December 2024
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

Update Ownership Changes with DSS/Gainwell Technologies

The Department of Social Services (DSS) would like to emphasize the importance of updating any ownership changes with not only the Department of Labor but also with DSS and Gainwell Technologies.

The Provider Assistance Center (PAC) will need to be contacted at 1-800-842-8440 to obtain an Application Tracking Number (ATN) and a new provider re-enrollment application will need to be completed in order to notify DSS and Gainwell Technologies of the ownership change.

Your provider profile and enrollment status with the Connecticut Medical Assistance Program serves as a key representation of your business or service, and ensuring its accuracy is important for various reasons. While many owners diligently update their information with the Department of Labor when an ownership change occurs, it is equally crucial to maintain accuracy within the DSS database and complete your enrollment and re-enrollment applications. This approach is necessary for your business to maintain:

1. **Importance of Reporting to proper state entities:** The Department of Social Services/Gainwell Technologies, and the Department of Labor play distinct roles in overseeing different aspects of your business. DSS and Gainwell focuses on social services, support services and claims processing. The Department of Labor concentrates on employment-related matters. Updating your information with both entities is required.

2. **Avoidance of Discrepancies:** Discrepancies between your profiles can lead to confusion and potential misunderstandings. Whether it is contact information, service details, or certifications, aligning all profiles mitigates the risk of conflicting information. If there was an ownership change and this was not reflected with your re-enrollment, it can cause problems with claim payment.

3. **Fulfillment of Other Requirements:** Many social service programs require providers to submit accurate information for compliance and reporting purposes. For example: most recently is the requirement of the **Behavioral Health Attestation.** By maintaining updated profiles with both DSS/Gainwell and the Department of Labor, you ensure that your data aligns with program requirements and facilitates smoother reporting processes. Accurate profiles enable efficient communication between your organization and government agencies. Timely notifications, updates, and communications from both the DSS and the Department of Labor are crucial for staying informed about regulatory changes, program updates, and other important announcements. If that information is not up to date, then risk of claim denials and enrollment issues can occur.

   ***If your group practice has been through an ownership change and you have not notified DSS/Gainwell Technologies, your group practice will not be able to fully complete the Behavioral Health Attestation.**

Some changes (e.g., a change in ownership or establishment of a new site) require the provider to complete a new provider enrollment application, which may require the issuance of a new NPI/non-medical provider identifier. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. In the instance of the issuance of a new non-medical provider identifier, it is important to note that the format of the provider number may vary from the previous number. In the instance of a merger, the provider must complete a new provider application or provider agreement, as indicated above. It is particularly important that a provider indicate, via a letter to Gainwell Technologies, which NPI/non-medical provider identifier will no longer be a valid billing provider.

Failure to inform Gainwell Technologies of changes may result in the denial of claims, misdirected payments, the loss of provider eligibility, or the recoupment of previously paid claims. Entering the new information on a claim form or prior authorization request is not notification of change.

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

Reminder of Pricing Documentation Requirements for Select Wheelchair Repair Codes

Claim submission guidelines are necessary for successfully submitting claims and we here at Gainwell Technologies are excited to offer resources to prevent delays in claim payments. In this article we will explore what the documentation requirements are for manual pricing for select wheelchair repair codes and highlight the methods to submit claims.

Providers should double-check their wheelchair repair claim and pricing documentation (invoice) before submission to confirm that the claim meets the following criteria:

As an example, if a claim is in a suspended status because the billed amount of a wheelchair repair procedure code is **greater than the max fee of $1000,** the following steps outlined in the provider bulletin PB 2024-42 should be taken. Once the claim is submitted, the pricing documentation specific to the repair being performed must be submitted with, at a minimum, the following details:

- HUSKY Health member identification (ID) number
- Date of Service for the claim
- Claim Internal Control Number (ICN)
- Provider National Identification Number (NPI)
- Pricing documentation (invoice) that is no older than twelve (12) months

The pricing documentation can be submitted to Gainwell Technologies (GT) utilizing one of three methods listed below:

Fax: 860-986-7995
Email: ctxix-claimattachments@gainwelltechnologies.com
Mail: Gainwell Technologies PO Box 2971 Hartford, CT 06104

Pricing of the manually priced claims will be completed within ten (10) business days, once all appropriate and complete documentation is received. If further assistance is required, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p. m. at 1-800-842-8440.

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Attention: Behavioral Health Providers

Year in Review for Behavioral Health Changes

As the year draws to a close, we would like to reflect on the key updates that have occurred throughout the year. Here are the highlights from this year's bulletins:

Mental Health Access Improvement Provider Bulletin 2024-02

- **New Medicare Provider Types**: As of January 1, 2024, Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) can enroll and bill Medicare independently for their services. This change, brought about by the Mental Health Access Improvement Act (S.828/H.R.432), allows these providers to bill Medicare Part B for approved services, expanding access to mental health care for Medicare beneficiaries.

Ensuring Compliance with New Clinic Performing Provider Requirements Provider Bulletin 2024-11

- **New System Changes for Behavioral Health and Enhanced Care Clinics**: Effective June 1, 2024, the Department of Social Services (DSS) requires all performing providers in Behavioral Health and Enhanced Care Clinics to be enrolled in the Connecticut Medical Assistance Program (CMAP) and be associated with their clinic for claims. This change ensures all claims are submitted with an enrolled provider's National Provider Identifier (NPI), enhancing the integrity and accuracy of the claim submission process.

Increased Reimbursement Rates for Behavioral Health Services Provider Bulletin 2024-39

- **Behavioral Health Services Rate Increase**: Pursuant to section one of Public Act 23-204, the Connecticut Department of Social Services (DSS) was allocated seven million dollars to increase reimbursement rates for select behavioral health services for children covered under HUSKY Health. Effective July 1, 2024, these increased rates apply to providers under the following fee schedules: Autism Spectrum Disorder, Physician Office and Outpatient, Behavioral Health Clinic and Outpatient Hospital (Behavioral Health), Psychologists, Behavioral Health Clinicians, Rehabilitation Clinics, Special Services, and Medical Clinics (including school based).

Attestation Process for Behavioral Health Providers Provider Bulletin 2023-56

- **New Attestation Requirement**: As of August 1, 2024, the deadline for the required attestation process for all Behavioral Health Providers Enrolled in Independent Practice and Group Practice: Psychologists, Licensed Marital and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Licensed Alcohol and Drug Counselors (LADCs) has passed and providers who are not compliant have started to receive claim denials. This attestation is mandatory for all licensed, enrolled behavioral health providers (type 33) and owners of behavioral health groups (type 86). Providers must complete training and submit the attestation form, ensuring compliance with state regulations.

Telehealth Updates for January 2025

Telehealth services will continue beyond the end date of 12/31/24 listed on the CMAP Telehealth Table. Updates to the Telehealth Table will include the January 2025 Healthcare Common Procedure Coding System (HCPCS) changes to ensure coding remains compliant with the Health Insurance Portability and Accountability Act (HIPAA). All updates regarding Telehealth will be issued in a forthcoming provider bulletin (PB) and posted on the www.ctdssmap.com Web site.

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Attention: Acquired Brain Injury (ABI), Autism, CT Home Care (CHC) and Personal Care Assistant (PCA), Waiver Service and Community First Choice (CHC) Support and Planning (S&P) Coach Providers

Reminder of the New Fiscal Intermediary (FI) for Waiver Service and S&P Coach Provider Credentialing and Important Updates and Reminders to the Enrollment and Re-enrollment Process

As previously communicated, GT Independence (GTI), is the new Fiscal Intermediary responsible for the credentialing of providers to become newly enrolled or those providers wanting to maintain their current re-enrollment status as a Waiver Service or S&P Coach provider. Providers should refer to Provider Bulletin PB 2024-84 for further information on the vendor transition and the impact it may have on both new and existing provider credentialing and enrollment.

The following provides a summary of steps and important reminders in the process of becoming a credentialed and enrolled Waiver Service or CFC S&P Coach Provider. Providers should refer to Provider Bulletin PB 2024-84 for further details.

Credentialing: Both new and existing providers who have received notification from Gainwell Technologies that their re-enrollment is coming due must contact GTI at providercredentialing@gtsd.org requesting credentialing documentation and providing the contact information of the individual who will be responsible for completing the credentialing process.

Once received, the credentialing application should be completed as soon as possible and returned to GTI with all supporting documents to providercredentialing@gtsd.org.

GTI will inform providers via email if all DSS requirements are met and the provider is approved, issuing their credentialing letter or if the application is incomplete or needs additional information.

Preparing for Online Enrollment/Re-enrollment: Providers must receive their credentialing letter from GTI in order to complete the enrollment or re-enrollment process. Once the credentialing letter has been received providers will access either the enrollment or re-enrollment wizard on the www.ctdssmap.com Web site.

Providers should read all instructions before beginning the Enrollment or Re-enrollment Application process and gather all data requested to be entered or verified. Should the application remain idle for more than 20 minutes, the system will time out and all data entered will be lost. As a result, a new application must be started.

Re-enrolling providers must use their Application Tracking Number (ATN) to access their prior enrollment information. The ATN is sent to the provider via their re-enrollment notification letter sent 6 and 3 months prior to their re-enrollment due date to the Trade Files section of their secure Web account. If the ATN cannot be found, providers must contact the Provider Assistance Center at 1-800-842-8440 for assistance.

Application Submission: Prior to submitting the enrollment or re-enrollment application, providers should carefully review all data for accuracy and completion, as once submitted, the application cannot be altered, and all omissions or changes must be sent to Gainwell Technologies.

Once the application is submitted providers will be presented with a link to any follow-on-documents. Providers should download this document and include it with all documentation sent to Gainwell Technologies. Providers will also be presented with a new ATN which should be added to each document sent to Gainwell Technologies, to ensure association to the submitted online application.

Last Step: To complete the application process, providers must submit their credentialing letter with the ATN presented upon application submission to Gainwell Technologies. The application cannot be forwarded on to DSS without the provider's credentialing letter.

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Attention: Home Health, CT Home Care (CHC), Personal Care Assistant (PCA), Acquired Brain Injury (ABI), Autism and Mental Health (MH) Waiver Service Providers

Electronic Visit Verification (EVV) Reminders

As a reminder, whether billing through Sandata Agency Management or Alternate EVV, providers must allow 48 hours for the visits to be loaded into the Medicaid Management Information System (MMIS) prior to claim submission. For the claim to be considered for payment, a visit from the Sandata Agency Management system must exist in one of the following three confirmed statuses:

- 02 – Confirmed – signals when a visit has been auto confirmed or manually verified and then confirmed. The visit is now ready and available to bill.
- 03 – In Process – signifies that a visit for the service has already been confirmed and a claim exported for claims processing.
- 04 – Closed – indicates that a visit has been confirmed, the claim has been exported for claims processing, and the claim has been paid or denied as appropriate. This status is set by the provider in the Santrax system.

If you receive any of the following EOB denials, be sure that **all** visits for **all** shifts are in a confirmed status and that the visits have not been adjusted or changed since they were first confirmed. When there is a change made to visits after the visit has been confirmed this requires the visit to be reconfirmed and then wait the suggested period of time before billing services.

For Non-Waiver Home Health Claims:

- EOB 3331 Confirmed Visit Not Found
- EOB 3332 Confirmed Visit Units are Exceeded

For Waiver Home Health Claims:

- EOB 3327 Confirmed Visit Not Found
- EOB 3328 Confirmed Visit Units are Exceeded

As a reminder for providers manually adding non-waiver clients within Sandata Agency Management, please be advised that there are two areas in which the client ID must be entered for the visit to be paid. Failure to do so will cause the visit to deny. Please reference Attachment A below for screen prints that demonstrate entry of the client ID in two locations. Sandata Agency Management users billing and/or adjusting claims via an alternate claim solution are advised that the visits will be available in the MMIS for payment within 24 hours. There are also some important resources For Alternate EVV, once the vendor has submitted a verified visit and it appears in the Sandata Aggregator, it may take an additional 48 hours for that visit to be available in the MMIS for payment.

Helpful and up-to-date information regarding the EVV HHCS implementation is available on the Connecticut Medical Assistance Program (CMAP) Web site – EVV Home Health Implementation Documentation Web page including Alternate

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EVV Specifications, Alternate EVV Frequently Asked Questions, Provider Bulletins, Important Messages, Town Hall materials, and training requirements.

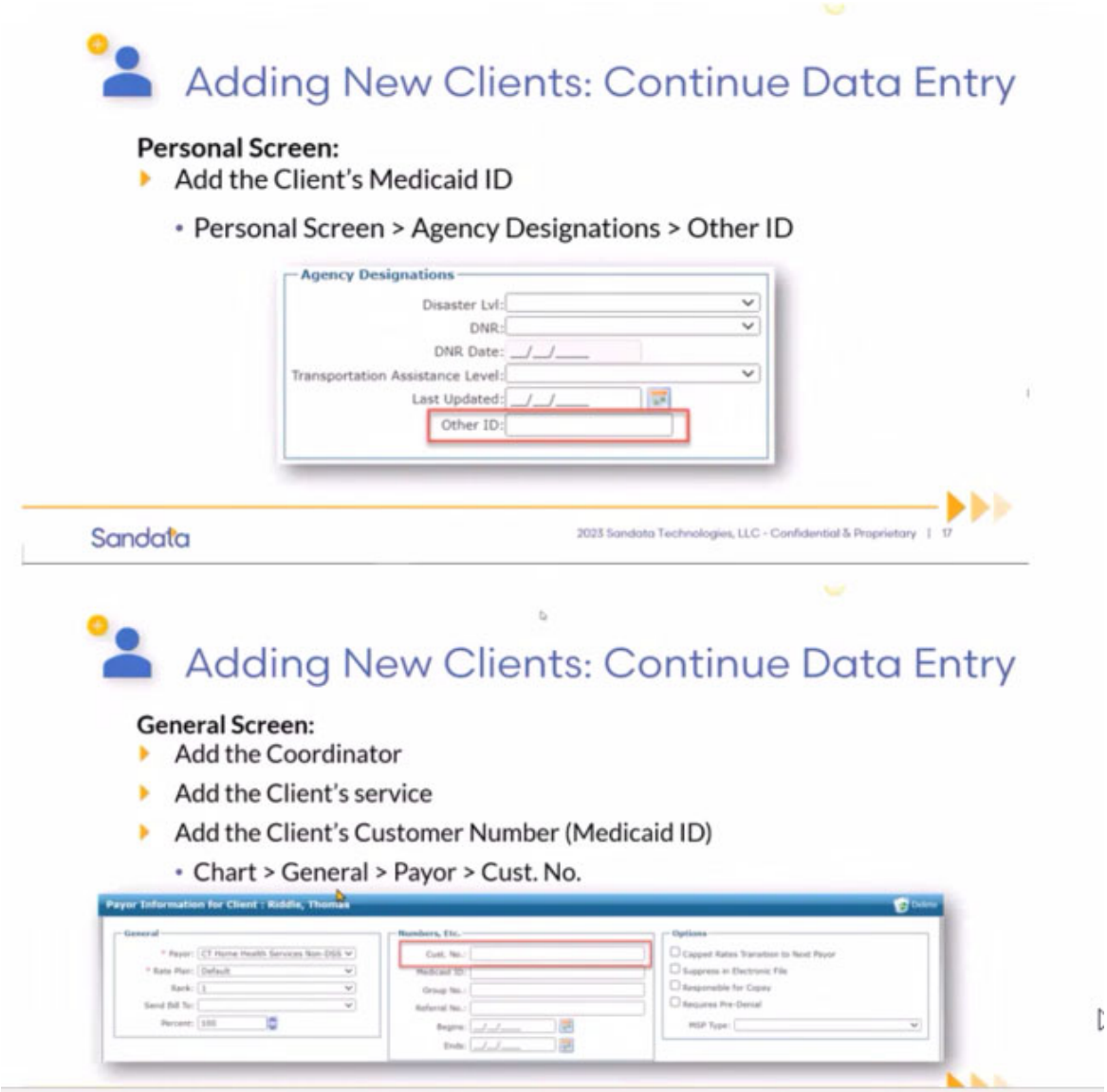
To access the current version of the Web page, click the refresh/reload icon near the address bar (also referred to as "location" or "URL" bar) in the Web browser.

For questions related to Alternate EVV support, providers can contact Sandata Technologies at the following email address: ctaltevv@sandata.com.

As a reminder, questions related to EVV can be submitted securely to ctevv@gainwelltechnologies.com.

Attachment A

Manual Client Data Entry – Non-Waiver Clients



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Attention: All Providers

Other Insurance/Medicare Submission Instruction Reminders

The Connecticut Medical Assistance Program (CMAP) is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage or Medicare, the benefits of these policies must be fully exhausted prior to claim submission to the CMAP. Chapter 11 of the Provider Manual contains important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment or denied a claim.

Chapter 11 can be accessed from the www.ctdssmap.com Web site by selecting Information > Publications, and then selecting the appropriate claim type from the drop-down box.

Third party insurance carriers are identified by a three-digit carrier code. It is important to note that these carrier codes are specific to the Connecticut Medical Assistance Program (CMAP). If you are experiencing claim denials due to an invalid carrier code, it is important to ensure CMAP values are submitted. A valid carrier code must be indicated for each other payer submitted on a claim. To ensure a valid CMAP carrier code is submitted, providers should use the carrier code(s) returned on the client's eligibility verification response.

For further information on carrier codes, providers may refer to Chapter 5 of the Provider Manual, available on the www.ctdssmap.com Web site. Providers are reminded that this chapter also contains information on what to do in the instance of discrepancies with a client's other insurance information, including contact information for HMS.

Providers are strongly encouraged to submit a valid CMAP specific carrier code in the primary identifier field (qualifier = PI). However, providers may also submit a valid CMAP specific carrier code in the secondary identifier field (qualifier = 2U).

As a reminder, for all crossover claims submitted by a provider (i.e., those that do not systematically crossover from Medicare), Medicare must be identified by the 3-digit carrier code of MPA or MPB. It is not sufficient to submit only a claim filing indicator of MA or MB. The claims must also be submitted with the appropriate claim adjustment reason codes (CARC). In the future, crossover claims submitted by providers that do not contain a valid carrier code in the primary or secondary identifier field, including the carrier code of MPA or MPB when appropriate, will deny with EOB code 2515 – Claim other payer carrier code is not on file. Providers may also see EOB 2535 – No valid other payer ID submitted at the detail, when there is a payment but no carrier codes.

Providers are required to obtain authorization prior to the service being rendered when the client has OI and the service requires prior authorization. Prior authorization is not needed when the client has Medicare as their primary insurance and Medicare covers the service. In these situations, the provider is submitting Medicare's co-insurance and/or deductible to be considered as secondary to Medicaid.

To assist providers with understanding other insurance/Medicare related claim denials, providers may refer to Chapter 12 of the Provider Manual, also available on the www.ctdssmap.com Web site. This chapter is revised as existing EOBs are modified and new EOBs are added.

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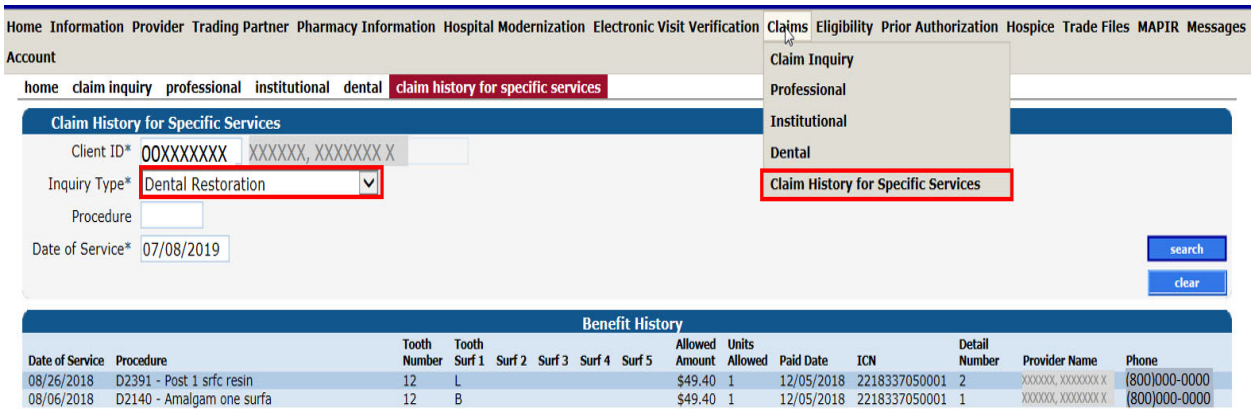
Attention: Dental Providers

Explanation of Benefits (EOB) Code 9992-Payment Amount Reflects Tooth Surface Pricing

Have you seen Explanation of Benefits (EOB) code 9992 "Payment Amount Reflects Tooth Surface Pricing" set on your claims and wondered what it meant? The EOB sets on claim details in accordance with the Department of Social Services (DSS) policy whereby providers are reimbursed for the total number of surfaces restored on a single tooth per one (1) year period when performed by any provider. For example, a provider is paid for performing a restoration on surfaces Lingual and Mesial (LM) on tooth 19. The same or a different provider submits a second claim for the same client within one year from the previous date of service for restoration on the surfaces Distal and Occlusal (DO) on the same tooth (#19). The second claim does not pay for a second two surface restoration; instead, the second claim pays the difference between the four-surface restoration and the previously paid two surface restoration and posts the Explanation of Benefit (EOB) code 9992 - Payment Amount Reflects Tooth Surface Pricing at the detail.

Providers can look up restoration services provided to a client within the past one year by logging into their secure Web portal account at www.ctdssmap.com, click on "claim history for specific services" from under the "Claims" link. Enter the Client ID, select "Dental Restoration" as the Inquiry Type, enter the Date of Service and click "Search."

Providers are reminded that there are two different policies for restorations. A pricing policy as described above, and a policy as described in Provider Bulletin PB 2016-45 where a restoration on the same tooth and surface is allowed once every two (2) years. Providers should check the patient history at the www.ctdhp.org Web site before providing any services.



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Appendix

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

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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.

PB24-84 New Fiscal Intermediary-GT Independence Update Reminder To Medical Provider Enrollment and Re-enrollment Process
PB24-83 Changes to Billing Modifiers for Long-Acting Reversible Contraceptive Devices in the Medical Federally Qualified Health Center (FQHC) Setting
PB24-82 Updates to the Reimbursement Rate for Select Long-Acting Reversible Contraceptive Device
PB24-81 Adding Select Procedure Codes for Electronic Consultations
PB24-80 Obstetrics Pay for Performance Program for Non-Participating Maternity Bundle Providers
PB24-78 Updates to Telehealth—January 2025 Updates
PB24-77 Out-of-State and Border Hospital Reimbursement-Effective January 1, 2025
PB24-76 Annual Update to the Inpatient Hospital Adjustment Factors and Update to the APR-DRG Weights
PB24-75 (1) January 2025 Quarterly HIPAA Compliant Update-Dialysis Fee Schedule (2) Updating Physician Administered Drugs on the Dialysis Clinic Fee Schedule
PB24-74 (1) January 2025 Quarterly HIPAA Compliant Updates-Family Planning Clinic, Medical Clinic & Behavioral Health Clinic Fee Schedules (2) Updating Physician Administered Drugs on the Family Planning Clinic, Medical Clinic & Behavioral Health Clinic Fee Schedules
PB24-73 January 2025 Quarterly HIPAA Compliant Update-Independent Radiology and Physician-Radiology Fee Schedules
PB24-72 1. January 2025 Quarterly HIPAA Updates-Physician-Office and Outpatient, and Physician Surgery Fee Schedules 2. Physician Administered Drug Reimbursement Updates
PB24-71 January 2025 Quarterly HIPAA Compliant Update-Laboratory Fee Schedule
PB24-70 January 2025 Quarterly HIPAA Compliant Update-Medical Equipment Devices and Supplies Fee Schedules
PB24-69 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
PB24-68 January 2025 Quarterly HIPAA Compliant Update—Clinic-Ambulatory Surgical Center Fee Schedule
PB24-67 Pediatric Inpatient Psychiatric Services: Implementation of a Voluntary Value-Based Payment (VBP) Program
PB24-66 UPDATED: Diagnosis Requirement for GLP-1 Agonist Medications
PB24-65 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)
PB24-64 Medicare Part D Co-pays for Dual Eligible HUSKY Low Income Subsidy Clients
PB24-63 1) January 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
PB24-62 Submission of Prior Authorization (PA) Requests for Medical Goods and Services
PB24-61 Policy Updates and Changes to Clinical Review Criteria
PB24-60 Pharmacy Local Fax Number Discontinuation
PB24-59 Updates to the Diabetic Supply Preferred Product List For Pharmacy Claims
PB24-58 Addendum to Medicaid Provider Enrollment and Re-enrollment Process
PB24-55 (1) COVID-19 Laboratory Testing Reimbursement Updates To the Family Planning Clinic and (2) Addition of Procedure Code to the Family Planning Clinic Fee Schedule
PB24-54 (1) COVID-19 Laboratory Testing Reimbursement Updates To The Medical Clinic Fee Schedule and (2) October 2024 Quarterly HIPAA Compliant Update—Medical Clinic Fee Schedule
PB24-53 October 2024 HIPAA Compliant Updates for MEDS
PB24-52 (1) Updated COVID-19 Vaccine Administration Guidance And Reimbursement (2) Pharmacy Coverage for at home COVID Test kits
PB24-51 Pharmacists Ordering, Prescribing, and Administering Vaccines
PB24-50 October 2024 Quarterly HIPAA Compliant Update - Physician Office and Outpatient Fee Schedule
PB24-49 COVID-19 Laboratory Testing Updates to Independent Laboratory Fee Schedule

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