Connecticut Department of Social Services
Caring for Connecticut

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Connecticut Medical Assistance Program
http://www.ctdssmap.com

The Connecticut Medical Assistance Program

Provider Quarterly Newsletter

New in This Newsletter

Connecticut Medicaid EHR Incentive Program
HIPAA 5010 and NCPDP Update
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Becomes Medicaid for Low Income Adults

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Connecticut Medicaid EHR Incentive Program

What is the Electronic Health Record (EHR) Incentive Program?

The EHR incentive program was established by the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act of 2009. The program aims to transform the nation's health care system and improve the quality, safety and efficiency of patient health care through the use of electronic health records.

Effective July 13, 2010, the U.S. Department of Health Services (HHS), the Centers for Medicare & Medicaid Services (CMS) and the Office of National Coordinator (ONC) released the final rule providing the parameters and requirements for the Medicaid EHR incentive program under the HITECH Act.
The Department of Social Services (DSS) is in the process of developing a system to manage incentive payments for Connecticut's eligible providers.

EHR Incentive Program Eligibility
The following eligible professionals and hospitals may participate in the EHR incentive program:

Eligible Professionals
- Physicians
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who are working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant

Providers can review the EHR Incentive Programs: Eligibility page on the CMS Web site for more information.

Eligible Hospitals
- Acute care hospitals (including critical access hospitals and cancer hospitals)
- Children's hospitals

Incentive Payments – Eligible Professionals
- Maximum incentives are $63,750 over six years
- First year payment is $21,250 if a provider adopts, implements or upgrades certified EHR technology
- Incentive payments are the same regardless of the starting year
- Must begin by 2016 to receive incentive payments

Providers can review the EHR Incentive Programs: Overview page on the CMS Web site for more information.

Incentive Payments – Eligible Hospitals
Hospital incentive payments are based on a formula provided in the statute that can be reviewed on the EHR Incentive Programs: Hospitals page and the Medicaid Hospital Incentive Payment Calculations document on the CMS Web site.

EHR Incentive Program Eligibility for Connecticut
Eligible professionals must be fully licensed and credentialed in Connecticut and may not be excluded from federal funding.

Eligible professionals and hospitals must demonstrate adoption, implementation or upgrade of a certified EHR system and "meaningful use" of the technology in order to qualify for the incentive payments.

"Meaningful use" is defined as using certified EHR technology to:

- Improve quality, safety, efficiency and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- All the while maintaining privacy and security

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To learn about certification and certified EHRs, as well as other programs designed to support providers, please review the Electronic Health Records and Meaningful Use page on the HHS Web site.

Connecticut Medicaid EHR Incentive Program Eligibility: Professionals

Professionals must not be hospital-based (may not perform 90% or more of their services in a hospital inpatient or emergency room setting) and must meet at least one of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume if they are a pediatrician
- Practice predominantly in a FQHC or RHC and have a minimum 30% patient volume attributable to needy individuals

Providers can review the EHR Incentive Programs: Medicaid Eligible Professional page on the CMS Web site for more information.

Connecticut Medicaid EHR Incentive Program Eligibility: Hospitals

Acute Care Hospitals

Acute care hospitals include cancer hospitals, critical access hospitals and short term general hospitals that meet all of the following criteria:

- Hospitals that have a CMS Certification Number (CCN) with the last four digits ending in the series 0001 – 0879 or 1300 – 1399 are eligible.
- It must have 10% Medicaid patient volume in order to participate.
- It is a primary health care facility where the average length of patient stay is 25 days or less.

Children's Hospitals

Only those hospitals that have CCNs in the 3300 – 3399 series are considered eligible children's hospitals.

Providers can review the EHR Incentive Programs: Hospitals page on the CMS Web site for more information.

EHR Incentive Program Start Date

DSS is working with CMS in coordination of the implementation date. Currently the anticipated time frame is mid-2011 to begin the enrollment of eligible providers. Information about the program will be published on www.ctdssmap.com.

EHR Incentive Program Provider Registration Start Date

Providers applying for incentive payments must register with the National Level Repository (NLR) through CMS. There will be additional registration required with the Connecticut Medicaid EHR Incentive Program once CMS reports on registered providers. More details about the registration for CT DSS providers will be published on www.ctdssmap.com.

Provider Resources

The HITECH Act created Health Information Technology Regional Extension Centers (RECs) to provide "on-the-ground assistance" to help providers to successfully adopt, implement, upgrade and achieve meaningful use of EHRs within two years. In Connecticut, the federally designated REC is:

- eHealthCT Web site

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HIPAA 5010 and NCPDP Update

Are you preparing for the transition to HIPAA 5010 and NCPDP D.0?

We hope you will take this opportunity to communicate with your internal software vendor, or clearinghouse about the changes that will be needed for you to be HIPAA compliant as of the beginning of January 2012.

Please share the following schedule with them and continue to watch our Web site (https://www.ctdssmap.com) for more information about the changes, publication of the Connecticut Companion Guides and testing with Connecticut Medical Assistance Program.

The availability of Companion guides and testing dates:

- Electronic Remit (835) - 11/15/2010
- Electronic Eligibility Request and Response (270/271) - 11/15/2010
- Electronic Pharmacy Transactions (NCPDP (B1, B2, B3 and E1 version D.0) - 11/15/2010
- Electronic Professional, Dental and Institutional (837P, 837D and 837I) - 01/15/2011
- Electronic File Acknowledgment (999) - 01/15/2011
- Electronic Enrollment (834), Electronic Claim Status Inquiry and Response (276/277), Electronic Prior Authorization (278) and Electronic Premium Payment - 03/1/2011

For Electronic Remittance (835) and Eligibility Request and Response (270/271) dual processing will be available from January 12, 2011 through the beginning of January 2012. For claims (837P, 837D and 837I) dual processing will be available from February 16, 2011 through the beginning of January 2012. For Claim Status Inquiry and Prior Authorization, dual processing will be available from April 6th, 2011 through the beginning of January 2012.

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National Health Reform – State Administered General Assistance Program Becomes Medicaid for Low Income Adults

Pursuant to section 2001 (a)(40)(A) of the Patient Protection and Affordable Care Act, the State Administered General Assistance Program (SAGA) has been discontinued and individuals formerly covered under SAGA are now covered under Medicaid effective **April 1, 2010**. This change transferred the 47,000 single, low-income adults covered by SAGA into the Medicaid program. These adults now have access to the fee-for-service Medicaid health care benefit package. This has a positive impact on the state budget as the state now receives federal reimbursement for what were previously all state expenditures.

The program name for this new Medicaid population is "Medicaid for Low Income Adults", which will be referred to as "Medicaid L-I-A."
For further information regarding this policy please refer to Provider Bulletins PB 10-37 "National Health Reform – State Administered General Assistance Program Becomes Medicaid for Low Income Adults" and PB 10-38 "National Health Reform – State Administered General Assistance Program Becomes Medicaid for Low Income Adults". To access the bulletins, from the Web site Home page, go to Information > Publications, enter PB10-37 or PB10-38 in the Bulletin Number Field and click search or contact HP's Provider Assistance Center (PAC) at 1-800-842-8440 or (860) 269-2028.

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Client Identification Number Inquiry

Beginning August 16, 2010, all providers must use the self service functionality found on the secure Web portal to identify a client ID number. The Provider Assistance Center (PAC) will no longer perform these client ID searches. The PAC will continue to assist providers experiencing discrepancies with client verification, such as multiple clients matching the identification criteria or when the two forms of identification do not match. The PAC will also continue to assist providers with obtaining client ID numbers for dates of service greater than 1 year.

The client ID number will be returned, if found, when submitting a client eligibility inquiry using the following criteria:

- Full Name + SSN, or
- Full Name + Birth Date, or
- Birth Date + SSN.

It is important to note that the full last name, first name, and middle initial must be entered exactly as it is stored in the Department of Social Services' Eligibility Management System in order to obtain the client's ID number. For further information regarding this policy please refer to Provider Bulletin PB 10-46 "Client Identification Number Inquiry". To access the bulletin, from the Web site Home page, go to Information > Publications, enter PB10-46 in the Bulletin Number Field and click search or contact the PAC at 1-800-842-8440 or (860) 269-2028.

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Provider Enrollment Application Tracking UPDATES to Status Recently Made to Web

Some recent enhancements to the Provider Enrollment Application Tracking status have been made to make them more specific, giving providers more information than ever before. Once an enrollment application has been submitted to the Connecticut Medical Assistance Program the enrollment status may be monitored through the www.ctdssmap.com Web site. Providers will no longer have to call the Provider Assistance Center for status.

To Track a Provider Enrollment/Re-enrollment:
1. Enter the ATN assigned when the provider enrollment was successfully submitted or the ATN communicated to you on your Provider Re-enrollment Due Notice.
2. Enter the Business OR Last Name used for the provider enrollment/re-enrollment.
3. Click search.

The Search Results panel displays below with information about this enrollment/re-enrollment application.

Possible Status values are as follows:

(continued on the next page)

Status	Description
Appln Mailed-Prov to Complete	This status is displayed when a paper enrollment or re-enrollment application has been sent to a provider. An ATN will remain in this status until HP receives the application from the provider.
Renewal Mailed-Prov to Complete	This status is displayed when the provider has been sent a letter that they are due to re-enroll in the Connecticut Medical Assistance Program. An ATN will remain in this status until HP receives notification that the application has been completed.
HP Reviewing Submitted Applctn	This status is displayed when HP has received the provider's enrollment or re-enrollment application and is reviewing the application for completeness. No action is required by the provider when an ATN is in this status.
HP Reviewing Dental Applctn	This status is displayed when HP has received the provider's dental enrollment or re-enrollment application and is reviewing the application for completeness. No action is required by the provider when an ATN is in this status.
Waiting Appl or Info from Prov	This status is used when HP has returned an incomplete enrollment or re-enrollment application to a provider, or when HP is waiting on a provider to submit the required supporting documentation to their Web enrollment/ re-enrollment application.
DSS Conducting Initial Review	This status is displayed when an application has passed HP's review criteria, and has been forwarded to DSS for review. No action is required by the provider when an ATN is in this status.
DSS Awaiting Info from Prov	This status is displayed when DSS is in the process of reviewing an enrollment or re-enrollment application and requires some additional information from a provider.
DSS Conducting Final Review	This status is displayed when DSS is conducting their final review of a provider enrollment/re-enrollment application. No action is required by the provider when an ATN is in this status.
HP Approved/Letter to be Sent	This status is displayed when HP has approved a provider's enrollment/ re-enrollment application. This status indicates that a provider will soon receive a letter that the enrollment/re-enrollment has been completed. No action is required by the provider when an ATN is in this status.
DSS Approved/Letter to be Sent	This status is displayed when DSS has approved a provider's enrollment/ re-enrollment application. This status indicates that a provider will soon receive a letter from HP that the enrollment/re-enrollment has been completed. No action is required by the provider when an ATN is in this status.
Denial Ltr to be Mail to Prov	This status is displayed when an enrollment or re-enrollment application has been denied, and indicates that a letter explaining the reason for denial will soon be mailed to the provider.
HP Denied	This status is displayed when HP has denied an enrollment or re-enrollment application. When an ATN is in this status, a letter has been mailed to the provider to indicate the reason for denial.
DSS Denied	This status is displayed when DSS has denied an enrollment or re-enrollment application. When an ATN is in this status, a letter has been mailed to the provider to indicate the reason for denial.
Enrollment Completed	This status indicated that a provider's enrollment application has been approved and fully processed. Providers should await receipt of their Provider Welcome Letter prior to claim submission.
ReEnrollment Complete	This status indicates that a provider's re-enrollment application has been approved.
Denied-No Response from Prov	This status indicates that the application has been denied due to a lack of timely response from a provider.

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Recent Changes to the PAC Automated Voice Response System Menu Options

On August 16, 2010 the HP Provider Assistance Center (PAC) implemented an enhancement to the Automated Voice Response System (AVRS). When a caller accesses the PAC line, a welcome message is heard. At the conclusion of the message, the following assistance menu options are offered:

1 Self Service Options
2 Claim and Enrollment Assistance NEW
3 Technical Assistance NEW

Please note that providers may press options 1, 2, or 3 to bypass this message and go directly to the different main menu options.

The **Self Service Option selection** will prompt callers to enter an AVRS ID & PIN. Once the AVRS ID & PIN are validated the caller can then choose from the available Self Service options.

PAC AVRS Self Service Main Menu Options:
1 Eligibility Verification
2 Remittance Advice
3 Claim Status
4 Diagnosis Code Lookup
5 Change PIN
6 Alphabetic Character Instructions
7 Fax Requests
8 Prior Authorization
0 Speak with Customer Service Representative
* Repeat the Menu

Options #2 **Claim Status and Enrollment Assistance** & #3 **Technical Assistance** will allow the provider to choose from several menu options to speak with a specialized Customer Service Representative.

Claim Status and Enrollment Assistance Menu Options:
1 Other Insurance/Medicare Billing Instructions
2 Provider Enrollment
3 Dental
4 Long Term Care/Home Health/Hospice
5 Pharmacy
6 Behavioral Health
7 Eyeglass Vision History
0 All other questions/Speak with CSR
* Repeat the Menu

Technical Assistance Menu Options:
1 EDI
2 Provider Electronic Solutions (PES)
3 Web Portal Account
4 Web Password Reset
0 All other questions/Speak with CSR
* Repeat the Menu

Providers can continue to access the AVRS and speak with PAC customer service representatives using the existing in-state toll free and local telephone numbers:
1-800-842-8440, in-state toll free
(860) 269-2028, local to Farmington and out-of-state
PAC Hours of Operation:
Monday-Friday, 8:00 am – 5:00 pm EST (excluding holidays)

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What impact does an Individual's Qualified Medical Beneficiary (QMB) Coverage Have on Prescription Processing?

When verifying eligibility, it is important for the provider to note all of the benefit plans included in the eligibility response rather than just looking for the ones you think cover pharmacy services. If the verification response indicates 'Medicare covered services only', the client only has QMB coverage. Medicare covered services means the client has coverage for co-insurance or deductible assigned to a Medicare paid claim. That does not necessarily mean that the client is without coverage for all pharmacy services.

Although QMB covers Medicare co-insurance and or deductible only, there are instances when pharmacy claims would be considered as such and the prescription co-pay would be covered as a professional crossover claim. An individual enrolled in a Medicare Part D Advantage Plan may have a Medicare Part B covered service process as a Medicare Part D prescription as they are not enrolled with traditional Medicare Part B. Examples of Medicare B covered medications include:

- Inhalation solutions administered via nebulizer
- Oral and injectable chemotherapy medications as defined by Medicare
- Epoetin Alpha (*specific Diagnosis Codes and Patient Location restrictions)
- Enteral nutrition products (*specific Diagnosis Codes and Patient Location restrictions)
- Diabetic Supplies

When the Medicare Part D co-pay for one of these medications is submitted in the NCPDP Pharmacy Point of Sale (POS) format for an individual with QMB coverage only, the claim will deny with Explanation of Benefits (EOB) code 4002 'NDC Not payable for program'. The same claim submitted for a client with ConnPACE and Medicare coverage would deny with EOB code 2509 'Bill Medicare first'. However, because ConnPACE does not cover Medicare Part B covered services, the misconception is that the client is responsible for the Medicare co-insurance which may be up to 20% of the Medicare allowed amount.
The co-insurance due is payable under the QMB coverage, but the claim needs to be converted from the Pharmacy NCPDP format to the CMS 1500 Professional claim format because it is a Medicare Part B covered service. When a client has Medicare and Medicaid or QMB coverage, Medicare will pay the claim and most claims will electronically cross over (be sent to) HP without any provider intervention. However, there are times when a co-insurance and/or deductible claim does not automatically cross over electronically. In these instances it is necessary for the provider to submit a co-insurance and/or deductible claim to HP. Additionally, when Medicare Part D processes a Medicare Part B covered service it does not automatically crossover.

Although the claim adjudicated as a Medicare Part D payment through an advantage plan, it is still considered a Medicare Part B primary payment and needs to be submitted as a professional claim. The professional crossover claim may be submitted either electronically, on a CMS 1500 paper claim form or through the Connecticut Medical Assistance Program Web site www.ctdssmap.com. For complete instructions on converting a pharmacy claim to a professional claim please refer to Provider Bulletin PB09-36 "Clarification of Billing Requirements for Medications Covered by Medicare Part D and Medicare Part B". To access the bulletin, from the Web site Home page, go to Information > Publications, enter PB09-36 in the Bulletin Number Field and click search.

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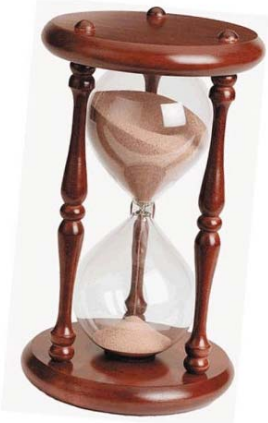
Are You Wasting Your Time?

Do you send checks to HP when you need to refund money related to a payment on a claim? That is definitely a waste of your time, checks, envelopes and postage. If you need to refund the entire payment amount of a claim, you can simply log on to your secure Web account, perform a claim inquiry on the claim in question, scroll down to the bottom of the claim and click the Void button. In the amount of time it takes to write a check, your refund can be complete via the Web portal! If you need to refund only a specific paid detail of a claim, you can use the adjustment feature of the Web claim. You can delete individual detail lines and then click the Adjust button and the claim will be reprocessed without the unwanted detail. Contact our Provider Assistance Center in-state toll free at 1-800-842-8440 or in the local Farmington area at (860) 269-2028 for details on how to eliminate the need to submit refund checks to HP.



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Dental Providers

Dental Federally Qualified Health Centers (FQHCs) and HUSKY B Co-pay Requirement

HUSKY B cost share requirements for dental services went into effect for dates of service July 1, 2010 and forward for dentists, dental groups and dental clinics. Federally Qualified Health Centers (FQHCs) will also be required to collect co-pay from HUSKY B clients effective 10/6/2010 . Since FQHCs are paid an all inclusive visit rate under procedure T1015, the co-pay will be a percentage of their T1015 rate. The co-pay amount for different procedures ranges between 20-100% of the fee schedule amount. If more than one procedure is performed on the same date of service at an FQHC, the highest co-pay amount will be applied to the claim. For example, if on the same visit a procedure with 20% co-pay requirement and another one with 50% co-pay requirement were performed on a HUSKY B client, the claim will pay 50% of the T1015 rate and the client will be responsible for the remaining 50%. Not all services are subject to the co-pay requirement. To promote good dental hygiene amongst clients, preventative and diagnostic services are exempt from the co-pay requirement. Please consult the dental fee schedule to determine which procedure codes are subject to the HUSKY B co-pay requirement and the applicable co-pay amount.

The dental fee schedule is accessible to providers from the Connecticut Medical Assistance Program Web site www.ctdssmap.com. From the Home page:

1. Select **Provider**;
2. Scroll down and click **Provider Fee Schedule Download**;
3. Scroll down and click **Dental**

The fee schedule lists the Connecticut Dental Health Partnership (CTDHP) fee and the client's cost share percentage. Please note, all other applicable CTDHP policies, regulations, prior authorization requirements and contact information remain unchanged. Questions about the cost share requirements? BeneCare's Provider Services Staff at 1-888-445-6665 is available to assist you Monday through Friday from 8:00 AM to 5:00 PM.

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Attention Home Health and Connecticut Home Care Billing Providers!

Are you receiving a denial for "Plan of Care exceeded or PA required," for a claim where units do not exceed the weekly units allowed? If so, please be sure to check if there is an existing PA for the procedure code/RCC billed within the span dates of service on the claim.

To check for an existing PA, go to the www.ctdssmap.com Web site and log-in to your secure provider account. From the Prior Authorization menu, click inquiry, enter the client ID and click search. If you find a PA for the procedure code within the dates of service billed, please note the following:

If the PA was requested by your Agency for Home Health Services:

- Units should have been authorized for the entire plan of care, including units up to the weekly audit limit
  - **Prior to June 1, 2010**, claims did not decrease the client's PA file, until units exceeded the weekly audit limit, which could have resulted in your agency already receiving payment for more than the plan of care authorized. If the plan of care has been exceeded, no further units will be paid for the procedure code/RCC authorized when the dates of service are within the span dates of service on the PA.
  - **Effective June 1, 2010**, if a PA exists for a procedure or RCC within the span dates of service on the claim, all units paid will decrease the PA on file, up to the number of units authorized. Units up-to the audit limit will no longer pay without decreasing the PA file.

If the PA was requested by the Access Agency Care Manager or Home Health Agency with a Connecticut Home Care Billing Provider:

- Prior Authorization requests received **prior to July 1, 2010** were authorized based on the units in excess of the weekly audit limit within the plan of care. All Claims which process against these PAs will continue to pay units up to the audit limit without taking units from the PA file.
- Dates of service on or after **June 1, 2010** with a PA received date on or after **July 1, 2010**, will immediately decrement the PA file.
-

For more information regarding these PA changes and their impact to claims processing, providers should refer to Provider Bulletin PB10-41 "Prior Authorization and Claims Processing Changes", located at www.ctdssmap.com -> Publications -> enter PB10-41 in the "bulletin number" field.

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Home Health Providers

Home Health Agency Alert: Immediate Action Required!

Effective **August 1, 2010**, all initial Home Health PA requests must be faxed to **(860) 269-2138**. This is a dedicated fax to expedite the processing of these initial requests. The Department of Social Services will **no longer accept** initial PA requests via telephone. Reauthorizations will continue to be faxed to **(860) 269-2137**. However, an increase in service or change in plan of care must be requested by contacting the Department of Social Services via telephone at **(860) 424-5192**. For more information on how to submit your PA requests or PA inquires, providers should access Provider Bulletin PB10-44 located at www.ctdssmap.com -> Publications -> enter PB10-44 in the "Bulletin Number" field.

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Prior Authorization Using Procedure Code Lists

HAVE YOU HEARD? The latest buzz is - Providers can now request prior authorization based on a list code associated with a list of procedure codes which may be billed interchangeably, based on the service provided, up to the number of units authorized. If you are tired of always having to modify your PA when there is a change in the client's service from RN to LPN, from secondary to primary or when Medication Administration services change, then you're going to think code lists are the greatest thing since sliced bread! Just think of the time you will save in:

- Fewer PA change requests
- A reduction in claim denials due to no service authorization for a particular code
- A reduction in rebilling once a change of authorization has been completed

To get the entire scoop on Prior Authorization using Procedure Code Lists, go to www.ctdssmap.com Web site -> Publications -> enter PB10-44 in the "Bulletin Number" field.

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Don't Underestimate the Power of DME Modifiers They Matter and Can Impact the Status of Your Claim

Knowing which modifiers are required and when can greatly reduce the number of claim denials you receive. For example: submitting a claim for the repair of equipment with modifier RB (Replacement of a part of a DME repair) alone, or a rental claim with only the RR (Rental) modifier will undoubtedly result in a claim denial with Explanation of Benefits (EOB) code 4272 'Procedure code and modifier combination is not valid for billing provider'.

Claims submitted in this manner will deny because these modifiers must be billed in conjunction with another modifier. Referencing the following chart may save you from submitting your claims incorrectly:

First Modifier	Description	Second Modifier	Description
RB	Replacement of a part of a DME repair	NU	New
RR	Rental	NU UE	New Used

Wondering where to find more information on modifier requirements?

- **Chapter 8.3** of the MEDs Provider Manual identifies unique claim submission requirements that apply for specific modifiers.
- The **Fee schedule** identifies if a procedure may be rented, repaired, or purchased and whether Prior Authorization (PA) is required for all or specific modifiers.
- **Provider Bulletin**:

  PB09-19 'Clarification of MEDS Fee Schedule and Policy' introduces the modifier KA 'Wheelchair add on option/accessory'.

  PB09-08 'Updated MEDS Fee Schedule and Replacement of RP Modifier' introduced modifier RB (Replacement of a part of a DME repair).

  PB04-17 'Changes to Medical Equipment, Devices and Supplies (MEDS) Services Fee Schedule' introduced new modifier requirements for rentals.

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Appendix

Holiday Schedule

Date	Holiday	HP	CT Department of Social Services
11/11/2010	Veteran's Day	Open	Closed
11/25/2010	Thanksgiving	Closed	Closed
11/26/2010	Thanksgiving	Closed	Closed

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Provider Bulletins

Below is a listing of all Provider Bulletins that have been posted to www.ctdssmap.com since the last Newsletter was published. To see the complete messages, please visit the Web site. All Provider Bulletins can be found by going to the Information -> Publications tab.

PB10-57 CMS National Correct Coding Initiative (NCCI)

PB10-56 Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)

PB10-56 October 1, 2010 Changes to the Connecticut Medicaid Preferred Drug List (PDL)

PB10-56 Clarification of Pharmacy Billing Requirements When a Primary Prescription Coverage is Exhausted and the Individual has Major Medical Coverage

PB10-55 Smoking Cessation Treatment Coverage for Pregnant Women Enrolled in Medicaid, Medicaid Low Income Adult (LIA) and HUSKY A

PB10-54 Dr. Gerson Sternstein's license suspension

PB10-53 New HUSKY B Client Cost Share for Dental Services

PB10-52 Personal Care Assistance (PCA) Services and Assistive Technology Added to the Connecticut Home Care Program (CHCP)

PB10-51 Medicaid Low Income Adults (Medicaid LIA) - Recoupment of SAGA Claims and Repayment as Medicaid

PB10-49 Therapy Prior Authorization Process Changes

PB10-48 Let e-Prescribing Streamline Your Workflow

PB10-47 Physician Radiology Fee Schedule Update

PB10-46 Client Identification Number Inquiry

PB10-44 Prior Authorization Request Changes New Procedure Code List for Nursing Services

PB10-43 Upcoming Changes to the Automated Voice Response System Menu Options

PB10-42 Usual and Customary Fee Clarification

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