**Connecticut Department of Social Services**
**Medical Assistance Program** **Provider Bulletin 2014-18**
www.ctdssmap.com **March 2014**

**TO:** **Access Agencies and CHC Service Providers**

**RE:** **Care Plan and Claim Submission Changes Under the Connecticut Home Care Program**

This bulletin serves to notify CHC Service providers of changes the Department of Social Services (DSS) will be making to the Connecticut Home Care Program for Elders (CHCPE); these changes are in reference to how services are authorized and will appear on the client's care plan. **These changes will be made through a staggered approach that will occur over April 2014.** As a result, these changes may not be immediately apparent to providers, on all of their client's care plans beginning April 1, 2014.

The following changes are being made to provide more flexibility in the authorization and reimbursement of services which occur outside of the original plan of care.
**Please Note:** These changes are not applicable to all providers as many of the changes are unique to identified services performed under the CHCPE program. Providers should review the following information carefully to ensure appropriate claim submission.

- **Implementation of a new modifier, U2 One Time Only.** This modifier will uniquely identify a care plan service that overlaps with another service order for the same time period. Use of this modifier is retroactive for dates of service **July 1, 2013** and forward for one - time only services that must be added to the client's care plan. Use of the U2 modifier will allow the Access Agency to:

    - Add a one - time only service July 1, 2013 and forward that increases the units or frequency of an existing care plan service without end dating and restarting the service order. As a result, providers will no longer need to recoup their claims in order to have a one - time only service added to the care plan.

    - Add an overlapping service order for a different frequency for the same service currently on the care plan. As a result, a client may have both a weekly and a monthly frequency of the same service on the care plan. Therefore, care plans will no longer be over or under stated, leading to over service or claim denials depending on when the service is provided.

This modifier may be used for all **non-medical** services under the CHCPE program except for the following services, which will **deny** if submitted with a U2 modifier:

- Highly Skilled Chore
- Minor Home Modifications
- PERS Service Installation
- Two-way PERS-ongoing service
- Care Management
- Assistive Technology

When authorized, the **U2** modifier will be associated to a procedure code on the care plan. The U2 modifier will appear in the Prior Authorization (PA) search results under the "Modifier" heading next to the "Procedure Code." The U2 modifier will also appear in the "Modifier" field,

directly under the "Procedure Code" field, when the PA line detail is opened.

**IMPORTANT:** When a one - time only service is authorized, providers must **submit both the procedure code and the U2 modifier on the claim** when billing a one - time only service.

- **Unique Procedure Code and Procedure Code with Modifier Lists** are being added for the following services:

  - **Meals**
  - **Adult Day Care**
  - **Adult Family Living/Foster Care**

The following lists will allow for greater billing flexibility when the services provided must be modified due to changes in the client's circumstances, resulting in a change or frequency of service. The following lists are retroactive for dates of service July 1, 2013 and forward:

**Meals Service**

| Service Description | Procedure List Code = **970** |
|---|---|
| Single Meal | 1218Z |
| Double Meal | 1220Z |
| Kosher Meal | 1221Z |

**Meals One Time Only Service**

| Service Description | Procedure/Modifier List Code = **ML** |
|---|---|
| Single Meal one - time only | 1218Z U2 |
| Double Meal one - time only | 1220Z U2 |
| Kosher Meal one - time only | 1221Z U2 |

**Adult Day Care Service**

| Service Description | Procedure List Code = **971** |
|---|---|
| Full Day – Non-Med | 1200Z |
| Full Day - Medical | 1201Z |
| Half Day | 1202Z |

**Adult Day Care One Time Only Service**

| Service Description | Procedure/Modifier List Code = **AD** |
|---|---|
| Full Day Non-Med one - time only | 1200Z U2 |
| Full Day Med one - time only | 1201Z U2 |
| Half Day one- time only | 1202Z U2 |

**Adult Family Living/Foster Care**

| Service Description | Procedure List Code = **972** |
|---|---|
| Level 1 | S5140 |
| Level 2 | 5140X |
| Level 3 | 5140Y |
| Level 4 | 5140Z |

**Adult Family Living/Foster Care One - Time Only Service**

| Service Description | Procedure/Modifier List Code = **FF** |
|---|---|
| Level 1 - one - time only | S5140 U2 |
| Level 2 - one - time only | 5140X U2 |
| Level 3 - one - time only | 5140Y U2 |
| Level 4 - one - time only | 5140Z U2 |

When services are authorized using a list, the **"list code"** will appear on the care plan. The "list code" will be found in the

PA search results under the "Procedure Code/List" or "Proc/Mod List" heading. The "list code" will also appear in the applicable Procedure Code/List or Proc/Mod List" field when the PA line item detail is opened.

**Please Note:** Services authorized using a Procedure Code or Procedure Code with Modifier list allows the provider to bill any service within the associated list **as long as the list code appears on the care plan.**

Providers must bill their claim with a Procedure Code or Procedure Code and modifier associated with the "list code" authorized on the care plan. **Providers should not submit the list code on their claim.**

Meal, Adult Day and Foster Care services may continue to be authorized by Procedure Code or Procedure Code with the U2 modifier. As a result, **only that procedure code or procedure code modifier combination may be submitted on the provider's claim.**

**Addition of TT – Subsequent Client Modifier**

**This modifier is being added to allow service to a second client in the home when the service is already being provided to another client. Use of the TT modifier is not restricted by procedure code. However, the procedure code on the care plan must contain the TT modifier and the TT modifier must be on the claim, in order for the provider to be reimbursed for the service provided to the subsequent client.**

**Methods of Claim Submission**

Providers have a variety of claim submission options available to them including securing the services of a clearing house or billing service to submit their claims to HP.

Depending on the Method of claim submission, Provider's should refer to the following information for placement of the **U2 modifier** on their claim:

**Electronic Claims – Vendor Software**

Providers currently submitting claims in the HIPAA 5010 X12 837 Professional format should contact their vendor who currently supports the ASC X12 837 Professional 5010 format. Placement of the modifier should be in Loop 2400, Segment SV01-3 of the 837 Professional 5010 format.

Providers who wish to submit their claims electronically should contract with a vendor who currently supports the ASC X12 837 Professional 5010 format.

Providers and/or vendors who wish to obtain the electronic claim specifications must purchase the Implementation Guide which contains the CMS HIPAA Transaction Specifications. As these specifications are not proprietary to HP, vendors must purchase the guide from the WPC Washington Publishing Company Web site at www.wpc-edi.com.

**Web Based Claim Submission**

Providers who currently submit their claims via the web will enter the modifier directly below the procedure code. To learn more about submitting web claims, refer to the "Instructions for Submitting Professional Claims" document which can be found on the provider's secure Web

account by clicking on Claims > Professional > and selecting the "Instructions for Submitting Professional Claims" link under "Quick Links."

Providers wishing to submit their claims via the web must have a secure Web account. A secure provider Web account is accessed via the secure site link located on the www.ctdssmap.com Web site.

Enrolled "CHC Service Providers" can easily submit claims directly to HP using the professional format under the claims menu of their secure provider Web account. For further information, providers should review Chapter 10 of the provider manual, section 9 for secure web account set up and section 10 Web claim submission. The provider manual is located on the www.ctdssmap.com Web site by clicking on Publications and scrolling to Provider Manuals, Chapter 10.

**Paper Claim Submission**

Providers who submit their claims on paper must use the 1500 CMS claim form. **Please Note:** Effective April 1, 2014, HP will only accept version 02/12 of the CMS-1500 claim form. Modifiers must be entered in field 24 D which is directly to the right of the procedure code. For more information on billing paper claims, providers should refer to Chapter 8 of the CHC provider manual located on the www.ctdssmap.com Web site. From the Home page, select Publications > Provider Manuals > Chapter 8 > Connecticut Home Care > View Chapter 8.

**Please Note:** Reimbursement for claims submitted on paper can take up to 45 days to process. It is highly recommended that providers who are currently submitting claims on paper consider a more efficient option for obtaining reimbursement for services such as the Web for interactive claims submission or vendor software for batch claim submission. Providers may also choose to secure the services of a clearing house or billing service.

**Provider Electronic Solutions Software**

**Effective October 1, 2014, Provider Electronic Solutions software will no longer be available to providers and will not be supported by HP.** Providers who currently use this software must be in the process of choosing an alternative method of claim submission. **Please Note:** Web claim functionality is similar to that of the Provider Electronic Solutions software with the added benefit of knowing immediately if the claim will pay or deny. HP is currently in the process of identifying and assisting providers who are currently using Provider Electronic Solutions Software in the transition to Web claim submission. Providers needing further assistance in the transition process should not hesitate to contact our Provider Assistance Center.

**Future Changes**

Additional changes are being developed to allow the Access Agency to make retroactive changes to the care plan without requesting that the provider recoup their claims. For example, one modification that is expected to be implemented later this year is when a client is hospitalized and the care plan needs to be terminated and then resumed upon the clients' return home.

A PA mass adjustment process will be implemented that will allow retroactive care plan changes to be made to a PA (service order) with claims processed

against it. The mass adjustment process will systematically adjust claims when a PA (service order) has been updated. As a result, claims paid to a provider when the client was hospitalized or out of the community, will be recouped.

Until this mass adjustment process is implemented, providers will continue to be required to recoup claims inappropriately paid due to periods of non-service. **Inappropriately paid claims or details on a paid claim can easily be recouped or adjusted via the provider's secure Web account.** Providers should select claims, claim inquiry and enter the 13 digit ICN of the paid claim. If the entire claim must be recouped, providers should scroll to the bottom of the claim and select the blue button for the option to void the claim. If the claim is to be adjusted, providers should delete the service line details on the claim corresponding to the periods of non-service, scroll to the bottom of the claim and select the blue button for the option to adjust the claim. In cases where the dates of service on the care plan exceed the period of non-service, the Access Agency should add an external note to the care plan. The external note should clearly indicate the periods of non-service to eliminate further claims being inappropriately submitted by the provider.

**Please Note:** For additional information on performing web claim transactions, providers should refer to the "Instructions for Submitting Professional Claims" document. This document can be found on the provider's secure Web account by clicking on Claims > Professional > and selecting the "Instructions for Submitting Professional Claims" link under "Quick Links."

**Provider Training**

HP will be offering Virtual Room Workshops in early April to assist providers with questions regarding the above noted changes. Providers should look for invitations to these workshops in the mail or on line at www.ctdssmap.com.

**From the Home page:**

- Select Publications, scroll to Forms > Workshop Registration Forms > CHC Service Provider Care Pan and Claim Submissions Workshop

  Or

- Select Provider Services, then Provider Training, and click "here". Scroll to the workshop schedule where providers can register online.

**Ongoing Communications**

- Under **Important Messages,** providers should click on the "Welcome to the CT Home Care Program Implementation" link. Scrolling to the provider training section of the document offers information on how to register for a workshop or how to obtain a copy of a past workshop presentation.

  **Please Note:** The **"**Welcome to the CT Home Care Program Implementation**"** link will be updated with the latest changes and communications regarding the CT Home Care Program as they become available to provide a one stop resource for CT Home Care Program Information. Providers should make a point of checking this message for future updates.