South Carolina Care Call

Users' Manual

Case Managers

**Community Long Term Care
Department of Health and Human Services
State of South Carolina**

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Section 1 – Introduction

The South Carolina Division of Community Long Term Care (CLTC) has developed User's Manuals to provide instruction and reference for providers who use Care Call. These manuals are available from the link labeled Care Call Manuals on the Care Call website at https://scc.govconnect.com. These manuals coupled with training provided by CLTC and careful attention to the instructions on both the Interactive Voice Response System (IVRS) and each web screen enable providers to perform Care Call's routine functions.

If questions remain after review of the User's Manual, contact CLTC via email at carecall@scdhhs.gov or by phone at 803-898-2590.

1.1 Background

The Care Call system is an automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. For documentation of case management, providers call a toll free number to document service delivery. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

1.2 How does Care Call Work?

Care Call is based on simple principles.

1. The case manager performs the required case management service.

2. The case manager uses a touch-tone phone to call the toll-free Care Call number to record the service provided.

3. From that IVR entry, Care Call generates a claim that is submitted electronically to MMIS for processing.

4. Claims are submitted for processing weekly on Sunday. Payment is made directly to the provider.

5. The provider uses the web to run reports that monitor services being provided, claims submission and payment by MMIS.

1.3 New or Improved Features in 2008

Each of these new or improved features is discussed in detail in this manual.

▪ Provider section for providers to enter address, phone number, fax number, and e-mail address.

- Claims resolution will be done via the web by the provider entering the required information regarding a missing claim. CLTC staff will review and resolve and the provider will be able to review the outcome of each claim resolution.

- Worker information will be managed via the web. Using Care Call, providers will register (add) a new worker (case manager), terminate a worker and view a worker's strikes.

- Existing reports for providers have been improved and several new reports added to assist in managing claims, authorizations and workers.

Section 2 – Using the Care Call Website

2.1 Getting Started

To use the Care Call Website, the provider needs
1. Access to the Internet,
2. For first time users, their Provider ID, password, and FEIN.
3. For repeat users, their Provider ID and password.

The Care Call website is https://scc.govconnect.com.

The Welcome screen below is the first Care Call screen. The first time the provider uses the website, you must enter your Provider ID in the Provider Log In section under "I am a new user (I need a password)". Press Create Password.

The next screen requires you to enter your CLTC assigned password, Federal Tax ID number, and a new password and then click Continue.

(If you do not know your CLTC assigned password, contact Community Long Term Care at 803-898-2590.)

The next screen indicates you have successfully created a new password and can now use the website. Pressing Continue takes you to the Main Menu.

Please make a note of your password and save it in a safe place. If you lose your password, you must call FDGS Client Services at 1-800-747-1374; press 2 for Client Services.

You will only need to set up your agency as a user one time. In the future, you will enter your ID and password from the Welcome Screen under Provider Log In to access your Care Call information. A provider user can only see information specific to the clients assigned to that provider.

2.2 Maintaining Your Provider Information

On the lower left side of the Main Menu is your Provider Information.

It is the place to record the contact information for your agency. The first time you sign on to the website after April 22, 2008, it will be prepopulated with the information Care Call has in its database for your agency or provider group. Please check the information to assure that it is complete and current.

This information will be used by CLTC to quickly communicate with you and give you information of importance to your agency. Examples include problems with the Care Call IVR System, changes in payment dates and other programmatic information. Please be sure that you keep your contact information updated so you can receive this information quickly.

To add or change any of the information, click on the Edit button. Care Call will allow you to edit each field except the Name field. When you have finished, click on Save and your provider information will be updated on the Menu Screen.

2.3 Adding Other Users from Your Agency

Many people within an agency can use the website. You can create other users at any time from the Main Menu by selecting Add/Edit/Delete Users.

You will see the following screen:

This screen lists each person at your agency who is able to use Care Call via the web and a blank line for you to add another by entering his name and password.

Considerations with this screen:
- Checking Admin allows the worker to create other users, do claims resolution, manage workers and run reports. It is important to remember that when you give a worker administrative rights, that worker can update the information for all other workers in your agency. Only give these rights to workers in your agency who need them.

- If the worker only needs to run reports, do not check Admin.
- When a worker no longer needs access to Care Call, use this screen to terminate their password and Care Call access. If the user leaves your agency, they will still have access to your information unless you terminate their password.

Click Continue to view the changes you have made to web users. Then, on this screen, click Accept to save your changes.

Confirm Changes

EXIT →

Select "Accept" to save any changes or select "Edit" to go back to the previous screen to make additional changes.

Admin	Name	Provider ID	PWD	Verify PWD	Terminate
☑	Maxine Jones	MJ2345	floyd4		☐
☑	Christopher Daley	CD6665	1bosco		☑
☑	Jo Ann Jax	JAJ946	charles8	charles8	☐
☑	James Newuser	JN0919	mentor1	mentor1	☐

Edit   Accept

When training your agency's users, please assure that they understand what functions they are authorized to perform on the web and that their status (admin or not) determines the screens that are displayed when they log in to Care Call.

Section 3 – Managing Workers

Providers must use the web to add new workers (case Managers), and terminate workers. They may also view a worker's strikes

To use the Care Call Website, the provider needs
1. Access to the Internet,
2. Their Provider ID and password
3. Information on their worker(s)

The Care Call website is https://scc.govconnect.com.

On the Welcome page, complete your provider log in:

When you log in, you are automatically taken to the Main Menu, click on Worker Registration/Termination.

3.1 Existing Workers

From the Main Menu, the user will first access the Provider Worker Edit screen seen below:

When first viewed, all the provider's workers will be sorted by Worker ID. You can use the arrows by the worker's last name to change this so that workers are listed alphabetically rather than by Worker ID.

Highlighting a worker line displays that worker's information on the bottom of the screen for editing. The provider can edit the worker's services, termination date and check/uncheck the Nurse Supervisor box. To save your changes, you click on the Continue button after editing. You will be given an opportunity to verify and confirm your changes before completion.

Note: If the worker changes his/her name, the provider must contact the CLTC office to have that change made in Care Call.

3.2 Rehiring a Worker

Highlight the worker line that will cause the worker's information to be displayed on the bottom of the screen. Delete the worker's termination date and save your changes. You will see that the worker is now active again.

Rehired workers will not have the 30-day grace period for strikes given to new workers. Any existing strikes that are still current will still apply.

The worker's gap in service will not be recorded in Care Call. This must be documented in your agency's records.

3.3 Adding a Worker

If you want to add a new worker, click on the Add Worker button at the bottom of the Provider Worker Edit screen above and the Add a New Worker screen below appears:

If the Provider ID logged in is not a Group Provider ID, the Worker ID field will pre-populate the first four characters of the Worker ID. Complete at least the fields with an asterisk for the new worker. Clicking on Continue saves the worker information added. By clicking on Add, you can add as many workers as you wish before clicking on Continue to save them all. You will be given an opportunity to verify and confirm your entries before completion.

All new workers have a 30-day grace period for strikes. That grace period begins the day the worker is registered and Care Call registration is effective immediately. Therefore, it is best that you not register the worker in Care Call until he/she has a client and is ready to perform services.

3.4 Verify and Save Worker Information Changes

As noted above, clicking the Continue button after adding or editing worker information brings you to the Verification page. The page shows worker additions and highlights information changes in red for you to review. If there is an issue with the changes, click Cancel to go to the previous screen and continue editing. If you are done, click Submit to save the information into Care Call.

Once the information is successfully saved to Care Call, you will see the Confirmation screen:

This screen can be printed to keep a record of all changes and additions.

3.5 View Worker Strikes

If you want to view the strikes for the worker on the highlighted line, click on the Strikes Against Worker button on the Provider Worker Edit screen:

You will then see a screen that reflects the strikes for the worker selected.

Section 4 – Entering Claims Using the IVRS

To use the Interactive Voice Response System (IVRS) (Care Call Phone System), the case manager needs
1. Access to a **touch-tone** telephone,
2. Their Worker ID number,
3. The client's CLTC number.

The Care Call telephone number is **1-888-978-2273**.

Sample script with no errors:

Care Call	Case Manager Response
Welcome to the South Carolina Care Call Voice Response System. To continue this call in English press 1.	**Press 1**
To check-in, press 1. To checkout, press 2.	**Press 1**
Please enter your eight-digit South Carolina Care Call Worker ID. To return to the main menu press the pound (#) key.	**The correct 8 digits are pressed**
You have entered **(the agency the case manger works for and case manager's name will be spoken)**. If this is correct, press 1, otherwise, press 2.	**Press 1**
Please enter the client's seven-digit CLTC number. **(Care Call will skip if calling from a telephone number that is authorized for the client.)**	**The correct 7 digits are pressed**
You have selected to provide services for **(client's name is spoken)**. If this is correct, press 1. If this is not correct, press 2.	**Press 1**
If the service is Case Management, press 1.	**Press 1**
You have selected Case Management, if this is correct, press 1, if this is not correct, press 2.	**Press 1**
For: ▪ Monthly Contact, press 1 ▪ Quarterly Visit, press 2 ▪ Re-evaluation Visit, press 3 ▪ Initial Visit, press 4	**Press the correct number**
You have entered **(sub service selected above)**. If this is correct, press 1, if this is not correct, press 2.	**Press 1**
(The Case manager's name and agency name are repeated) You are providing **Case Management** for **(the client's name**	**Press 1**

is repeated). If this is correct, press 1. If this is not correct, press 2.	
Your check-in is successful at (time). To end this call press 9.	

It is very important to hear "Your check-in is successful" before hanging up the phone. This phrase indicates your call was successful and claims will be submitted to MMIS for payment.

If you encounter any problems using the system, send an e-mail to carecall@scdhhs.gov.

Section 5 – Claims Resolution

Providers must use the web to add claims as allowed by CLTC policy that were not entered timely via the IVRS. Claims resolution can be done for dates of service back one calendar year. Providers should check the claim information carefully before submitting resolutions to complete any changes or edits to each claim since the resolution for any claim can only be submitted one time.

To use the Care Call Website, the provider needs
1. Access to the Internet,
2. Their Provider ID and password
3. Information on missing claims

The Care Call website is https://scc.govconnect.com.

On the Welcome page, complete your provider log in:

When you log in, you are automatically taken to the Main Menu, click on Submit Resolutions and Old Claims.

From the Main Menu, the user will first access the Resolution Search screen seen below:

The provider ID will be pre-populated unless a Group Provider ID has been used to log in. If a Group Provider is logged in, the user must select one of the Provider ID's in the Group from the dropdown box. The user also must select the appropriate service from the drop down box.

When you click on the Add Resolution button, the Add Old Claim(s) CM screen appears:

Provider Add Old Claim(s) CM

Instructions: Enter claim information in the blanks. To enter additional claims, click the "Add Claim" button to add additional lines for new claims. When all of the claims have been entered, click "Continue" to verify the claim information.

EXIT →

Case Management

Provider: EX0887

Enter the claim information below.

CLTC #	Worker ID	Service	Date of Service	Reason	Action
1234567	81818181	....		....	....
Jones, Mary	Farmer, Gayle		📅 Calendar	1 - Care Call Not Functioning	
				2 - Client Terminated	
				3 - Worker Forgot to Call	

Calculate T   d Claim

Cancel   Continue

To add a claim, you must enter the following information:
- The client's CLTC #,
- The Case Manager's Worker ID,
- The type of service (from the drop down)
  - Monthly Contact
  - Quarterly Visit
  - Re-evaluation Visit
  - Initial Visit:
- Date of Service
- Reason
  - Care Call Not Functioning
  - Client Terminated
  - Worker Forgot to Call
- Action
  - Blank (claim will not be submitted). If you are not sure whether or not this claim should be submitted, you should leave the action blank.
  - Submit

If there are additional claims to add, click on the Add Claim button for each additional line needed. Clicking the Calculate Total Claims button will display the number of clients you indicated received service with Submit selected as the Action.

When you have finished adding claims, click Continue and you will see the screen below which allows you to verify the claims that were added.

Note that a claim added through this resolution process is not assigned a claim number until reviewed and accepted by CLTC. If the information on this screen is not correct, you can click the Edit Changes button to revert to the Add Resolutions screen for additional changes.

When you click on Submit, you will see the confirmation screen. This screen can be printed for your records.

The CLTC regional office will be automatically notified through Care Call when you submit resolutions to be processed. They will research the resolution to determine whether to accept or reject and whether or not to add a strike. Strikes will be given in all cases up to the limit when the resolution is not submitted timely. The screen above shows whether it is timely or not.

You can check on the status of the processing of the Resolutions by running a Resolutions report for the date(s) of service. If a Resolution is accepted by CLTC, the claim will then appear in the regular claim reports. This report is described in more detail in Section 6 of this manual.

Section 6 – Reports

Included in Care Call are multiple reports that providers can use to review and manage their activities. These reports are accessible via the web at any time and contain real-time, current information that can be displayed in four different formats: HTML, Excel, Word or PDF.

To use the Care Call Website, the provider needs
1.   Access to the Internet,
2.   Their Provider ID and password

The Care Call website is https://scc.govconnect.com.

On the Welcome page, complete your provider log in:

When you log in, you are automatically taken to the Main Menu screen where each report type is listed.

Main Menu

Instructions: Select a menu item below.

EXIT →

Administrative Functions
Administrator Access Only

-- Add/Edit/Delete Users
-- Worker Registration/Termination
-- Submit Resolutions and Old Claims

Provider Information
Select Edit to change

Name:
eMail1:
eMail2:   You need to ensure that this
Phone1:   information is accurate, complete
Phone2:   and updated.
Fax:

Edit

Create Report Template

Activity Reports
-- Client Activity
-- Provider Activity
-- Authorized Services - Exceptions

Provider Reports
-- Billing Invoice
-- Remittance Advice
-- Provider Schedule
-- Time & Attendance
-- Preliminary Invoice
-- Resolutions

Worker Reports
-- Workers by Provider
-- Infractions by Worker
-- Worker SSN Check

Service Quality Reports
-- Open Authorizations
-- Unauthorized Phone Number
-- Overlapped Claims

Select the button below to view previously run reports or execute previously created report templates.

View Reports

Select the report you want to run by clicking on the title or click on the View Reports button if you want to see a previously run report or display a previously created report.

If you click on a specific report, the next screen displayed will be the Report Filtering and Sorting screen. Most reports have a filtering and sorting screen like the one shown below.

Report Filtering & Sorting
Activity and Provider Reports

Instructions: Select or enter the filtering and sorting options below then click "Run Report" to generate the report. See the Online Instructions for a detailed explanation of these options.

By this screen, a user can specify a date range or specific values to be matched in the Care Call database for inclusion in the report. Depending on the report, uses have a Detail, Summary or List View of the report data. On most reports the user can select custom record sorting (though users should b aware that grouping in the reports overrides the sort criteria).

NOTE: Some reports have their own unique Filtering and Sorting screen that may be different from the example above. Users must pay careful attention to the available criteria as well as the View formats listed for the report.

After selecting your report criteria, you can Save as a Template, Run a Report or Save and Run. When you make your selection, a screen similar to the one below will appear:

On the left side are any Report Templates you have saved. Many users find this feature helpful if they need to routinely run reports with the same filter and sort criteria. You can also edit parts of the report, such as the date range or worker ID. Click on the name of the template to open and run it.

On the right, are the reports in progress and reports that have been run in the last three days. The first one on the list, when you first access this screen will show the Status as "in process" and the Status will change to complete when the report has collected the data you specified and is ready for your review. Click on the appropriate icon for the report to open the report for viewing, saving to your hard drive or printing. From this page, the user can return to the Main Menu or Exit Care Call.

This manual will provide a brief description of the reports available to providers. Only by using them can the provider determine which best meet his needs and obtain the full benefit from the robust reporting capabilities Care Call offers. It is important to remember that reports are available on demand (unless otherwise noted) and contain current, up-to-the minute information.

6.1 Client Activity Report

Known as the "core report", the Client Activity report contains all services provided in a given time period, specifying the overall picture of the service that was provided from the time the worker arrives at the client's site through submission of the claim and payment to the worker or Agency. It includes all relevant information related to the service delivery (worker, client, units, date/time and any exceptions). The report can be grouped and sorted using several different criteria including case manager, client, worker and date of service.

6.2 Exception Report

This report displays claims for which exceptions are indicated. The user may select all exceptions or any subset of exceptions for all or any subset of services. Included in the report is the ability to list missed visits or the absence of a claim for a visit that was authorized and should have been made. Exceptions are used to readily identify claims that do not meet the business rules established by CLTC for the program. Exceptions are discussed in more detail in the last section of this manual. Case Management can only generate A1, G and I exception codes.

6.3 Unauthorized Phone Number Report

This is a separate report listing all exceptions where the number called by the worker does not match any of the authorized numbers in Care Call.

An integral component of Care Call program is the use of caller ID to track telephone numbers used by workers when performing in home or community based care. If the calls are made from the phone number associated with the client, there is validation that the worker was actually in the home or appropriate setting at the time the calls were made. If the calls are made from a number other than the home, there are concerns that the care was not provided at all or the length of time spent in the home performing the service is not valid. This report will indicate if the call was made from a number recognized by Care Call, but not authorized for that client. For example, if a check-out for one client is made from another client's phone, this information will be included in the report.

6.4 Resolutions Report

The Resolutions Report shows claim resolutions submitted by providers along with CLTC status and disposition. It is used to view and check status of claim corrections and any strikes that have been assessed as a result.

6.5 Preliminary Invoice Report

This report is designed to provide detailed information about claims that were and were not submitted to MMIS for processing. It includes
- Claims that were submitted to MMIS for processing and payment, regardless of when they were entered into Care Call.
- Claims entered since the last claim submissions that were not submitted to MMIS due to some critical exception condition.

This report is made available via the web every Sunday. This replaces the e-mail report that providers have been receiving. **It is important that you run this report each week if you want to have the preliminary invoice information.   A history of this report is not maintained on the web; only the current report is available.**

6.6 Billing Invoice Report

This gives a list of claims for each service date, along with the MMIS billing status and amount. With this report, providers have documented what was submitted for payment each week and then monitor the Remittance Advice to ensure that each claim was adjudicated as expected.

6.7 Provider Activity Report (Worker Activity Report)

This report lists by worker all services performed during a given time period and the total dollars billed to MMIS for that worker.

6.8 Open Authorizations

This report lists all open authorizations for the provider user. Open means that the authorization has a Start Date before the selected Date of Service, and the End Date is either after the Date of Service or there is no end date for that authorization. The report includes information about the client, the date authorized, the service, and the authorized units. The report also can display either all open authorizations, or only duplicate pairs of authorizations: authorizations issued, perhaps at different times that overlap on the Date of Service.

6.9 Remittance Advice Report

This report allows the provider to download the electronic remittance advice that is generated by MMIS on a weekly basis.

6.10 Workers by Provider Report

This report lists al workers registered by the provider. It can report either all workers or all active workers. It can be used by providers to determine workers that are employed to provide care.

6.11 Infractions by Worker Report

This report lists strikes that have been entered for registered workers. Providers can use this information when doing performance appraisals for employees and/or to identify the need for progressive discipline.

6.12 SSN Worker Report

This report is designed to allow the State to trace the employment history of a worker by SSN or name across providers. However, it can be used by providers to identify if the worker's SSN is already registered in Care Call. Running this report will indicate how many different times Care Call recognizes the social security number. This indicates if the worker has worked for or is currently working for other agencies.

6.13 Time and Attendance Report

This report lists by worker all services performed during a given time period. It is a useful tool for providers who need to know the revenue billed by a selected worker for a specified time period.

Section 7 – Exception Codes

7.1 Initial Exception Codes

Care Call assigns an Exception Code to a claim that does not meet all the established criteria for a "clean claim". Providers should run Exception Reports routinely to identify and address claims needing resolution to assure that all services provided are submitted for payment in a timely manner.

Because claim data displayed in reports is real time, exception codes can change as the issue is naturally resolved by the system. (Example – When entering claims, the client is not listed so the CLTC number is entered. The claim has an A1 exception because the service if not authorized. If the service becomes authorized, the exception code no longer appears.)

Some exceptions are informational only and will be submitted to MMIS if there are no other issues with the claim (exception with "Yes" in the Submit to MMIS column below). Others (marked "No") cannot be submitted to MMIS for payment until or unless the information on the claim is updated. Updates that can be made by the provider using are specified in the Claims Resolution Process section of this manual.

Others exceptions that prevent submission for payment are resolved when additional information is given to Care Call. There include:
- A1 – No authorization to match service delivery. The provider should contact the CLTC office if you believe the exception is not warranted. CLTC can add an authorization to cover the visit if warranted.
- I2– Worker is not registered. The provider should register the worker.

Many exceptions are not applicable for Case Managers and are so marked in the Comments column below.

Exception Codes effective April 2008

Symbol	Definition	Submitted to MMIS	Comments
A1	No authorization to match service delivery	No	
A2	Service Not Performed	No	Not applicable
A3	Client is authorized for a different Day	No	Not applicable
A4	Client is authorized for a different service	No	Not applicable
B	Non-authorized service period	Yes	Not applicable
C1	No check-in but checkout exists	No	Not applicable
C2	No checkout but a check-in exists	No	Not applicable
D	Daily units provided less than units authorized	Yes	Not applicable
E	Daily units provided exceed units authorized	Yes	Not applicable
F	Weekly hours worked more than hours authorized	Yes	Not applicable

G1	Check-in and checkout phone numbers do not match authorized	Yes	
G2	Checkout phone number does not match authorized	Yes	
G3	Check-in phone number does not match authorized	Yes	
G4	Check-in and checkout phones match other client or provider	Yes	
G5	Checkout phone number matches different client or provider	Yes	
G6	Check-in phone number matches different client or provider	Yes	
I1	Worker entered is not registered to perform service	No	
I2	Worker is not registered	No	
M	Missing Data	No	Not applicable

7.2 Exception Codes after Claims Resolution Process

As explained in the Claims Resolution Section of this manual, providers and CLTC staff perform claims resolution activities via the web. There are two steps to the process,
1. The provider adds old claims, specifying the reason, and submits it to CLTC for review.
2. After review, CLTC may accept the added claim and submit it for payment or deny the claim.

Using the Resolution report, the provider can review CLTC's determination of these claims:
- If CLTC accepts the provider's addition, it will be assigned a claim number.
- If CLTC denies the provider's addition, the resolution will be marked denied and the claim will not be entered.