December 2023
Connecticut Medical Assistance Program
https://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

- **Hospital, LTC & Dental Providers:**
  Reminder of Re-Enrollment Timeframes
- **Physicians, Nurse Practitioners, Certified Nurse Midwives, Podiatrists, Optometrists:**
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Attention: All Providers

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

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** username and state 'is no longer the master user for XXX reason'.
- The letter must list the **NEW** user's full name.
- The letter must list the provider's log-in User ID and AVRS ID (Medicaid Provider Number) or NPI.
- 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 date of the letter must be within 30 days of submission 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 of receiving the letter with a reset password. 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, click on "Account Maintenance" and update the contact's name, phone number, email address, and 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: Hospital, LTC & Dental Providers

Reminder of Re-Enrollment Timeframes

After initial enrollment, the Department of Social Services (DSS) requires all providers (organizations, individuals, employed/contracted by an organization provider, including residents, and ordering/referring/prescribing providers) to periodically re-enroll in the Connecticut Medical Assistance Program, based on pre-defined periods of time. Those time periods differ by taxonomy/provider type/provider specialty. Re-enrollment periods for each provider type/specialty can be found by selecting the link titled "Enrollment/Re-enrollment Criteria Matrix" in Chapter 3 of the Provider Manual, available on the www.ctdssmap.com Web site by selecting Information > Publications and scrolling down to the link to that chapter. This information is also available on the www.ctdssmap.com Web site by selecting Provider > Provider Matrix and then clicking the link "Follow on Document Requirement by Provider Type and Specialty".

The purpose of re-enrollment is for DSS to receive updated information from the provider, including current license and Federal Employer Identification Number (FEIN) information, or changes of address. Most provider re-enrollment notices are systematically generated six (6) months prior to a provider's re-enrollment due date. Provider re-enrollment notices for Long Term Care and ICF/IID providers will systematically be generated eight (8) months prior to a provider's re-enrollment due date. Providers are required to go to the Web portal at www.ctdssmap.com to complete their re-enrollment. Simple step-by-step directions are available through www.ctdssmap.com an online tool to assist providers with this process.

Providers can also refer to Chapter 10 for step-by-step instructions on Web portal enrollment and re-enrollment, available on the www.ctdssmap.com Web site by selecting Information > Publications and scrolling down to the link to that chapter. Unless noted as an exception in Chapter 3, Section 3.2, any paper re-enrollment applications received will be denied, with a letter that the provider is required to re-enroll via the Web portal. All notices will be sent electronically through the secure message portal. An alert message will appear in the providers contact email notifying them of a pending message in the secure message portal.

If after three (3) months the provider has not re-enrolled or their re-enrollment application has not yet been finalized, a reminder letter is sent to the provider that they must complete the re-enrollment process prior to their re-enrollment due date. If after this three (3) month period the re-enrollment process is still not completed, the provider will receive a Provider Enrollment/Re-enrollment Rejection Notice.

For Long Term Care and ICF/IID providers, the letter notification process varies slightly in that they will receive an additional notification thirty days prior to their re-enrollment due date that provides additional instructions in accordance with statutes regarding the Long-Term Care or ICF/IID provider's responsibility to clients should the Medicaid provider agreement be terminated.

Regardless of provider type, if a provider does not re-enroll by their re-enrollment due date, the provider

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will be dis-enrolled on that date and will not be able to get reimbursed for the claims submitted for payment for dates of service after that deactivation date. Additionally, prior authorizations will not be uploaded for waiver clients if the provider is not enrolled.

Providers with Secure Web portal access can view their re-enrollment due date on their home page of their Secure Web portal once logged in as well as on the OPR spreadsheet. Organization providers can view the re-enrollment due date of their members by accessing the "Maintain Organization Members" panel.

Please note that each application, once submitted by the provider, must be processed by Gainwell Technologies and the Department of Social Services' (DSS) Quality Assurance Unit. The application must be submitted to allow adequate time for these processes to occur, which typically takes several weeks to complete. To check the status of a re-enrollment application, select Provider Enrollment Tracking from either the Provider submenu or the Provider drop-down menu on the www.ctdssmap.com Web site.

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Attention: Physicians, Nurse Practitioners, Certified Nurse Midwives, Podiatrists, Optometrists

Understanding Surgical Same Day Procedure Edits (NCCI)

CMS established global periods in the form of follow-up days for certain surgical procedure codes to reduce improper payments.

Q: What is a 'global period'?

A: A global period is the number of days which all necessary services normally furnished by a physician (before, during, and after the procedure) are included in the reimbursement for the procedure performed. The global surgery policy divides surgical procedures into two groups – **major and minor surgery**.

Q: How is major surgery/procedure defined?

A: Major procedures/surgical codes are procedures that have a 90-day global period on the "Medicare Physician Fee Schedule Database/Relative Value File". The reimbursement for one major procedure/major surgery includes reimbursement for Evaluation and Management (E&M) services provided by the physician on the day of, and 90 days after the major procedure/surgery.

Q: How is minor surgery/procedure defined?

A: Minor procedures are procedures that have a 0- or 10-days global period. These procedures include related E&M services provided by the physician on the day of, and 0 to 10 days after the procedure, depending on the complexity of the procedure.

Q: Where can I find the related 'Medicare National Physician Fee Schedule Database/Relative Value File' to see which global period is assigned to the codes I might be billing?

A: https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files
In the zip file, select the Excel file titled, "PPRRVU23_JUL.xlsx" once appropriate year is downloaded.

The spreadsheet will look like this:

2023 National Physician Fee Schedule Relative Value File July Release

CPT codes and descriptions only are copyright 2022 American Medical Association. All Rights Reserved. Applica

Dental codes (D codes) are copyright 2023/24 American Dental Association. All Rights Reserved.

RELEASED 05/10/2023

HCPCS	MOD	DESCRIPTION	STATUS CODE	NOT USED FOR MEDICARE PAYMENT	WORK RVU	NON-FAC PE RVU	NON-FA NA INDICAT
A0021		Outside state ambulance serv	I		0.00	0.00	
A0080		Noninterest escort in non er	I		0.00	0.00	
A0090		Interest escort in non er	I		0.00	0.00	
A0100		Nonemergency transport taxi	I		0.00	0.00	
A0110		Nonemergency transport bus	I		0.00	0.00	
A0120		Noner transport mini-bus	I		0.00	0.00	
A0130		Noner transport wheelch van	I		0.00	0.00	
A0140		Nonemergency transport air	I		0.00	0.00	
A0160		Noner transport case worker	I		0.00	0.00	
A0170		Transport parking fees/tolls	I		0.00	0.00	
A0180		Noner transport lodgng recip	I		0.00	0.00	
A0190		Noner transport meals recip	I		0.00	0.00	
A0200		Noner transport lodgng escrt	I		0.00	0.00	
A0210		Noner transport meals escort	I		0.00	0.00	
A0225		Neonatal emergency transport	I		0.00	0.00	

PPRRVU23_JUL_V0510

Q: Are there any modifiers I may report when billing these services?

A: For **major** surgical procedures, an E&M service addressing the decision to perform the surgery IS payable on the date of surgery. This service may be reported with **modifier 57**, if appropriate. Other pre-operative E&M services on the date of surgery are NOT separately reportable.

What is modifier 57?

'E&M service that resulted in the decision to perform a major surgical procedure'

For **minor** surgical procedures, an E&M service addressing the decision to perform the surgery is NOT separately payable on the date of surgery and should not be reported even if the patient is "new" to the provider. If an unrelated significant and separately identifiable E&M service is performed on the day of surgery and before the surgery, it may be reported with **modifier 25**, if applicable.

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What is modifier 25?
'Significant, separately reportable E&M on the same day as the surgery'

For all surgical procedures, other E&M services related to the surgical procedure or to post-operative complications are NOT separately payable on the day of surgery and should not be reported.

For all surgical procedures, significant and separately identifiable post-operative E&M services rendered on the day of surgery that are unrelated to the diagnosis for which the surgical procedure was performed ARE separately payable. These services may be reported with **modifier 24 or 25**, if appropriate.

What is Modifier 24?
'Unrelated E&M service during the postoperative period'

NOTE: If a surgery code and an E&M code are reported by the same physician for the same date of service and if one of these modifiers (24, 25, or 57) is not correctly appended to one of the codes, payment for the column two E&M code will be denied and the column one surgery code will be eligible for payment.

NOTE: Modifiers 24, 25, and 57, when appropriate, will override NCCI Edits but will NOT override current DSS policy edits that are in place to support policy. See Sec. 17b-262-34P (i)(3) of the Regulations of CT State Agencies, which states that "The Department will not pay for related E&M encounters on the same day as surgery."

Q: If payment for a claim with E&M code denied because the provider did not append one of these modifiers when it would have been appropriate to do so, what can I do?

A: Resubmit the claim with the modifier.

Understanding National Correct Coding Initiative (NCCI) Edits

The NCCI edits are designed to promote correct coding and to control improper coding that could lead to inappropriate payments. They are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. The edits apply to both Current Procedural Terminology (CPT) Level I codes and Healthcare Common Procedure Coding System (HCPCS) Level II codes.
The coding policies of NCCI are based on coding conventions defined in the American Medical Association's Current Procedural Terminology Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

NCCI for Medicaid contains two types of edits:

1. **Procedure-to-Procedure (PTP)** edits define pairs of Healthcare Common Procedure Coding System (HCPCS) /Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The PTP edits prevent improper payments when incorrect code combinations are reported.

2. **Medically Unlikely Edits (MUEs)** define, the maximum Units of Service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service.

It is important to note that there are two separate NCCI pages, one for each program. Conducting a general search of "NCCI" or "National Correct Coding Initiative" directly from the CMS.gov website may take the user to the Medicare page, not the Medicaid page. Providers and others should go to the Medicaid NCCI web page to obtain Medicaid-related NCCI information and edit files.

CMS has published a variety of helpful materials to help providers navigate NCCI edits and better understand NCCI methodologies, including but not limited to the linked below:

NCCI for Medicaid | CMS
How To Use NCCI Tools (PDF)
Proper Use of Modifiers 59, XE, XP, XS, and XU (PDF)

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Attention: Hospital Providers

Prior Authorization Reminders

Providers are submitting an increased number of inquiries surrounding Prior Authorization (PA) requirements. As a reminder, all Inpatient hospital stays require PA, except for Maternity Admissions with Delivery.

Effective for dates of service 11/1/2022 and forward, in-state and border hospitals will no longer need to submit notifications of labor and delivery admissions to the Medical ASO, Community Health Network of Connecticut, Inc.

As a reminder, authorization is not required for HUSKY Health Members who deliver during an inpatient admission. Additionally, authorization is not required when a HUSKY Health Member is in observation status.

Attention: Acquired Brain Injury (ABI), Connecticut Home Care (CHC), Personal Care Assistance (PCA), Mental Health (MH) Waiver Service Providers, and Home Health Agencies:

Confirmed Visit Not Found Error 3327

This reason code will set when the claim contains an EVV mandated service for which there is no matching confirmed visit in the Santrax system that contains the same client ID, provider ID, date of service, service code and modifier(s).

To resolve this error the provider must verify that the visit that they are trying to bill is in a confirmed status in the Santrax system prior to rebilling. It may take anywhere from 24 to 48 hours for a confirmed visit to be communicated to Gainwell Technologies, so the visit may not be able to be billed immediately following visit confirmation. Provider should also ensure that the claim details match the confirmed visit's details, or this EOB may set again.

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Attention: Hospice Agencies

Important Hospice Lock-In Reminders

Hospice Providers are reminded of the documented criteria for entering election, revocation, transfer, discharge and extension transactions as follows:

Election Transactions

- The completed **W-406 or W-406S Election form** should be available at the time the Election Transaction is submitted online to ensure:
  - ◊ Correct entry of the "Hospice Election Effective Date"
  - ◊ Correct entry of the Election Transaction Eligibility type
    - ♦ Medicaid (HM)
    - ♦ Medicaid and Medicare A (HD)
  - ◊ Form is signed by client or client's representative acknowledging the Hospice election.
- To ensure the **"Hospice Election Effective Date",** documented on the W-406 or W-406S Election form is captured, a Hospice Election Transaction must be submitted by the Hospice Agency, via their Hospice Secure Web Account **within seven (7) business days** of the effective date of the Hospice election, when:
  - ◊ A client initially elects the Hospice benefit.
  - ◊ Re-elects the benefit after revocation.
  - ◊ Re-elects the benefit after discharging from the care of another Hospice Agency or their own Agency.

Pending HUSKY Eligibility

- The Election Transaction must be entered via their Hospice Secure Web Account **within seven (7) business days** of the **client's eligibility being added to the client's eligibility file.**
- To ensure capture of the "Hospice Election Effective Date" as documented on the W-406 or W-406S Election form, **client eligibility should be checked on a regular basis.**

Other Important Points to Remember about Election Transactions

- Submission of the Election Transaction **does not automatically update the client's eligibility file.**
- **It may take up to two (2) business days for the submission of the Hospice Election Transaction to appear as a lock-in on the client's eligibility file**.
- Hospice Providers must make their own corrections prior to the Election Transaction appearing on the eligibility file, as **once the eligibility file has been updated, submitted corrections may not be allowed.**
- **Failure to submit a timely "Election Transaction", could result in lost Hospice lock-in days,** requiring the Hospice Agency to lock-in the Hospice Election with the first day the on-line transaction tool will allow.

Exceptions to Untimely Submission of the Notice of Election (NOE)

- Fire, floods, earthquakes, or other unusual events that inflict extensive damage to the Hospice's ability to operate.
- An event that produces a data filing problem due to a DSS systems issue that is beyond the control of the Hospice.
- Retroactive client eligibility. (Refer to the "Pending HUSKY Eligibility" section above for Election Transaction Requirements).
- Other circumstances determined by DSS to be beyond the Hospice's control.

Please Note: *Hospice Agencies should have internal procedures in place to ensure all Hospice Transactions are entered in a timely manner.*

Hospice Discharge Transactions

- A **discharge should be entered timely** to update the lock-in as soon as possible to avoid delay in entering

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additional transactions or delaying treatment by other providers in the care of a client.

- A **discharge must be entered** for each revocation.
- A **discharge should not be entered** if a client is being directly transferred to another Hospice Agency. An automatic discharge will be entered upon receipt of the transfer transaction by the receiving Hospice Agency.

Other Important Points to Remember about Discharge Transactions

- Submission of the discharge transaction **does not automatically update** the lock-in on the client's eligibility file.
- Entry of the transaction, updating the eligibility file may take **up to two (2) business days.**
- Discharges may be updated **until the discharge transaction appears on the eligibility file.**
- A new election cannot be entered **until the discharge transaction has been entered and the client's eligibility file updated.**

Hospice Transfer Transactions

- **A transfer transaction may be submitted** up to three (3) days prior to the transfer date or three (3) days after the transfer date.
- **A transfer transaction must be entered** by the Hospice Agency directly receiving a client from another Hospice Agency.
- **A discharge from the transferring Hospice will not occur** until the transfer transaction is received by the receiving Hospice.

Other Important Points to Remember about Transfer Transactions

- Submission of the transfer transaction **does not automatically update the lock-in on the client's eligibility file.**
- Entry of the transaction may take **up to two (2) business days.**
- Hospice transfer transactions may be updated **until the transfer transaction appears on the eligibility file.**

Hospice Extension Transactions

- **An on-line extension transaction is entered by a Hospice Agency to extend the lock-in of a client that will exceed** the initial twelve (12) month election period or subsequent twelve (12) month extension period.
- **A Hospice extension may be submitted up to** thirty (30) days prior to the end date of the most current Hospice lock-in segment.
- **A Hospice extension cannot be submitted more than** three (3) business days after the end date of the current Hospice segment.

Other Important Points to Remember about Extension Transactions

- Submission of the extension transaction **does not automatically update the lock-in on the client's eligibility file.**
- Entry of the transaction **may take up to two (2) business days.**
- Hospice Extension transactions may be updated **until the Extension transaction appears on the eligibility file.**

For more information on Hospice lock-in requirements or Hospice Claim Submission, please refer to the following documents:

⇒ Latest Hospice Refresher PowerPoint Presentation on the www.ctdssmap.com Web site. https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/2022_Hospice_Refresher.pdf

⇒ Provider Manual chapter 7, Medical Policy and Chapter 8 Claim Submission Instructions are also available on the www.ctdssmap.com Web site. From the Home Page> Information > Publications > Provider Manuals Chapter 7 & 8. To view chapter 7 or 8.

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Attention: Medical Equipment, Devices and Supplies (MEDS) Providers

Understanding Common Medical Equipment, Devices and Supplies (MEDS) Claim Denials

Durable Medical Equipment, Orthotics, Prosthetics, and Supplies have limits on the frequency that items can be dispensed to an eligible member. If a HUSKY member exceeds the limit on an item, prior authorization approval must be requested with accompanying medical documentation as to why the limit needs to be exceeded.

The list of DME, Medical Surgical Supplies and O&P procedure codes subject to quantity limitations can be found on the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com. From this page, go to “Provider”, then to “Provider Fee Schedule Download”. Click on “I accept”, then click on “Click here for the Fee Schedule Instructions”. The list of procedure codes will be found at the end of this section, entitled Table 19, “MEDS Procedure Codes - Quantity Limitations”.

In addition to frequency limits, Correct Coding Initiative (NCCI/MUE) edits will deny items billed in excess of what CMS allows. However, the (NCCI/MUE) edits do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent the use of an inappropriate code combination or items that are not appropriately reported together (unbundled).

Prior authorization (PA) will not override the daily federally required National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs). MUEs are “per day” edits that take precedence over the maximum quantity allowed per month. Additional units requested per month via PA will not override the MUE. Providers should continue to utilize an appropriate day span, by entering the “From” and “To” dates in MM/DD/YY format on the claim detail to avoid claim denials due to MUE as well as any daily contract quantity limitations set by CMAP.

Please note: Equipment that is in working order should not be replaced, although it may have exceeded its life expectancy. Please refer to the MEDS fee schedule for fee schedule rates, pricing information and prior authorization information. The MEDS fee schedule can be accessed at the link below: www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download".

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Recent Updates of Provider Manuals

Chapter 5 Claim Submission Information of the Provider Manual has been updated. Updates include:

Section 5.11 pages 123—124

There have been updates made to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) section.

- Addition of information about claim submissions for vaccines
- Immunization Administration Codes
- Routine Childhood Vaccinations including Periodicity and Immunization Schedule

Section 5.12 pages 127—128

A new section has been added which includes new information regarding Physician-Administered Drugs.

- Physician-Administered drugs
- Unclassified drugs
- Physician-administered drugs obtained through a pharmacy

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Appendix

Holiday Schedule

Date	Holiday	Gainwell Technologies	CT Department of Social Services
1/1/2024	New Year's Day, observed	Closed	Closed
1/15/2024	Martin Luther King Jr. Day	Closed	Closed
2/12/2024	Lincoln's Birthday, observed	Open	Closed
3/29/2024	Good Friday	Closed	Closed
5/27/2024	Memorial Day	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.

PB23-87 1. January 2024 Quarterly HIPAA Compliant Updates—Behavioral Health Clinic Fee Schedule 2. Updating Physician Administered Drugs on the Behavioral Health Clinic Fee Schedule
PB23-86 Updating Physician Administered Drugs on the Dialysis and Family Planning Clinic Fee Schedules
PB23-85 January 2024 HIPAA Compliant Updates for MEDS
PB23-84 January 2024 Quarterly HIPAA Compliant Update—Laboratory Fee Schedule
PB23-82 1. January 2024 Quarterly HIPAA Compliant Updates-Medical Clinic Fee Schedule 2. Updating Physician Administered Drugs on the Medical Clinic Fee Schedule
PB23-81 Out-of-State and Border Hospital Reimbursement-Effective January 1, 2023
PB23-80 Annual Update to the Inpatient Hospital Adjustment Factors and Update to the APR-DRG Weights
PB23-79 January 2024 Quarterly HIPAA Compliant Updates-Dental Fee Schedules for Adult and Children
PB23-78 Obstetrics Pay for Performance Extended
PB23-77 January 2024 Quarterly HIPAA Compliant Update—Clinic—Ambulatory Surgical Center Fee Schedule
PB23-76 1) January 1, 2024 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
PB23-75 Updating the Reimbursement Rates for Nursing Services For Home Health Adult Complex/High Tech Level of Care
PB23-74 January 2024 HIPAA Compliant Update to the Independent Audiology and Speech and Language Pathology Fee Schedule
PB23-73 January 2024 HIPAA Compliant Update to Rehabilitation Clinic Fee Schedule
PB23-71 1. January 2024 Quarterly HIPAA Compliant Updates-Physician-Office and outpatient, and Physician Surgery Fee Schedules, 2. Physician Administered Drug Reimbursement Updates, 3. Increase to the Reimbursement Rate for ParaGard
PB23-70 January 2024 Independent Radiology and Physician-Radiology Fee Schedules—Quarterly HIPAA Compliant Update
PB23-69 Addition of Periodontal Benefits
PB23-68 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)
PB23-67 Prior Authorization Threshold for Procedure Code B9998—NOC Enteral Supplies
PB23-66 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients
PB23-65 Policy Updates and Changes to Clinical Review Criteria
PB23-64 New Hepatitis C Policy
PB23-63 UPDATED: Pediatric Inpatient Psychiatric Services: Interim Voluntary Value-Based Payment Opportunity for Increasing Needed Capacity and Interim Rate Add-On for Acuity and Revised Discharge Delay Policy
PB23-62 October 2023 Quarterly HIPAA Compliant Update—Physician Office and Outpatient and Clinic and Outpatient Hospital Behavioral Health
PB23-61 Veyo Transition to MTM
PB23-60 Rate Increases for Select Home Health and Home and Community Based Services (HCBS) Effective June 1, 2023
PB23-59 Hospice Rates for Federal Fiscal Year 2024
PB23-58 Addition of Screening, Brief Intervention, and Referral To Treatment (SBIRT) Codes to the Medical Clinic and Rehabilitation Clinic Fee Schedules
PB23-57 Adding Select Procedure Codes for Evaluating/Management Services to Dental Fee Schedules
PB23-56 UPDATED: Attestation Requirement for Behavioral Health Clinician Groups and Behavioral Health Licensed Clinicians
PB23-55 New Medicaid Coverage of Targeted Case Management for Integrated Care for Kids (InCK) in New Haven
PB23-54 Multi-disciplinary Examinations for Medical, Behavioral Health and Dental Services
PB23-53 Policy Updates and Changes to Clinical Review Criteria
PB23-52 Updates to the CHESS Reimbursement Process
PB23-51 Clinical Treatment Hours for Substance Use Disorder (SUD) Intensive Outpatient (IOP) and Partial Hospitalization (PHP) Programs
PB23-50 Reimbursement for Intermediate Substance Use Disorder (SUD) Treatment at Behavioral Health FQHCs
PB23-49 Rate Increases for Select Home Health and Home and Community Based Services (HCBS)
PB23-48 Obstetrics Pay for Performance
PB23-47 July 2023 Quarterly HIPAA Compliant Update—Physician Office and Outpatient Fee Schedule
PB23-46 July 2023 HIPAA Update to Medical Equipment Devices And Supplies (MEDS) Fee Schedule
PB23-45 Continuation of Add-on Rate for Vent Bed Stays For Chronic Disease Hospitals

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