



# **South Carolina Care Call**

## **Users' Manual**

# **Children's Day Care Services**

**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, coupled with training provided by CLTC and careful attention to both the instructions on 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](mailto: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 children's day care and services provided in a participant's home, workers call a toll free number upon starting and ending services. 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 care coordinators 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 provider provides a service that has been prior authorized.
2. The provider uses a touch-tone phone to call the toll-free Care Call number.
3. The provider enters the child seven digit identification number. Care Call identifies the child and the services authorized for the child.
4. From that telephone interaction, Care Call generates a claim that is submitted electronically to MMIS for processing.
5. Claims are submitted for processing weekly on Sunday. Payment is made directly to the Provider.
6. The provider uses the web to run reports that monitor services being provided, claims submission and payment by MMIS.

## 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.

**Welcome**

Welcome to the South Carolina Care Call Service Monitoring system. This is a fast, powerful, and accurate system that provides real-time access to information about client care. The online database provides an effective solution to manage information about cases, providers, aides, and client services and ensures that payment is made for only authorized services that have been performed. This system also generates automated billing on a weekly basis based on verified delivery of services.

With this system, you have the ability to do the following:

- Ensure DHHS pays only for services rendered.
- Verify authorized services are provided.
- Produce on-line, real-time reports of services rendered with the ability to produce standardized and ad-hoc reports in a secure, Internet environment. The reports will be available to CLTC staff and DHHS specified providers Internet.
- Create reports for services not delivered as authorized.
- Create weekly provider reports of billed and unbilled activities, missed visits, and reasons for unbilled activities.
- Eliminate opportunities for fraud.

**SC DHHS Links**

- [DHHS Home Page](#)
- [Medicaid Information](#)
- [Provider Information Center](#)
- [Long Term Care Information](#)
- [Medicaid Provider Manuals](#)
- [CLTC Scopes of Services](#)
- [DHHS Telephone Directory](#)
- [SC Access](#)

**SC CLTC Staff Log In**  
(South Carolina DHHS Employees Only)

Enter User ID:

Enter Password:

**Log In**

**Provider Log In**  
Select the item below which applies to you

**I am a REGISTERED USER (I Have a Password)**

Enter Medicaid Provider ID:

Enter Password:

**Log In**

**I am a NEW USER (I Need a Password)**

Enter Medicaid Provider ID:

**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.

**Create Password**

**Instructions:** Enter the password you would like to use for the SC Care Call Service Monitoring System. Password must be 6-8 characters in length. Enter your Federal ID for added security. All fields are required.

**EXIT →**

Create <Provider Name> Password

Enter your CLTC-assigned Password:

Enter your Federal Tax ID Number:

Enter your new Password:

Re-enter your new Password:

**Continue**

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

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

**Success**

**EXIT →**

Your new Password has been successfully created. Please make note of your Password and keep it in a safe place.

**Continue**

**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.

The screenshot shows the 'Main Menu' interface with a dark blue header. Below the header, there are instructions: 'Instructions: Select a menu item below.' and an 'EXIT' button with a right-pointing arrow. The main content area is divided into three columns. The left column is titled 'Administrative Functions' and contains a 'Data Reconciliation' section with links: 'Add/Edit/Delete Users', 'Worker Registration/Termination', 'Enter Missed Visit Codes', and 'Submit Resolutions and Old Claims'. The middle column is titled 'Provider Information' and is highlighted with a red border. It contains the text 'Select Edit to change' and a list of contact information: Name: Alexander, Chris; eMail1: calexander@sccworks.com; eMail2: cra@fuse.net; Phone1: 803-555-1212; Phone2: 803-241-5678; Fax: 803-555-1234. Below this information is an 'Edit' button. The right column is titled 'Create Report Template' and contains three sections: 'Activity Reports' (Client Activity, Provider Activity, Authorized Services - Exceptions, Resolutions), 'Worker Reports' (Workers by Provider, Infractions by Worker, Worker SSN Check), and 'Service Quality Reports' (Open Authorizations, Unauthorized Phone Number, Overlapped Claims). Below these sections is a 'View Reports' button and a note: 'Select the button below to view previously run reports or execute previously created report templates.'

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.

## Main Menu

Instructions: Select a menu item below.

**EXIT →**

### Administrative Functions

**Data Reconciliation**

- Add/Edit/Delete Users
- Worker Registration/Termination
- Enter Missed Visit Codes
- Submit Resolutions and Old Claims

### 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**

### Provider Information

Select Edit to change

Name:

eMail1:

eMail2:

Phone1:

Phone2:

Fax:

You need to ensure that this information is accurate, complete and updated.

**Edit**

You will see the following screen:

## Provider Administrative Functions

### Add or Edit a Provider

**EXIT →**

Add or Edit a Provider By Entering or Selecting the Criteria Below:

Admin	Name	Provider ID	PWD	Verify PWD	Terminate
<input checked="" type="checkbox"/>	Maxine Jones	EX6543	floyd4		<input type="checkbox"/>
<input checked="" type="checkbox"/>	Christopher Daley	EX6543	1bosco		<input type="checkbox"/>
<input checked="" type="checkbox"/>	Jo Ann Jax	EX6543	charles8		<input type="checkbox"/>
<input type="checkbox"/>	<input style="width: 150px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>

**Add**
**Continue**

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, missed visit documentation, 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
<input checked="" type="checkbox"/>	Maxine Jones	MJ2345	floyd4		<input type="checkbox"/>
<input checked="" type="checkbox"/>	Christopher Daley	CD6665	1bosco		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Jo Ann Jax	JAJ946	charles8	charles8	<input type="checkbox"/>
<input checked="" type="checkbox"/>	James Newuser	JN0919	mentor1	mentor1	<input type="checkbox"/>

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 – Entering Claims Using the IVRS**

- When the child arrives at day care, the provider will need to call into Care Call to record the arrival.
- When the child leaves day care, the provider will need to call into Care Call to record the departure.
- Once a call has been made, If the child will be leaving the day care and returning later, eg: medical appointment away from the center, the provider will need to check out when the child leaves; check in when the child return, then check out again when the child leaves for the day.

## Section 4 – Claims Resolution

Providers must use the web to resolve issues with pending claims or to add claims as allowed by CLTC policy. The claims resolution process is only for claims being submitted to MMIS for payment. A provider can only submit a resolution to edit a specific existing claim to CLTC for review ONE time. 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.

Claims resolution can be done for dates of service back one calendar year. However, to be timely, the claim must be for a date of service ten days or less from the date the claim appeared or should have appeared on the Preliminary Invoice Report.

To use the Care Call Website, the provider needs

1. Access to the Internet
2. Use Internet Explorer as the web browser
3. Their Provider ID and password
4. Information on pending/missing claims

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

On the Welcome page, complete your provider log in:

**Welcome**

Welcome to the South Carolina Care Call Service Monitoring system. This is a fast, powerful, and accurate system that provides real-time access to information about client care. The online database provides an effective solution to manage information about cases, providers, aides, and client services and ensures that payment is made for only authorized services that have been performed. This system also generates automated billing on a weekly basis based on verified delivery of services.

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- Verify authorized services are provided.
- Produce on-line, real-time reports of services rendered with the ability to produce standardized and ad-hoc reports in a secure, Internet environment. The reports will be available to CLTC staff and DHHS specified providers Internet.
- Create reports for services not delivered as authorized.
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(South Carolina DHHS Employees Only)

Enter User ID:

Enter Password:

**Log In**

**Provider Log In**  
Select the item below which applies to you

**I am a REGISTERED USER (I Have a Password)**

Enter Medicaid Provider ID:

Enter Password:

**Log In**

**I am a NEW USER (I Need a Password)**

Enter Medicaid Provider ID:

**Create Password**

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

**Main Menu**

Instructions: Select a menu item below. EXIT →

**Administrative Functions**

- Add/Edit/Delete Users
- Worker Registration/Termination
- Enter Missed Visit Codes
- **Submit Resolutions and Old Claims**

**Provider Information**  
Select Edit to change

Name:

eMail1:

eMail2:

Phone 1:

Phone 2:

Fax:

**Edit**

You need to ensure that this information is accurate, complete and updated.

**Create Report Template**

<b>Activity Reports</b>	<b>Worker Reports</b>
-- Client Activity	-- Workers by Provider
-- Provider Activity	-- Infractions by Worker
-- Authorized Services - Exceptions	-- Worker SSN Check
<b>Provider Reports</b>	<b>Service Quality Reports</b>
-- Billing Invoice	-- Open Authorizations
-- Remittance Advice	-- Unauthorized Phone Number
-- Provider Schedule	-- Overlapped Claims
-- Time & Attendance	
-- Preliminary Invoice	
-- Resolutions	

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

**View Reports**

## 4.1 Resolving an Existing Claim

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

**Resolution Search**

Instructions: If you logged in as a Provider Group, select your Provider ID. If you are adding Resolutions for Adult Daycare, Meals or Case Management, select the Service and press "Add Resolution". If you are adding or editing Resolutions for In Home services, select the Service and press "Add Resolution". Then provide a Date of Service range and select "Search." EXIT →

Provider ID:

Select Service:

**Cancel** **Add Resolution**

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 must select the Service. When In-Home is selected, the screen below appears.

### Resolution Search

**Instructions:** If you logged in as a Provider Group, select your Provider ID. If you are adding Resolutions for Adult Daycare, Meals or Case Management, select the Service and press "Add Resolution". If you are adding or editing Resolutions for In Home services, select the Service and press "Add Resolution". Then provide a Date of Service range and select "Search."

**EXIT →**

**Provider ID:**

**Select Service:**

**Date of Service:** From:   To:

You must specify the Date(s) of Service and click on the Search button. Then the Edit Resolutions screen appears:

### Provider Edit Resolutions

**Instructions:** To prepare a claim resolution for an existing claim, make the necessary corrections to Worker ID, Service, and Check-in or Check-out, select a reason, and select the submit action. To remove an existing claim from the list of possible resolutions, select the delete action. To add a claim resolution, enter the claim information in the bottom section of the screen, along with a reason, and select the submit action. Additional blanks for adding claims can be added by pressing the "add claim" button. When all of the desired resolutions have been entered, press the "continue" button to verify the entries.

**EXIT →**

**In Home Services**

Date Range: 12/28/2001 to 01/03/2002  
Provider: EX0887

ID, D.S., Reason	Worker ID	Service	Check in/out (mm:PM am/pm)	Exception / Timely	Reason	Action
D.S.: 01/01/02 Claim: 12245679901 ELTC #: 1224567 Jones, Mary	49390895 Clark, Catherine	PCI	In: 2:20 pm Out: 2:47 pm	22 Yes	.....	.....
D.S.: 01/01/02 Claim: 12245679902 ELTC #: 0465197 Brown, Gene	00493944 Waltz, Dawn	PCI	In: 2:20 pm Out: [ ] [ ] pm	22 No	.....	.....
D.S.: 01/01/02 Claim: 12245679904 ELTC #: 1598754 Alexander, Chris	20498893 Adler, Carol	PCI	In: 3:45 pm Out: 4:45 pm	22 Yes	.....	.....
D.S.: 01/01/02 Claim: 12245679904 ELTC #: 0244135 Kelly, Sandy	20493495 Chuang, Josh	PCI	In: [ ] [ ] pm Out: 2:50 pm	22 Yes	.....	.....
D.S.: 01/01/02 Claim: 12245679905 ELTC #: 9944561 Logan, Mike	30004982 Sandul, Andrew	PCI	In: 3:55 pm Out: 4:55 pm	22 Yes	.....	.....

Date of Service	ELTC #	Worker ID	Service	Check in/out (mm:PM am/pm)	Timely	Reason	Action
<input type="text" value="Calendar"/>	1234967 Jones, Mary	49390895 Clark, Catherine	PCI	In: 02:20 pm Out: 02:47 pm	Yes	.....	.....

The screen will display all existing claims with exception codes that prevent submission to MMIS that match the date(s) of service specified in your search, that have not already been submitted on a previous resolution and that can be corrected through the Claims Resolution process. There include:

- A4 – Client is authorized for a different service. The resolution should be to change the service to the one that is authorized.

- C1 – No check-in but checkout exists. The resolution should be to add a check-in time.
- C2 – No checkout but check-in exists. The resolution should be to add a checkout time.
- I2 – Worker is not registered. There are three possible resolutions:
  - Correct the Worker ID if it is incorrect;
  - Register the worker if it is a new worker that has not yet been registered by your agency; or
  - Delete the claim if it is incorrect.

After editing the appropriate fields, you must specify a reason that the resolution is being submitted. The choices are:

- Care Call not functioning
- Client's phone not available
- Client's phone not functioning
- Client emergency
- Not submitted to MMIS
- Client not in Care Call
- Worker Error

You must then choose the action for each claim. The choices are

- Blank - Take no action. Claim will continue to reappear in this list. If you are not sure whether or not this claim should be submitted, you should leave the action blank.
- Submit - Submit the changes to the claim as a Claim Resolution
- Delete - Do not submit, and remove the claim from this list in the future. An example would be a check-in without a checkout. If the worker has a successful claim for that day, this would be a duplicate claim. Deleting it will prevent seeing it when you do future resolutions.

Click on the Continue button to have the claim saved in Care Call and forwarded to CLTC for review and resolution.

## 4.2 Adding a Claim

There is a blank field at the bottom of the screen where you can enter a new claim that was not added via the IVR at the time the service was provided. Example - You would add a claim if your worker provided services but was unable to check-in or check-out when services were provided, so that Care Call does not have any claim for that service.

Date of Service	CLTC #	Worker ID	Service	Check in/out (HH:MM:am/pm)	Timely	Reason	Action
	11234567	43080885	PD	In: 02:20 pm Out: 02:47 pm	Yes		

Buttons: Cancel, Add Claims, Continue

Adding a claim via the Claims Resolution process must follow existing CLTC policy.

To add a claim, you must enter the following information:

- Date of Service
- The client's CLTC #,
- The Worker ID,
- The type of service (from the drop down)
- The check-in time
- The check-out time
- Reason (from the drop down)
  - Care Call not functioning
  - Client's phone not available
  - Client's phone not functioning
  - Client emergency
  - Not submitted to MMIS
  - Client not in Care Call
  - Worker Error
- Action
  - Leave blank (claim will not be submitted)
  - Submit

If there are additional claims to add, click on the Add Claim button for each additional line needed.

When you have finished updating and/or adding claims press Continue and you will see the screen below which allow you to verify the changes/additions you have made. The changes/additions you made show on the screen in red.

## Provider - Verify Resolutions and Old Claims

Instructions: Review highlighted items. Click "Edit Changes" to return to previous screen and make corrections. Click "Submit" to record the entries in the database.

EXIT →

Service Date Claim #	Submission Date	Provider	Worker ID Name Strike, Removal	CLTC Area, # Client Name	SVC Units	Check In Check Out	Exceptions Reason	Timely
12/10/2007 07121011238	12/18/2007	EX0875	08752433 Smithard, Harriet 0 2/4/2009	14 1456788 Wihood, Henrietta	PC2 1.1	9:48 AM 10:52 AM	C2, J1 Client's phone not functioning	Yes
12/12/2007 0712120452	12/19/2007	EX0875	08752433 Smithard, Harriet 0 2/4/2008	14 1456788 Wihood, Henrietta	PC2 1.1	9:48 AM 10:52 AM	C2 Worker error	Yes
12/10/2007 0712011235	12/19/2007	EX0225	08752422 Smithard, Harriet 0 2/4/2009	14 1422527 Feaster, Ramona	COMA 2.0	2:24PM 4:52PM	A4 Worker error	Yes
12/12/2006 "New Claim"	12/19/2007	EX0875	08752433 Smithard, Harriet 0 2/4/2008	14 1456788 Wihood, Henrietta	PC1 2.0	7:45AM 9:46AM	Not submitted to MMIS	No
12/10/2006 "New Claim"	12/19/2007	EX0225	08752422 Smithard, Harriet 0 2/4/2009	14 1422527 Feaster, Ramona	PC2 2.2	6:02AM 9:10AM	Not submitted to MMIS	No

Edit Changes
Submit

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

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

**Provider - Resolutions and Old Claims Confirmed** EDIT

Resolution Claim #	Resolution Date	Resolution ID	Resolution Status	Resolution Description	Resolution Date	Resolution Time	Resolution Reason	Resolution Status	
12/10/2007 0712101238	12/10/2007	EN0878	08783433	Smithard, Harriet D 2/4/2008	14 1488788	PC2 1.1	9:48 AM 10:52 AM	GL 11 Client's phone not functioning	Yes
12/10/2007 0712101239	12/10/2007	EN0879	08783433	Smithard, Harriet D 2/4/2008	14 1488788	PC2 1.1	9:48 AM 10:52 AM	OS Worked error	Yes
12/10/2007 0712101235	12/10/2007	EN0859	08783432	Smithard, Harriet D 2/4/2008	14 1488787	COMA 2.8	9:24 PM 4:59 PM	AA Worked error	Yes
12/10/2006 "New Claim"	12/10/2007	EN0879	08783433	Smithard, Harriet D 2/4/2008	14 1488788	PC2 2.0	7:45 AM 9:46 AM	Not submitted to NMO	No
12/10/2006 "New Claim"	12/10/2007	EN0859	08783432	Smithard, Harriet D 2/4/2008	14 1488787	PC2 2.2	6:05 AM 9:16 AM	Not submitted to NMO	No

[Click here to print](#)

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 or claim edits will then appear in the regular claim reports. This report is described in more detail in Section 7 of this manual.

## Section 5 – Managing Missed Visits

Providers must use the web to document the reason a child did not attend day care.

To use the Care Call Website, the provider needs

1. Access to the Internet,
2. Their Provider ID and password
3. Information on the missed visit(s)

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

On the Welcome page, complete your provider log in:

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Welcome to the South Carolina Care Call Service Monitoring system. This is a fast, powerful, and accurate system that provides real-time access to information about client care. The online database provides an effective solution to manage information about cases, providers, aides, and client services and ensures that payment is made for only authorized services that have been performed. This system also generates automated billing on a weekly basis based on verified delivery of services.

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(South Carolina DHHS Employees Only)

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Enter Password:

**Log In**

**Provider Log In**  
Select the item below which applies to you

**I am a REGISTERED USER (I Have a Password)**

Enter Medicaid Provider ID:

Enter Password:

**Log In**

**I am a NEW USER (I Need a Password)**

Enter Medicaid Provider ID:

**Create Password**

When you log in, you are automatically taken to the Main Menu, click on Enter Missed Visit Codes.



## Main Menu

Instructions: Select a menu item below. **EXIT →**

### Administrative Functions

**Data Reconciliation**

- [Add/Edit/Delete Users](#)
- [Worker Registration/Termination](#)
- [Enter Missed Visit Codes](#)
- [Submit Resolutions and Old Claims](#)

### 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**

### Provider Information

Select Edit to change

Name:

eMail1:

eMail2:

Phone1:

Phone2:

Fax:

You need to ensure that this information is accurate, complete and updated.

**Edit**

From the Main Menu, the user will first access the Add or Edit a Missed Visit Reason Code screen seen below:

## Add or Edit a Missed Visit Reason Code

Please follow the instructions provided for each step. **EXIT →**

**Search for a claim by entering information in the fields below:**

Search By Date of Service (DOS)	Search By Provider ID:	Search By CLTC #:
<p>Enter DOS:*</p> <p>From: <input type="text"/> <a href="#">Calendar</a></p> <p>To: <input type="text"/> <a href="#">Calendar</a></p> <p style="text-align: center;">*required</p>	<p>Provider ID:</p> <p style="text-align: center;">MJ2345</p> <p style="text-align: center;">*required</p>	<p>Enter CLTC #*:</p> <p style="text-align: center;"><input type="text"/></p> <p style="text-align: center;">*optional</p>

**Back**
**Cancel**
**Continue**

The provider ID will be prepopulated. The user must specify the Date(s) of Service as search criteria. The client's CLTC# is not required.

When you click on the Continue button, the following screen appears:

**Select a Missed Visit Reason Code**

Please follow the instructions provided for each step.

**EXIT →**

Select the Missed Visit Reason Code for <provider name> from the dropdown menu below:

Client Name	CLTC #	Date of Service	Services	Missed Reason
Clark, Catherine	1234567	01/01/2008	PC 1	.....
Wells, Dawn	1234567	01/01/2008	PC 2	Missed Visit Service Interruption Not a Missed Visit
Adler, Carol	1234567	01/01/2008	Comp	.....

**Cancel** **Continue**

It lists all missed visits for the Date(s) of Service specified in your search. You may choose the reason the visit was missed:

- Missed Visit – This should be used if this is truly a missed visit, when the client desired services and the agency was not able to provide them.
- Service Interruption – This should be used when the client is unavailable for services. An example would be if the client is hospitalized.
- Not a Missed Visit – This should be used if Care Call shows a missed visit for a day when the authorization did not indicate services should be provided. This should be used very rarely. Example: The service is authorized for each Wednesday; Christmas falls on Wednesday and your agency has notified CLTC that it will not provide services on that holiday.

Click on the Continue button to have the missed visit reason saved in Care Call.

## 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

4. Access to the Internet,
5. Their Provider ID and password

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

On the Welcome page, complete your provider log in:

The screenshot shows the 'Welcome' page of the SC CLTC Staff Log In system. The page has a blue background and contains the following elements:

- Welcome** header.
- Text describing the system: 'Welcome to the South Carolina Care Call Service Monitoring system. This is a fast, powerful, and accurate system that provides real-time access to information about client care. The online database provides an effective solution to manage information about cases, providers, aides, and client services and ensures that payment is made for only authorized services that have been performed. This system also generates automated billing on a weekly basis based on verified delivery of services.'
- Text: 'With this system, you have the ability to do the following:'
- A bulleted list of capabilities:
  - Ensure DHHS pays only for services rendered.
  - Verify authorized services are provided.
  - Produce on-line, real-time reports of services rendered with the ability to produce standardized and ad-hoc reports in a secure, Internet environment. The reports will be available to CLTC staff and DHHS specified providers Internet.
  - Create reports for services not delivered as authorized.
  - Create weekly provider reports of billed and unbilled activities, missed visits, and reasons for unbilled activities.
  - Eliminate opportunities for fraud.
- SC DHHS Links** section with a list of links:
  - [DHHS Home Page](#)
  - [Medicaid Information](#)
  - [Provider Information Center](#)
  - [Long Term Care Information](#)
  - [Medicaid Provider Manuals](#)
  - [CLTC Scopes of Services](#)
  - [DHHS Telephone Directory](#)
  - [SC Access](#)
- SC CLTC Staff Log In (South Carolina DHHS Employees Only)** form with fields for 'Enter User ID:' and 'Enter Password:', and a 'Log In' button.
- Provider Log In** form with the instruction 'Select the item below which applies to you'. It has two sections:
  - I am a REGISTERED USER (I Have a Password)** with fields for 'Enter Medicaid Provider ID:' and 'Enter Password:', and a 'Log In' button.
  - I am a NEW USER (I Need a Password)** with a field for 'Enter Medicaid Provider ID:' and a 'Create Password' button.

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

### Data Reconciliation

- [Add/Edit/Delete Users](#)
- [Worker Registration/Termination](#)
- [Enter Missed Visit Codes](#)
- [Submit Resolutions and Old Claims](#)



## Provider Information

Select Edit to change

Name:  
eMail1:  
eMail2:  
Phone1:  
Phone2:  
Fax:

You need to ensure that this information is accurate, complete and updated.

**Edit**



## Create Report Template

### Activity Reports

- [Client Activity](#)
- [Provider Activity](#)
- [Authorized Services - Exceptions](#)

### Worker Reports

- [Workers by Provider](#)
- [Infractions by Worker](#)
- [Worker SSN Check](#)

### Provider Reports

- [Billing Invoice](#)
- [Remittance Advice](#)
- [Provider Schedule](#)
- [Time & Attendance](#)
- [Preliminary Invoice](#)
- [Resolutions](#)

### 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 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.

[EXIT →](#)

**1 Select Your Filtering Options (Narrow the Report Details)**

→ Select SERVICE Date or Date Range (For 1 day's information, select the same date for "From" and "To")

From:   To:

→ Select CLTC Area:

→ Enter a Case Manager ID:

→ Enter a CLTC #:  \* At Risk Flag:  \*

→ Select Service:   
Hold down Ctrl key to make multiple selections.

→ Enter a Provider ID #:  \*

→ Enter a Worker ID #:  \*

→ Select an Exception Code:   
Hold down Ctrl key to make multiple selections.

View Details  View Summary Only  View List

\* If any of these fields are left blank, your report will contain all available data for the items you selected.

---

**2 Select the Item(s) By Which You Would Like Your Report To Be Sorted**

Select Sort 1:

Select Sort 2:

Select Sort 3:

---

**3 Give a name and description to the report template**

\* Template Name  Template Description

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, users have a Detail, Summary or List View of the report data. On most reports the user can select custom record sorting (though users should be 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.

Missed Visits are listed on the bottom of the Exception Report.

## 6.3 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.

## 6.4 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. **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.**

## 6.5 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.

## 6.6 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.

## **6.7 Remittance Advice Report**

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



## 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 the worker calls in for a service, that claim carries a C2 exception until the worker calls out and completes the claim. Then the exception is removed.)

Some exceptions do not keep the claim from submitting 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 (such as A1) must be addressed by CLTC.

#### Exception Codes effective April 2008

Symbol	Definition	Submitted to MMIS	Comments
A1	No authorization to match service delivery	No	
A2	Service Not Performed	No	No check-in or checkout performed on authorized date of service. Needs to be addressed as a missed visit.
A3	Client is authorized for a different Day	No	
A4	Client is authorized for a different service	No	
B	Non-authorized service period	Yes	Service authorized for a specific time period of the day but performed outside that time period.
C1	No check-in but checkout exists	No	
C2	No checkout but a check-in exists	No	
D	Daily units provided less than units authorized	Yes	Claim submitted for units provided only
E	Daily units provided exceed units authorized	Yes	Claim submitted for authorized units only
F	Weekly hours worked more than hours authorized	Yes	Claim submitted for authorized hours
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	For Financial Management Service clients only

## 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 updates and/or adds old claims, specifying the reason, and submits it to CLTC for review.
2. After review, CLTC may accept the changed/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 changes/additions:
  - For an existing claim, the exception code can change to AR, CR, IR or MR as appropriate. For example, a claim missing a check-out would change from C2 to CR if CLTC accepts the resolution.
  - For a new claim submitted via the claims resolution process, it will be assigned a claim number.
- If CLTC denies the provider's changes/additions:
  - For an existing claim, the exception code can change to AX, CX, IX or MX as appropriate. For example, a claim missing a check-out where the worker has reached the maximum number of strikes would be changed from C2 to CX.
  - For a new claim submitted via the claims resolution process, the resolution will be marked denied and the claim will not be entered.