September 2025 - Revised
Connecticut Medical Assistance Program
https://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

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Attention: All Providers

Billing of Influenza Vaccines for the 2025-2026 Flu Season

Gainwell Technologies would like to remind providers of the importance of reporting the correct Healthcare Common Procedure Coding System (HCPCS) code for each vaccine product being billed to the Connecticut Medical Assistance Program (CMAP). If the 11-digit National Drug Code (NDC) reported on the claim does not correspond to the vaccine code reported on the same claim detail, the vaccine will be denied.

As a reminder, providers are asked to submit the outer carton NDC when billing vaccine products. Since the HCPCS codes for flu vaccines are updated every year, providers must ensure that they have cross-walked the vaccine NDC to the correct HCPCS code. The following resources are available to assist providers with selecting the correct HCPCS code for each vaccine billed:

Influenza Vaccine Products for the 2025-2026 Influenza Season
GSK Vaccine Product Codes
Coding and Billing Season Readiness Checklist
CSL Seqirus Influenza Portfolio Coding and Billing Guide
FluMist Coding and Reimbursement Coding Resource
Sanofiflu Coding & Billing for the 2025/2026 Season

Providers who are enrolled with the Connecticut Department of Public Health's (DPH) Connecticut Vaccine Program (CVP) should continue to refer to communications disseminated via DPH regarding the vaccines covered through the CVP, including the NDCs used for ordering through DPH. Consistent with the current DSS CMAP reimbursement policy, vaccines obtained for free through the DPH CVP are not eligible for reimbursement; however, a separate administration fee may be billed to the CMAP.

For more information regarding the CVP, refer to the communications disseminated by the DPH Vaccine Coordinator, CVP and the DPH Immunization website:
Connecticut Vaccine Programs

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Attention: All Providers

Need to Change Your Master User for the Secure Web Portal?

If you have a person leaving your organization that is delegated as your Master User, it's best to have them change the Master User information before they leave, giving access to the new user.

Log in to the Secure Web Portal, go to Account and select Account Maintenance, update the contact information to the new user. Then that new person can reset the password and security questions. This also enables the new user to be able to contact Gainwell Technologies Provider Assistance Center if they have any login issues in the future.

If the Master User is no longer part of the organization, providers will be required to submit a Master User Change Request with the following information:

- The Master User Change Request must be on office letterhead.
- The letter must clearly state the reason for the Master User Change Request.
- The letter must contain the **previous** Master User's name and state 'is no longer the master user for XXX reason'. *If you do not know who the Master User was, please state in your letter that the previous Master User's name and User ID is unknown.*
- The letter must list the provider's User ID (if known) and AVRS ID (Medicaid Provider Number) or NPI and AVRS ID (Medicaid Provider Number). *AVRS ID is mandatory as many providers have multiple AVRS IDs under one NPI.*
- The letter must list the **NEW** Master User's full name.
- The letter must list the **NEW** Master User's email address, telephone, and/or fax number.
- The letter must be signed and dated by either an owner, board member, or authorized representative that was listed on the last enrollment/re-enrollment application.
- The letter must list the signers' email address and phone number.
- The date of the letter must be within 30 days of submission date to Gainwell Technologies.

The Master User Change Request should be faxed to 1-877-413-4241. Gainwell Technologies will contact the New Master User within 48 hours after letter validation process has been completed. Please be aware that the User ID for the Secure Web Portal account remains the same as before, **only the password is reset**.

Once the new Master User has been granted access to the secure Web portal account, they should log in to the account, and under the Account tab, select Account Maintenance and update the contact's name, phone number, email address, security questions and answers with their own information. Gainwell Technologies cannot update this information, only the new master user can do so.

Once the information has been updated by the new Master User, it will be reflected in our system. The new Master User will now be responsible for maintaining the secure Web portal account and all the clerks associated with the account.

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Attention: All Providers

Medicaid Policy Updates—Action Required for GLP-1, Weight-Loss Medications and PAP Therapy

The Department of Social Services (DSS) has issued several important Medicaid policy updates affecting prescribing, dispensing, and reimbursement for GLP-1 medications, weight-loss treatment coverage, and positive airway pressure (PAP) therapy. These updates are relevant to **all provider types** (physicians, APRNs, PAs, pharmacists, long-term care facilities, clinics, and hospitals). Please review and incorporate the following into your clinical and billing workflows to ensure compliance and uninterrupted patient care.

1. Diagnosis Requirement for GLP-1 Agonist Medications (Provider Bulletin 2024-66)

- **Effective December 15, 2024**: All prescriptions for GLP-1 receptor agonists (Byetta, Bydureon, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza/liraglutide) must include an **ICD-10 diagnosis code for Type 2 diabetes mellitus** in field 424-DO of the NCPDP D.0. pharmacy claim format.
- Claims without the approved diagnosis were **denied** unless client had transitional coverage.
- Coverage was limited to **FDA-approved indications for Type 2 diabetes**.

A list of acceptable ICD-10 codes is available at www.ctdssmap.com under the Pharmacy Information tab.

2. Updated GLP-1 Medications and Weight-Loss Medication Coverage (Provider Bulletin 2025-31)

- **Transitional coverage:** Members who began GLP-1 therapy for non-diabetic indications prior to December 15, 2024, were given a transitional coverage window.
- **After July 31, 2025**: GLP-1 prescriptions for transitional members, without a Type 2 diabetes diagnosis were no longer covered.
- **Effective July 1, 2025**: DSS began covering two FDA-approved oral weight-loss medications: Orlistat and Phentermine, available to HUSKY A, B, C, and D members through the pharmacy benefit.

3. Zepbound for Obstructive Sleep Apnea (Provider Bulletin 2025-32)

- **Effective July 1, 2025:** DSS will reimburse **new prescriptions for Zepbound** through the pharmacy benefit when prescribed for the treatment of **obstructive sleep apnea (OSA)** in adults age 18 and older. Coverage applies under HUSKY Health Programs A, B, C, and D.

Coverage requirements:

- Documented **OSA diagnosis** with an **apnea-hypopnea index (AHI) ≥ 15**
- Member is **currently using and will continue to use positive airway pressure (PAP) therapy**, unless contraindicated
- Member is actively participating in **comprehensive lifestyle interventions** (e.g., diet modification, physical activity, nutritional counseling, and/or behavioral therapy)
- **Diagnosis code G47.33 (Obstructive sleep apnea)** submitted on the pharmacy claim in Field 424-DO

Prior Authorization (PA):

- Prescribers must submit the **Zepbound for Treatment of Obstructive Sleep Apnea PA Form** at therapy initiation and annually thereafter.
- PA forms must include all required information; incomplete submissions will be denied.

The Zepbound Prior Authorization form can be obtained at www.ctdssmap.com > Information> Publications> Forms or from www.ctdssmap.com click on Pharmacy Information > Pharmacy Program Publications > Zepbound for Treatment of Obstructive Sleep Apnea

We strongly encourage all providers and pharmacy partners to become familiar with each bulletin and its respective prior

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authorization form(s) to ensure proper diagnosis coding/ requirements, documentation, and patient communication considering these changes.

4. Provider Action Items

- Review all members currently on **GLP-1 therapy** or **PAP therapy** to ensure they meet new requirements.
- Update prescribing and billing workflows to include mandatory **diagnosis coding and documentation**.
- Familiarize staff with revised **prior authorization forms** and processes.
- Communicate changes to patients to support continuity of care.

For additional details, please visit www.ctdssmap.com or contact the **Gainwell Technologies Provider Assistance Center** at **800-842-8440 (Mon–Fri, 8:00 AM – 5:00 PM)**.

Attention: Waiver Providers

Important Reminder for All Providers Approved for a New Waiver Program

When a provider is approved for a new waiver program and receives a new AVRS ID number, it is essential to notify Sandata to ensure the new AVRS ID number is associated to the provider's existing Santrax account.

To do this, providers must send an email to **ctcustomercare@sandata.com** with the following information:

- The **new AVRS ID number**
- The **service program** the provider is approved to deliver
- A copy of the **approval letter** from GT Independence
- The **current Santrax account number** to which the new AVRS ID should be linked in the Subject Line

These steps are essential to maintain accurate records and ensure seamless service delivery.

Additional Guidance:

Every time a provider is enrolled with a **new type and specialty**, they are required to contact Sandata to inform them of the new service. This ensures the **AVRS ID is properly attached** to the provider's Santrax account.

If the AVRS ID is **not linked** to the Santrax account, clients will not appear in the provider's Santrax portal, which will prevent them from viewing prior authorizations (PAs) and the billing for the services provided.

Prompt communication with Sandata helps avoid billing issues and ensures accurate claim processing.

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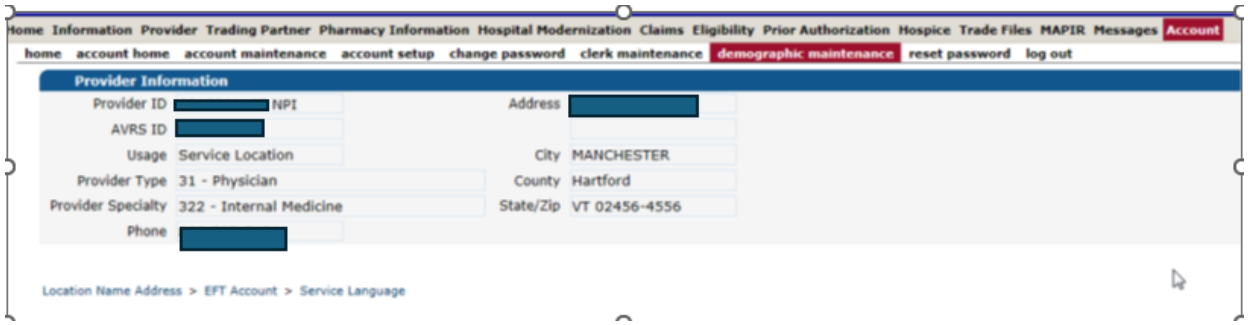
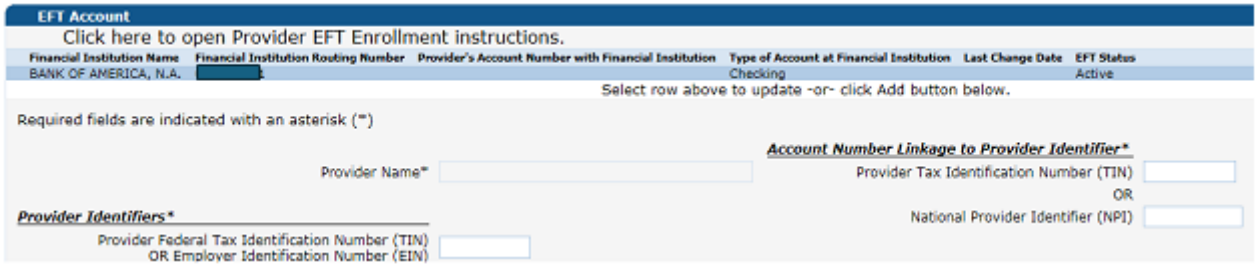
Attention: All Providers

EFT Requirement Reminder

As a reminder, the Department of Social Services (DSS) requires providers to participate in electronic funds transfer (EFT). EFT provides for the direct deposit of your payment into a financial account of your choosing and is available to Connecticut Medical Assistance Program providers. The information gathered as part of the EFT enrollment process is in accordance with the requirements set forth in the Affordable Care Act and the CORE 380 EFT Enrollment Data Rule.

To enroll in EFT, please visit the provider Web site at www.ctdssmap.com and log into your Secure Web portal account. Once logged in, please go the Account tab, and click on the "Demographic Maintenance" option. Once enrolled in EFT, providers may make changes to their EFT data at any time. ***Note, only the main account holder or Master User is permitted to add/change EFT data.***





Please refer to the Provider Demographic Maintenance section in Chapter 10 of the Provider Manual for further instructions on how to update this information. The Provider Manual can be accessed by going to the provider Web site at www.ctdssmap.com, selecting Information > Publications and by selecting Chapter 10.

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

When a provider makes a change to their Electronic Funds Transfer (EFT) information, Gainwell Technologies mails a letter to the provider confirming the change. The letter contains the new EFT information. Upon receipt of this letter, providers should confirm that the changes are valid. If a discrepancy exists, the provider should contact the Provider Assistance Center at 1-800-842-8440 immediately.

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Attention: Dental Providers

REVISED Prior Authorization (PA) Requirement for Replacement Restorations—Avoiding Denials

Dental providers submitting PAs for replacement restorations within a 24-month period must take extra care when entering information into the BeneCare system to avoid claim denials.

Example:

On January 3, 2025, the member received a distal-occlusal (DO) restoration on tooth #30. Later, on August 15, 2025 — less than a year after the initial procedure — the same tooth required the restoration to be redone. As a result, the provider submitted a Prior Authorization (PA) for another DO restoration on tooth #30. The PA was approved, and the procedure was completed.

However, when the claim was submitted for this second restoration, it was denied with either:

- **Error Code 9992** – "Payment amount reflects tooth surface pricing," or
- **Denial Code 5010** – "Exact Duplicate"

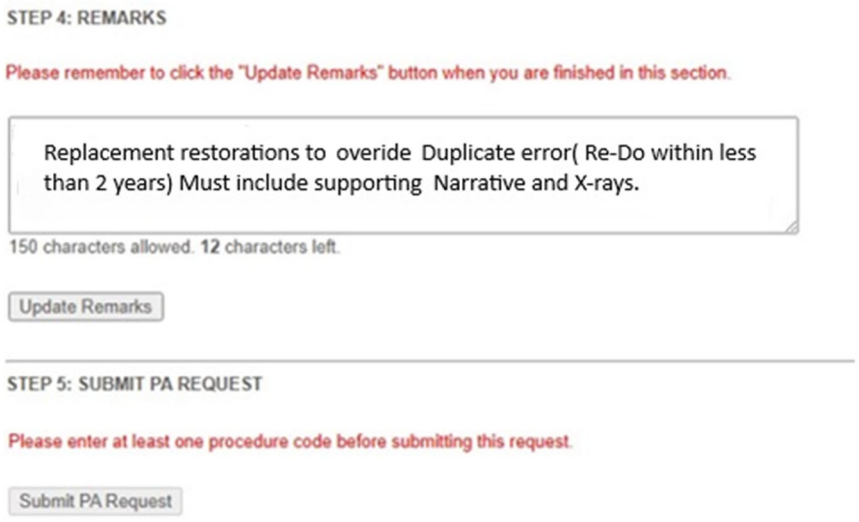
This denial occurred even though the PA was approved. The reason for the denial is that **Benecare requires specific documentation** when a restoration is being replaced within 24 months. Simply obtaining PA approval is not sufficient.

To avoid future denials, follow these key steps on Step 4 – REMARKS in your Prior Authorization:

When submitting a PA through the Connecticut Dental Health Partnership (CTDHP) website https://ctdhp.org, on **Step 4 (REMARKS)** of the Prior Authorization form, your comments are critical. Missing or incorrect information in this section can lead to the PA being created as a standard dental prior authorization versus CTDHP creating the PA to cover replacement restorative services.

1. **Under Step 4 (REMARKS) clearly indicate replacement restorations on your Prior Authorization**: must include **"REPLACEMENT RESTORATION/S"**
2. **Add Provider's Narrative:** A clear narrative is required to explain why the replacement is necessary.
3. **Attach Supporting X-Rays**

Note: Whether the service is provided by a new provider or the same provider, strict adherence to documentation and system input protocols is essential.



For Prior Authorization questions BeneCare's Prior Authorization support line can be reached at: 1-888-445-6665. For claim questions, please contact the Provider Assistance Center at 1-800-842-8440.

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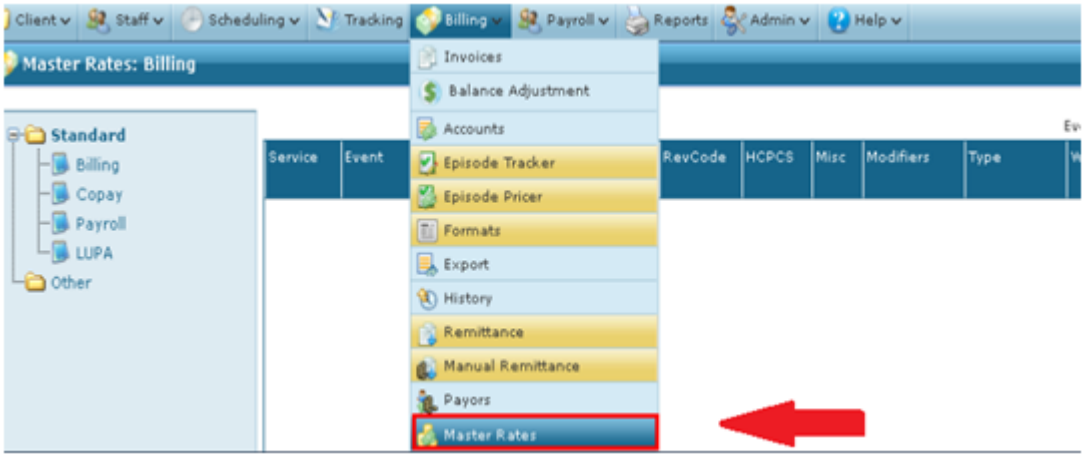
Attention: Waiver and Non-Waiver EVV Providers Using Sandata

Entering and Updating Provider Billing Rates in Sandata

New providers: Part of setting up your database is adding your Usual and Customary billing rates into your Santrax portal. Existing providers must clone current rates to capture updated rates and effective dates. Both new and current providers should follow the steps below to enter or change their rate information.

1. Go to the Billing Menu > Master Rates



2. The Rates and Effective Date are the two editable columns in the Billing Rates table below. Data in the other columns are pre-populated and remain read-only. To enter the Rate: A. Double-click in the Rate cell on a Service line to enter your specific billing rate for that Service. B. Press the Enter key or click outside of the cell to close the field. C. Click Save

Service:

Service	Event	Shift	Type	Week Rate	Weekend Rate	Cap	Rank	Effective Date
PCA	HR	DEF- Default Value	Hourly	$11.00	$12.10	-	-	12/31/2016
PCA	MU	DEF- Default Value	Hourly	$11.50	$12.60	-	-	12/31/2016
PCA	LI	DEF- Default Value	Hourly	$11.00	$12.10	13	1	12/31/2016
PCA	ML	DEF- Default Value	Hourly	$11.50	$12.60	13	1	12/31/2016
HHA	HR	DEF- Default Value	Hourly	$11.00	$12.10	-	-	12/31/2016
HHA	MU	DEF- Default Value	Hourly	$11.50	$12.60	-	-	12/31/2016
HHA	LI	DEF- Default Value	Hourly	$11.00	$12.10	13	1	12/31/2016

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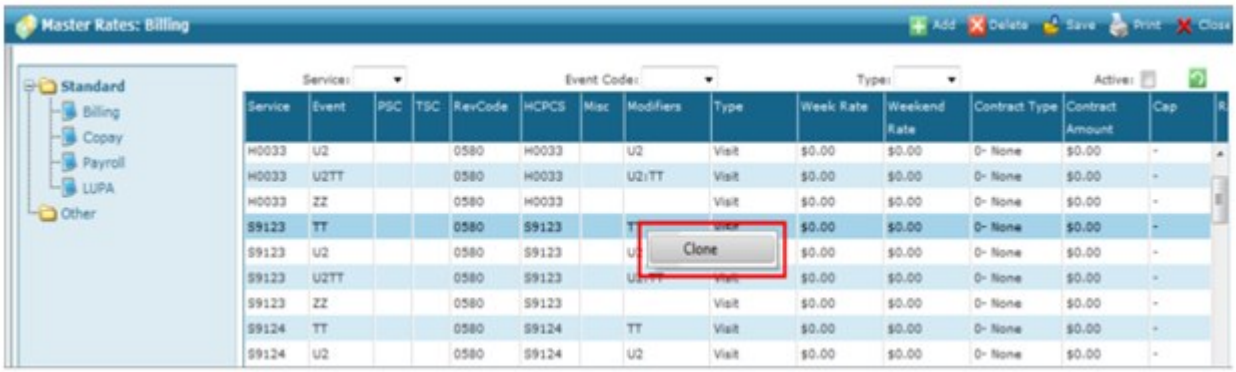
Updating Rates

Billing Rate entries must be cloned to capture updated rates and effective dates. To clone an existing rate, follow the steps below:

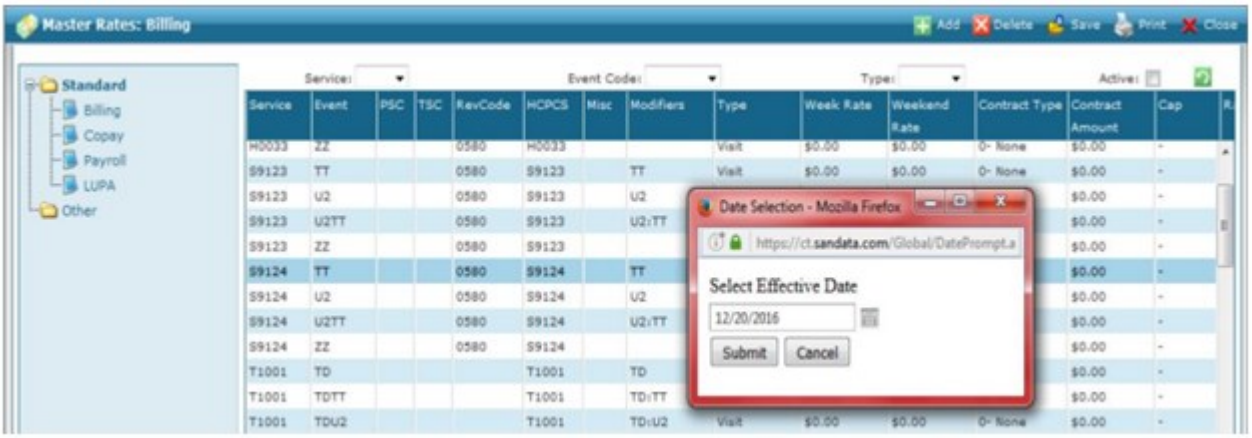
A. Click to highlight a line entry in the Billing Rates table.

B. Right-click on the highlighted line.

C. Click the Clone button that appears on the screen.



D. Select the effective date for the new entry and click Submit as noted in the image below.



E. The new line will appear at the bottom of the rates table where the new rate can be entered for that effective date.

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Attention: Home Health Agencies

Important Updates to Expanded Service Opportunity For COPE/Confident Caregiver

Recently approved modifications have enabled the Department of Social Services to make updates for the Care of Older People in their Environment (COPE)/Confident Caregiver, a Medicaid - funded home and community-based services (HCBS), support at home option ARPA initiative for the Medicare Savings Program (MSP). These updates apply specifically within the Acquired Brain Injury (ABI) I & II, Autism, Connecticut Home Care Program for Elders (CHCPE), and Personal Care Assistance (PCA) Waiver programs, expanding the service opportunity to allow occupational therapist (OT) groups and individual OTs to enroll as COPE/Confident Caregiver billing providers effective September 1, 2025. Previously, only Home Health Agencies (HHAs) could enroll as billing providers. Effective September 1, 2025, OT groups and individual OTs will be able to bill for their portion of COPE/Confident Caregiver services.

As a result of these updates, there is now an option for a registered nurse (RN) employed by an HHA and OT to separately be retained by the client or their representative. Therefore, HHAs may choose to provide only the more limited nursing component of COPE/Confident Caregiver and not be responsible for the more substantial OT component.

OT groups and individual OTs throughout the State will soon be available to provide the OT component of COPE/Confident Caregiver, however, there is a need for more HHA-employed RN partners. HHAs are encouraged to enroll for this more limited COPE/Confident Caregiver role so the evidence-based program can be made available to Medicaid HCBS clients throughout Connecticut.

Limited model guidelines:

If the RN and OT do not work for the same organization, each entity will bill for their component of the COPE/Confident Caregiver services.

- The RN's COPE/Confident Caregiver services will be billed by the employing HHA.
- The OT's COPE/Confident Caregiver services will be billed by the individual OT or OT group.
- The RN and OT should confer and coordinate COPE/Confident Caregiver services for their shared client.

The RN must work for a Medicaid-enrolled HHA. In the COPE/Confident Caregiver model, the RN will conduct the first visit in-person, or as a telehealth/phone visit if travel is not possible, followed by 1-2 phone visits. The billing code for the RN visits is the same whether in-person or via telehealth/phone. The telehealth modifier **should not** be included when submitting the claim.

Please note there is still the option for COPE/Confident Caregiver services to be provided exclusively by an **HHA that renders the RN and OT components and bills for both services.**

For more information regarding an overview of the COPE/Confident Caregiver Program, how to become a COPE/Confident Caregiver billing provider, training, and service reimbursement, please go to the www.ctdssmap.com Website. From the home page under Important Messages, click the link to access the Important Message to Home Health Agencies regarding COPE/Confident/Caregiver posted on 9/8/2025.

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Attention: Individual Occupational Therapists and Occupational Therapist Groups

Sign Up to Become a COPE/Confident Caregiver

Individual Occupational Therapists (OT) and Occupational Therapist Groups can now enroll as billing providers for COPE/Confident Caregiver services. For an overview of the services, rates, recent DSS updates for the program, how to become a COPE/Confident Caregiver billing provider, service referral process and resources, go to the www.ctdssmap.com Website. From the Home Page under Important Messages, select the Important Message to Occupational Therapist Groups and Individual OTs for sign up to become a COPE/Confident Caregiver provider (posted 9/8/25).

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Appendix

2025 Holiday Schedule

Date	Holiday	Gainwell Technologies	CT Department of Social Services
1/1/2025	New Year's Day, observed	Closed	Closed
1/20/2025	Martin Luther King Jr. Day	Closed	Closed
2/12/2025	Lincoln's Birthday, observed	Open	Closed
2/17/2025	Presidents' Day	Closed	Closed
4/18/2025	Good Friday	Closed	Closed
5/26/2025	Memorial Day	Closed	Closed
6/19/2025	Juneteenth Day	Open	Closed
7/4/2025	Independence Day	Closed	Closed
9/1/2025	Labor Day	Closed	Closed
10/13/2025	Columbus Day	Closed	Closed
11/11/2025	Veterans' Day, observed	Closed	Closed
11/27/2025	Thanksgiving Day	Closed	Closed
11/28/2025	Day after Thanksgiving	Closed	Open
12/25/2025	Christmas	Closed	Closed

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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.

PB25-47 Addition of Prior Authorization on Select Radiology Procedure Codes
PB25-45 Anti-Embolism Stockings
PB25-42 Updates to the Diabetic Supply Preferred List for Pharmacy Claims
PB25-41 Update to Table 26: List of Diagnosis Codes for Medical Nutrition Therapy (MNT) Services
PB25-40 Submission of Prior Authorization Requests and Letters of Medical Necessity
PB25-39 Revised Billing Guidelines for (Non-Adjunctive) Continuous Glucose Monitors (CGMs) and Adjunctive Non-Implanted CGMs
PB25-38 Changes to Prior Authorization of Physical Therapy, Occupational Therapy, and Speech Therapies
PB25-37 Increased Reimbursement Rates for Select Medication Administration Services
PB25-36 HUSKY B Allowance Updates—Vision and Hearing Aid Services
PB25-35 Reimbursement Rates for SUD Treatment at Free-Standing Residential Treatment Facilities
PB25-34 Policy Updates and Changes to Clinical Review Criteria
PB25-33 New Coding and Reimbursement for Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services
PB25-32 Zepbound for Treatment of Obstructive Sleep Apnea
PB25-31 Updated Diagnosis Requirement for GLP-1 Agonist Medications And New Coverage of FDA Approved Weight Loss Drug Phentermine and Orlistat
PB25-30 Updates to Autism Spectrum Disorder Services
PB25-29 Addition to CPT Code to the Rehabilitation Clinic Fee Schedule
PB25-28 Changes to Prior Authorization Process for Medical Goods And Services: Provider Notification of Determinations and Requests for Additional Information
PB25-27 1) July 1, 2025 Changes to the Connecticut Medicaid Preferred Drug List (PDL) 2) Reminder About the 5-Day Emergency Supply 3) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL) 4) Pharmacy Web PA Tool
PB25-26 Private Non-Medical Institution (PNMI) Rate for Adult Mental Health Rehabilitation
PB25-25 Prior Authorization of Medical Home Health Services
PB25-24 Prior Authorization of Genetic Testing
PB25-23 July 2025 Quarterly HIPAA Compliant Update—Behavioral Health Clinic Fee Schedule and Freestanding Alcohol Treatment Centers Fee Schedule
PB25-22 July 2025 Quarterly HIPAA Compliant Update—Physician Office and Outpatient Fee Schedule
PB25-21 Third Party Liability (TPL) Audit Letter and Report Distribution Changes: Electronic Delivery via the Web Portal
PB25-20 Inability to Fill Prescription Notice
PB25-19 Electronic Claims Submissions, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)
PB25-18 New Coverage of Medical Nutrition Therapy (MNT)
PB25-17 New Fasenra (benralizumab) and Xolair (omalizumab) Prior Authorization Clinical Criteria Requirements
PB25-16 Pharmacists Prescribing and Dispensing Emergency or Hormonal Contraceptives
PB25-15 Policy Updates and Changes to Clinical Review Criteria
PB25-14 New Coverage of Certified Doulas
PB25-13 April 2025 Quarterly HIPAA Compliant Update—Physician Office and Outpatient Fee Schedule
PB25-12 April 2025 Quarterly HIPAA Compliant Update—Medical Equipment Devices and Supplies Fee Schedules
PB25-11 REVISED-Certified Dietitian-Nutritionist Enrollment Criteria
PB25-10 NEW Drug/Product Prior Authorization Form
PB25-09 IMPORTANT REMINDER Concerning Ownership Changes
PB25-08 Update to the Place of Service for Calcium Edetate (J0600)
PB25-07 January 2025-Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes
PB25-06 Connecticut Medical Assistance Program Provider Satisfaction Survey
PB25-05 DPH Doula Certification and Enrollment Criteria
PB25-04 Wegovy Coverage for Risk Reduction of Major Adverse Cardiac Event (MACE) in Adults with Established Cardiovascular Disease and either Obesity or Overweight
PB25-03 New Services added to select Home and Community Based Services Medicaid Waiver Programs—Community Aging in Place-Advancing Better Living for Elders (CAPABLE)
PB25-02 New Services added to select Home and Community Based Services Medicaid Waiver Programs—Care of Older People in their Environment (COPE)/Confident Caregiver
PB25-01 Policy Updates and Changes to Clinical Review Criteria

What regular feature articles would you like to see in the newsletter? We would like to hear from you!!

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