



March 2017
Connecticut Medical Assistance Program
<http://www.ctdssmap.com>

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

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- Home Health Providers: Service Authorization Reminder
- All Providers: Fee Schedule Updates for 2017
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Attention Outpatient Hospital Providers

Physician Prior Authorization Required on Outpatient Claims

If prior authorization is required for separately reimbursable professional services associated with an outpatient hospital service and the practitioner has not obtained the required Prior Authorization (PA), the hospital shall not bill for or be reimbursed for the technical component associated with such professional services. To determine whether the service billed requires PA, providers may review the provider fee schedules located at www.ctdssmap.com. The PA field on the fee schedule will indicate which services require a physician PA to allow both the physician and the hospital outpatient claim to be paid.

If PA is required, the hospital should verify that the physician obtained a PA. If the physician did not obtain PA, the service is not payable. If the outpatient claim is submitted with a procedure code that requires a professional PA and there is no PA record on file in an approved status, the service will deny with Explanation of Benefits (EOB) code 3013 "Service Requires a Professional Prior Authorization".

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Attention All Providers

New Eligibility System

Have you come across a client identification (ID) number that begins with 10 instead of the usual 00? You may wonder if it is valid or not. Rest assured, it is a valid client ID. The Department of Social Services (DSS) has started the conversion process to a new eligibility system called ImpaCT. This conversion is scheduled to be done in multiple phases; the completed phases, now complete, include clients associated with the Middletown, Torrington, Hartford, Danbury, and Stamford offices. Existing client ID numbers will not change

as clients are converted to ImpaCT. However, clients who have never applied to the Connecticut Medical Assistance Program (CMAP), and are screened for eligibility in the ImpaCT system, will have an ID beginning with 10. Client IDs will continue to be 9 digits. Please continue to check eligibility prior to providing services.

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Attention Home Health and Access Providers

Reminder to Home Health Agencies ABI, CHC, and PCA Waiver Client Services Must be in the Care Plan

SERVICE AUTHORIZATION REMINDER TO ALL HOME HEALTH AGENCIES: Home Health services rendered to State Funded Connecticut Home Care (CHC) clients and HUSKY A or HUSKY C clients with a Connecticut Home Care (CHC), Personal Care Assistance (PCA) or Acquired Brain Injury (ABI) Waiver are required to be on the client's care plan in the form of a Prior Authorization (PA) for the Procedure Code, Procedure/modifier code list or Revenue Center code (RCC) associated with the service(s) to be provided to the client, regardless if the services to be provided exceed standard benefit. These services include skilled nursing by an RN or LPN, Medication Administration, Home Health Aide, Physical Therapy, Occupational Therapy and Speech Therapy services.

State Funded CHC or HUSKY A or C benefit clients with a CHC Waiver: Effective July 1, 2013, all Home Health services provided to CHC state funded clients or waiver clients must be authorized by the Access Agency managing their care. As a result, all home health services must be on the CHC client's Care Plan in order for Home Health Agencies to be reimbursed for the services provided.

HUSKY A or C clients with PCA Waiver: Effective February 25, 2016, all home health services provided to PCA Waiver clients must be authorized by the Access Agency managing their care. As a result, all home health services must be on the PCA client's Care Plan in order for Home Health Agencies to be reimbursed for the services provided.

HUSKY A or C clients with an ABI Waiver: Effective September 1, 2016, all home health services provided to ABI Waiver clients must be authorized by the Case Management Agency managing their care. As a result, all home health services must be on the ABI client's Care Plan in order for Home Health Agencies to be reimbursed for the services provided.

Community Health Network (CHN) PAs: Services exceeding standard benefit that have been authorized by CHN prior to the above ABI, CHC or PCA effective date or to the client becoming ABI, CHC or PCA eligible must be end dated. A new authorization will be established by the Access Agency (CHC or PCA) or Case Management Agency (ABI) upon service confirmation with the Home Health Agency.

Beacon Health Option (formerly Value Options (VO) PAs: Services exceeding standard benefit that have been authorized by Beacon Health Options prior to the ABI, CHC or PCA effective date or the client becoming ABI, CHC or PCA eligible will be linked to the client's Care Plan by the Access Agency.

Home Health Agencies currently servicing clients at or below standard benefit who become ABI, CHC or PCA eligible must contact the Access or Case Management Agency managing the client's care as soon as possible for confirmation of service so an applicable service authorization can be

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Attention Home Health and Access Providers

Reminder to Home Health Agencies ABI, CHC, and PCA Waiver Client Services Must be in the Care Plan

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added to the client's Care Plan. Home Health Services that are not on the client's Care Plan will not be paid.

Service Authorization impact on EVV: Effective 4/1/2017, in order for a Home Health Agency to schedule a client in EVV, a PA, for the Home Health Services to be provided to a CHC State Funded or ABI, CHC or PCA Waiver client, must first be uploaded to Hewlett Packard Enterprise by the Access Agency or Case Management Agency. A daily service authorization file is then sent by Hewlett Packard Enterprise to Sandata. This process can take up to seven (7) to ten (10) days from the time the services are requested. Providers not receiving authorizations in the Sandata system within this time frame should check for a service authorization via their Hewlett Packard Enterprise secure Web account. If the authorization is there, it should appear in the providers EVV system within a day or two. Authorizations that do not appear in the providers EVV system should be directed to Sandata Customer Care at:

1-855-399-8050

or ctcustomercare@sandata.com, Monday thru Friday 8:00 AM – 6:00 PM.

Client Eligibility impact on EVV: A client must be ABI, CHC or PCA eligible in the Department of Social Services' eligibility system with a PA for the service to be provided in EVV in order for the client to be available to the provider for activation in EVV. Home Health Agencies can check in, service

the client and check out without an active client and service authorization in the EVV system. However, an exception as to unknown client and no service authorization will display until the client and service authorization is received in the EVV system. As a result, providers should check eligibility on new clients via their Hewlett Packard Enterprise secure Web account and report eligibility issues to the Community Options unit, Formerly the Alternate Care Unit at the Department of Social Services using the following e-mail address:

HomeandCommunityBasedServices.dss@ct.gov.

The following information should be provided when directing eligibility issues to the Community Options unit: the client's name, client ID and the date service began or is scheduled to begin. Place the words "**ABI, CHC or PCA Client Eligibility Issue**" in the subject line of the email.

Attention ABI, CHC and PCA Non-Medical

Service Providers:

Service Authorization Reminder To All ABI, CHC and PCA Service Providers: Non-medical services rendered to State Funded Connecticut Home Care (CHC) clients and HUSKY A or HUSKY C clients with a Connecticut Home Care (CHC), Personal Care Assistance (PCA) or Acquired Brain Injury (ABI) Waiver are required to be on the client's Care Plan in the form of a Prior Authorization (PA) for the Procedure Code or Procedure/modifier code list

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Attention Home Health and Access Providers

Reminder to Home Health Agencies ABI, CHC, and PCA Waiver Client Services Must be in the Care Plan

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associated with the service(s) to be provided to the client. These services include mandated, optional and EVV non-applicable services. Providers should refer to the EVV Service code listing located in the General Information and Questions section of the Electronic Visit Verification Implementation Important Message. The Important Message can be found on the www.ctdssmap.com Web site Home Page.

State Funded CHC or HUSKY A or C benefit clients with a CHC Waiver: Effective July 1, 2013, all non-medical services provided to CHC state funded clients or waiver clients must be authorized by the Access Agency managing their care. As a result, all non-medical services must be on the CHC client's Care Plan in order for the CHC Service provider to be reimbursed for the services provided.

HUSKY A or C clients with PCA Waiver: Effective February 25, 2016, all non-medical services provided to PCA Waiver clients must be authorized by the Access Agency managing their care. As a result, all non-medical services must be on the PCA client's Care Plan in order for a PCA Service provider to be reimbursed for the services provided.

HUSKY A or C clients with an ABI Waiver: Effective September 1, 2016, non-medical ABI services provided to ABI Waiver clients must be authorized by the Case Management Agency managing their care. As a result, all non-medical ABI services must be on the ABI client's Care Plan in order for the ABI Service provider to be reimbursed for the

services provided.

Service Authorization impact on EVV: Effective January 1, 2017, in order for an ABI, CHC or PCA service provider to schedule a client in EVV, a PA, for the services to be provided to a CHC State Funded or ABI, CHC or PCA Waiver client, must first be uploaded to Hewlett Packard Enterprise by the Access Agency or Case Management Agency. A daily service authorization file is then sent by Hewlett Packard Enterprise to Sandata. Service authorizations should be in the EVV system within seven (7) to ten (10) days of service request. Providers not receiving authorizations in the Sandata system within this time frame should check for a service authorization via their Hewlett Packard Enterprise secure Web account. If the authorization is there, it should appear in the providers EVV system within a day or two. Authorizations that do not appear in the providers EVV system should be directed to Sandata Customer Care at:

1-855-399-8050 or ctcustomer@sandata.com, Monday thru Friday 8:00 AM – 6:00 PM.

Client Eligibility impact on EVV: A client must be ABI, CHC or PCA eligible in the Department of Social Services eligibility system with a PA for the service to be provided in EVV in order for the client to be available to the provider for activation in EVV. ABI, CHC or PCA Service providers can check in, service the client and check out without an active client and service authorization in the EVV system. However, an exception as to unknown

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Attention Home Health and Access Providers

Reminder to Home Health Agencies ABI, CHC, and PCA Waiver Client Services Must be in the Care Plan

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client and no service authorization will display until the client and service authorization is received in the EVV system. As a result, providers should check eligibility on new clients via their Hewlett Packard Enterprise secure Web account and report eligibility issues to the Community Options unit, Formerly the Alternate Care Unit at the Department of Social Services using the following e-mail address:

HomeandCommunityBasedServices.dss@ct.gov.

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

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Attention Home Health Providers, ABI Case Management Agencies and CHC and PCA Access Agencies

Care Plan Requirements for Beacon Health Option PA

CARE PLAN REQUIREMENTS FOR BEACON HEALTH OPTION PRIOR AUTHORIZATIONS (PAs): As a reminder, Beacon Health Options, formerly Value Options, service authorizations obtained by Home Health Agencies for clients with an Acquired Brain Injury (ABI), Connecticut Home Care Program for Elders (CHCPE) or Personal Care Assistance (PCA) benefit plan must be added to the client's Care Plan by the Case Management or Access Agency care managing the client. Home Health, ABI Case Management, CHCPE and PCA Access Agencies should implement internal procedures to comply with their responsibilities to ensure a client's Beacon Health Options service authorization is linked

to their Care Plan in a timely manner to prevent PA file upload issues and claim denials.

Home Health Agencies are currently responsible for:

- Obtaining the service authorization from Beacon Health Options.
- Communicating current Beacon Health Option PA information to the Case Management or Access Agency Care Manager when asked to provide services to a client with an ABI, CHCPE or PCA benefit plan.
- Contacting Beacon Health Option to end date the current PA and issue a new PA, when noti-

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Attention Home Health Providers, ABI Case Management Agencies and CHC and PCA Access Agencies

Care Plan Requirements for Beacon Health Option PA

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fied by the Case Management or Access Agency that the client's current ABI, CHCPE or PCA Care Plan is being end dated and a new Care Plan is being established, due to a change in Access or Case Management Agency.

The Case Management or Access Agency is currently responsible for:

- Determining if a Beacon Health Options PA already exists when requesting a Home Health Agency provide services to an ABI, CHCPE or PCA client.
- Linking the client's Beacon Health Options PA to the Care Plan prior to uploading the Care Plan to Hewlett Packard Enterprise.
- Notifying the Home Health Agency of intent to

end date a current ABI, CHCPE or PCA Care Plan and establish a new Care Plan. This notification will allow the Home Health Agency to notify Beacon Health Options to end date the current PA and issue a new PA which can then be linked to the new Care Plan by the Case Management or Access Agency in a timely manner.

Timely notification by the Case Management or Access Agency of intent to end an ABI, CHCPE or PCA Care Plan and reissue a new Care Plan will prevent Care Plan overlaps and upload issues for the Case Management and Access Agencies and prevent the need to manually recoup claims by the Home Health Agency to expedite the upload of Service Authorizations.

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All Providers

Electronic Funds Transfer Requirement Reminder

As a reminder, the Department of Social Services (DSS) requires providers to receive payment through Electronic Funds Transfer (EFT) to the provider's financial banking institution. As part of the ongoing initiative to reduce expenses, DSS is moving away from issuing paper checks. Providers that do not have valid EFT information on file will receive a letter requesting updated EFT information. If EFT information is not received within thirty (30) calendar days of that letter, **claim payment will be**

delayed by up to thirty (30) days from the date a claim is submitted for processing. This will continue to occur until updated EFT information is provided. Maintaining accurate EFT information will ensure that your claims are processed and paid in the timeliest manner.

To enroll in EFT, visit the provider Web site at www.ctdssmap.com and log into your Secure Web portal account. Once logged in, click on the Demo-

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All Providers

Electronic Funds Transfer Requirement Reminder

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graphic Maintenance tab. Once enrolled in EFT, providers may change their EFT data at any time. Only the main account holder is permitted to add/update EFT information.

Please refer to the Provider Demographic Maintenance section in Chapter 10 of the Provider Manual for further instructions on how to update this information. Chapter 10 is located on the www.ctdssmap.com Web site by selecting Information > Publications and then scrolling down to Provider Manuals.

Please note: Once you add or update EFT infor-

mation, you will receive a paper check for one financial cycle so that a test transaction can be sent to your financial institution to validate the account information provided. No further action is required. You will receive your payment via EFT in the next financial cycle in which you have claim activity. Please note that you are not at risk for delayed claim payments during this validation process.

If you need assistance in establishing your secure Web portal account, resetting a password or enrolling in EFT, please contact the Provider Assistance Center at 1-800-842-8440.

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Attention All Providers

New Fee Schedule Updates for 2017

Effective January 1, 2017, several fee schedule changes and updates were made by the Department of Social Services (DSS). Please reference the changes and updates to provider fee schedules on the www.ctdssmap.com Web site. To access the fee schedules, go to "Provider", "Provider Fee Schedule Download", and click on the "I Accept" button. Once you open the fee schedule page, you will find a list of alphabetized fee schedules for your area of expertise. Clicking on the CSV next to the fee schedule you would like to view opens the file. You will be able to search for particular procedure codes, their descriptions, if modifiers are required, rate types, max fee, effective date, end dates and PA requirements. The fee schedule will help guide you by procedure codes to a particular rate type payment for a service. There also will be important information at the

top and bottom of some of the fee schedules.

The fee schedules that contain changes or updates include:

- Clinic-Clinic and Outpatient Hospital Behavioral Health
- Clinic-Dialysis
- Clinic Family Planning/Abortion
- Clinic-Rehabilitation
- Dental Adult, Dental Pediatric
- Independent Physical Therapy and Occupational Therapy
- Independent Radiology
- Lab
- Physician Office and Outpatient Services
- Physician Radiology
- Physician Surgical
- Special Services

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Attention All Providers

Submitting Claim Adjustments on the Web

Are you still submitting a paper Paid Claim Adjustment Request (PCAR) form, or writing out a refund check to return payment on a previously paid claim? Do you wish you had a faster way of completing this task? Well, Hewlett Packard Enterprise has a way for you to never have to submit a PCAR or return a check in the mail for over-payment again! This includes claims that may exceed the timely filing limit. If you are an active billing provider with a secure Web account, you have the option to easily submit claim adjustments or claim recoupments without the expense of paper or postage. The Web Claim Submission tool on the secure Web portal allows providers to easily void claims. Access this tool via the www.ctdssmap.com Web site by logging into the Secure Web portal and selecting "Claim Inquiry". Enter the appropriate search information to identify the claim, for example, a 16 digit Internal Control Number (ICN). Once you've found the

claim, and the portion of the claim in need of adjustment, correct it right on that claim. Once you have all the corrected information, scroll to the bottom of the page and click "Adjust". Just like that, you will receive an instant result that your claim has been adjusted.

When voiding a claim, a similar process is used. Search for the claim in need of being voided via the claim inquiry tool. Once this claim is selected and opened, scroll down to the bottom of the claim and click on the "Void" button. It's that simple!

A claim void may also be submitted via an electronic 837 ASC X12 file. The frequency code of "8" is submitted to recoup a previously paid professional or dental claim. An "8" in the third digit of the Type of Bill is submitted to recoup a previously paid institutional claim.

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Attention Medicaid/Medicare Providers

Submitting Medicare Advantage Plan Crossover Claims to CT Medicaid

To submit claims to the Connecticut Medical Assistance Program (CMAP) for payment of previously adjudicated claims from a Medicare Advantage plan, the claim adjustment reason code (CARC) of 3 for co-payment should not be used. The CARCs of 1 for deductible, or 2 for co-insurance, are the only

CARCs that will result in the creation of a crossover claim type for CT Medicaid. The use of the CARC 3 will result in the claim being processed as a straight Medicaid claim and will deny for "Bill Medicare first". Providers should use CARC 2 for co-payment amounts.

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Attention Primary Care Providers

Identifying Incentive Payments

Are you a provider who is receiving an incentive payment? Are you receiving more than one? Sometimes the HUSKY Health Primary Care Increased Payments Policy (Formerly known as the ACA Enhanced Payments) and the Person-Centered Medical Home (PCMH) Initiative can become a bit confusing. Here is some clarification on these incentives, and how to spot them on an Explanation of Benefits (EOB).

HUSKY Health Primary Care Increased Payments Policy (formally known as ACA Enhanced Payment): Reimbursed for Evaluation and Management (E&M) services to qualified providers at a rate that would be paid for the services (if the services were covered) under Medicare. The higher payments apply to primary care services delivered by a physician who has self-attested to a covered specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists who attest and are within those designations are recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes specified in the regulation. In order to receive this enhanced payment, eligible providers must have completed the attestation available on the www.ctdssmap.com Web site. This enhanced payment is denoted on a provider's Remittance Advice (RA) with one of the following Explanation of Benefits (EOB) codes:

EOB 9964 - PRICING ADJUSTMENT - ACA MAX FEE PRICING APPLIED

EOB 9965 - ACA ENHANCED RATE ADD ON

Person-Centered Medical Home (PCMH) Initiative: Under the PCMH initiative, practices/clinics that demonstrate a higher standard of person-centered primary care service qualify for a higher level of reimbursement for the said primary care services from the Department of Social Services. This program is administered through the Department's Administrative Services Organization – Community Health Network (CHN) and to qualify both the practice/clinic AND the individual rendering provider must be PCMH approved. The incentive payment is directly linked to the address submitted on your claims. This means, if your location changes, you can NOT use the secure Web portal to change your location's address. To change or update this information, you will have to get in touch with your CHN representative to properly update your location and send a letter, on your business letterhead, to Hewlett Packard Enterprise. A PCMH incentive payment is denoted on a provider's RA with one of the following EOB codes:

EOB 9975 - PRICING ADJUSTMENT - PCMH PERCENTAGE RATE APPLIED

EOB 9972 - PRICING ADJUSTMENT - PCMH PARTIAL OR NO PERCENT RATE APPLIED

Attention All Providers

Retroactive Rate and Patient Liability\Applied Income Mass Adjustments

Payment rates are established by the Commissioner and paid by the Department of Social Services (DSS) in accordance with all applicable federal and state statutes and regulations per Section 17b-262-530. The Department is also responsible for calculating patient liability/applied income for clients that reside in a nursing facility per Section 17b-262-708. When retroactive changes are made by the Department to rates and/or patient liability/applied income, Hewlett Packard Enterprise performs mass adjustments to previously paid claims. These mass adjustments occur on a monthly basis. Below, please see the specific guidelines for these said adjustments.

Retroactive Rate Changes:

Providers are reminded to **always** bill their usual and customary charge when submitting charges to Hewlett Packard Enterprise for the Connecticut Medical Assistance Program (CMAP). Submitting your usual and customary charge will ensure that when DSS makes retroactive changes to the fees, claims will be identified, selected and mass adjusted when the detailed billed amount is greater than the allowed amount without the need for manual adjustments to be made by the provider. Claims that are impacted will automatically be adjusted by Hewlett Packard Enterprise the **second cycle** of the following month and will appear on your remittance advice (RA) with an internal control number (ICN) beginning with region code 55.

Retroactive Patient Liability/Applied Income Changes:

As a reminder, mass adjustments due to patient liability/applied income changes within a client's profile are processed the **first cycle** of every month for changes that occurred in the client's profile in the previous month. Patient liability/applied income changes within the client's profile do not require claim adjustments to be performed by providers. If DSS makes a change to a client's patient liability/applied income information that would increase or decrease the amount previously deducted, the provider will see the change made through the mass adjustment process on a future RA. Claims that are impacted will automatically be adjusted by Hewlett Packard Enterprise and will appear on your RA with an ICN beginning with region code 53.

A copy of the most recent "Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health and CADAP Programs)" claims processing cycle schedule can be found on the www.ctdssmap.com Web site. From the home page, click on "Provider", then "Provider Services", scroll down to "Schedules", then click on the "2017 Cycle/Claim Submission Schedule Jan-Jun".

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Attention All Providers

Birth to Three Enrollment

The Department of Social Services (DSS) will be making changes to the administration of the Birth to Three Waiver program. These changes are targeted for claims with dates of service July 1, 2017 and forward. Current billing practices will remain in effect until that time.

Effective for dates of service July 1, 2017 forward, Birth to Three providers will submit claims for Birth to Three services directly to Hewlett Packard Enterprise, who will make payment directly to the service provider. Birth to Three providers will no longer submit claims for Birth to Three services to the Office of Early Childhood (OEC). OEC is contracting with a vendor to assist providers in billing. This vendor will be reaching out to all Birth to Three providers in the near future.

To facilitate this change, all Birth to Three waiver providers must enroll in the Connecticut Medical Assistance Program (CMAP) with a provider type of "Special Services" and specialty of "Birth to Three Billing Provider" in order to receive reimbursement for services rendered on or after July 1, 2017. Birth to Three waiver providers who have been authorized by OEC to provide services may begin enrolling as "Birth to Three Billing Providers" effective April 1, 2017.

Hewlett Packard Enterprise will offer online enrollment and secure Web account training to those providing Birth to Three waiver services who will be enrolling as a "Birth to Three Billing Provider". Dates for these workshops can be

found on the www.ctdssmap.com Web site. From the Home page select Provider > Provider Services > under Provider Training click the "here" link to open the Training Information Page. Under Workshops click on the Birth to Three Enrollment Workshop Invitation. Published workshop invitations may be obtained via electronic messaging. Providers of Birth to Three services who are not already signed up to receive electronic messaging should perform the following steps to subscribe:

1. Access the www.ctdssmap.com Web site.
2. Select Provider > E-mail Subscription from the drop-down menu.
3. Once on the E-mail Subscription page, enter the e-mail address you wish to subscribe.
4. Re-enter the e-mail address for verification.
5. From the right hand side of the page, use the checkboxes to select "**Birth to Three**" and any other available subscriptions you would like to receive.
6. Once complete, select Save.

The Workshop presentation will also be available to providers on the Training Information page under the Materials heading on or about the date of the first scheduled Enrollment Workshop. Providers should click on the Birth to Three Workshop link and select the workshop they wish to view/download.

Attention All Providers

Resident Re-Enrollment

The Department of Social Services (DSS) requires all providers to periodically re-enroll. As of January 1, 2017, many residents have reached their re-enrollment due date and should have received or will be receiving re-enrollment notification letters. Residents with a residency longer than three years, who are reaching the end of their enrollment, **MUST** re-enroll by the re-enrollment due date included on the letter in order for their claims to continue to process. The notification letter is sent 6 months prior to the re-enrollment due date, to the address you have on file in CMAP to allow adequate time for the completion of the re-enrollment application. This letter contains your Application Tracking Number (ATN) and provider ID required to access the re-enrollment application via the online Re-enrollment Web Wizard Tool and will include the instructions on how to complete the re-enrollment process.

If the residency period is continuing **AFTER** the re-enrollment due date, it is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice. Residents with re-enrollment applications that are not fully completed by the residents' re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP).

To re-enroll, residents will need to go to the www.ctdssmap.com and select provider re-enrollment from the provider drop-down menu. Once the panel below is displayed, you must en-

ter the ATN and NPI or AVRS ID included on your letter and click Next.

The screenshot shows a web application interface for re-enrollment. At the top, there is a navigation menu with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, home, provider enrollment, provider re-enrollment, provider enrollment tracking, provider fee schedule download, ehr incentive program, and oos instructions/information. Below the menu is a heading "Log In to Your Re-Enrollment Application". The main content area has a sub-heading "Log In to Your Re-Enrollment Application" and a bullet point: "Please enter your Application Tracking Number (ATN) found on your re-enrollment letter at 1-800-842-8440 for assistance in obtaining your ATN." Below this, it says "Required fields are indicated with an asterisk (*)". There are two input fields: "ATN*" and "NPI/Non medical provider identifier (AVRS ID)*". A "Next" button is located at the bottom right of the form.

If you wish to check the status of a re-enrollment application once you have submitted it, select “Provider Enrollment Tracking” from either the Provider submenu or the Provider drop-down menu and enter the ATN and business name or last name and click search.

Please note: Once a resident becomes a licensed physician with the Department of Public Health (DPH) and wishes to continue to participate in CMAP, the provider must submit a brand new enrollment application as a fully licensed physician. In this instance, it is not necessary to re-enroll the resident AVRS/MCD ID.

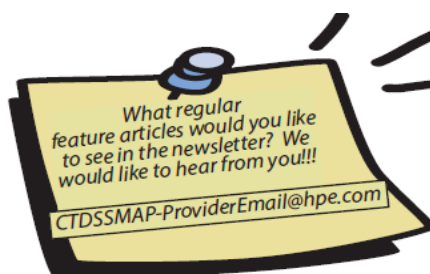
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Appendix

Provider Bulletins

Below is a listing of Provider Bulletins that have recently been posted to www.ctdssmap.com. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the information -> Publications tab.

- | | | | |
|----------------|----------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------------------------------------------------------------------------------------------|
| PB17-08 | Changes to the Prior Authorization Process for Genetic Testing Services | PB16-94 | 2017 Ambulatory Surgical Centers, Dialysis Clinics, Freestanding Behavioral Clinics Fee Schedules HIPAA Compliance Update |
| PB17-07 | Authorization for Palivizumab (Synagis) | PB16-93 | 2017 Family Planning Clinic Fee Schedule Update—Addition of Td, Tdap, Smoking Cessation and PrEP Services |
| PB17-06 | Changes to the Prior Authorization Process for Cranial Remodeling Orthoses | PB16-92 | 2017 Independent Radiology Fee Schedule HIPAA Compliant Update |
| PB17-05 | Updated MEDS Fee Schedule Changes | PB16-91 | 2017 Independent Physical and Occupational Therapy Fee Schedule HIPAA Compliant Update |
| PB17-04 | Changes to the Prior Authorization Process for Continuous Positive Airway Pressure and Bi-level Positive Airway Pressure Devices | PB16-90 | Interpreter Services for Individuals With Limited English Proficiency And Hearing Impairments |
| PB17-03 | Important Changes to Evaluation and Assessment Services for Home Health Care Services—Addition of Review of Care Plan Code—G0162 | PB16-88 | Coverage for Kyleena - Intrauterine Device (IUD) |
| PB17-01 | Scope of Practice for Licensed Alcohol and Drug Counselors—Updated Policy Transmittal | PB16-87 | Reporting Requirements for E-Consultants Performed at Federally Qualified Health Centers |
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