



**Connecticut Department
of Social Services**

Caring for Connecticut

January 2010

Connecticut Medical Assistance Program

<http://www.ctdssmap.com>

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

.....

EDS Changes Name to HP
Web Claim Submission is Here
Claim Inquiry on the Web
H1N1
e-Prescribing is Here
New Hospice Benefit
Web Security Certificate Message

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EDS Changes Name to HP



In August 2008, Hewlett-Packard (HP) acquired EDS, fiscal agent and claims processor for the Connecticut Medical Assistance Program. On Wednesday, September 23, 2009, the EDS business unit of HP changed its name to HP in most locations across the country and around the world.

How will that affect providers in Connecticut? You probably won't notice much of a change. You'll begin to see the HP logo or the HP Enterprise Services

name on correspondence. You'll begin to receive emails from an @hp.com email address rather than an @eds.com address. You'll hear the HP name when calling the Farmington office. Think of it as a sports team changing jerseys. The same players are on the field working hard to deliver the outstanding services you've come to expect from a trusted business ally.

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Other Insurance Billing Guides

The Department of Social Services and HP are pleased to announce new Other Insurance/Medicare Billing Guides for [Institutional](#), [Professional](#) and [Dental](#) providers are now available. Providers can access this guide from the Connecticut Medical Assistance Program Web site www.ctdssmap.com Information page, under Publications, then Claims Processing Information. This guide will assist providers with submitting claims when the client has primary coverage

through commercial insurance or Medicare, and secondary coverage through Connecticut Medicaid. Field by field instructions illustrating the correct format for completing the other insurance and/or Medicare information is provided for all claim submission methods. This guide will assist with correct claim submission and decrease the number of re-submission. The following are submission methods documented in the OI/Medicare billing guides:

- UB-04 claim submission form
- CMS-1500 claim submission form
- ADA Dental claim submission form
- Provider Electronic Solutions Software
- Web Claim submission
- ASC X12N 837 I, 837 P and 837 D Health Care Claim

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Provider Participation Status

State of Connecticut Regulations for the Department of Social Services (DSS), Section 17b-262-524 of the Provider Participation Policy, require the periodic re-enrollment of all providers. Providers will receive a notification letter 30 days prior to their re-enrollment due date. It is very important that providers respond to this re-enrollment notification. Providers that fail to respond in a timely manner will be dis-enrolled from the Connecticut Medical Assistance Program.

providers must be actively submitting claims. It is the Department of Social Services' policy to dis-enroll providers who have not had any claim activity for the past twelve (12) months. If providers are dis-enrolled from the program for this reason, a letter will be sent notifying the providers that this action has been taken.

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Further, in order for providers to continue to partici-

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Claim Inquiry on the Web: What do Internal Control Numbers (ICNs) Represent?

When using claim inquiry on the Web providers are sometimes faced with a list of claims that were submitted for a client. In some situations understanding how the Internal Control Number (ICN) is assigned will help you identify the claims you are viewing. An ICN is assigned by HP to each claim. This unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking.

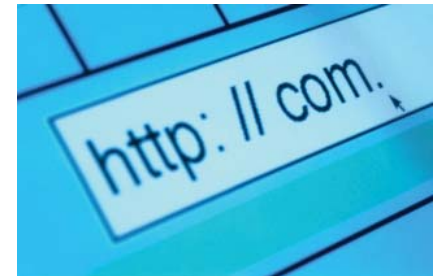
The ICN consists of 13 digits and contains the following information:

20-09-032-123-456

1 2 3 4 5

1. **Claim Region** – the manner in which the claim was submitted
Commonly used regions.

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS (Medicare EOMB)
20	ELECTRONIC CLAIMS
22	INTERNET CLAIMS
50	ADJUSTMENTS - NON-CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS – REFERENCE/PATIENT LIABILITY
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
59	INTERNET ADJUSTMENTS, 837 ADJUSTMENTS, POS REVERSALS



Claim Inquiry on the Web

A comprehensive [ICN Region list](https://www.ctdssmap.com/) can be found on the Web site <https://www.ctdssmap.com/>, under Information> Publications> scroll down to the Claims Processing Information panel, click on [ICN Region Code List](#).

2. **Year of Receipt** – The year in which the claim is received.

3. **Julian Date of Receipt** – The Julian calendar date of receipt

The Julian calendar numbers the days of the year 1-365 (1-366 for leap year). For instance, 001 is January 1, and 032 (shown above) is February 1.

4. **Batch Number** – An internal number assigned by HP to uniquely identify a batch.

5. **Claim Number** – A sequential number also assigned by HP to uniquely identify a claim within a batch.

Examples:

ICNs	Claim Region	Julian Date
200911111111XX	Electronic claim - Batch	4/21/09
220922222222XX	Claim submitted on the Web	8/10/09
110833333333XX	Paper claim submitted w/ attachment (Medicare)	11/29/08
590912222222XX	Web adjustment/voided claim	5/02/09

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Web Claim Submission is Here

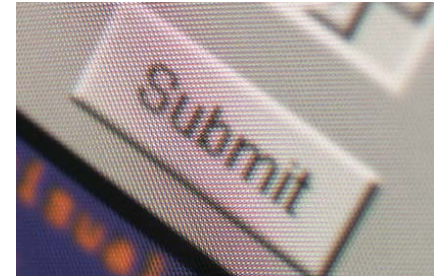
Web claim submission is now available at www.ctdssmap.com. Providers may now submit claims which include Medicaid secondary claims (Third Party Liability and Medicare crossover claims). Previously processed claims may also be adjusted, voided or re-submitted using the Web portal. To submit claims from the Provider Internet portal, go to www.ctdssmap.com and login to your secure Web account.

The claims tab will now provide an option for Institutional, Professional and Dental claim submission. To re-submit, void or adjust a claim, you need to first retrieve the

claim via claim inquiry and then select the appropriate buttons on the bottom of the page to make your selection. A claim submission guide is available for each claim type and is located by clicking on the Institutional, Professional or Dental link. This guide and a Frequently Asked Questions list are located in the upper left corner of the claim submission Web page.

The Pharmacy provider community may perform claim inquiries and claim voids, but the claim submission, resubmission or adjustment feature is not available.

If you have any questions, please



contact the Provider Assistance Center toll-free at 1-800-842-8440 or locally to Farmington at 860-269-2028 and select option # 8 to speak to a call center representative. This option # 8 is staffed by representatives specially trained in Web claim submission.

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Thank You!!

A special thanks to all of our pilot providers who tested our new Web claim submission tool. Many of you gave us constructive feedback that resulted in changes that have improved the efficiency of the tool!

Dawn Finkle from Champion Ambulance Service, Inc. is quoted as saying "The Web site is very user friendly – it's as easy to submit a new claim as it is to request an

adjustment or a complete takeback. I've also found the turn around time very quick indeed. If anyone were to ask if I would recommend this Web site, my answer would be a resounding yes!!"

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Claim Tips

Web Adjustment Tips

Crossover claims cannot be adjusted on the Web. If you want to adjust a Medicare crossover claim, you need to void the original claim, copy the claim, make any necessary changes and re-submit it as a new claim.

Claims with dates of service that exceed timely filing guidelines, or that have an Internal Control Number (ICN) beginning with 12 or 13, must be adjusted by submitting a Paid Claim Adjustment Request form to HP.

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Claim Tips

(continued from page 3)

Pending Claims Tip

Do you want to know the status of claims that you have submitted to HP since your last Remittance Advice (RA) was issued? There is no need to wait until your next RA is issued. Simply perform a Web claim inquiry by clicking on the box titled "Pending claims" and click the Search button. A list of all claims that have been processed since your last RA will be displayed with the claim's status of Paid, Denied or Suspended. A Suspended status means that DSS or HP must review this claim before the claim is paid or denied. There is no action a provider must take to resolve this claim. Denied claims can be corrected, if applicable, and immediately re-submitted before the payment cycle cutoff.

Copy Claim Tip

Do you submit claims for clients that are similar each month? For example, if you submit claims for monthly oxygen expenses, each monthly claim looks much the same as the previous month's claim. The Web copy feature allows the provider to copy a previously paid claim, make the necessary changes, such as a change in the date of service, and submit this new claim with very little data entry required. This feature has been very well received by the provider community. To copy a claim, simply retrieve the paid claim by performing a claim inquiry, click the copy button at the bottom of the Web page, make the necessary changes and click submit. It's that easy!

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H1N1

The following Current Procedural Terminology (CPT) codes have been added to the Physician Office & Outpatient Fee Schedule.

90470 – H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

90663 – Influenza virus vaccine, pandemic formulation, H1N1

Consistent with current policy, the department will provide reimbursement for administration of the vaccine only, since the Department of Public Health will distribute the H1N1 vaccine to providers at no cost. Reimbursement for procedure code 90470 will be \$12.52.



Annual Influenza Vaccination is the Most Effective Method for Preventing Influenza

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It's Flu Season

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Flu vaccination is a covered service for eligible recipients. According to the CDC, the following changes or updates are recommended for 2009. Annual vaccination of all children aged 6 months-18 years should begin as soon as the influenza vaccine is available. Annual vaccination of all children aged 6 months-4 years and older children with conditions that place them at increased risk for complications from influenza should continue to be a primary focus of vaccination efforts.

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New Hospice Benefit to be Implemented in January 2010

A hospice benefit will be available to Medicaid clients enrolled in the Connecticut Medical Assistance Program effective January 2010.

Hospice is compassionate end-of-life care that includes medical and supportive services intended to provide comfort to the individual who is terminally ill. Hospice care aims to manage a client's illness and pain but does not treat the underlying terminal illness.

Medicaid eligible clients who elect the hospice benefit will have their care for the terminal illness or related condition managed by a Hospice Agency. The

Hospice Agency is responsible for the coordination and reimbursement of services provided by other healthcare providers. Services unrelated to the hospice condition may be billed by certain providers.

Providers should review Provider Bulletin [PB09-54](#) which provides billing and additional information to all providers regarding the "New Hospice Benefit". To access this bulletin, go to the www.ctdssmap.com Web site and click on Information > Publications. Once there, enter the bulletin number in the Bulletin Search fields.

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Web Security Certificate Message and Access Issues to www.ctdssmap.com

HP recently upgraded HTTPS SSL certificates on the www.ctdssmap.com Web site. There have been some providers that have experienced messages that the Web site security certificate was not updated when trying to access our Web site, www.ctdssmap.com. This message can occur if the updated root certificates were not delivered via the Microsoft Automatic Update during patch process. There is a possibility that some provider workstations do not have the most recent root certificate package installed. Users must have 2048-bit Microsoft Root Certificate.

Providers receiving a message regarding the Web site's Security Certificate need to make the following update to your PC by contacting your IT department or by following the directions to the Microsoft link below.

Microsoft Update for Root Certificates [May 2009] (KB931125)

<http://www.microsoft.com/downloads/details.aspx?FamilyID=f814ec0e-ee7e-435e-99f8-20b44d4531b0&displaylang=en&Hash=sVNGMRqGnCjZfnk%2bHrJcSEeVZIs9pH61bPMbqVTSS8hkPe36sxjLpokVfCjlxoePqe%2b016tqayndP71M6b9cQ%3d%3d>

- After clicking on the above [link](#).
- Click on "Continue" button.
- Follow validation instructions with screen shots.
- Click on "Download" button.
- Save file to a folder and then click on "Run".

Please contact your local IT group for assistance with this download, if your IT department is still having difficulties please contact the Provider Assistance Center at 800-842-8440 or locally at (860) 269-2028 (Farmington).

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New Non-Urgent Prior Authorization Fax Number

HP is pleased to announce a new non-urgent prior authorization fax number. This new fax number will allow for quicker data entry of prior authorization requests into the Connecticut MMIS. **Providers should fax all non-urgent prior authorization requests to 860-269-2137.** Please be sure to only fax one prior authorization request at a time.

Please note that this non-urgent PA fax number is only for services that providers would send to **HP** for prior authorization. This change does **not** apply to the non-urgent prior authorization requests for services that are sent to other PA vendors (ie: Value Options, Logisticare, First Transit, Qualidigm, BeneCare or for Managed Care clients, the appropriate Managed Care Plan) or for pharmacy authorizations.



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Annual Provider Satisfaction Survey

Thank you to all of the providers who participated in the Provider Satisfaction Survey which was mailed to all providers in February 2009. Over this past year – results were tallied and action plans have been developed to respond to the feedback that was submitted to HP.

While a number of common concerns were received and have been addressed - the top three common concerns and responses are listed below:

Concern	Response
Improve the Provider Enrollment/ Re-enrollment process	HP and DSS have initiated a project to review the entire provider enrollment and re-enrollment process. Recommendations and systematic efficiencies are being identified and prioritized. Upcoming changes will be communicated to the provider community once finalized.
Move toward more electronic distribution of communications and eliminate paper communications sent through the US mail	HP continues to collect provider's email address for distribution of provider notifications (Bulletins, newsletters, etc.). HP also has begun posting the quarterly newsletter to the Connecticut Medical Assistance Program Web site www.ctdssmap.com
Clearer billing instructions for claims with other insurance	HP has developed and posted to the secure Web portal instructions on billing with other insurance based on the claim type.

HP is excited to move forward and continue to work on improving the provider experience. HP and DSS are planning on sending out the next Annual Provider Satisfaction Survey in the first quarter of 2010 and are pleased to introduce a Web based survey format next year. More details on the 2009 Annual Provider Satisfaction Survey will be published in early 2010.



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Pharmacy Providers

e-Prescribing is Here

Surescripts, the prescribing network, recently announced its 4th Annual SafeRx Awards, highlighting the top 10 states that send prescriptions electronically. The SafeRX awards were created to raise awareness of how e-prescribing improves patient safety with a more secure, accurate, and informed process for prescribing medications. Connecticut was ranked 8th in the country for 2008. The Connecticut Medical Assistance Program went live with e-Prescribing on October 14, 2009. All Medicaid providers with Surescripts certified e-prescribing software have access to Medicaid, SAGA, ConnPACE, CADAP, HUSKY and Charter Oak enrolled clients for the following transactions:

- Eligibility
- Formulary
- Medication History

In order to access information for the Connecticut Medical Assistance Program population please contact your e-Prescribing software vendor to download

Connecticut formulary files. If you have any technical questions, please contact Surescripts Support at 866-765-1684 or email support-mn@surescripts.com. To learn more about the SafeRx awards and to view the complete state-wide report, visit www.surescripts.com/safe-rx-awards.html. This site has some great resources, such as access guides for physicians, buyer's guide worksheets, initiatives and incentives, and a wealth of other data to assist with e-prescribing adoption. Look forward to next year's awards to see Connecticut's rating!



e-Prescribing Improves Patient Safety

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Effective January 1, 2010 Medicare Part D Non-Formulary Drugs Will No Longer be Covered by the Connecticut Medical Assistance Program

Due to recent legislation, the Connecticut Medical Assistance Program will no longer cover Medicare Part D non-formulary medications.

Any claim submitted for a Medicare Part D non-formulary medication will be denied. The pharmacy and prescriber should work with the Medicare Part D Prescription Drug Plan (PDP) sponsor to either change the medication to a Medicare Part D formulary alternative or obtain Prior Authorization (PA) from the PDP.



Medicare Part D Non-formulary Drugs no Longer Covered

The Department will continue to cover drugs excluded by Medicare Part D (barbituates, benzodiazepines, etc.). To avoid unnecessary claim denials, these medications should be billed as Medicaid primary prescription claims. Caution should also be taken when adjusting previously paid Medicare Part D non-formulary claims paid by the Connecticut Medical Assistance Program prior to January 1, 2010 as the re-processed claim will **not** be paid.

Please make any necessary claim adjustments by December 31, 2009.

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Pharmacy Providers

New Prior Authorization Requirement for Synagis

Effective September 1, 2009, physicians are required to obtain prior authorization when prescribing Palivizumab (Synagis®) to clients enrolled in the Connecticut Medical Assistance Program when the medication is obtained in a retail setting only. Please reference Provider Bulletin [PB09-41](#) for further clarification and the updated modified recommendations by the American Academy of Pediatrics (AAP).

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November 1, 2009 Additions to the CADAP Formulary

To see which medications have been added to the CADAP formulary, please refer to Provider Bulletin [PB09-40](#). The CADAP formulary can also be accessed on the Connecticut Medical Assistance Program Web site's Pharmacy Information Page by clicking on the [CADAP Formulary Update](#) link.

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Hospice Providers

Important Hospice Information

PROVIDER ENROLLMENT

Only entities who are Medicare certified and Licensed by the Department of Public Health as a Hospice Agency may enroll as a Hospice Agency in the Connecticut Medical Assistance Program. Entities who wish to enroll as a Hospice Agency should access the www.ctdssmap.com Web site, and click on Provider > Provider Enrollment. Please be sure to read the instructions before submitting an online enrollment application.

CLIENT ELIGIBILITY

Providers should check eligibility to determine if the client has an active Hospice benefit. Providers should refer to the www.ctdssmap.com Web site, and click on Information > Publications > Provider Manuals > [Chapter 4](#), Client Eligibility for information regarding available client eligibility verification options.

RESOURCES RELATING TO THE HOSPICE BENEFIT

Providers should review Provider Bulletin [PB09-54](#) which provides billing and additional information to all providers regarding the "New Hospice Benefit". Providers should refer to the www.ctdssmap.com Web site to obtain this bulletin. Once on the Web site, click on Information > Publications and then enter the bulletin number in the Bulletin Search fields.

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Transportation Providers

Update to Transportation Prior Authorization Process

Effective November 9, 2009, HP implemented an update to the transportation Prior Authorization (PA) process. This update will reduce the number of transportation claims that have denied with the Explanation of Benefits (EOB) 4801 "Procedure Not Covered. Check: Prior Authorization, FTC, Referring Provider, Quantity Restrictions" when the provider has been issued multiple PAs with overlapping dates of service (DOS). PAs submitted by First Transit and LogistiCare identified by the system to have overlapping dates of service for the same provider, same client and same procedure codes as an existing PA have been voided. The existing PA is modified to include all dates of service. Authorized units, used units and available units are modified to include totals from all PAs.

Example: The system identifies an existing PA N8888888 for (DOS 4/30/2008 – 5/6/2008) and a new PA N9999999 for (DOS 5/5/2008 – 5/12/2008). Both PAs are for the same client, same provider and same procedure codes. Previously, if a claim was submitted for DOS 5/5/2008 the system used PA N8888888. The claim submitted at a later date for DOS 4/30/08 denied since PA N8888888 was exhausted with the claim for DOS 5/5/2008 and 4/30/08 does not fall within the DOS range for N9999999.

With the new process, PA N8888888 is modified to include all DOS 4/30/2008 – 5/12/2008. The authorized units, used units and available units are modified to include totals from both PAs. The "Search Results" panel lists the status on all line items for PA N8888888 as "Approved with Modifications" and the "External Text" panel for all line items reads "The PA N8888888 is altered due to voiding PA N9999999". The status for all line items for PA N9999999 is "Voided". The "External Text" reads "The PA N9999999 is voided. Please refer to PA N8888888".

Providers may see a PA where one line item is voided and one line item is altered. In this case the "External Text" will read:

"PA Nxxxxxxx line item 1 is voided. Please refer to PA Nxxxxxxx."

"PA Nxxxxxxx line item 2 is altered due to voiding PA Nxxxxxxx."

Claims which previously denied due to this issue have been reprocessed in the December 4, 2009 financial cycle and was communicated to the provider community via a banner message.

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Dental Providers

Claim Submission Changes for Supernumerary Teeth

Dental providers will be pleased to learn that the Department of Social Services has updated the Connecticut interChange System to include supernumerary tooth numbers in accordance with the American Dental Association's Universal/National Tooth Designation System designated as "JP" (A-T for primary dentition and #1 – 32 for permanent dentition). The supernumerary tooth numbers are as follows:

AS-TS Supernumerary Teeth Corresponding to Primary Teeth

51-82 Supernumerary Teeth Corresponding to Permanent Teeth

Prior to this update, providers were required to submit claims for procedures performed on supernumerary

teeth on paper claim forms using the unspecified procedure code D7999. These claims were then manually priced by the Department's dental consultant. With the recent changes, providers can now submit these claims electronically using a procedure code from the Dental fee schedule and the claims will pay off of the fee schedule rate. This will greatly improve the efficiency of claims processing and expedite payment for services rendered to Connecticut Medical Assistance Program clients. Please refer to bulletin [PB09-25](#) for a list of procedure codes that can be billed for supernumerary teeth.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
01/18/2010	Martin Luther King's Day	Open	Closed
02/12/2010	Lincoln's Birthday	Open	Closed
02/15/2010	Presidents Day	Closed	Closed
04/02/2010	Good Friday	Closed	Closed

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Appendix

Provider Bulletins

Below is a listing of all Provider Bulletins that have been posted to www.ctdssmap.com since July 1, 2009. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> [Publications tab](#).

		PB09-43	Fee Schedule Updates
		PB09-44	Requirements for Payment to Chronic Disease Hospitals
		PB09-45	Change in Professional Fee (Dispensing Fee)
		PB09-46	List of Frequent Reason for Pharmacy Claim Denials and Resolution
PB09-29	Regulations for the Requirements of Payments to Hospice Providers		
PB09-32	Electronic Prescribing (e-Prescribing) Program	PB09-47	Enhanced Client Identification Number Inquiry Verification on the Web
PB09-33	Emergency Prescription Voucher for State Administered General Assistance Clients Released from Correctional Facilities	PB09-48	Expansion of the Nursing Home Drug Return Program
PB09-34	Change to the Home Health Services Fee Schedule	PB09-49	Carve Out of Medical Federally Qualified Health Centers from Managed Care
PB09-35	Web claim submission is now available for Home Health and Long Term Care Providers	PB09-49	Routine Laboratory Services
PB09-36	Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B	PB09-50	January 1, 2010 Changes to Pharmacy Coverage in the Connecticut Medical Assistance Program
PB09-37	Regulations for the Requirements for Payments of Services Provided by Psychiatric Residential Treatment Facility (PRTF) Providers	PB09-51	Termination of Medicaid Eligibility for Certain Non-Citizens
PB09-38	Change in Maximum Allowable Cost (MAC) Reimbursement	PB09-52	Clinical and Surgical Pathology Services Fee Schedule Correction
PB09-38	Change to Early Refill Criteria	PB09-53	Disproportionate Share Hospital Audit and Reporting Protocol with Attachments
PB09-38	Day Supply Change for One-Time Fill When PA is Required	PB09-54	New Hospice Benefit
PB09-38	Elimination of Vacation Early Refill	PB09-55	Additional Requirements for Customized Wheelchairs for Clients Living in a Nursing Facility or ICF/MR
PB09-39	H1N1 Billing Requirements for Clinics and Hospital Outpatient Departments	PB09-56	MEDS – DME Fee Schedule Changes for Patient Lifts
PB09-40	CADAP Formulary Update - Effective November 1, 2009	PB09-57	Correction to Provider Bulletin 2009-25 Updates to Requirements for Dental Claim Submissions
PB09-41	New Prior Authorization Requirement for Synagis	PB09-58	Clarification on the January 1, 2010 Changes to Pharmacy Coverage in the Connecticut Medical Assistance Program
PB09-42	Changes to the Medicaid Preferred Drug List (PDL)		
PB09-42	New Preferred Drug List (PDL) for the ConnPACE and SAGA Programs		
PB09-43	H1N1 Billing Guidelines		
PB09-43	Addition of Prior Authorization		

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