedure Code Listing section of this chapter.

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8.11 Local Health Department

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Local Health Departments

Local health departments (LHDs) can enroll as a provider type eligible to bill for Tuberculosis (TB) related services. Payment to local health departments is limited to a select group of procedure codes listed on their Local Health Department fee schedule under the rate type “TB”. These procedure codes are essential for the diagnosis, treatment and management of individuals diagnosed with TB. Please refer to the Tuberculosis (TB) Benefit section in this chapter for additional information.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.12 Mental Health Group Home

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Mental Health Group Home

Private non-profit mental health residential group homes of 16 beds or less provide rehabilitative services in self-care and independent living to assist individuals with a serious and persistent mental illness requiring care in a group home setting to achieve their highest degree of independent functioning and recovery.

Rehabilitative services may include but are not limited to individual, family and group counseling; behavior management training and intervention and supportive counseling directed at solving daily problems related to community living and interpersonal relationships. Rehabilitative services further include but are not limited to teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, meal planning and preparation, personal grooming, management of financial resources, shopping, use of leisure time, interpersonal communication and problem-solving and assistance in developing skills necessary to support a full and independent life in the community.

HUSKY A, HUSKY C, and HUSKY D clients are eligible for these services under the Connecticut Behavioral Health Partnership (CT BHP), which is an integrated behavioral health system currently operated by the Departments of Children and Families (DCF), Mental Health and Addiction Services (DMHAS) and Social Services (DSS).

The CT BHP Administrative Services Organization (ASO), Beacon Health Options, is responsible for authorizing behavioral health services for clients serviced by Mental Health Group Home providers. Authorization of service is required for all client populations. The covered services and authorization requirements can be viewed on the CT BHP website at www.ctbhp.com.

Payment rates follow the CT BHP Fee Schedule, available at www.ctbhp.com, for HUSKY A clients and the Special Services Fee Schedule, available at www.ctdssmap.com, for HUSKY C and HUSKY D clients.

Providers must submit all claims for HUSKY A, HUSKY C, and HUSKY D to Gainwell Technologies. Timely filing requirements for claims submission for CT BHP covered services are 120 days for HUSKY A clients and 365 days for HUSKY C and HUSKY D clients.

As Mental Health Group Home Services are not Waiver Services, additional “waiver” requirements to determine eligibility do not apply.

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8.13 Personal Care Assistance (PCA) Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Personal Care Assistance (PCA) Waiver

The goals of the PCA waiver program are to provide non-medical home based assistance of daily living services (i.e. bathing, dressing, eating, etc.) to eligible individuals who have a severe, chronic and permanent physical disability requiring assistance with at least two or more daily living activities. Application for and implementation of services must occur prior to age 65. Daily living services include activities such as bathing, feeding, dressing, housekeeping, transferring, chores, and toileting. Effective October 1, 2019, PCA waiver services will include mental health counseling, adult day health care and hourly, overnight and per diem personal care services. The PCA waiver is now administered by the Home and Community Based Services Unit.

All services are required to be in the PCA Care Plan except for the initial assessment, re-assessments, in Hospital, Nursing Home and re-evaluation of client status reviews performed by an Access Agency. Other services not required to be on the Care Plan are Assistive Technology, Environmental Accessibility Adaptations and Transitional Services. Services which must be on the PCA Care Plan are included in the PCA Procedure Code Crosswalk, which can be found in the procedure code/modifier section of the claim submission instructions in this chapter.

All services for the following billing providers must be on the PCA care plan. Providers who may submit claims directly to Gainwell Technologies include the Access Agencies, who in addition to the services noted above, also bill a daily case management fee. PCA Service Providers who are appropriately credentialed may provide and bill for Support Broker and Adult Family Living/Foster Care services. Allied Community Resources is the billing provider for all other non-medical PCA services under Community First Choice provided by contracted providers not enrolled in the Connecticut Medical Assistance Program. In addition, Home Health Agencies are the billing providers for skilled nursing services rendered to PCA clients.

Electronic Visit Verification (EVV) Overview

Effective 9/1/2016, DSS, under contract with Gainwell Technologies, implemented Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page, accessed from the www.ctdssmap.com Home page, for more information on EVV including Interface Specifications, training documents and videos, publications and a Frequently Asked Questions (FAQ) document located under General Program Information and FAQ's tab.

As a result of the EVV implementation, a number of PCA services are EVV mandated or EVV optional while others are not applicable for EVV. Providers should click on the PCA Procedure Code Crosswalk link for EVV Mandated and Optional services.

Effective for dates of service 1/1/2017, providers who deliver non-medical services to PCA clients that are EVV mandated are required to implement DSS's EVV system for the purposes of scheduling and visit verification.

Providers are also encouraged to use EVV for the services they provide that

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

are EVV optional.

EVV Implementation

In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. Upon verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Implementation Web page located on the Home page of the www.ctdssmap.com for information on registering for mandatory training, what to do when you get your Welcome Kit, training publications and videos.

Home Health Agencies who render services to PCA clients are required to implement the DSS EVV system effective for dates of service **4/1/2017**.

Claim Submission - EVV Mandated Services

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit mandated services via EVV.

Effective for dates of service **1/1/2018**, EVV service providers have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a *confirmed* visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

Claim Submission - EVV Optional Services

Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file, when providers choose to use EVV optional services. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit optional services via EVV. Providers who choose not to use EVV for optional services, must submit their claims directly to Gainwell Technologies:

- Via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC X12N 837P – Health Care Claim Professional transaction

Claim Submission - EVV Non-applicable Services

Providers whose services are not mandated or optional for EVV must submit all services with dates of service 9/1/2016 and forward directly to Gainwell Technologies for payment using one of the following methods:

- Web claim submission via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC X12N 837P – Health Care Claim Professional

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Contact Information – Enrollment and Billing Issues

Gainwell Technologies 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@dxc.com
- This should be your first 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.

Contact Information – Electronic Claim Submission Issues

Gainwell Technologies Electronic Data InterChange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8 AM to 5 PM (EST), excluding holidays

Contact Information – EVV Related Issues

For Fixed Visit Verification (FVV) Requests, Prior Authorization or Claims issues, contact:

ctevv@dxc.com or the Provider Assistance Center at 1-800-842-8440

Contact Information – Santrax Software

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

Contact Information – Care Plan Related Issues

- **Agency on Aging of South Central CT (AASCC)** at:

  chcbilling@aoascc.org

  Agencies without secure e-mail, please fax service order inquiries to AASCC at: (203) 528-0455. All other provider information may be faxed to (203) 752-3064.

  Providers must include, on an Excel spreadsheet, the applicable following information when contacting AASCC regarding service authorization inquiries: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

- **Connecticut Community Care (CCCI) at:**
  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 Gainwell Technologies, from and to dates of service, the type service (PCA services 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) at:**

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SWCAABillings@swcaa.org

Providers must include the following information when submitting service authorization issues to SWCAA:

Client name, the client EMS number, the type of service (PCA services. per 15 min, Recovery Assistant, Meals, double per day etc.), frequency of service and the number of units or hours per visit. Providers should go to www.swcaa.org for a directory of care managers by zip code, frequently asked questions and SWCAA's provider inquiry form.

- **Western Connecticut Area on Aging (WCAA) 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.

Contact Information – Medicaid Waiver Client Eligibility Issues

The Home and Community Based Services Unit at DSS at the following email address: Waiver.DSS@ct.gov

- The client's name, client ID and the date service began or is scheduled to begin should be provided. Place the words "PCA Client Eligibility Issue" in the subject line of the email.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.14 Private Non-Medical Institution (PNMI)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Private Non-Medical Institution (PNMI)

Private Non-Medical Institutions (PMNI), formerly Residential Treatment Centers, provide integrated, longer-term treatment services for children and youth unable to function in their homes, schools or communities. Department of Children and Families (DCF) is the sole billing provider for this program. While not all PNMI services are medical in nature, the PNMI option is designed to allow HUSKY Health Program participation for the treatment portion of residential treatment facility admissions. A set of out-of-home services is financed under the HUSKY Health Program for an array of behavioral health treatment and non-medical support services.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.15 Psychiatric Residential Treatment Facility (PRTF)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Psychiatric Residential Treatment Facility (PRTF)

A Psychiatric Residential Treatment Facility (PRTF) provides inpatient psychiatric services. The PRTF can be a Medicare or accredited psychiatric hospital or an accredited psychiatric facility that is not a hospital. PRTF services must be provided under the direction of a physician. PRTF providers:

- Must comply with the Condition of Participation (COP) for the use of restraints and seclusion
- Must provide annual attestation to DSS confirming compliance with COP, restraint and seclusion
- If located in the State of CT, must be licensed with the Department of Children and Families
- Must be accredited by approved Accrediting Organizations

PRTF providers should refer to the claim submission instructions in this chapter prior to submitting claims for services.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.16 School Based Child Health

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

School Based Child Health Services (SBCH)

School Based Child Health (SBCH) services are diagnostic, evaluative, and rehabilitation treatment services provided by the Local Education Agencies (LEAs) to meet the special education needs of children and youth who have disabilities. The Board of Education for each city/town is the billing provider. School Based Child Health providers must be enrolled to receive reimbursement for the services provided. The Department of Social Services (DSS) contracts with the Department of Administrative Services (DAS), who as the DSS contracted billing service by DSS receives each city/towns' invoices. DAS submits claims directly to Gainwell Technologies on behalf of the Board of Education for each city/town invoice received.

New school districts joining the School Based Child Health (SBCH) Program must enroll as a School Based Child Health Provider. Enrolled SBCH providers must also re-enroll every 36 months. When it's time to re-enroll, enrolled SBCH providers will receive a notification to re-enroll letter.

Training Materials for School districts/staff joining the School Based Child Health Program

Information regarding the on-line enrollment process, next steps to becoming an enrolled provider and information regarding the re-enrollment process can be found on the www.ctdssmap.com Web site. From the Home Page select Provider>Provider Services>Provider Training and click on the "here" link. Under the Materials heading click on the "School Based Child Health Workshop" link, then on the "Presentation" link.

For information regarding interim claiming, random moment time study, admin claiming and cost reporting, download the New District Training PowerPoint below.

http://portal.ct.gov/DSS/Health-And-Home-Care/School-Based-Health-Care-Program/School-Based-Child-Health---SBCH

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.17 Targeted Case Management (TCM)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Targeted Case Management (TCM)

TCM programs are Connecticut Medical Assistance Program optional state plan services. Such services are provided to eligible HUSKY C and HUSKY D persons who are members of a target group. The Department of Developmental Services (DDS) and the Department of Mental Health and Addiction Services (DMHAS) are enrolled with the Department of Social Services (DSS) to provide case management services to the target groups specified by DSS. Such services are performed by an individual case manager for the purpose of assisting and enabling an eligible person to gain access to needed medical, social, educational, clinical, or other services.

Effective February 1, 2015 and as part of a State Plan Amendment, DSS also enrolls and reimburses providers who are not connected to DDS or DMHAS for Targeted Case Management (TCM) services.

Effective for dates of service July 1, 2016, providers certified by DMHAS as having a competency in providing case management services to adults with serious and chronic mental illness are eligible to enroll as a BHH/TCM Waiver Billing provider with a specialty of CMI Private Fee for Service. Providers enrolled under this specialty may submit Targeted Case Management (TCM) services provided to this population directly to Gainwell Technologies, the Department of Social Services' (DSS) Fiscal Intermediary, for payment.

TCM/CMI Private Fee for Service providers should refer to the claim submission instructions in this chapter for information regarding the submission of TCM services.

TCM Service Guidelines

Services must be identified in the TCM service Plan.

Claims cannot be submitted when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management is not reimbursable when the case management activities constitute the direct delivery of underlying medical, educational, social or other services to which an eligible individual has been referred, including but not limited to services related to foster care programs.

The Primary Diagnosis code must be on the table of ICD-10 diagnosis codes for DMHAS Targeted Case Management services. Refer to the diagnosis code field of the claim submission instructions below for access to this table.

Prior Authorization

Prior Authorization (PA) is required for TCM services in excess of twelve 15 minute units per month. Prior Authorization must be obtained from the Department of Social Services Behavioral Health Administrative Services Organization, Beacon Health Options.

Refer to Chapter 9 Prior Authorization for details.

Service Reimbursement

TCM/CMI Private Fee for Service Providers are reimbursed based on the rate on their Fee Schedule located on the www.ctdssmap.com Web site.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.18 Behavioral Health Home (BHH)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Behavioral Health Home (BHH)	The Department of Social Services (DSS) and Department of Mental Health and Addiction Services (DMHAS) are implementing a behavioral health home (BHH) model which specializes in care coordination services for individuals with severe and persistent mental illness. The effective date of this model is July 1, 2016. The model calls for DMHAS to fund care coordination services by expanding their provider grants to existing mental health providers who are also Medicaid enrolled providers (Mental Health Clinics and State operated outpatient clinics). The billing provider will be DMHAS. Performing providers will be DMHAS State Operated Facilities and DMHAS Private Non-Profit providers. Claims will be submitted to Gainwell Technologies by the Department of Administrative Services (DAS).
Prior Authorization	There are no Prior Authorization requirements.
BHH Service Guidelines	Services will be bundled and submitted under a single case management procedure code at one (1) unit per month.
Service Reimbursement	Case Management Services must be billed using procedure code T2022 – Case Management per month with a reimbursement rate of $300 per unit at one (1) unit per month.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.19 Tuberculosis (TB) Benefit

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Tuberculosis (TB)

The Tuberculosis (TB) benefit provides coverage for TB related services for those with TB who are not otherwise eligible for the HUSKY Health Program. TB services provided by physicians, advanced practice registered nurses, certified midwives, clinics, independent radiologists, home health agencies, local health departments (LHD) and outpatient hospitals may bill for services related to a TB diagnosis. A limited pharmacy coverage is also included.

All eligible providers can bill for TB related services using their applicable fee schedule.

Home Health Agencies may only bill G0493, Skilled Services by a Licensed Nurse (LPN) and G0494, Skilled Services by a Registered Nurse (RN) on the Home Health Fee Schedule related to a TB diagnosis.

LHDs are only able to bill the following procedure codes listed on the "Local Health Department" fee schedule for TB related services:

Procedure Code	Description	Rate
36415	Routine venipuncture	$3.47
86580	Tb intradermal test	$4.50
99202	Office/outpatient visit new	$20.50
99212	Office/outpatient visit est	$20.50
G0493	Skilled services by a LPN for the observation and assessment of the patient's condition, 15 minutes	$58.76
G0494	Skilled services by a RN for the observation and assessment of the patient's condition, 15 minutes	$58.76
G9012	Other specified case mgmt	$91.52
T1023	Program intake assessment	$58.76

Claims that do not have a valid TB related diagnosis codes as the primary diagnosis when submitted for reimbursement will be denied. To identify appropriate ICD-10-CM TB related diagnoses codes, please refer to Table 12 in the Fee Schedule Instructions.

The fee schedule instructions can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com.

To access the instructions from the Connecticut Medical Assistance Program Web site Home page:

1. Click on Provider
2. Click on Provider Fee Schedule Download
3. Review the End User License Agreements and select either:
   - I Accept
   - I Do Not Accept

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In order to access the fee schedule, you must accept the end user license agreements.

4. Select the Fee Schedule Instructions quick link and scroll down to the TB Related Diagnosis Codes table.

Providers should refer to provider bulletin, PB 19-33 along with their provider specific billing Chapter 8 for further guidelines for submitting claims for TB related services.

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8.20 Mental Health (MH) Waiver

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Mental Health (MH) Waiver

The Mental Health (MH) Waiver provides HUSKY C clients and those clients moving from the Money Follows the Person (MFP) initiative with a variety of community supported individual and group services, in addition to crisis intervention and transitional case management. Non-medical services such as home accessibility adaptations, non-emergency transportation, and specialized medical equipment, not otherwise payable under the HUSKY Health Program, are also included.

The Department of Social Services (DSS) has contracted with Advanced Behavioral Health (ABH) who is responsible for the credentialing of non-medical MH Waiver Service and ALSA providers and with the Department of Mental Health and Addiction Services (DMHAS) who is responsible for the credentialing of the state agency providers, servicing MH Waiver clients

Effective for dates of service February 1, 2020 and forward, providers of non-medical MH Waiver services will be required to enroll as either MH Waiver Service Providers or Assisted Living Service Agencies (ALSAs) for reimbursement of the services provided. Enrollment for Non-Medical Mental Health Waiver Service providers will be for a period of two years, with reenrollment required to continue to service MH waiver clients. Assisted Living Service Agency (ALSA) providers will be required to re-enroll every 5 years.

Providers should refer to Provider Bulletin PB 19-27 on the www.ctdssmap.com Web site Publications page for further enrollment and billing information. Workshop presentations regarding enrollment and billing can also be accessed on the www.ctdssmap.com Web site via the "Provider Training" link.

Non-Medical Waiver Services

Not all performers are required to be enrolled billing providers in the Connecticut Medical Assistance Program to service MH Waiver clients. ABH will be the billing provider for individual Recovery Assistant (RA) providers and those agencies and individuals who provide Highly Skilled Chore, Assistive Technology, Home Accessibility Adaptations and Specialized Medical Equipment services. Please refer to the claim submission instructions for specific billing requirements when submitting claims for these services.

The Department of Social Services Community Options Unit administers this waiver, requiring that all non-medical services be on the care plan. Advanced Behavioral Health (ABH) is responsible for uploading all service orders in the form of a Prior Authorization (PA) for non-medical services. MHW non-medical services are billable by ABH, the MHW Fiscal Intermediary, MHW Service providers or Allied Community Resources, the Community First Choice Fiscal Intermediary. These providers should refer to the Mental Health Waiver Procedure Code Crosswalk for specific codes billable under their specific provider specialty. All non-medical services uploaded to the care plan will auto approve except Highly Skilled Chore, Home Accessibility Adaptations, Assistive Technology and Specialized Medical Equipment, when they exceed the maximum $ amount per year. Those PAs that exceed the yearly $ maximum will remain in an in - process status until approved by DSS.

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Assisted Living Services	ALSA services are not required to be on the care plan.
Home Health Services	Home Health Services are not required to be on the care plan at this time.
Electronic Visit Verification Overview	Effective 9/1/2016, DSS, under contract with Gainwell Technologies, implemented Electronic Visit Verification (EVV). Gainwell Technologies partnered with Sandata to implement their suite of products (Santrax TM) that has been integrated with interChange, the Connecticut Medical Assistance Program claims processing system. Providers should refer to the Electronic Visit Verification Web page, accessed from the www.ctdssmap.com Home page, for more information on EVV including Interface Specifications, training documents and videos, publications and a Frequently Asked Questions (FAQ) document located under General Program Information and FAQ's tab. As a result of the EVV implementation, a number of Mental Health Waiver services are EVV mandated while others are not applicable for EVV. Providers should click on the Mental Health Waiver Procedure Code Crosswalk link for EVV Mandated and Optional non-applicable EVV services. Effective for dates of service **7/1/2021**, providers who deliver non-medical services to Mental Health Waiver clients that are EVV mandated are required to implement DSS's EVV system for the purposes of scheduling and visit verification.
EVV Implementation	In order to implement the EVV system, providers must first complete mandatory training to assist in the start–up and navigation of the EVV system. Upon verification of completed mandatory training, providers will receive their Sandata Welcome Kit. Providers should refer to the Electronic Visit Verification Implementation Web page located on the Home page of the www.ctdssmap.com for information on registering for mandatory training, what to do when you get your Welcome Kit, training publications and videos.
Claim Submission - EVV Mandated Services	Claims will be systematically generated via EVV when the visit check-in and check-out matches the schedule and service authorization on file. Submitted claims requiring adjustment or void must be voided in interChange via an 837 transaction or interactively through the provider's secure Web account. Once voided, providers should refer to the training video on the Electronic Visit Verification Web page as to how to resubmit mandated services via EVV. Mental Health Waiver Service providers who use EVV to schedule and check in and out of EVV for services provided, have the choice of submitting claims for EVV mandated services to Gainwell Technologies for claim adjudication from their own system, via the www.ctdssmap.com secure Web site, from the Santrax system or any combination of these three methods. Claims submitted outside of the Santrax system are subject to visit validation requirements as those submitted from Santrax and must match a confirmed visit in Santrax that contains the same client ID, provider ID, date of service, service code and modifier(s).

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Claim Submission - EVV Non-applicable Services

Providers whose services are not mandated for EVV must submit all services with dates of service 2/1/20 and forward directly to Gainwell Technologies for payment using one of the following methods:

- Web claim submission via the internet Web site at www.ctdssmap.com
- Vendor software utilizing the following HIPAA ASC X12N 837P – Health Care Claim Professional

Contact Information – Enrollment and Billing Issues

Gainwell Technologies 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@dxc.com
- This should be your first 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.

Contact Information – Electronic Claim Submission Issues

Gainwell Technologies Electronic Data InterChange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8 AM to 5 PM (EST), excluding holidays

Contact Information for Client Eligibility Issues

Advanced Behavioral Health (ABH)

- Lori-Lynn French
- Telephone – 860-704-6177
- Email – lfrench@abhct.com

Contact Information for Prior Authorization (PA) Issues

Advanced Behavioral Health (ABH)

- Telephone – 860-704-6201

Contact Information – EVV Related Issues

Contact the EVV Email Mailbox
ctevv@dxc.com

For issues regarding:

- Missing a member from your Santrax system and your agency has verified that the member is eligible on their waiver benefit plan and has a valid PA on the www.ctdssmap.com portal.
- A PA is present on the www.ctdssmap.com portal, but is not present in the Santrax system.

  NOTE: It can take up to 48 hours before a PA that is present on the www.ctdssmap.com portal is present in Santrax.

- Unsure who to contact for assistance
- Need additional support resolving your issue with Sandata
  NOTE: Please be sure to include your Sandata ticket number, if applicable.

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Contact Information – Santrax Software Issues	**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 If you are experiencing issues with the Santrax system or its functionality, please be sure to obtain a Sandata ticket number for your call.

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8.21 Connecticut Housing Engagement and Support Services (CHESS)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Connecticut Housing Engagement and Support Services (CHESS)

The purpose of the Connecticut Housing Engagement and Support Services (CHESS) Program is to provide support services to Medicaid members experiencing homelessness and specified clinical conditions, especially help with finding and staying in affordable housing and connecting to medical and behavioral health services.

Providers enrolling as CT Housing Engagement and Support Service (CHESS) providers must be on the DMHAS Approved list of providers.

Prior Authorization

Beacon Health Options will provide the required prior authorizations (PAs) for the four (4) service codes used for the CHESS program. Once PAs are created, Beacon Health Options will then upload the PAs to Gainwell Technologies to be displayed on the CMAP Web site, www.ctdssmap.com.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.22 Community First Choice Support and Planning Coach Services

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Community First Choice Support and Planning Coach

Support and Planning Coach is a new provider specialty under the Community First Choice Program. Enrolled providers will bill services directly to Gainwell Technologies and will receive reimbursement directly from DSS.

Provider Services

Agency Providers enrolling as Community First Choice (CFC) Support & Planning (S&P) Coach providers will assist in the development and management of the client's CFC budget, service planning and hiring. Billable services are limited to:

Support and Planning Coach services – Includes assisting the participant in developing and managing any and/or all aspects of their individual budget, in addition to providing support in interviewing and managing staff.

Skills Training and Development services – Further provides Electronic Visit Verification (EVV) Support Training and skills development in the managing and scheduling of CFC service providers and training and skills development in the navigation of on-line (EVV) Time tracking. EVV tasks include assisting the participant with adding or modifying and approving service visits via the EVV online portal.

Provider Reimbursement

Reimbursement of these services, Prior Authorization requirements and maximum units allowed per day can be found on the CFC Fee schedule. From the www.ctdssmap.com Home page Provider > Provider Fee Schedule Download > after reading the Provider License Agreement > click "I Accept" > click the "CSV" link at the end of "Community First Choice – Services **CSV.**

NOTE: CFC Support and Planning Coach services are those indicated with Rate Type – CFS.

Provider Credentialing

To receive reimbursement for CFC Support and Planning Coach services, providers **MUST** meet the following credentialing requirements:

EVV training and webinar: Staff identified as providing S&P Coach must attest to meeting the EVV training requirements, which includes previous training and experience, or completing the online training series. Staff that are new to EVV (no prior experience/training) must complete the online video series and webinars by following this link. **Connecticut Consumer Direct Video Library (wistia.net).**

Individual staff must complete the EVV Training Self-Attestation form. Click the EVV Training Self Attestation form link to access the form. This form can also be found on the www.ctdssmap.com Training page.

Person-Centered Planning Training: Staff must attend a Person-Centered training and will receive a Certificate of Completion. Staff who already have a certificate of completion for person-centered planning, or certification as an Aging and Disability specialist, which meet annual certification requirements, may substitute their existing certification.

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Provider Assurances: The Community First Choice Support and Planning Coach Provider Assurances Form outlines the specific details in which the provider agency agrees to meet all the requirements of the program, including how individual staff providing S&P Coach services have met both the EVV and Person-Centered Planning requirements noted above. An agency point person must complete the Provider Assurances form. A copy of the Provider Assurances form must be sent to Allied Community Resources to receive a credentialling letter. Click the Provider Assurances Form link to access the form. This form can also be found on the www.ctdssmap.com Training page.

Credentialing Letter: A credentialing letter is required to complete the CFC S&P Coach provider enrollment with Gainwell Technologies.

Staff Training - Providers interested in EVV or Person-Centered Planning Training should contact Karri Filek at karri.filek@ct.gov.

Provider Enrollment

Once a credentialing letter is received, providers must go to the www.ctdssmap.com Web site Home page and select "Provider Enrollment" from the drop-down "Provider" menu to access the Enrollment Wizard.

Prior to enrolling, providers are encouraged to review the CFC S&P Coach Enrollment Workshop PowerPoint Presentation on the Provider Training Page for important navigational tips, and next steps in the enrollment process, including tracking their submitted application. Providers with enrollment questions should contact the Provider Assistance Center (PAC) at 1-800-842-8440. PAC is available Monday-Friday 8:00 a.m. to 5:00 p.m. excluding holidays

Post Enrollment

Once enrolled, re-enrollment will occur every five (5) years. Upon receipt of your Provider Enrollment Approval letter and PIN letter, each received under separate cover, providers should set-up their Primary Account Holder Secure Web Account and applicable clerk accounts.

Refer to the CFC S&P Coach Enrollment Workshop PowerPoint Presentation for information on setting up Primary and clerk secure Web accounts.

Review the CFC S&P Coach Billing and Web Claim Submission PowerPoint Presentation on the www.ctdssmap.com Provider Training Page for information on secure Web Primary and Clerk account set-up and capabilities including verification of client eligibility, service authorization and claim submission of billable services, access to program contacts and resources.

To access the Billing Workshop Presentation, from the Home page > Provider> Provider Training > Under Materials > **Community First Choice Support and Planning Coach Billing and Web Claims Submission Workshops Presentation** or click the link to access: CFC S&P Coach Billing and Web Claims Submission Workshop Presentation.

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Prior Authorization

Prior authorization is required for all CFC S&P Coach Services provided to clients with a HUSKY or HUSKY with an ABI, CHC or PCA Waiver benefit plan. Service Authorization will be uploaded via batch or entered interactively by the Access Agencies currently providing PA for ABI, CHC or PCA Waiver client services.

PA for CFC S&P Coach services for HUSKY clients with an Autism Waiver will be entered interactively by the client's DSS Autism Case Manager currently providing PA for Autism Waiver services.

CFC S&P Coach services must be on the client's Care Plan and will be authorized in $ dollars, with a procedure code list of 44, which includes service authorization for both Support & Planning Coach (2043Z) and Skills Training & Development (H2014) services.

The Procedure Code Crosswalk applicable to the client's Waiver has been updated to include CFC S&P Coach services. The crosswalk may be used as a CFC S&P Coach care plan reference guide for both HUSKY only clients or HUSKY clients with an ABI, Autism, CHC or PCA Waiver.

CFC S & P Coach services are not Mandated services for EVV.

Claim Submission

Claim for CFC S& P Coach services may be submitted via:

- the internet Web site at www.ctdssmap.com
- Vendor software utilizing the HIPAA ASC X12N 837P – Health Care Claim Professional transaction.

Although authorized in $ dollars, services must be billed in units. Services are billed in 15 - minute increments and are limited to a per day maximum as referenced on the fee schedule.

For additional claim submission information, providers should refer to the CFC S&P Coach Billing and Web claim Submission PowerPoint Presentation on the www.ctdssmap.com Web site.

To access the Billing Workshop Presentation, from the Web site Home page > Provider> Provider Training > Under Materials > **Community First Choice Support and Planning Coach Billing and Web Claims Submission Workshops Presentation** or click the link to access: CFC S&P Coach Billing and Web Claims Submission Workshop Presentation.

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8.23 Prior Authorization

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Prior Authorization is required for the Connecticut Home Care Program, ABI, Autism, CHC, Mental Health and PCA Waivers. Prior Authorization is also required for DDS Specialized Services - NF Residents, Mental Health Group Home, Targeted Case Management Non-Contracted, Connecticut Housing Engagement & Support Services (CHESS) and CFC Support and Planning Coach providers. Please refer to Chapter 9 of the Provider Manual for full Prior Authorization requirements, contact information, and related forms. Providers should also refer to Chapter 7, Medical Policy for additional service requirements.

Although Waiver and Special Services are often nonmedical in nature and often not covered by other insurance or Medicare, Medicaid is the payer of last resort. As a result, all other insurance, including Medicare, should be pursued prior to billing Gainwell Technologies.

ABI, Autism, CHC, MHW and PCA Waivers

Medical services for ABI, Autism, CHC, MHW and PCA clients who are Title 19 eligible are billed by the Home Health Agency. As Medicaid is the payer of last resort, services must be billed first to all other payers. Claims for clients covered under Medicare, however, who do not meet the Medicare level of care for being homebound, can be submitted directly to Gainwell Technologies with an adjustment reason code of 150, 151 or 152 and the Advanced Beneficiary Notice (ABN) issue date, indicating that Medicare does not cover the claim. These claims are subject to a monthly Other Insurance Audit. If the claim is selected, the provider is required to send a copy of the ABN indicating that the client did not meet the Medicare level of care for the services provided, in addition to a copy of the other insurance Explanation of Benefit (EOB) indicating payment or denial for each other insurance carrier indicated on the client's eligibility file, active on the date of service.

Claims for State Funded CT Home Care clients are not subject to the Medicare Cost Avoidance requirements as noted for CHC Title 19 eligible clients above.

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8.24 Claim Submission Instructions

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Electronic Claim Submission References	As a reminder, providers are required to submit claims electronically, unless the claims meet the exception criteria outlined below. Providers should use the following resources for electronic claim submission information: • Chapter 6, Electronic Data Interchange Options, for electronic claim submission options located at www.ctdssmap.com by selecting Information > Publications • Chapter 10, AVRS/Web Portal, for internet claim submission instructions located at www.ctdssmap.com by selecting Information > Publications • Implementation Guide found at www.wpc-edi.com • Companion Guide located at www.ctdssmap.com by clicking on the Trading Partner tab, then the EDI tab for format and code set information • Chapter 7 for Connecticut Medical Assistance Program for regulations and policy guidelines. Please note that, while the instructions below are intended to instruct providers on how to submit paper claims, this section can be reviewed by all providers to gain insight on claim requirements, such as permissible modifiers.
Paper Claims Exception Criteria	Paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. Please note that the only version of the form that is accepted is the CMS-1500 Health Insurance Claim Form Version 02/12.
How to Obtain CMS-1500 Claim Forms	Providers submitting paper claims must use original red CMS-1500 claim forms, as these claims will be electronically scanned. Original red CMS-1500 claim forms are obtained from private printing vendors.
Where to Send Completed CMS-1500 Claim Form	Mail completed CMS-1500 claim forms to: Gainwell Technologies P.O. Box 2991 Hartford, CT 06104
CMS-1500 Required Fields for Claim Submission	The instructions below are for paper claims only. In this section, there are directions for completion of each field on the CMS-1500 and fields not required are noted. Black ink only should be used when completing the claim form. Do not use highlighter on claims or attachments.

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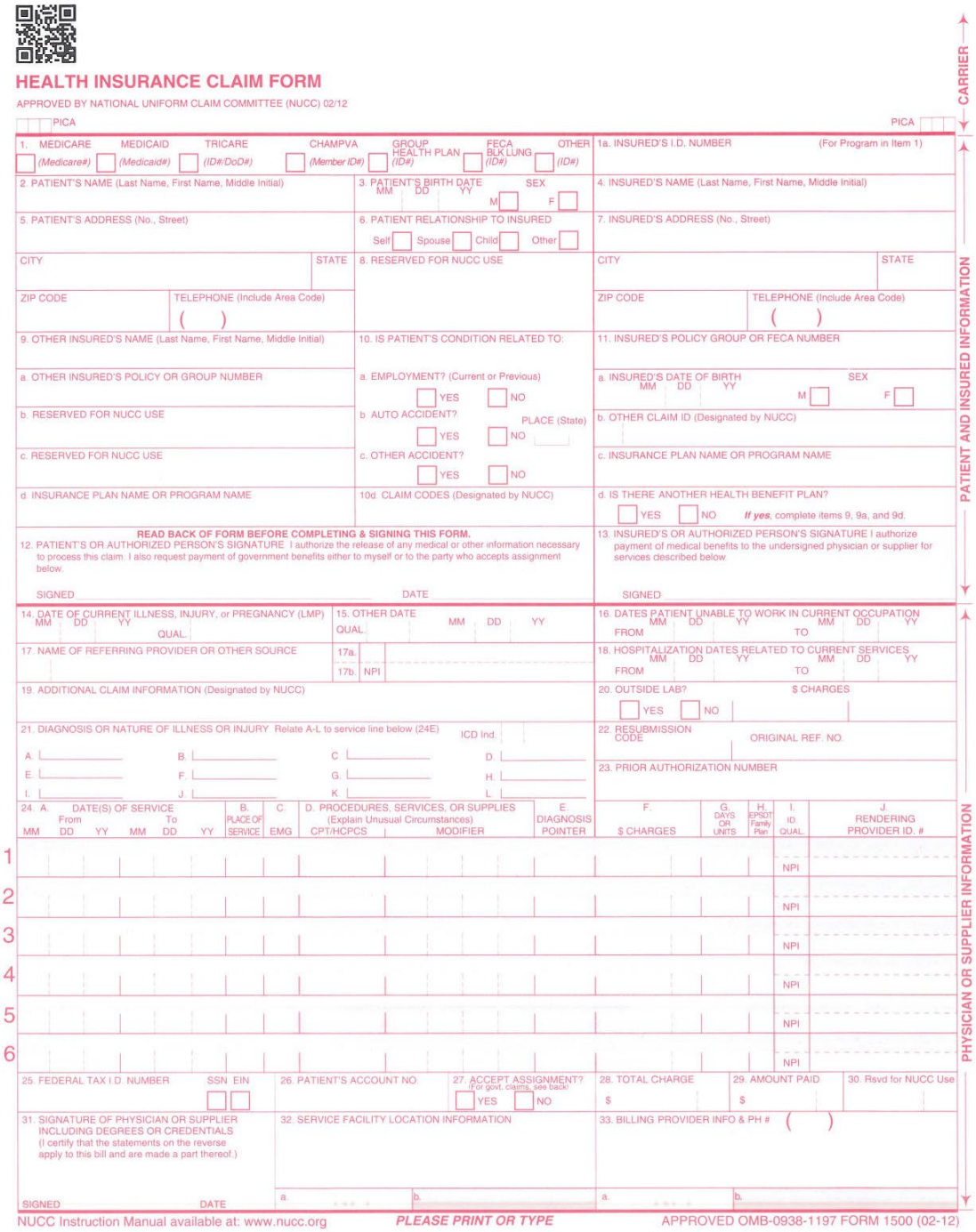
CMS-1500 Health Insurance Claim Form (version 02/12)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Please reference the following chart for information on required fields for submission of the CMS-1500 Health Insurance Claim Form (version 02/12).

CMS-1500 Required Fields

**Paper Claim Field No. and Name		Description
1.	TYPE OF CLAIM	Not required.
1a.	INSURED'S I.D. NUMBER	Enter the client's 9-digit Connecticut Medical Assistance Program ID number exactly as it appears on the CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS). **NOTE:** If submitting a paper claim for Medicare or Medicare HMO coinsurance and/or deductible, enter the client's Medicare number in Field 1a.
2.	PATIENT'S NAME	Enter the client's name (last name, first name, middle initial). **NOTE:** The client's name should be spelled the same way as communicated by the AEVS.
3.	PATIENT'S BIRTH DATE	Not required.
	SEX	Not required.
4.	INSURED'S NAME	Not required.
5.	PATIENT'S ADDRESS	Not required.
6.	PATIENT RELATIONSHIP TO INSURED	Not required.
7.	INSURED'S ADDRESS	Not required.
8.	RESERVED FOR NUCC USE	Not required.
9.	OTHER INSURED'S NAME	Not required.

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**Paper Claim Field No. and Name		Description
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the client's 9-digit Connecticut Medical Assistance Program ID number when submitting a claim for Medicare coinsurance and deductible. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Professional claim type.
9b.	RESERVED FOR NUCC USE	Not required.
9c.	RESERVED FOR NUCC USE	Not required.
9d.	INSURANCE PLAN NAME OR PROGRAM NAME	**Medicaid is always the payer of last resort.** 1) Non Medicare Other Insurance If the client has other insurance coverage and a payment was received, enter the 3-digit other insurance carrier code, paid amount, and payment date. Enter the total amount paid by the other insurer(s) in Field 29 of the CMS-1500 claim form. If a denial was received from the other insurer, enter the 3-digit other insurance carrier code(s) followed by "Not Applicable" or "N/A" followed by the denial date. A response from each and every other insurance policy the client has must be indicated in this field. **The other insurance Explanation of Benefits (EOB), indicating a payment or denial, does not need to be attached to the claim, unless required to override timely filing.** Refer to Chapter 5, Section 6 for additional information on timely filing. A complete listing of insurance carrier codes can be accessed and downloaded from the Web site www.ctdssmap.com, by selecting Information, then Publications. The 3-digit insurance code(s) may also be obtained through the AEVS. If the 3-digit code for a specific insurance carrier does not appear on the list, the provider should enter "999", along with the paid amount and payment date in Field 9d. Refer to Chapter 4, Section 3 for information on accessing the AEVS. Providers unable to obtain a response from a documented carrier listed on the client's eligibility file, should refer to the subrogation procedures in Chapter 5, Section 3. A copy of the Third-Party Billing Attempt Form is accepted in lieu of an EOB. NOTE: Claims for **ABI, Autism, CHC, DDS Specialized Services, Mental Health or PCA Waiver** non-medical services will not cost avoid (deny) if other insurance information on the client eligibility file is not listed on the ABI, Autism, CHC, DDS Specialized Services, PCA or Mental Health Waiver (Non-Medical) Service claim. 2) Medicare Insurance (Dually Eligible) *When Medicare Makes a Payment* If the client has Medicare and a payment was received: • Enter either "Medicare" or "MPB" in this field. If a Medicare Health Maintenance

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**Paper Claim Field No. and Name		Description
		Organization (HMO) is the primary insurer and a payment was received, the words “Medicare HMO” must be indicated in this field (field 9d). • **Do not enter the amount Medicare paid in field 9d or in field 29** of the CMS-1500 claim form. • The date of the EOMB does not need to be indicated in this field. **The Explanation of Medicare Benefits (EOMB), indicating a payment from Medicare or the Medicare HMO, must be attached to the paper claim.** Please note that: • Providers must submit one paper claim attached to one EOMB. • Claims with multiple EOMBs attached to one claim or multiple claims attached to one EOMB will not be processed and will be returned to the provider. • The following information must be exactly the same on the paper claim and on the EOMB: Patient name, detail dates of service, procedure codes and modifiers (if any), units, and billed amounts (each line). • The number of lines submitted on the claim must have corresponding lines on the EOMB. • Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB. • When submitting a paper coinsurance and/or deductible claim for Connecticut Medical Assistance Program payment, providers must submit the claim information on an original (red) paper claim form. *When Medicare Indicates a Denial* If the client has Medicare and a denial was received: • Indicate either “Medicare N/A”, “MPB N/A” or “Medicare HMO N/A”. • Indicate the date of the EOMB in field 9d. (Note: If the provider has a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and that letter is dated within one year from the date of service on the claim, indicate the date of that letter in place of the EOMB date.) • Field 29 must be blank. **The Explanation of Medicare Benefits (EOMB), indicating a denial from Medicare or the Medicare HMO, should not be attached to the paper claim.** Refer to Chapter 5, Section 3 for more information on third party claim submission requirements. **NOTE:** For subrogation procedures, refer to Chapter 5, Section 3. A copy of the Third Party Billing Attempt Form is accepted in lieu of an EOB. **NOTE:** Claims for ABI, Autism, CHC, DDS Specialized Services – NF, Mental Health or PCA Waiver non-medical services will not cost avoid (deny) if Medicare information on the client eligibility file is not listed on the ABI, Autism, CHC, DDS, Mental Health or PCA Waiver (Non-Medical) Service claim. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is

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**Paper Claim Field No. and Name		Description
		available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop-down box, select the Professional claim type.
10.	IS PATIENT'S CONDITION RELATED TO:	**NOTE:** If "yes" is indicated in 10a, 10b, or 10c, enter the date in MM/DD/YY format in Field 14.
10a.	EMPLOYMENT? (Current or Previous)	Enter an "X" in the appropriate box.
10b.	AUTO ACCIDENT? PLACE (State)	Enter an "X" in the appropriate box. If "Yes" is indicated, enter the state where the accident occurred.
10c.	OTHER ACCIDENT?	Enter an "X" in the appropriate box.
10d.	CLAIM CODES (Designated by NUCC)	Not required.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required.
11a.	INSURED'S DATE OF BIRTH SEX	Not required.
11b.	OTHER CLAIM ID (Designated by NUCC)	Not required.
11c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Not required.

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**Paper Claim Field No. and Name		Description
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date in MM/DD/YY format for the illness or injury identified in 10a, 10b, or 10c.
	QUAL.	Not required.
15.	OTHER DATE QUAL	Not required.
	DATE	Not required.
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.

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**Paper Claim Field No. and Name		Description
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Not required for ABI, Autism, CHC, CFC, Mental Health and PCA Waivers, PNMI, Mental Health Group Homes, School Based Child Health and CFC S&P Coach providers. If applicable, enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. • **DN** Referring Provider • **DK** Ordering Provider • **DQ** Supervising Provider Enter the qualifier to the left of the vertical, dotted line.
17a.	UNLABELED FIELD	Not required.
17b.	NPI	If entered, ordering or referring provider must be an enrolled Connecticut Medical Assistance Program Provider, effective with dates of service on or after November 1, 2013. Note: OPR edits do not apply to the following: Provider Type 36: Access Agencies and PCA Non-Medical Waiver Service Providers, Provider Type 50: Community First Choice, Provider Type 51: Autism Waiver Service Providers Provider type 52: ABI Case Management Agencies and ABI Non-Medical Waiver Service Providers, Provider Type 57: CHC Access Agencies and CHC Non-Medical Service Providers, Provider Type 77: Mental Health Waiver Non-Medical Service Providers, Provider Type 12: School Based Child Health, Private Non-Medical Institutions, Psychiatric Residential Treatment Facilities, Community Service, Mental Health Group Home Providers; Provider Type 53, DMHAS BHH Billing Provider.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not required.
19.	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Not required.

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**Paper Claim Field No. and Name		Description
20.	OUTSIDE LAB? $ CHARGES	Not required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24 E) ICD Ind	Enter the ICD indicator of 0 for ICD-10-CM. NOTE: Not required for claims submitted by ABI Service Providers, Autism Service Providers, Community First Choice Billing Providers, CHC Access Agencies, CHC (Non-Medical) Service Providers, School Based Child Health, CFC S&P Coach or PCA Billing providers. **DDS Specialized Services Providers – NF clients** **If diagnosis unknown, use default diagnosis code F79.** **Mental Health Waiver Service Providers - A primary diagnosis code is not required.** **MHW Fiscal Intermediary – A primary diagnosis code is required.** Use diagnosis code on table 10. This table can be found via the www.ctdssmap.com Web site. From the Home page, select Provider > Provider Fee Schedule Download. Click the I Accept button at the bottom of the page and click on the "Click here for the Fee Schedule Instructions". Under the table listing, click on Table 10. TCM\CMI Private Fee for Service Providers and the DMHAS BHH Billing Provider are restricted to billing services on Table 17 – DMHAS Targeted Case Management services. This table can be found via the www.ctdssmap.com Web site. From the Home page, select Provider > Provider Fee Schedule Download. Click the I Accept button at the bottom of the page and click on the "Click here for the Fee Schedule Instructions". Under the table listing, click on Table 17.
	A. – L.	Enter the ICD-10-CM diagnosis code. No more than 12 ICD-10-CM diagnosis codes can be listed.
22.	RESUBMISSION CODE ORIGINAL REF. NO.	Not required.
23.	PRIOR AUTHORIZATION NUMBER	Not required.

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**Paper Claim Field No. and Name		Description
24A.	DATE(S) OF SERVICE	Enter the "from" and "to" date(s) of service in MM/DD/YY format. **NOTE 1 :** Claims cannot span more than one client benefit period within the same month (i.e. client on MFP or MFP – Post and another waiver in the same month). Claims must be split with MFP or MFP – Post, dates of service on one claim and the waiver dates of service on another claim. **NOTE:** The "to" date of service is not required if submitting claims for one date of service. When the same service is performed on consecutive dates, and the number of units allowed per day = 1, enter the first date of service in the "from" field and the last date of service in the "to" field. The number of units entered in Field 24G must be equal to the number of days spanned by the "from" and "to" dates. The same procedure must have been performed on each of the dates spanned. If services were not performed on consecutive days, the procedures must be itemized on separate lines. **ABI and ABI II Providers**: As applied income may be due from an ABI or ABI II waiver client, claims cannot span multiple calendar months. Note: Although calculated on the claim, Applied Income is not deducted from the claim. When submitting consecutive days of service, spanned dates of service cannot exceed the frequency (calendar week or calendar month) as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **Autism Waiver Service Providers:** As applied income may be due from an Autism waiver client, claims cannot span multiple calendar months. Note: Although calculated on the claim, Applied Income is not deducted from the claim. When submitting consecutive days of service, spanned dates of service cannot exceed the frequency (weekly or monthly) as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **CHC Providers:** When submitting consecutive days of service, spanned dates of service cannot exceed the frequency (calendar week or calendar month) as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **CHC Providers:** Although Applied Income and Cost Share are not deducted from the claim, Applied Income and Cost Share are calculated and stored for future claims processing and reporting. As a result, dates of service on the CHC claim cannot span multiple months. **DDS/DMHAS TCM Providers:** Only one TCM allowed per calendar month. **DMHAS BHH Billing Provider:** Only one TCM allowed per calendar month.

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**Paper Claim Field No. and Name		Description
24A.	DATES OF SERVICE (cont'd)	**Mental Health Group Home Providers:** The "from" date of service of the initial month of service, must equal the first day of the month in which service is performed. The "to" date of service is not required, however, if entered must equal the "from" date of service. When the same service is performed on consecutive months, enter the first day of service of the month in the "from" field of detail 1. Enter the first day of the month of the second month of service in the "from" field of detail 2. The client must have received a minimum of 40 hours of service per month, prorated for a partial month, for one unit of service to be billed in a given month. Dates of service may span multiple calendar months. **Mental Health Waiver Non-Medical Service Providers:** As applied income may be due from a Mental Health Waiver service client, claims cannot span multiple calendar months. Note: Although calculated on the claim, Applied Income is not deducted from the claim. When submitting consecutive days of service, spanned dates of service cannot exceed the frequency (calendar week or calendar month) as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **Personal Care Attendant (PCA) Providers:** As applied income may be due from PCA waiver clients, claims cannot span multiple calendar months. Note: Although calculated on the claim, Applied Income is not deducted from the claim. When submitting consecutive days of service, spanned dates of service cannot exceed the frequency (calendar week or calendar month as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **PNMI Providers**: The "from" date of service must equal the first day of the month. The "to" date of service is not required. When the same service is performed on consecutive months, enter the day of the first month of service in the "from" field of detail 1. Enter the first day of the second month of service in the "from" field of detail 2. The client must reside at the facility on the first day of each month for a service to be billed. Dates of service may span multiple calendar months.

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**Paper Claim Field No. and Name		Description
24B.	PLACE OF SERVICE	Enter the Place of Service (POS) code for the location where services were performed. Use the following POS code(s) when submitting claims for Connecticut Medical Assistance Program services: **NOTE:** Only an access agency (CHC provider type/specialty 57/541) can submit claims for CHC initial assessments. Providers should enter the two-digit place of service a.k.a. Facility Type Code in Field 24B. **NOTE:** Enter both the "from" and "to" dates of service when submitting claims for the same procedure performed on consecutive days. The two-digit Place of Service (Facility Type Code) is entered in field 24B.

Code	Description
Acquired Brain Injury (ABI)	
12	Home
99	Other Place of Service
Autism Waiver	
12	Home
99	Other Place of Service
Connecticut Home Care (CHC)	
11	Office
12	Home
13	Assisted Living Facility
16	Temporary Lodging
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
99	Other Place of Service
Community First Choice Support and Planning Coach	
12	Home
99	Other Place of Service
DDS Specialized Services – Nursing Facility Residents	
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
19	Off Campus – Outpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
99	Other Place of Service

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<table>
<tr><th colspan="2">**Paper Claim Field No. and Name</th><th>Description</th></tr>
<tr><td></td><td>PLACE OF SERVICE (Cont'd)</td><td>
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td colspan="2">DDS Waiver Services</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>16</td><td>Temporary Lodging</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
<tr><td colspan="2">Mental Health Group Home</td></tr>
<tr><td>14</td><td>Group Home</td></tr>
<tr><td colspan="2">Mental Health Waiver</td></tr>
<tr><td>11</td><td>Office</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>13</td><td>Assisted Living</td></tr>
<tr><td>14</td><td>Group Home</td></tr>
<tr><td>21</td><td>Inpatient Hospital</td></tr>
<tr><td>31</td><td>Skilled Nursing Facility</td></tr>
<tr><td>32</td><td>Nursing Facility</td></tr>
<tr><td>33</td><td>Custodial Care Facility</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
<tr><td colspan="2">Private Non-Medical Institutions</td></tr>
<tr><td>16</td><td>Temporary Lodging</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
<tr><td colspan="2">Psychiatric Residential Treatment Facility</td></tr>
<tr><td>56</td><td>Psychiatric Residential Treatment Center</td></tr>
<tr><td colspan="2">Personal Care Assistance Services</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td colspan="2">School Based Child Health Services</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>16</td><td>Temporary Lodging</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
<tr><td colspan="2">Targeted Case Management</td></tr>
<tr><td>11</td><td>Office</td></tr>
<tr><td>12</td><td>Home</td></tr>
<tr><td>13</td><td>Assisted Living Facility</td></tr>
<tr><td>14</td><td>Group Home</td></tr>
<tr><td>16</td><td>Temporary Lodging</td></tr>
<tr><td>31</td><td>Skilled Nursing Facility</td></tr>
<tr><td>32</td><td>Nursing Facility</td></tr>
<tr><td>49</td><td>Independent Clinic</td></tr>
<tr><td>50</td><td>Federally Qualified Health Center</td></tr>
<tr><td>53</td><td>Community Mental Health Center</td></tr>
<tr><td>57</td><td>Non-residential Substance Abuse Treatment Facility</td></tr>
<tr><td>71</td><td>State or Local Public Health Clinic</td></tr>
<tr><td>99</td><td>Other Place of Service</td></tr>
</table>
</td></tr>
<tr><td>24C.</td><td>EMG</td><td>Not required.</td></tr>
</table>

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**Paper Claim Field No. and Name		Description
24D.	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	Enter the applicable procedure code for the service performed.
	Acquired Brain Injury (ABI) Services	Only ABI services authorized that appear on the ABI care plan can be billed on the claim. For services not EVV mandated, providers should refer to the current ABI Procedure Code Crosswalk for procedure codes and procedure code/modifier billing combinations associated to a list code authorized on the ABI Care Plan.
	Autism Waiver Services	Only Autism Waiver Services authorized that appear on the Autism Waiver Care Plan can be billed on the claim. To determine if the service has been authorized, providers should refer to their secure Web account and click on Prior Authorization then Prior Authorization Search. Providers should also reference the Autism Procedure Code Crosswalk for information such as unit increment, span dates of service requirements, valid service authorization frequencies and Care Plan Limitations.
	Connecticut Home Care	Only CHC services authorized that appear on the CHC care plan can be billed on the claim. For services not EVV mandated, providers should refer to the current CHC Procedure Code Crosswalk, for procedure codes and procedure code/modifier billing combinations associated to a list code authorized on the CHC Care Plan.
	DDS Specialized Services for Clients Residing in a Nursing Facility	Effective for dates of service February 1, 2019, all services billed on the claim must be prior authorized. Providers should refer to the Prior Authorization Inquiry selection from the Prior Authorization menu from their secure Web account for authorized services.
	Mental Health Waiver Services	Effective February 1, 2020, only Mental Health Waiver non-medical services that appear on the client care plan can be billed on the claim and be reimbursed to the provider. Providers should refer to the Mental Health Waiver Procedure Code Crosswalk for information such as billable codes, unit increments, span dates of service requirements, valid service authorization frequency and Care Plan Limitations.
	Personal Care Attendant (PCA) Services	Only PCA services authorized that appear on the PCA care plan can be billed on the claim. For services not EVV mandated, providers should refer to the PCA Procedure Code Crosswalk for procedure codes and procedure code/modifier billing combinations associated to a list code authorized on the PCA Care Plan.

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**Paper Claim Field No. and Name		Description
	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS (cont.) **Targeted Case Management Services**	Enrolled TCM\CMI Private Fee for Service providers may submit claims for case management services directly to Gainwell Technologies for reimbursement.

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**Paper Claim Field No. and Name		Description
	MODIFIER **All Providers of Non-Medical Waiver and Special Services:** ABI Autism CHC MHW PCA	**The following modifiers may be billed when authorized on the Care Plan:** When providing services to a client with a Hospice "lock-in" and the services provided are: a) not related to the client's "Hospice" condition, or b) not a duplicate of those performed by the Hospice provider, The following modifier may be billed: **GW - *"Services not related to the Hospice patient's terminal condition"*** must be billed with the procedure code for each service on the claim. Providers should contact the Hospice provider, as noted in the "lock-in" section of the client's eligibility verification, with any questions they may have regarding duplication of service. The following additional modifiers may be billed when authorized on the Care Plan: **U2 - *One Time Only Service*** A U2 modifier authorized and associated with a procedure code on the care plan must be billed on the claim in order for the provider to be reimbursed for: - additional units needed on a day a MHW service is provided - a service overlap with another service order for the same period - the addition of an overlapping service that is for a different frequency Providers must bill with this modifier when: - an individual procedure code(s) is authorized with a U2 modifier - a Procedure Code/Modifier List(s) is authorized such as: AB-Meals or ML Meals - One Time Only AD-Adult Day Care – One Time Only **TT** – ***Subsequent Client*** A TT modifier is authorized and must be billed on the claim when the same or different services are being provided to more than one client in the same visit. The primary client is usually the client requiring the most care or as designated by the case manager. A subsequent client becomes the primary client when the primary client is not serviced during the visit. The TT modifier is a pricing modifier, which reduces the claim payment by 50%. Providers must bill with this modifier: - if an individual procedure code is authorized with a TT modifier - a Procedure Code/Modifier List(s) is authorized such as: 33 – PCA Services per 15 min

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**Paper Claim Field No. and Name		Description
	MODIFIER (cont.)	**Note:** Only services authorized that appear on the care plan can be billed on the claim. Providers should refer to the current crosswalk listed below for applicable billing combinations associated to a list code authorized on the care plan: ABI Procedure Code Crosswalk Autism Procedure Code Crosswalk CHC Procedure Code Crosswalk PCA Procedure Code Crosswalk Mental Health Waiver Procedure Code Crosswalk ***Community First Choice Services*** When a CF Code List is authorized, any combination of the associated procedur codes or procedure codes with modifiers may be serviced as needed on the car plan and billed up to the authorized dollar amount on the PA. **Note: Home Health Agencies servicing ABI, Autism, CHC and PCA Waiver clients should refer to the Home Health Claim Submission Chapter 8 for related services.**
	School Based Child Health Services	**TR** – School based IEP Out-of-District **NOTE:** On paper claims for Medicare coinsurance and/or deductible, the Medicare procedure codes and modifiers must be entered, if any. Modifier must match Medicare EOMB when they are the primary payer.

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**Paper Claim Field No. and Name		Description
24E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 on the claim form. When multiple services are performed, the primary reference letter for each service should be listed first. The reference letter(s) should be A – L or multiple letters as applicable. Alpha characters only are accepted. Note: N/A for ABI, Autism, CHC, PCA, MHW Service providers and School Based Child Health claims. **DDS Specialized Services – Nursing Facility Residents** Providers should enter applicable diagnosis. If unknown, use diagnosis code F79. **Mental Health Waiver Fiscal Intermediary** – Provider must enter the diagnosis code reference letter of the primary diagnosis code from Table 10 recorded in field 21. If additional diagnosis codes are applicable to the service detail line, enter the corresponding diagnosis code reference letters, up to 4 per line detail.
24F.	$ CHARGES	Enter the usual and customary charge for the procedure indicated. **NOTE:** When the same services were performed on consecutive days, enter the total charges for all services performed within these consecutive days.
24G.	DAYS OR UNITS	Enter the number of days or units for each service provided. **NOTE: ABI, Autism, CHC, Mental Health and PCA Waiver Service Providers:** Units billed within the spanned dates of service cannot exceed the number of units allowed within the frequency of the service billed as noted on the care plan. To access the client's care plan, log on to your secure Web account at www.ctdssmap.com, click on Prior Authorization, Prior Authorization Search. **NOTE:** When submitting claims for consecutive days, where the unit increment equals one per day, the number of units must be equal to the number of days billed in Field 24A. **NOTE: Mental Health Group Home and Private Non-Medical Institution Services:** Enter 1 unit for each month of service provided. **NOTE: DMHAS Services:** Enter 1 unit for any billable service provided during the month. **NOTE: TCM\CMI Private Fee for Service**: 12 units of 15 min increments allowed per month without PA. Note: Services less than 8 minutes are not billable units. **NOTE: DMHAS BHH Billing Provider:** Enter 1 unit per month for monthly case management services.

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**Paper Claim Field No. and Name		Description
24H.	EPSDT FAMILY PLAN	Not required.
24I.	ID. QUAL.	ABI, Autism, CHC, MHW and PCA Service Providers: Not Required When rendering/performing provider NPI is required, this field (shaded area) must contain the three-character taxonomy qualifier (PXC). Allied for ABI, Autism, CHC, CFC and PCA Self Directed Services: Required When a Social Security Number or non-medical provider identifier (NPI) is provided in field 24J, this field (shaded area) must contain the two-character taxonomy qualifier (G2).
24J.	RENDERING PROVIDER ID. #	Enter the performing provider's taxonomy in the **shaded** area of field 24J. (Taxonomy is not required for non-medical providers who are not required to have an NPI and are not enrolled with Gainwell Technologies.) Enter the performing provider's NPI/Non-Medical Provider Identifier in the **un-shaded** area of field 24J. **ABI, ABI II, Autism, CHC, CFC and PCA self-directed services:** Enter the Social Security Number (SSN) or Federal Employee Identification Number (FEIN) of the performing provider for each line of the claim for which services are submitted. **Mental Health Group Homes:** Not required. **MH Waiver Provider:** Enter the Social Security Number (SSN) or Employer Identification Number (EIN) of the performer for individual recovery assistance (procedure code 1212M). For providers of 1208Z, 1209M, 1397Z or T2029 services who are not enrolled non-medical MHW service providers, a SSN or EIN may be entered, but is not required. **DDS Specialized Services – Clients Residing in a Nursing Facility:** Not required.
25.	FEDERAL TAX ID NUMBER	Not required.
26.	PATIENT'S ACCOUNT NO.	Enter the patient's account number. Providers have the option of submitting up to 12 alphanumeric characters for their own accounting purposes.
27.	ACCEPT ASSIGNMENT?	Not required.
28.	TOTAL CHARGE	Enter the total dollar amount, which is the sum of the charges from each line in Column 24F.

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**Paper Claim Field No. and Name		Description
29.	AMOUNT PAID	Enter the **total** amount paid, if any, by the other insurance carrier(s). Enter the other insurance carrier code(s), payment amount and paid date in Field 9d. Refer to Chapter 5, Section 3 for further third party liability requirements. **NOTE:** Do not enter previous Connecticut Medical Assistance Program or Medicare payments for coinsurance or deductible claims in this field. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Professional claim type.
30.	Rsvd for NUCC Use	Not required.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Enter the signature of the billing provider or designated agent. Enter the date of signature on the claim. For computer generated forms, print the words "computer-generated" in this field. **NOTE:** A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	Not required for ABI, ABI II, Autism, CHC, DDS, Mental Health Group Home, PCA, PNMI, School Based Child Health, and Mental Health Waiver Providers. Employment and Day Supports, and Targeted Case Management Providers: Enter the name and address of the facility where services were performed, if other than home or office.
a.		Not required.
b.		Not required.
33.	BILLING PROVIDER INFO & PH #	Enter the billing provider's name, address with zip + 4 code, and telephone number. PLEASE NOTE: To avoid claim denial, please enter a nine-digit zip code in this field. The address must be the address provided upon enrollment in the Medical Assistance Program.
a.		Enter the ten-digit National Provider Identifier of the billing provider, if applicable Note: Not Required for ABI, ABI II, Autism, CHC, Mental Health, PCA non-medical Waiver services, CFC or CFC S&P Coach Billing Providers Note: Not required for DDS Specialized Services Providers for clients residing in a Nursing Facility.

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**Paper Claim Field No. and Name		Description
b.		When Field 33a contains a NPI, enter the three-digit ID Qualifier “PXC” and the taxonomy of the billing provider or, if applicable, enter the non-medical provider identifier (i.e. the 9-digit AVRS/Medicaid ID). (Qualifier and taxonomy is not required for non-medical providers.) TCM\CMI Private Fee-For-Service Providers must bill with taxonomy 163WC0400X.

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8.25 Procedure Code Listing

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Overview

The following pages contain procedure code lists to be used only when submitting claims for the waiver programs and special services below. For all other waiver programs and special services not included in this section, please refer to Section 8.25 for instructions on accessing the appropriate fee schedule. Providers should review Chapter 7, Medical Services Policy, as applicable to the waiver program or special services for complete information on reimbursement and payment limitations.

Autism Waiver Procedure Code List

*Please note that this list is effective for claims with dates of service prior to January 1, 2018. For a list of applicable procedure codes and rates for services on or after January 1, 2018, please reference the Autism Provider Fee Schedule or Autism Fiscal Intermediary Fee Schedule as applicable. For access to the fee schedule, please refer to section 8.25 Fee Schedules at the end of this chapter.

Procedure Code	Procedure Code Description
1013Z	Interpreter American Sign Language, Per 15 min.
1222Z	Personal Service Installation
1223Z	Two-Way Personal System Ongoing Services
1301Z	Job Coach, Direct Hire, Per 15 min.
1302Z	Job Coach, Agency, Per 15 min.
1303Z	Life Skills Coach, Direct Hire, Per 15 min.
1304Z	Life Skills Coach Agency, Per 15 min.
1305Z	Social Skills Group Per 15 min.
1306Z	Specialized Driving Assessment
1397Z	Assistive Technology
1398Z	Personal Support, Direct Hire, Per 15 min.
1399Z	Personal Support Agency, Per 15 min.
1402Z	Respite, Facility Based
1404Z	Respite, Agency, In Home, Individual, Per 15 min.
1405Z	Respite, Direct Hire, Individual Per 15 min.
1406Z	Respite, Agency Out Of Home, Per 15 min.
1407Z	Respite, Direct Hire, Indiv Per Diem
Procedure Code	Procedure Code Description

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5151C	Individual Respite Direct Hire In Home; Per Diem
5151D	Individual, Respite Agency, In Home; Per Diem
5151E	Individual, Respite Direct Hire, Per 15 min.
9768Z	Community Training Homes Level A, Per diem
9769Z	Community Training Homes Level B, Per diem
9770Z	Community Training Homes Level C, Per diem
H2019	Therapeutic Behavioral Services, Per 15 min.
S0209	Wheelchair Van, Mileage, Per Mile
S0215	Non-Emergency Transportation, mileage per mile
T1013	Sign Language or Oral Interpretive Services, Per 15 min.
T2003	Non-Emergency Transportation Encounter/Trip
T2025	Waiver Services: Not Otherwise Specified
T2030	Live In Care Giver, Per month

DDS Specialized Services for Clients Residing in a Nursing Facility
Billable Services and Restrictions

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Procedure Code	Description	Allowed Units	Prior Authorization Required	Diagnosis Restrictions
97537	Community or Work Reintegration Training, per 15 min.	24 per day	Yes, authorized per year of service	If unknown, use F79
T2020	Day Habilitation Waiver, per diem	1 per day	Yes, authorized per year of service	If unknown, use F79
T2021	Day Habilitation Waiver, per 15 min	24 per day	Yes, authorized per year of service	If unknown, use F79
H2019	Therapeutic Behavioral Services, per 15 min.	8 per day	Yes, authorized per year of service	If unknown, use F79
97802	Medical nutrition therapy re-assessment and intervention, per 15 min.	8 per day	Yes authorized per year of service	If unknown, use F79

DDS Waiver Procedure Code List

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Procedure Code	Procedure Code Description	Payable under Program
1200Z	Adult Day Health – Full Day (Non-Medical)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1201Z	Adult Day Health - Full Day (Approved Medical Model Provider)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1202Z	Adult Day Health – Half Day (Less than or Equal to 4 Hrs)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1222Z	Personal Service, Installation	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1223Z	Two-Way Personal System Ongoing Services	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1308Z	Senior Supports, Direct Hire, Per 15 Min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1309Z	Parenting Supports, Direct Hire, Per 15 Min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1310Z	Continuous Residential Supports	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1311Z	Parenting Support Per 1/4 Hour	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1312Z	Senior Supports Agency Per 1/4 Hour	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1315Z	Prevocational Services, Per 15 Mins	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1316Z	Prevocational Services, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1397Z	Assistive Technologies Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1415Z	Family Training-Individual	MFP – IFS/Comp Waiver DDS IFS Waiver
1416Z	Family Training-Group	MFP – IFS/Comp Waiver DDS IFS Waiver
1417Z	Environmental Accessibility Adaptations	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1430Z	Occasional Personal Services-Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver

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Procedure Code	Procedure Code Description	Payable under Program
1431Z	Limited Personal Services - Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver
1432Z	Moderate Personal Services - Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver
1433Z	Extensive Personal Services - Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver
1434Z	Core Assisted Living Services - Per Day	MFP – IFS/Comp Waiver DDS Comp Waiver
1501Z	Peer Support Agency, Per 15 Minutes	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1502Z	Peer Support Individual, Per 15 Minutes	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1503Z	Training and Counseling Services for Unpaid Care Givers, Per Month	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
1504Z	Shared Living, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
2021T	Group Supported Employment, extra hours, per 15 min	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
2025Z	Other Goods And Services	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
97535	Self-Care Management Training	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
97537	Community Work Reintegration Training	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
9764Z	DDS Residential Habilitative Services	MFP – IFS/Comp Waiver DDS Comp Waiver
9768Z	CTH-Level A (Less then 24-Hour Supervision)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
9769Z	CTH-Level B (24-Hour Supervision) (End dated 12/31/2019)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
9770Z	CTH-Level C (Ongoing, Comprehensive Care) (End dated 12/31/2019)	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
H0045	Respite Care Services not in home, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver

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Procedure Code	Procedure Code Description	Payable under Program
H2019	Therapeutic Behavioral Health Services, Per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S0209	Wheelchair Van	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S0215	Non-Emergency Transportation, mileage, Per mile	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S0316	Follow-up/Reassessment	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S5135	Adult Companion Care per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S5150	Unskilled Respite Care, per 15 min	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S5151	Unskilled Respite, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
S9470	Nutritional Counseling, diet	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T1013	Sign Language or Oral Interpretive Services, Per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T1019	Personal Care Services per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2003	Non-Emergency Transportation Encounter/Trip	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2018	Habilitation, Supported Employment, Waiver, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2019	Habilitation, Supported Employment, Waiver, Per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2020	Day Habilitation, Waiver, Per Diem	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2021	Day Habilitation, Waiver, Per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2025	Individual Goods and Services	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2029	Specialized Medical Equipment, NOS, Waiver	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver

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Procedure Code	Procedure Code Description	Payable under Program
T2030	Live in Care Giver	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2039	Vehicle Modifications, Waiver, Per Service	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver
T2040	Financial Management, Self-Directed, Waiver, Per 15 min.	MFP – IFS/Comp Waiver DDS Comp Waiver DDS IFS Waiver

Employment and Day Support Waiver Procedure Code List

Procedure Code	Procedure Code Description
1200Z	Adult Day Health – Full Day (Non-Medical)
1201Z	Adult Day Health – Full Day (Approved Medical Model Provider)
1202Z	Adult Day Health – Half Day (Less than or Equal to 4 Hrs)
1397Z	Assistive Technologies Per Day
1402Z	Facility Based Respite
1404Z	Respite, Agency, In Home, Individual
1405Z	Respite, Direct Hire, Out of Home, Individual Per 15 Min.
1406Z	Respite, Agency, Out of Home, Individual
1407Z	Respite, Direct Hire, Out of Home, Individual Per Diem
1501Z	Peer Support Agency, Per 15 Minutes
1502Z	Peer Support Individual, Per 15 Minutes
5152Z	Respite, Agency, Rate 1, Group
5153Z	Respite, Agency, Rate 2, Group
5154Z	Respite, Agency, Rate 3, Group

Procedure Code	Procedure Code Description
S5151	Unskilled Respite Care, Not Hospice, Per Diem
5151A	Group, Unskilled Respite Care, Agency Rate 2, Not Hospice; Per Diem
5151B	Group, Unskilled Respite Care, Agency Rate 3, Not Hospice; Per Diem
5151C	Individual, Direct Unskilled Respite Care, Not Hospice; Per Diem

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5151D	Individual, Respite Agency, Unskilled Respite Care, Not Hospice; Per Diem
5151E	Individual Respite Direct Hire In Home per 15 mins
97537	Community/Work Integration
9753A	Individualized Day Support
H2019	Therapeutic Behavioral Services, Per 15 Minutes
1575P	Transportation – Mileage
S0209	Wheelchair Van, Mileage, Per Mile
S0215	Non-Emergency Transportation; Mileage, Per Mile
T2003	Non – Emergency Transportation; Encounter/Trip
T1013	Sign Language or Oral Interpretive Services, Per 15 Minutes
1013Z	Interpreter American Sign Language
T2018	Habilitation, Supported Employment, Waiver; Per Diem
T2019	Habilitation, Supported Employment, Waiver: Per 15 Minutes
T2020	Day Habilitation, Waiver; Per Diem
T2021	Day Habilitation, Waiver; Per 15 Minutes
T2025	Waiver Services; Not Otherwise Specified
2025Z	Other Goods and Services
T2029	Specialized Medical Equipment, Not Otherwise Specified Waiver
T2040	Financial Management, Self-Directed, Waiver; Per 15 Minutes

Targeted Case Management Procedure Code List

Department of Developmental Services/Comp Waiver Program Only

Procedure Code	Procedure Code Description
9780Z	DDS Targeted Case Management

Department of Mental Health and Addiction Services

Procedure Code	Procedure Code Description
2023T	Targeted Case Management - CMI; per week

Behavioral Health Home Procedure Code List

Department of Mental Health and Addiction Services

Procedure Code	Procedure Code Description
T2022	Case Management, Per Month

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Psychiatric Residential Treatment Facility (PRTF) Procedure Code List

Procedure Code	Procedure Code Description
T2048	Behavioral health; long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem

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8.26 Fee Schedules

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Overview

Fee schedules can be accessed on the Connecticut Medical Assistance Program Web site at: www.ctdssmap.com. The following Waiver and Special Services fee schedules are available at this Web site:

- CT Home Care which includes Connecticut Home Care (CHC), including Assisted Living
- Mental Health Waiver Service and Fiscal Intermediary Provider
- Mental Health Waiver Assisted Living Provider
- Acquired Brain Injury Case Management
- Acquired Brain Injury DOS Prior to 09/01/2016
- Acquired Brain Injury Fiduciary
- Acquired Brain Injury II DOS Prior to 09/01/2016
- Acquired Brain Injury Service Provider
- Autism Waiver Fiscal Intermediary
- Autism Waiver Service Provider
- Community First Choice - Assessments
- Community First Choice – Services
- Community First Choice – Support & Planning Coach Provider
- Connecticut Housing Engagement and Support Services (CHESS)
- Local Health Department
- Personal Care Attendant (PCA)
- Special Services, including DDS Specialized Services for Clients residing in a Nursing Facility, Mental Health Group Home*, Private Non-medical Institution (PNMI), and School Based Child Health (SBCH)
- Targeted Case Management Non-Contracted

*Mental Health Group Home providers should refer to the www.ctbhp.com Web site for the HUSKY A fee schedule.

All other Waiver Program and Special Services providers should reference section 8.24 for a procedure code list.

To access your fee schedule from the Connecticut Medical Assistance Program Web site Home page:

1. Click on Provider.
2. Click on Provider Fee Schedule Download.
3. Review the End User License Agreements and select either:
   - I Accept
   - I Do Not Accept

   In order to access the fee schedule, you must accept the end user license agreements.
4. Locate the fee schedule applicable to your taxonomy/type/specialty.

Select the Fee Schedule Instructions quick link for detailed instructions on accessing and using the fee schedule.

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