December 2025
Connecticut Medical Assistance Program
https://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

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- **Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) and Personal Coach Providers and Home Health Agencies:**
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- **Maternity Bundle Providers:**
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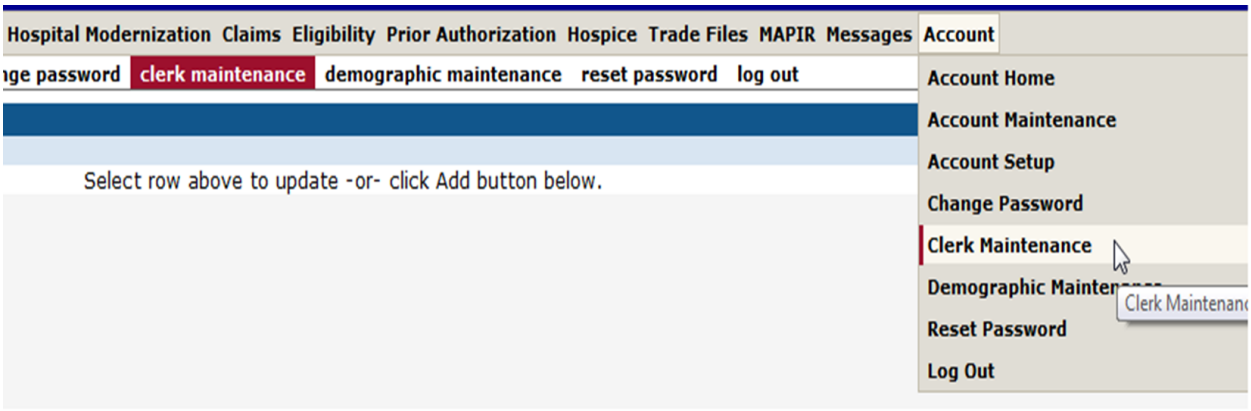
Attention: All Providers

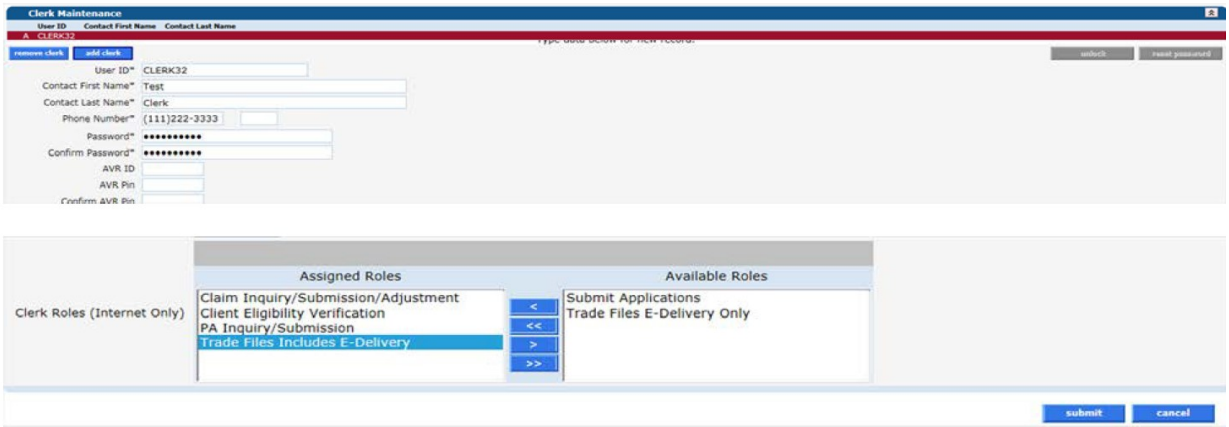
Stay Ahead with eDelivery Letters

Gainwell wants to encourage providers and associated clerks to sign up for eDelivery to ensure secure, uninterrupted access to important communications. The Electronic Delivery of Letters initiative has replaced the mailing of most paper letters previously received from the Connecticut Medical Assistance Program (CMAP) through the United States Postal Service (USPS). This service plays a key role in producing high-quality healthcare results.

Master account users are responsible for providing and maintaining clerk access. This includes adding clerks, changing the role(s) for clerks, removing clerks, and resetting passwords. In the example shown, to add a clerk, the master account user would click the **Clerk Maintenance** section of the secure web portal at www.ctdssmap.com by selecting clerk maintenance from either the account submenu or the account drop-down menu.



To create a new clerk account, click 'add clerk' and fill out the required fields, then click 'submit.'



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The roles that can be assigned to the clerk are:

Claim Inquiry/ Submission/ Adjustment
PA Inquiry/ Submission
Client Eligibility Verification
Submit Applications
Trade Files E-Delivery Only
Trade Files Includes E-Delivery

For additional information on Clerk Maintenance, please access Chapter 10 from the www.ctdssmap.com Web portal, by selecting Information > Publications.

Please refer to provider bulletin PB 2019-15 for information on how to access eDelivered letters. The publication provides details on the retention period information for these letters, impact on clerk roles, procedures for accessing locked or disabled Secure Web portal accounts and instructions for providers who do not currently have a Secure Web portal. It is vital that the alerts received from eDelivery letters go to an email account that is checked regularly to prevent missing the 6 month and 3-month re-enrollment alerts.

Attention: Behavioral Health Clinics & Behavioral Health Clinicians

Billing Guidance for Non-Licensed Providers

New Billing and Supervision Guidance for Non-Independently Licensed Providers associated with Clinics and Behavioral Health Clinicians

DSS has issued important clarification on billing for behavioral health services provided by non-independently licensed clinicians under supervision in clinic or group settings (Provider Bulletin PB 2025-49). Providers have two options:

Option 1 - The supervising provider can be billed by entering the supervising provider's National Provider Identifier (NPI) under the rendering provider field. The non-licensed provider does not need to be entered into the claim.

Option 2 - The non-licensed provider can be billed as the rendering provider if they are enrolled under National Plan and Provider Enumeration System (NPPES) and have a valid NPI and behavioral health taxonomy. The supervising provider that is supervising the non-licensed provider needs to be entered under the supervising provider field. **NOTE: This option is available for electronic claims only and not available for Web claims. Web claims must use Option 1.**

Key points to remember:

- The bulletin applies to Behavioral health clinicians' groups, clinics, enhanced care clinics, FQHCs, school-based health clinics, and medical clinics where supervision is required for associate level or provisionally licensed providers such as an LMSW, or LPC-A.
- Providers are able to follow either option, the non-licensed provider does not need to be entered on the claim under Option 1.
- Common EOB's you will receive for incorrectly submitted claims.
  - ◊ 1073 - Supervising Provider is Missing
  - ◊ 1074 - Supervising Provider is not on File
  - ◊ 1075 - Supervising Provider not Active on DOS
  - ◊ 1076 - Supervising Provider Not Associated with Billing Group
  - ◊ 1077 - Associated License Clinician NPI is not on the NPPES
  - ◊ 1078 - Associated Licensed Clinician Taxonomy / Credentials Invalid

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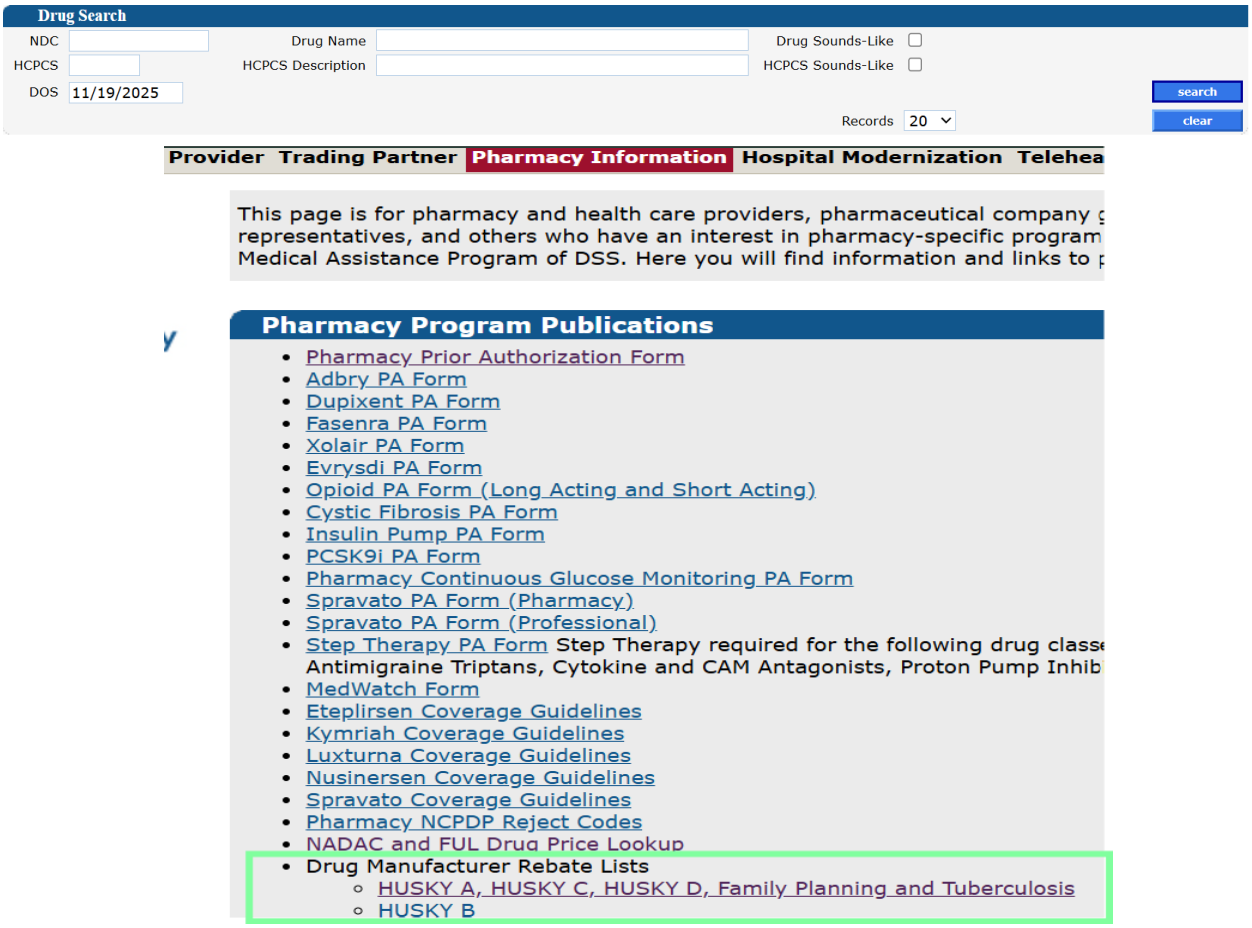
Attention: Physicians, APRNs, Certified Nurse Midwives, Optometrists, Podiatrists, Clinics and Outpatient Hospital Providers

Participating Labelers for Physician-Administered Drugs

Connecticut Medicaid, by statute, will only pay for a drug procedure billed with a National Drug Code (NDC) when the pharmaceutical manufacturer of that drug is a participating labeler with the Centers for Medicare and Medicaid Services (CMS). A 'participating labeler' is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State with a rebate for products reimbursed by Medicaid programs. A labeler is identified by the first 5 digits of the NDC.

In addition to verifying that an NDC is rebateable, the specific procedure code being billed must also be listed on the provider's applicable fee schedule.

Providers can determine whether an NDC is rebateable or not by utilizing the "Drug Search" functionality under the Provider tab from our website. Please be aware that even though the drug may be rebateable, not all labelers participate in all client benefit plans. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code to the list of participating labelers maintained on the Connecticut Medicaid website at www.ctdssmap.com. From the home page of our website, click on the "Pharmacy Information" tab, then on the client's benefit plan under the "Drug Manufacturer Rebate Lists" posted in the "Pharmacy Program Publications" panel.



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Attention: Autism Spectrum Disorder Providers

Reminder of New ASD Services

DSS has issued a bulletin that as of 10/1/2025 all ASD services covered under HUSKY A, C, and D are now also covered under HUSKY B. (Provider Bulletin PB 25-57)

Key points to remember:

- Addition of procedure codes 97156, 97156 (U2) and T1016.
- The codes above can only be delivered by: Qualified Healthcare Professional (Board Certified Behavioral Analysts (BCBA), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Counselor (LPC), and Licensed Clinical Social Worker (LCSW's).
- Changes to Prior Authorization for certain procedure codes.
  - ◊ **H0031**- Changes have been made to concurrent authorization process to allow up to 6 hours (1 hour = 1 unit). Changes to frequency have been revised from every 90 days to one authorization per member per six (6) months per provider.
  - ◊ **H0032**- Changes to frequency have been revised from every 90 days to one authorization per member per six (6) months per provider.
  - ◊ **H0032** (TS) - Changes to frequency have been revised from every 90 days to one authorization per member per six (6) months per provider

Attention: Acquired Brain Injury (ABI), Autism, Connecticut Home Care (CHC) and Personal Care (PCA) Waiver Service Providers, Support & Planning Coach Providers & Home Health Agencies

Claim Submission Reminder—Caught with Less Than Expected Reimbursement?

Gainwell Technologies publishes a Financial Cycle schedule twice per year for the period from January through June and from July through December, at least one month before the first cycle of the published schedule. These schedules provide the cutoff date/time for claims submitted for processing within a given cycle. The schedule cutoff date/time, however, does not prevent circumstances that could occur resulting in claims not reaching Gainwell Technologies. Providers are not restricted to how frequently claims may be submitted. Providers are encouraged to submit claims early and often to allow the opportunity for corrective action should a file fail or claim deny, reducing the financial impact should either occur.

Providers highly dependent on Connecticut Medical Assistance Program funds to successfully run their business should consider more frequent claim submission within a financial cycle with the majority of their claims submitted early enough to identify successful processing or take action to correct file failure before cycle cutoff. Multiple submissions within a cycle also allows opportunity to review denied or partially denied claims for correction and resubmission to maximize reimbursement.

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Attention: Maternity Bundle Providers

Maternity Bundle Payments: Troubleshooting Guide—Where is My Bundle Payment?

Providers have reported uncertainty on how to locate the Bundle payments. The following checklist and guidance will help you quickly locate your payments.

1. **Check the Correct Place for Your Bundle Payment**

   Bundle payments do not appear as standard claim payments. They appear as supplemental payment files and/or RA line items.

   A. Supplemental Payment Files (CTDSSMAP Secure Web Portal)

   Navigate: Trade Files – Download

   Depending on your practice's role, look for:

   - "Mat Bundle Accountable" – for the Accountable Provider (TIN receiving attribution)
   - "Mat Bundle Payment" – for the payment-receiving provider

   B. Remittance Advice/835 Indicators

   On RA or 835, look for:

   - Expenditure Reason Code: **8340 (Maternity Bundle Case Rate)**
   - The RA will display the Case Rate payment, Client ID, Client Name, and From DOS (which will always be the first day of the month).
   - PLB Segment: The PLB03-1 field (Adjustment Identifier) will indicate LS – Lump Sum. The PLB03-2 field (Reference Identification) will be populated with an internal tracking number. It will be prefaced with a value of MB (maternity bundle). If these indicators appear, payment has been issued.

   In addition, services included in the Case Rate that are zero paid will be identified on the RA with EOB code 9950 'Service Is Covered by Monthly Maternity Bundle Case Rate Payment', and the 835 will contain CARC code CO245 and RARC M15.

2. **Review Timing of the Payment Cycle**

   Case-Rate payments are generated in the first claim cycle of the month for the previous month. If a trigger is submitted late, payments shift accordingly. For example, if a claim with a trigger for a date of service in January is received and paid in the middle of March, the case rate payment for the month of January and forward, will be issued in the 1st claim cycle in April.

3. **If Payment Is Still Missing – Prepare to Escalate**

   Gather the following information:

   - Provider TIN
   - Member name & Client ID
   - Date of Service of the trigger claim
   - Claim number (ICN)
   - Expected payment months
   - Whether the trigger file was found under "Mat Bundle Accountable" and/or "Mat Bundle Payment"

   Then contact your CHNCT Provider Engagement Services Representative for review. They are the first line of support for Maternity Bundle payment issues.

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

Missing Prior Authorization

A prior authorization (PA) in an approved status is one of the two requirements that need to be met for a client to appear in a provider's electronic visit verification (EVV) system. Once an active waiver benefit plan and an approved PA are present in the CMAP provider portal for a client then they will appear in the provider's EVV system (Santrax).

If a client is missing in a provider's Santrax system and the client has the proper waiver eligibility, the next step is to research the client's prior PAs. Log into the secure site at www.ctdssmap.com, from the "Prior Authorization" menu, select "Prior Authorization Search", then enter the client ID and click Search. The PA must be present in an "Approved" status to be present in Santrax. If the status is "In Process", the PA is currently under review at DSS. This may take a few days to resolve. For assistance with an "In Process" PA, please contact the access agency, Advanced Behavioral Health (ABH), or Autism care manager responsible for the client's care plan.

Please remember it takes approximately 48 hours to see a PA in Santrax based on the "Determination Date" on the PA as viewed via the secure Web account. Also, please make sure that the PA you are reviewing is an EVV mandated service. To determine if a service is EVV mandated, please navigate to the New Provider Information page on the Electronic Visit Verification Web page found at www.ctdssmap.com and access the EVV Service Code Listing.

Providers can also review the Procedure Code Crosswalk associated with the client's waiver on the www.ctdssmap.com Web site by navigating to "Provider", then "Provider Services", then scrolling to the bottom of the page and clicking "here" under "Provider Training". This will open the Connecticut Medical Assistance Program (CMAP) Training Information page which is where you will find the most up-to-date Procedure Code Crosswalks.

After a provider has verified that the client is enrolled in the correct waiver benefit plan with an approved PA on the DSS portal, and the PA is still not visible in Santrax, make sure to remove the check mark beside "Hide Outdated Auths" and "Hide Voided Auths" in the Santrax system. This will reveal all authorizations uploaded to the Santrax system.

If a provider has performed all the troubleshooting tips detailed above and still cannot see the client or PA in Santrax, please send an email to the EVV mailbox at ctevv@gainwelltechnologies.com for further assistance. Please indicate if the client or PA is missing from the Santrax system and provide the client's PA number as displayed on the CMAP secure site with the eligibility verification number. Please note: If the provider has a service order number but does not have a PA number, please contact the access agency, DSS Autism Case Manager, or ABH representative responsible for the client's care plan for assistance.

PLEASE NOTE: Neither Gainwell Technologies nor Sandata can enter a PA into the CMAP portal on behalf of an access agency, DSS Case Manager, or ABH.

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

Next Steps for New Providers Mandated to Use EVV

Getting started with your Santrax account is an important step in ensuring smooth operations and compliance. The process begins by visiting the www.ctdssmap.com Web site. Once on the site, hover over **Electronic Visit Verification (EVV)** and select **New Provider Information**. This will open a list of documents that will assist in familiarizing your agency with the EVV program.

The first requirement is enrolling in **Sandata Learn**, by clicking on our Learning Management System Enrollment Instructions. Another page will generate and you must click on Learning Management System Enrollment Instructions one more time. Please follow the four-page instruction sheet which includes creating your Sandata Learn account. This platform hosts all mandatory training courses that must be completed before your account can be created. Once you finish these trainings, the system will automatically notify Sandata, signaling that you are ready for the next step. Please also submit your certificates of completion to Sandata (see last page of instructions), at which time you will receive an email confirmation from **Sandata**.

After your training is confirmed, Sandata will create your Santrax account and send a **Welcome Kit** via the email address that you listed as the contact within your agency. This kit includes your agency-specific login credentials and instructions for accessing the system. Keep in mind, it can take up to two weeks to receive your Welcome Kit.

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Appendix

2026 Holiday Schedule

Date	Holiday	Gainwell Technologies	CT Department of Social Services
1/1/2026	New Year's Day, observed	Closed	Closed
1/19/2026	Martin Luther King Jr. Day	Closed	Closed
2/12/2026	Lincoln's Birthday, observed	Open	Closed
2/16/2026	Presidents' Day	Closed	Closed
4/3/2026	Good Friday	Closed	Closed
5/25/2026	Memorial Day	Closed	Closed
6/19/2026	Juneteenth Day	Open	Closed
7/3/2026	Independence Day, observed	Closed	Closed
9/7/2026	Labor Day	Closed	Closed
10/12/2026	Columbus Day	Closed	Closed
11/11/2026	Veterans' Day, observed	Closed	Closed
11/26/2026	Thanksgiving Day	Closed	Closed
11/27/2026	Day after Thanksgiving	Closed	Open
12/25/2026	Christmas 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.

PB25-76 Cell and Gene Therapy for Sickle Cell Disease
PB25-66 Maternity Bundle Payment Program-Performance Year 2
PB25-65 Medical Nutrition Therapy—Billing Update
PB25-64 Prescription 30-Day Supply and Returns
PB25-63 1. Removal of Prior Authorization (PA) Requirement for Adbry, Dupixent, Fasenra, and Xolair
2. Diagnosis Code Requirement for Adbry, Dupixent, Ebglyss, Fasenra, Tezspire, and Xolair
PB25-62 1) January 1, 2026 changes to the Connecticut Medicaid Preferred Drug List (PDL) 2) Reminder Regarding the 5-day Emergency Supply 3) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL) 4) Pharmacy Web PA Tool
PB25-61 1. Changes to Orthodontia Benefit for HUSKY B
2. Updated Orthodontia Qualifications
PB25-60 Medicare Part D Co-Pays for Dual Eligible HUSKY Low Income Subsidy Clients
PB25-59 New Pharmacy Clinical Prior Authorization Criteria and Prior Authorization Forms for Non-Preferred Drugs in 11 Targeted Classes
PB25-58 Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule (HUSKY Health Program)
PB25-57 October 2025—Updates to Autism Spectrum Disorder Services
PB25-56 Implementation of Children's Mental Health Urgent Crisis Centers Services for Children 18 Years Old And Younger
PB25-55 Prescription 30-Day Supply and Returns
PB25-54 Wegovy Coverage for Metabolic-Associated Steatohepatitis (MASH) and new diagnosis Requirement for Wegovy for Major Adverse Cardiovascular Events (MACE)
PB25-53 Coverage of Custom Breast Prosthesis
PB25-52 Policy Updates and Changes to Clinical Review Criteria
PB25-51 Enteral & Parenteral Supplies Used for Services Other Than Nutrition—Billing and Prior Authorization (PA) Guidance
PB25-50 Update of Enhanced Care Clinic Access to Services Monitoring
PB25-49 Billing Guidance of Supervision of Individuals Not Licensed to Practice Independently When Providing Behavioral Health Service in Clinic or Group Settings
PB25-48 Performing Providers Required for Behavioral Health Federally Qualified Health Centers (FQHCs)
PB25-47 Addition of Prior Authorization on Select Radiology Procedure Codes
PB25-46 October 2025 Quarterly HIPAA Compliant Update—Medical Equipment Devices and Supplies Fee Schedule
PB25-45 Anti-Embolism Stockings
PB25-44 Hospice Rates for Federal Fiscal Year 2026
PB25-43 October 2025 Quarterly HIPAA Compliant Update—Physician Office and Outpatient Fee Schedule
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

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

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