TO: Connecticut Home Care Service Providers, Home Health Agencies and Access Agencies

RE: Important Claim Processing Update

This bulletin serves to communicate important changes to Connecticut Home Care Program (CHC) claim processing. The following Explanation of Benefit (EOB) messages currently display on claims in a suspended status. This means the claim will not deny for these reasons. The Department of Social Services (DSS) has maintained these edits in a suspended status while the Access Agencies continue to make progress in adding care plans to the portal on the www.ctdssmap.com Web site.

3015 CHC care plan required

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

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

3016 Service not covered under CHC care plan

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

Resolution:
The service is not payable unless the care manager adds the service to the client's care plan, the service authorization is uploaded to the claims processing system with the correct servicing provider NPI or AVRS ID and the provider submits the correct procedure code. Contact the care manager for assistance.

5151 Units exceed frequency units on CHC care plan

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

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

IMPORTANT CHANGES

Effective November 1, 2013, claims that contain these EOB messages will begin to deny. Upon receiving any one of these denials, the CHC Service Provider or Home Health Agency should verify the client's care plan in the portal. If the care plan in the portal does not reflect the plan communicated

via the care manager, please contact the care manager for assistance.

Claim Resubmission

Once the care plan is updated, if the claim was completely denied, the claim can simply be resubmitted via the Web claim submission tool. Providers can resubmit a denied claim by retrieving the claim via the claim search panel and then clicking on the resubmit button at the bottom of the page.

If the claim was partially paid, the paid claim should be adjusted, not resubmitted. A claim adjustment is performed by retrieving the claim via the claim search panel and then clicking on the adjust button at the bottom of the page.