

interChange Provider Important Message

Provider Enrollment/Re-enrollment/Add Alternate Service Location FAQ – Updated as of March 2022

ATTENTION PROVIDERS: This Frequently Asked Questions (FAQ) document has been developed to provide answers to commonly asked questions regarding provider enrollment and/or re-enrollment. This document is intended to assist providers with their enrollment/re-enrollments/add alternate service location, but this is not an all-inclusive document. Further information may be found in provider bulletins, as well as Chapter 3 and Chapter 10 of the Provider Manual. The Provider Manual chapters may be accessed by going to www.ctdssmap.com clicking on Information and then Publications. If your question is not answered by reviewing these documents, please call the Provider Assistance Center at 1-800-842-8440.

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Q48: I already have a Secured Web Portal Account, and I have a clerk role. How do I access letters that have been electronically posted to the account? And what if I am a clerk on several different AVRS/MCD IDs?

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Department of Mental Health and Addiction Services (DMHAS) Performing Provider FAQ

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Q1a: What is the difference between the following provider types: an organization? An organization that is employed/contracted by another organization? An individual practitioner? An employed/contracted by an organization individual? Or, an ordering/prescribing/referring provider?

A: The definitions of each are as follows:

Organization: an organization provider would be an entity who is considered the biller and performer of service. An example would be a hospital provider or an agency that bills on behalf of other providers. Reimbursement is made to the organization.

Organization that is employed/contracted by another organization: An organization that is associated another entity that is responsible for billing the services provided. An example would be a group home for which services are billed through a State agency. Reimbursement is made to the billing entity.

Individual Practitioner: An individual practitioner provider would be a single individual who is considered the biller and performer of service. An example would include a single physician office practice. Reimbursement will be made directly to the individual practitioner.

Employed/Contracted by an Organization: A member of an organization such as a provider group, clinic, hospital outpatient clinic, or FQHC would be a performing provider. **NOTE: RESIDENTS:** Residents are also considered employed/contracted by an organization participation type and should select this radio button. The organization would bill for the services provided by the member/performer of the organization. Reimbursement will be made directly to the organization. **IMPORTANT:** The organization and each member of the organization must enroll/re-enroll.

Ordering/Prescribing/Referring Provider Only: An individual provider who wishes to participate solely as an ordering or prescribing or referring provider who does **NOT** intend to bill or receive payment directly from the Connecticut Medical Assistance Program.

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Q1b: What is the difference between the term ACTIVE BILLER versus a PERFORMING PROVIDER?

A: The definitions of each distinction are as follows:

ACTIVE BILLER: Providers with a distinction of active billers are those providers that bill for services rendered and receive direct payments for services provided

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to a CMAP client(s). (In order to be considered active, the provider must have enrolled/re-enrolled and have a current provider agreement.)

PERFORMING PROVIDER ONLY: Providers with a distinction of PERFORMING PROVIDER ONLY are providers that are members of an organization, that do not directly bill for services but has an organization bill for his/her services. Performing Provider Only also identifies those providers that are currently enrolled in a resident program, or are solely enrolled as an OPR provider only.

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Q2: How does a group re-enroll with members who are new and existing?

A: Each provider is responsible for his/her enrollment/re-enrollment. If a provider indicates on a Web enrollment that he/she is a part of an organization/group/clinic, the provider will be prompted to provide the organization's/group's/clinic's identifier (either NPI or AVRS ID). (Note: The organization/group/clinic is not required to submit a list of their performers or the individual provider agreements as part of the organization/group/clinic's enrollment/re-enrollment. Organizations can add/delete actively enrolled members via a function on the "Maintain Organization Members" panel on the secure Web portal (refer to Chapter 10 of the provider manual).

Each provider will receive a notice six months, or eight months for LTC and ICF/IID providers, prior to their re-enrollment due date advising the provider to access the Web portal to complete and submit a re-enrollment application. The notice will provide the Application Tracking Number (ATN) assigned to the performer's re-enrollment. Re-enrollment for all providers must be submitted on the public portal. It is imperative the re-enrollment application is completed as soon as possible to allow adequate processing time. If an application has not been finalized by the provider's re-enrollment due date, the provider will be dis-enrolled from Connecticut Medical Assistance Program (CMAP) and will have to submit a new application. The provider's contracts will not be reinstated until the application has been processed, reviewed and approved.

Please note: The re-enrollment notice will be sent via eDelivery. If a provider has not yet created their Secure Web portal account, they will be mailed to the address designated as the enrollment address in the Enrollment Address type section of the application.

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Q3: I am a Person Centered Medical Home (PCMH) or Glide Path Provider and I need to add a provider as a Primary Care Provider (PCP). What do I need to know so I can correctly associate a PCP under a PCMH?

A: If you are a PCMH or Glide Path provider and you are adding a member to your group via the Web, and your intent is for that provider to be a PCP under your PCMH/Glide Path practice, you must first log in to your Secure Web portal account on the www.ctdssmap.com Web portal to associate the member to your group and then use CHN's Change Request Form in order to add that practitioner as a PCP. Conversely, if you are dis-associating a member from your group and that member is no longer a PCP under your PCMH/Glide Path practice, you must first log in to your Secure Web portal account on the www.ctdssmap.com Web portal to dis-associate the member from your group and then use CHN's Change Request Form in order to remove that provider as a PCP under the PCMH/Glide Path practice. CHN's change request form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the Forms & Documents link. Once on this page, locate the PCMH and Glide Path Change Request Form.

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Q4: Whose responsibility is it to maintain a performer's address?

A: It is the sole responsibility of all providers, including the performer, to keep his/her enrollment address updated with the address where the provider wishes to receive all enrollment mailings (i.e. re-enrollment notification). A performer may belong to more than one group, so it is critical the performer identifies the enrollment address he/she prefers for these types of mailings.

If you are a performing provider that has been issued a PIN and created a Secure Web portal account, you may login to that account and update your address information.

If you have not yet been sent a PIN and do not have a Secure Web portal account yet, in order to update your address, please send a signed request on your letterhead to Gainwell Technologies at: P.O. Box 5007/Hartford, CT 06102-5007; or, fax your signed request on your letterhead to 1-877-899-5401. **NOTE:** All performing providers may update their address via the enrollment/re-enrollment wizard at the time of enrollment or re-enrollment.

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Q5: Is there a list available confirming the required documents I need to provide to Gainwell Technologies?

A: The additional forms/documents you need to submit will be presented to you upon the submission of your Web enrollment/re-enrollment/add alternate service location. However, the list of required documents needed in addition to



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your application for your type and specialty is also available on the Web portal. Please visit: www.ctdssmap.com. From the menu bar, click on PROVIDER, then on PROVIDER MATRIX and click on the “Follow on Document Requirements by Provider Type and Specialty” and scroll down within the document to locate your specific provider's type and specialty Follow on Document requirements.

If additional copies of maintenance forms are needed (National Provider Identifier (NPI) Submission form, Medical or Dental Director Certification, etc.), the forms are located on the CMAP Web site. Please visit www.ctdssmap.com. From the menu bar, click on INFORMATION, then on PUBLICATIONS. **NOTE:** Please do **NOT** send in a copy of your completed Web application.

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Q6: Can a provider submit a paper application?

A: All providers must enroll, re-enroll, and submit add alternate service location address applications via the Web portal. For more information on how to submit an on-line application, please see Chapter 10 of the Provider Manual.

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Q7: If a performing provider is enrolled with multiple groups, to which address is the re-enrollment notice mailed?

A: The Affordable Care Act (ACA) changes require the performers to enroll/re-enroll themselves. The re-enrollment due notice, and any enrollment related mailings, will be sent to the enrollment address that was provided on the performer's initial application, or the latest re-enrollment application.

The performer is responsible to maintain his addresses. For example, if the performer leaves an organization whose address was used as the enrollment address, the performer must make an update to the address.

To make address updates: If you have been issued a PIN and created a Secure Web portal account, you may login to that account and update your address information.

If you have not yet received a PIN and do not have a Secure Web portal account yet, in order to update your address, please send a signed request on your letterhead to Gainwell Technologies at: P.O. Box 5007/Hartford, CT 06102-5007; or, you may fax your signed request on your letterhead to 1-877-899-5401. **NOTE:** The performing provider may update his address via the enrollment/re-enrollment wizard only at the time of enrollment or re-enrollment.

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Q8: How do providers in an outpatient hospital and/or clinic enroll as performing providers?

A: Performers within an outpatient hospital/clinic setting have two enrollment options:

1) “Traditional” Enrollment: If the performing provider is not currently enrolled, the performer must complete an enrollment through the Web portal and would need to provide the NPI/Medicaid ID of the hospital/clinic to which he/she is to be associated. If the provider was **previously enrolled** as a Medicaid provider and his/her contracts are no longer active, a re-enrollment must be submitted. In the event a provider is uncertain whether he/she has ever had a Medicaid Identification Number (MCD ID), the provider may call the Provider Assistance Center at 1-800-842-8440 for assistance. The Provider Assistance Center will then assign a re-enrollment ATN.

2) Via the Demographic Maintenance Panel on the secure Web portal: If the performer is currently enrolled as an active Medicaid provider, the outpatient hospital/clinic must log in to the secure Web portal and add the provider through the MAINTAIN ORGANIZATION MEMBERS panel under the Demographic Maintenance panel. Refer to Chapter 10 for specific instructions.

To determine which provider type(s) and or specialty(s) are allowed enrollment under a provider group/clinic/hospital outpatient clinic/FQHC/waiver program, providers can access the following document located on the www.ctdssmap.com Web site under Information > Publications > Forms > Provider Enrollment/Maintenance Forms or by selecting the link below:

[Group Type to Individual Type Crosswalk](#)

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Q9: How do school based providers enroll?

A: School districts wishing to enroll or re-enroll as a Medicaid Provider under the School Based Child Health (SBCH) Program can go to the CMAP Web site at www.ctdssmap.com. An addendum to the standard provider agreement will be presented as part of the enrollment and re-enrollment application, however no additional information will need to be submitted.

Most school districts are a municipal entity governed by a board of education. In most cases, a school district will be required to provide the managing employees in the Corporate Officers section of the application. However, if the school district is governed by a board or owner(s) other than a local or regional board of education, the additional questions in the Corporate Officers may be required.



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Any questions regarding the completion of this section should be directed to the SBCH Program at DSS.SBCH@ct.gov.

SBCH providers are required to re-enroll every three years.

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Q10: What provider type applications are processed by the Department of Social Services?

A: All applications are reviewed for completeness by Gainwell Technologies. Once all required information has been gathered, Gainwell Technologies will forward the application to the Department of Social Services' (DSS') Quality Assurance (QA) Unit for its review. It is DSS QA's unit that makes the final decision on whether an application is approved; or, if it is denied.

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Q11: What is the enrollment period for Long Term Care (LTC) providers?

A: The re-enrollment period for all LTC facilities is 60 months. A notice to re-enroll will be sent eight months prior to the re-enrollment due date. A reminder notice will be sent within 90 days, 60 days and 30 days of their re-enrollment due date if an application has not been submitted. The 30 day notice will serve as a warning of pending deactivation and the need to transfer their clients and meet all other statutory regulations.

In most cases, additional documentation is not required as part of the re-enrollment application; however, the Enrollment/Re-enrollment Criteria Matrix should be reviewed to ensure additional information, for example a copy of your DCF license, if required, is sent to Gainwell Technologies. The Certification & Transmittal will be forwarded by DPH to Gainwell Technologies but is not required as part of the application process.

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Q12: Are there different enrollment requirements for physician assistants (PA)?

A: The enrollment requirements for Physician Assistants (PAs) mirror the requirements for enrolling physicians with the following exceptions:

- PAs can only enroll as performing providers in an organization/group, clinic, or hospital; not as an independent practitioner.
- When completing an application on the Web portal, PAs must also submit the Name & NPI of their supervising physician. The supervising physician



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and the PA must be linked to the same group. (Please reference [Provider Bulletin 2011-82](#), December 2011)

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Q13: What are the biggest changes related to the ACA?

A: The ACA requires the following:

- All providers who order or prescribe or refer services for a client enrolled in the Connecticut Medical Assistance Program (CMAP), must now enroll in CMAP. New functionality has been incorporated into the enrollment Wizard to accommodate these types of providers. The Ordering, Prescribing, and Referring providers will be excluded from all provider searches. Failure to be enrolled in CMAP will cause the claim submitted by the servicing provider to be denied.
- If a practice is increasing the number of locations in which it is providing services, a new add alternate service location application must be completed for that new service location. If a practice is closing a service location and moving it to a new location, this update may be done via the Location Name Address panel under Demographic Maintenance on the secure Web site.
- Monthly license verification against data maintained by various licensing agencies, such as the Department of Public Health, the Department of Children and Families, the Department of Consumer Protection,
- Monthly vehicle registration validation against data maintained by the Department of Motor Vehicles.
- Monthly sanctions verification against the list of federally excluded providers.
- Monthly verification against the Social Security Administration's list of deceased providers.
- Providers must re-enroll at least every 5 years for the vast majority of provider types. Re-enrollment timeframes are viewable on the provider Web portal at www.ctdssmap.com by selecting Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty.
- Application fees for institutional providers. DSS is awaiting clarification from The Centers of Medicare & Medicaid Services (CMS) before completing the process to collect these fees.

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- For initial enrollments for Home Health providers and Medical Equipment, Devices, and Supplies (MEDS) providers, and any provider identified by the Department of Social Services' Quality Assurance Unit as high risk at the time of re-enrollment, are subject to a background investigation. The ACA requires these providers to be screened, which includes getting fingerprinted.

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Q14: Why does one organization (such as a large medical practice) have multiple groups?

A: Physicians and APRNs must have their own groups, even if they share the same specialties. Pediatricians, OB-GYNs, dentists, Family Medicine specialties, and behavioral health clinicians are restricted to joining groups that share the same specialty. For instance, an OB-GYN provider cannot be linked to a physician group with a specialty of Internal Medicine. Internal medicine groups can have multiple specialties under one group, if the taxonomy falls under the internal medicine type/specialty (refer to the provider type/specialty/taxonomy crosswalk under Information > Publications > Forms on the www.ctdssmap.com Web site). Each group can share the same NPI as a separate Medicaid ID is assigned to each group. For more information on enrollment restrictions, please refer to the document below.

[Group Type to Individual Type Crosswalk](#)

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Q15: If my organization has a change in ownership, will a new enrollment application be required, or can I just provide proof of the change of ownership?

A: If there is a change of ownership, the provider must complete a new enrollment application and submit a letter stating the new enrollment is due to a change of ownership. If you are a Long Term Care facility, please contact the Provider Assistance Center and advise them there is change of ownership and you will be assigned a **re-enrollment** ATN. All other provider types can submit a new web enrollment application. A copy of the bill of sale will also be required.

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Q16: What is required for a change of address? I am closing one location and opening another, what is needed to update my address in CMAP? I am adding a new service location to all my currently enrolled locations, what is needed to update my address in CMAP?

A: For a:

- **Billing Provider:** A billing provider may maintain his/her address via the secure Web portal at www.ctdssmap.com. The address maintenance feature is located under the Demographic Maintenance Panel. There, a provider can maintain his/her billing, mail to, service location, enrollment, and home office addresses. **NOTE: SERVICE LOCATION ADDRESSES:** If an organization is adding to the total number of locations in which he/she provides services, then a new application must be completed for that new location, following the instructions in the next bullet. However, if an organization is simply closing a service location and relocating, a re-enrollment form is not required; an address change may be made.
- **Adding an Alternate Service Location:** If a billing provider is increasing the total number of locations in which services are provided, a new application must be completed. To submit an application to add an alternate service location address, please go to our Web site, www.ctdssmap.com. Go to PROVIDER, then to ADD ALTERNATE SERVICE LOCATION ADDRESS. Once you select this link, you will be directed to the Secure Web portal. You must log on to the Secure Web portal to submit this type of application. You may then follow the directions as presented on the panels.

PLEASE NOTE: A master Web user can assign clerks to submit an add alternate service location application. If the clerk assigned is associated to multiple AVRS IDs, the clerk will need to utilize the secure Web portal switch provider function to guarantee the application is submitted for the correct AVRS ID.

- **Performing Provider:** It is the sole responsibility of the performer to keep his/her addresses updated. All enrollment correspondence is sent to the Enrollment Address on file; therefore, it is imperative for the provider to ensure Gainwell Technologies is provided with the most current enrollment address he/she wishes to receive all enrollment mailings. A performer may belong to more than one group, so it is critical the performer identifies the enrollment address he/she prefers for these types of mailings.

If you have been issued a PIN and created a Secure Web portal account, you may login to that account and update your address information.



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If you have not yet been issued a PIN and do not yet have a Secure Web portal account, in order to update your address, please send a signed request on your letterhead to Gainwell Technologies at: P.O. Box 5007/Hartford, CT 06102-5007; or fax the signed request on your letterhead to 1-877-899-5904. **NOTE:** The performing provider may update his address via the enrollment/re-enrollment wizard only at the time of enrollment or re-enrollment.

If you are adding an alternate service location address, that address must first exist under the billing provider to which you are associated. You may then submit a signed request on your letterhead to Gainwell Technologies at: P.O. Box 5007/Hartford, CT 06102-5007; or fax the signed request on your letterhead to 1-877-899-5401.

- **PCMH and Glide Path Providers Only:** If you are a PCMH or Glide Path provider, a change to your address information for an existing PCMH/Glide Path site may affect your claim payments. To ensure your practice receives the fee differential payments for primary care services, your primary and/or alternate service location address submitted on claims **MUST** match exactly to the primary and/or service location address. The Web portal will not allow a PCMH or a Glide Path provider to update its address via the Secure Web portal. Please submit the request to update the address in writing to Gainwell Technologies's Provider Enrollment Unit at P.O. Box 5007, Hartford, CT, 06102-5007.

Once Gainwell Technologies has updated the address, whether it be as simple as adding a suite number or a total overlay of an address due to the move of an office, the update must be communicated back to CHN using CHN's Change Request Form. This form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the Forms & Documents link. Once on this page, locate the PCMH and Glide Path Change Request Form. If there are claims to be processed for the address you are updating, please do not initiate that address update via the Web portal.

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Q17: Is the EFT form and voided check needed for a re-enrollment?

A: The re-enrollment Web Wizard has been updated to allow a provider to verify and update the EFT information already on file. Therefore, it is no longer a requirement to submit an EFT form with a voided check at the time of re-enrollment. If the provider does need to update the EFT information that is on file, the provider may do so either at the time of re-enrollment via the Re-enrollment Web Wizard; or through the secure Web portal at www.ctdssmap.com on the EFT Account panel under Demographic Maintenance.

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Q18: I updated my EFT information via the Demographic Maintenance panel on the secure Web site and I am getting an error message. What do I do?

A: A provider is only permitted to make one EFT update per day. If this is a second attempt on the same day, please wait 24 hours to make the correction. If this is the first attempt and an error message is received, verify the EFT status. If the EFT status is in a “pre-note” status, no updates can be made to the information. The “pre-note” status means that the banking information on file has already been sent to the bank for verification. Once this information is verified with the bank, the status will change to either an ACTIVE status or a FAILED status. EFT information can only be updated if it is in one of these statuses.

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Q19: If I need assistance with the Web wizard, what tools are available?

A: If assistance is needed in the completion of an enrollment, re-enrollment, or add alternate service location Web application, please refer to Chapter 10 for more information. If further assistance is needed, please call the Provider Assistance Center at 1-800-842-8440. Please note: Gainwell Technologies continually offers provider workshops on a variety of subjects. To view a list of upcoming sessions, please visit our Web site at www.ctdssmap.com. Once there, on the left side menu, please click on PROVIDER SERVICES, and then scroll down to the PROVIDER TRAINING section. There is a link to the training schedule in this section.

There are also sample enrollments posted on the Web wizard to help a provider complete a Web application. These samples are located on the BEFORE YOU CONTINUE Panel.

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Q20: I am completing a Web application for an organization or individual billing provider and I have entered all the information required on the following panels: Partners and Members, Managing Employees or Controlling Interests. However, I am receiving an error message that is not allowing me to proceed to the next panel. Why am I getting an error message?

A: Scroll to the top of the screen, you will see a row for each individual for whom you have entered information. (If you are completing a re-enrollment, this panel will display the information Gainwell Technologies currently has on file). If there is a row that is blank, the “Add” button may have been clicked more than once. Please click on the blank row and either enter the required information; or hit “Cancel”. Repeat for each blank row. Once all blank rows either have information in them, or have been cancelled, you should be able to proceed to the next panel in the Wizard. If there are no blank rows at the top



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of the screen, please click on each row to verify all the required fields have been completed for each individual (i.e. DOB is mm/dd/ccyy, percentage of ownership is a whole number, etc.). Once verified, you should be able to proceed to the next panel in the Wizard.

If you still are not able to proceed, please call the Provider Assistance Center at 1-800-842-8440 for assistance.

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Q21: I have started my enrollment/re-enrollment/add alternate service location application on the Web but am unable to complete it because my session timed out, or I exited the Wizard to obtain information I needed in order to complete the application. Can I still use the same ATN to resume the completion of my application?

A: Enrollment Type:

- **Enrollment:** For an initial or first time enrollment, if an internet session times out, any data previously entered is not saved. The provider must start the enrollment application again from the beginning.
- **Re-enrollment:** Yes. A re-enrollment ATN will remain active until an application is submitted. However, once you start a re-enrollment application, you must fully complete that application. You cannot partially complete an application and save it to return to later. If verifying the status of the ATN on the secure Web portal at www.ctdssmap.com, the ATN status must show “Renewal Mailed-Prov to Comp” in order for the ATN to be used. If you cannot use the ATN, and you verified that the status is not in the “Renewal Mailed-Prov to Comp” status, please call the Provider Assistance Center at 1-800-842-8440 for assistance.
- **Add Alternate Service Location:** If an internet session times out, any data previously entered is not saved. The provider must start this application type again from the beginning.

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Q22: How do I verify the status of my enrollment, re-enrollment, add alternate service location application ATN?

A: To view an ATN status, visit www.ctdssmap.com, select Provider, then select Provider Enrollment Tracking. Once on the Provider Enrollment Tracking panel, the provider must enter the assigned ATN and the Business Name or Last Name of the provider to which the ATN pertains. The status of the application is then displayed. For complete instructions on accessing this feature on the Web portal



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at www.ctdssmap.com, as well as a complete list of application statuses and their descriptions, please refer to Chapter 10.

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Q23: I am trying to submit my Web re-enrollment using the ATN listed on the notice to re-enroll. Why am I getting an error that the ATN is invalid?

A: If the ATN listed is in any status other than **Renewal Mailed-Prov to Comp**, it is no longer “useable”. The status of the ATN can be verified via the Web. If the ATN is in any other status than “Renewal Mailed-Prov to Comp” status, please call the Provider Assistance Center at 1-800-842-8440 for assistance.

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Q24: What are the ATN statuses and what do they mean?

A: A list of all ATN statuses and their definitions can be found in Chapter 10 of the Provider Manual. To access Chapter 10, visit www.ctdssmap.com, click on Information, then Publications, then click on the link for Chapter 10.

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Q25: How do I know if I need to submit an enrollment application or a re-enrollment application?

A: If a provider has ever had a Medicaid ID (even if the ID is currently inactive) with the CMAP program, then the provider must obtain a re-enrollment ATN and submit a re-enrollment application. If a provider is uncertain if he/she has ever had a Medicaid ID, the provider may call the Provider Assistance Center at 1-800-842-8440 for assistance.

PLEASE NOTE: If an initial enrollment form is completed and the Gainwell Technologies Enrollment Team finds an existing Medicaid ID for the provider, the enrollment application will be denied, and a re-enrollment ATN generated; notification will be sent to the provider advising the provider must complete a re-enrollment application using the ATN provided.

PLEASE NOTE: If the provider wishes to change his/her specialty (i.e., internal medicine to cardiology), an application is not required. You may complete an NPI submission form to initiate this change. This form must be returned to Gainwell Technologies for processing. To download the NPI submission form, go to www.ctdssmap.com, click on Information, then Publications, then scroll down to the Provider Enrollment/Maintenance Forms section and click on the form titled National Provider Identifier (NPI) Submission Form.

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Q26: I used to be enrolled with Medicaid and I know I had a Medicaid ID (AVRS). I would now like to re-enroll. How do I obtain an ATN? Other than my NPI and/or AVRS ID, is there any other information I need to provide to have an ATN created?

A: In addition to your NPI and/or MCD (AVRS) ID, you will need to provide the address to which you want all enrollment related mail to be sent. If this address is not provided, the letter containing your ATN will be sent to the last enrollment address that was on file. Once you have this information, please call the Provider Assistance Center at 1-800-842-8440 and request a re-enrollment ATN. You will receive a letter within 7-10 business days advising the ATN that has been assigned to your re-enrollment. At that time, you will be able to access the Web portal re-enrollment Wizard at www.ctdssmap.com.

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Q27: I have to update my CLIA certification but my enrollment/re-enrollment/add alternate service location application has already been finalized. How do I get this information updated?

A: You can submit a copy of the CLIA certificate with a cover letter on your letterhead to Gainwell Technologies. Please include both the NPI(s) and AVRS ID(s) to which the CLIA update applies. The letter and CLIA certificate must be mailed to: Gainwell Technologies Provider Enrollment/P.O. Box 5007/Hartford, CT 06102-5007.

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Q28: Why do I have to disclose Social Security Numbers (SSNs) when completing an enrollment/re-enrollment/add alternate service location application? How is the information used?

A: The Department of Social Services Quality Assurance Unit (DSS QA) is responsible to credential each provider. This credentialing activity includes checking all providers, owners, and board members against several Centers of Medicare & Medicaid Services (CSM) files for any sanctioned or disciplinary actions against anyone associated with the submitted application. Gainwell Technologies receives these files on a monthly basis. These files are:

- The Office of Inspector General (OIG) file
- The Adverse Actions file

These files are also checked at the time of enrollment/re-enrollment/add alternate service location. Per the Centers for Medicare & Medicaid Services (CMS), Gainwell Technologies must collect the SSNs of providers, corporate officers, owners and managing employees at the time of application to ensure that an enrolling or re-enrolling Medicaid provider has not been sanctioned by OIG.



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In addition to the OIG and the Adverse Action files, all data is also validated against the Social Security Administration's (SSAs) Death Master file as well.

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Q29: I am a subsidiary of an organization and am completing a Web enrollment. How do I complete the Owners Information Panel?

A: On the panel labeled Board Members, Partners or Managing Administrators Information, select "Yes" for the question "Are you a nonprofit organization or an organization without an owner?" You will be required to enter information of the administrative staff (i.e. President, VP, Treasurer, CEO, managing partners etc.).

You will also need to answer "Yes" to the question "Is your corporation a subsidiary of another company" and indicate the company name and location in the fields below.

On the Controlling Interest panel, it is not required to list any information; however, an answer is required to the question "Does the applicant and/or owner, partner, member or officer have an ownership or controlling interest in any other provider?"

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Q30: If board members are volunteer and not involved in day to day operations, do we still need to list them?

A: Yes, please refer to the Board Members, Partners or Managing Administrators Information Re-enrollment panel. For both non-profit and profit organizations, the provider must supply the information for the administrative staff. The person(s) responsible for the day to day operations of the organization would include the President, Vice President, Treasurer, CEO, managing partners, etc.

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Q31: Once an application is at DSS for review, what is the turnaround time?

A: The time in which the Department of Social Services' (DSS') Quality Assurance (QA) Unit needs to complete its review of applications can vary by provider type/specialty, and other factors; therefore, there is no definitive time frame available. However, on average, provided all documentation has been received and is in good order, DSS' QA Unit can complete their review within 7 - 14 business days. Gainwell Technologies then has a week to finalize the application once approved by DSS.

The following provider types may also be subject to site visit by DSS as part of their application process:



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- DME Suppliers
- Home Health Agencies
- Hospice Agencies
- Medical Transportation
- Alcohol and Drug Abuse Clinics
- Independent Labs
- Independent Radiology Centers

It is important to take processing time into account and allow ample time for a site visit (if applicable). Providers will receive their notice to re-enroll six months (eight months for Long Term Care and ICF/IID providers) prior to their re-enrollment due date. If the application is not finalized before the re-enrollment due date, the provider's contracts will be "shut-off" and will not be reinstated until the application is approved by DSS and finalized by Gainwell Technologies.

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Q32: I received a Return To Provider (RTP) letter stating, "must register taxonomy." What do I have to do?

A: This letter is to alert you that the taxonomy you supplied to Gainwell Technologies is not registered with the National Provider and Plan Enumeration System (NPPES), but it will not hold up your CMAP application. To add the additional taxonomy, please contact NPPES directly.

NPPES Contact Information:

By phone: 1-800-465-3203 (TTY: 1-800-692-2326)

By e-mail: customerservice@npienumerator.com

By mail: NPI Enumerator/P.O. Box 6059/Fargo, ND 58108-6059

Please note that NPPES currently has a limit on the number of taxonomies that can be registered under a single NPI. If you have exceeded the limitation, please submit a letter to Gainwell Technologies advising the taxonomy limitation has been exceeded.

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Q33: I am currently enrolled as an Ordering/Prescribing/Referring (OPR) Provider. Can I join a group/organization or become an individual billing provider?

A: If you would like to now become an individual billing provider, please contact the Provider Assistance Center at 1-800-842-8440 to be assigned a re-enrollment ATN. You will receive a letter within 7-10 business days containing the ATN.



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Once you have received the ATN, you can go to www.ctdssmap.com and complete a re-enrollment application to change your provider type to an “Individual Practitioner”.

The OPR application has an amended provider agreement as OPRs are not paid for services rendered. Please contact the Provider Assistance Center at 1-800-842-8440 to be assigned a re-enrollment ATN. You will receive a letter within 7-10 business days containing the ATN. Once you receive the ATN you go to www.ctdssmap.com and complete a re-enrollment application to change your provider type to a “Member of an organization” or an “Individual (billing) provider”.

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Q34: I am trying to add a provider to my group via the Demographics panel on my secure Web account and I am getting an error message that states “The member you have selected cannot join your organization due to their provider type and specialty”.

A: Within some organizational types, there are some restrictions as to which specialties a performing provider can be associated. For example, a pediatric APRN can only be associated to a pediatric APRN group. For more information and a complete list of these restrictions, please refer to the following:

[Group Type to Individual Type Crosswalk](#)

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Q35: I am a resident that needs to enroll in the CMAP program. What do I need to do?

A: First, please work directly with your resident coordinator. A valid NPI with the student taxonomy must be assigned in the National Plan and Provider Enumeration System (NPPES). Your sponsoring organization must submit your name, NPI, SSN, Date of Birth (DOB), and resident effective dates to the Connecticut Department of Public Health (DPH). DPH will then issue a permit number based off this information. If your sponsoring organization only sends DPH information annually, updates need to be made yearly prior to the permit’s end date.

Once you know your sponsoring organization has submitted your information to DPH, you must enroll using the Provider Enrollment Wizard located on the Web site www.ctdssmap.com. You will need your permit number and your permit’s effective and end dates. From the Home page, click on the Provider tab, and then click on Provider Enrollment to begin the enrollment process. Residents must complete the entire enrollment application in order to enroll in Connecticut Medical Assistance Program (CMAP).

If you are a resident who has obtained a license from DPH, you must enroll as a physician, podiatrist, or dentist, not a resident. To enroll, please select Provider



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Enrollment via the www.ctdssmap.com Web site. At this time, the provider will select the appropriate provider type (such as “Physician”, “Podiatrist”, or “Dentist”) and the appropriate specialty. The provider will be asked to supply all relevant provider information, including their newly issued DPH license number (not your resident permit number). Upon enrollment under the provider’s newly licensed specialty, they will receive a new AVRS ID.

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Q36: I am enrolling as a resident; what information do I need to supply on the Web application?

A: During the enrollment process, the resident will have an option to select provider type and specialty. For Provider Type, select “Resident,” and then choose either “Medical”, “Podiatrist”, or “Dental” for Provider Specialty. Residents will automatically be assigned taxonomy 390200000X (Student/Resident).

Residents will be required to supply their National Provider Identifier (NPI), Social Security Number (SSN), DPH permit number, and DPH permit effective and end dates when enrolling via the Web. Any residents that do not yet have an NPI or SSN, or permit number, must first obtain these prior to submitting an enrollment application to CMAP. Please note that the resident must be registered with the National Provider Plan and Enumeration System (NPPES) with the resident/student taxonomy for the submitted NPI.

If you need to obtain the resident’s permit number, please visit the DPH website and do a license/permit search:

<https://www.elicense.ct.gov/Lookup/LicenseLookup.aspx>

Upon completion of the Wizard enrollment application, residents will receive an Application Tracking Number (ATN) and will have an opportunity to print a hard copy of the application submitted via the Web. Please do not send the hard copy to Gainwell Technologies. Once the application has been submitted via the Web, no additional action is needed by the resident. The application will be submitted to DSS’ Quality Assurance Unit for review and the resident will be notified via a letter of their approval or denial for participation in CMAP. If approved, the residents will be assigned an AVRS (Automated Voice Response System) ID which will be noted on their approval letter.

Step by step enrollment instructions are located in Chapter 10 of the provider manual. Or click on this link:

[Resident Step by Step Enrollment Instructions](#)



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Q37: Do hospitals have to associate residents to their organizations?

A: No. Hospitals are not required to associate residents under the hospital's AVRS ID.

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Q38: Will residents be required to re-enroll? And if so, how often will they need to re-enroll?

A: Once enrolled, residents will be required to re-enroll every three years via the on-line Re-enrollment Web Wizard. A notification will be sent as the resident approaches their re-enrollment due date.

NOTE: A monthly permit validation process will be systematically performed to ensure that you are still on file at DPH with a valid/active permit record. If your CMAP contracts have been end dated based on an expired permit number, a re-enrollment application must be submitted once DPH has reactivated your permit. To obtain a re-enrollment ATN number, please call the Provider Assistance Call Center (PAC) at 1-800-842-8440.

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Q39: What are the claim processing edits for resident-hospital billing?

A: Inpatient and Outpatient claims will deny with EOB 1035 "Referring provider not enrolled on date of service" on the provider's Remittance Advice (RA), if the referring provider is a resident and is not enrolled in CMAP.

Residents are not permitted to be an attending provider. If the hospital bills a claim with the resident as the attending provider, the claim will deny with EOB 1042 "Resident not allowed as Attending Provider."

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Q40: Will residents appear on the list of Ordering/Prescribing/Referring Providers?

A: To verify if the resident is going through enrollment or is already enrolled, hospitals can view the list of ordering/prescribing/referring providers on the Home page of the provider's secure Web site at www.ctdssmap.com. Once logged on to the secure site, the link to the list is in the upper right corner under Quick Links.

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Q41: I am a resident and I just became a fully licensed provider. I would like to see CMAP clients. What do I need to do?

A: If a currently enrolled resident becomes fully licensed through DPH prior to the time they are due to re-enroll, the resident must enroll in CMAP as a fully-licensed provider. To enroll, please select Provider Enrollment via the www.ctdssmap.com Web site. At this time, the provider will select the appropriate provider type (such as “Physician”, “Podiatrist”, or “Dentist”) and the appropriate specialty. The provider will be asked to supply all relevant provider information, including their newly issued DPH license number (not their resident permit number). Upon enrollment under the provider’s newly licensed specialty, they will receive a new AVRS ID. The resident’s existing AVRS ID will then be deactivated. NOTE: the provider will need to be associated to an organization if he/she has enrolled as a performing provider.

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Q42: I am a hospital based practitioner. Am I required to enroll in CMAP?

A: Yes. Professional services rendered by a hospital based practitioner during an inpatient stay must be billed on a professional claim and will be reimbursed outside of All Patient Refined, Diagnosis-Related Group (APR-DRG) classification systems. For additional information regarding Hospital Based Practitioners, please click on the following link:

[Hospital Based Practitioners - Inpatient Services](#)

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Q43: There are data fields on the application that state the information is needed for Health Information Technology (HIT), Health Information Exchange (HIE), and for Electronic Health Record (EHR) purposes. Do I need to supply this information?

A: Providers are now able to supply additional information when completing their enrollment/re-enrollment/add alternate service location applications. The following information may now be supplied as part of the Web portal application:

- Facility information can be supplied by individual providers
- A mobile and pager number may also be supplied by individual providers for the provider’s primary service location address.
- Many individuals and organizations are now able to supply Health Information Technology (HIT)/and Health Information Exchange (HIE) contact information.



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- Many individuals and organizations are now able to supply information on whether they use an Electronic Health Records (EHR) system and, if so, which system is in use.

While none of the above information is required, it is often useful in many aspects of program administration for the Department of Social Services (DSS). We encourage providers to take the opportunity to supply this information.

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Q44: In the HIT/HIE Contact and EHR Information panel, I am being asked to enter Direct Message Email Address. What is this email address and how can I obtain it?

A: Direct Mailbox is a functionality of your 2014 Certified EHR (CEHRT) system and is needed to meet the attestation requirements of Stage 2 Meaningful Use of the CMS EHR Incentive Program. This functionality of your 2014 Certified EHR system has to be enabled in order to use it. Alternately, you can have a standalone Direct Messaging system which can be incorporated into your CEHRT. The Direct messaging requires the use of a secure email address with accompanying public and private key certificates. Direct messaging provides assurance that health information is encrypted and shipped to a valid and verified recipient making it easy to send secure email to providers and patients outside your internal systems. The goal is to have information follow a patient through transitions of care and interactions with providers, hospitals, payers and Health Information Exchanges.

You can use direct messaging instead of mail or fax to send patient information to your colleagues, and it is easier to save electronic information into patient records than to transfer patient information received on paper into your EHR.

Security requires encryption of the email message and attachment during transport AND verification that the sender and recipient are valid healthcare entities. Most programs require a physical government issued identification before receiving a Direct digital certificate. Your practice administrator verifies identification of practice participants with known information (physicians, nurses, administrators) who become part of Direct Messaging. This method allows for a rapid method for everyone to be vetted for the purpose of communicating securely across the regional, state and nationwide network.

DIRECT Messaging sends electronic patient information immediately, so physicians can receive automatic admission and discharge notifications and provide timely follow up care.

Direct Mailbox email address is not the same as the email you use to exchange unsecure information. You can contact your CEHRT vendor for further



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information about the Direct Messaging functionality of your EHR system and to set up the Direct Mailbox email address if it has not already been set up.

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Q45: I received an e-mail with the subject, “CMAP E-Delivery Alert - Letter (s) Available.” It notes that I have letters posted to the Secure Web Site; what does this mean?

A. The Department of Social Services (DSS) has implemented an electronic process to deliver the Connecticut Medical Assistance Program’s (CMAP’s) letters. This process has replaced the mailing of many of the paper letters you used to receive from CMAP from the United States Postal Service (USPS). All letters identified as a part of this electronic delivery method are instead posted to your Secure Web portal account.

Several provider bulletins have been sent; they are: PB2019-15, PB2019-20, and PB2019-31; please refer to these bulletins for more information. You can search for a bulletin by going to www.ctdssmap.com, select from the menu bar, INFORMATION, then PUBLICATIONS. The Bulletin Search area is on the top of that page.

Please note: The e-mail is sent to the e-mail address associated to your Secure Web portal account; therefore, it is imperative you maintain your e-mail on your account(s) to ensure you are notified of the letter(s) posted to your account.

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Q46: How do I sign-up to receive mailings from the CMAP program electronically to my Secure Web portal account?

A. If you already have set up your Secure Web Portal account, there is nothing additional you need to do to receive any mailings included in the electronic delivery process. Please refer to the provider bulletin, PB 2019-15, for additional access information on eDelivery.

If you have not yet created a Secure Web Portal account, you may request a Personal Identification number (PIN) by submitting an e-mail to webmaster-ctmedicalprog@gainwelltechnologies.com. The e-mail must contain both your NPI and AVRS ID.

The e-mail notifying you that letters have been posted is sent to the e-mail address associated to your Secure Web portal account; therefore, it is imperative you maintain your e-mail on your account(s) to ensure you are notified of the letter(s) posted to your account.

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Q47: I already have a Secure Web Portal Account. How do I access letters that have been electronically posted to the account?

A. Once you have logged into your account, select Trade Files, then Download from the menu items, and then select eDelivery from the Transaction Type drop down box. This then will display the posted letters. Please refer to the provider bulletin, PB 2019-15, for more information. There are several screen prints included in the bulletin to help illustrate these steps.

Please note: An e-mail is sent to the e-mail address associated to your Secure Web portal account as new letters are posted; therefore, it is imperative you maintain your e-mail on your account(s) to ensure you are notified of the letter(s) posted to your account.

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Q48: I already have a Secure Web Portal Account, and I have a clerk role. How do I access letters that have been electronically posted to the account? And what if I am a clerk on several different AVRS/MCD IDs?

A. Once you have logged into your account, select Trade Files, then Download from the menu items, and then select eDelivery from the Transaction Type drop down box. This then will display the posted letter(s). Please refer to the provider bulletins, PB2019-15, PB2019-20, and PB2019-31, for more information. There are several screen prints included in the bulletin to help illustrate these steps.

If you are a clerk associated to multiple organizations, you may continue to use the switch provider functionality to navigate to the AVRS ID to which the letter(s) have been posted.

Please note: An e-mail is sent to the e-mail address associated to your Secure Web portal account as new letters are posted; therefore, it is imperative you maintain your e-mail on your account(s) to ensure you are notified of the letters posted to your account.

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Q49: I received an e-mail notifying me of a letter(s) posted to my Secure Web portal account; however, when I login to view the letter(s), it/they are not there. What am I doing wrong?

A. The e-mails are generated and sent when a letter is posted to a Secured Account. It is possible that the posting process has not completed by the time you receive the e-mail. The posting process may take several hours, so please log back in a few hours and check again.

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Q50: I am an Ambulance provider (Type 26/Specialty 260). I am completing my online application and am being asked the following question: “Are you enrolling to provide paramedic intercept services only?” Why am I being asked this question?

A. If you do provide paramedic intercept services, additional information is needed from you in order to fully review your application. If you answer, “Yes,” after you submit your application, a document will be presented to you. This is a Follow-on-Document (FOD). You will need to print it and send it back in with the additional information it identifies before your application can be reviewed.

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Q51: I am an Ambulance provider (Type 26/Specialty 260). I am completing my online application and am being asked to enter my Vehicle Identification Number(s) (VINs). Why?

A. A requirement to enroll in the Connecticut Medical Assistance Program (CMAP) is that all in-state ambulance providers provide proof the vehicles in their fleet(s) are currently registered vehicles with the Department of Motor Vehicles (DMV). In the past, this requirement was met by having you send in a paper copy of the current vehicle registration(s).

The Department of Social Services (DSS) has now automated its verification process. DSS systematically validates your vehicle’s information against a file it receives from the DMV. Please refer to provider bulletins previously published for additional information; for example, PB19-05. You can search for a bulletin by going to www.ctdssmap.com, select from the menu bar, INFORMATION, then PUBLICATIONS. The Bulletin Search area is on the top of that page.

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Q52: How will I know when I need to re-enroll?

A: If you have created a secure Web portal account, you may log in at www.ctdssmap.com. Once logged in, you will see your re-enrollment due date on the account Home page.

Additionally, each provider will receive a notice six months, or eight months for LTC and ICF/IID providers, prior to their re-enrollment due date advising the provider to access the Web portal to complete and submit a re-enrollment application. The notice will provide the Application Tracking Number (ATN) assigned to the performer’s re-enrollment. Re-enrollment for all providers must



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be submitted on the public portal. It is imperative the re-enrollment application is completed as soon as possible to allow adequate processing time. If an application has not been finalized by the provider's re-enrollment due date, the provider will be dis-enrolled from Connecticut Medical Assistance Program (CMAP) and will have to submit a new application. The provider's contracts will not be reinstated until the application has been processed, reviewed and approved.

Please note: The re-enrollment notice will be sent via eDelivery. If a provider has not yet created their Secure Web portal account, they will be mailed to the address designated as the enrollment address in the Enrollment Address type section of the application.

If you have not received your letter, please log in to your secure Web portal account to retrieve a copy of the letter. If you still need to obtain a copy of the letter, you may call the Provider Assistance Center at 1-800-842-8440.

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Q53: What will happen if I do not respond to my re-enrollment due notice by my re-enrollment due date?

A: If a provider's re-enrollment application is not finalized by their re-enrollment due date, the provider will be dis-enrolled. While you have six (6) to complete your re-enrollment application, or eight (8) months for LTC and ICF/IID providers, you are strongly encouraged to access the Web portal and complete it as soon as possible. Please remember that the re-enrollment application must be reviewed by DSS' QA Unit before it can be finalized and so appropriate time needs to be allotted within that 6 month time period for that review. Please reference Q31 for more information on DSS QA review times.

If a provider is dis-enrolled due to lack of response to provider re-enrollment, your contracts will not be re-instated until you have completed a new re-enrollment application and that has been approved by DSS' QA Unit. In these instances, the provider must obtain a new ATN to re-enroll by contacting the Provider Assistance Center at 1-800-842-8440.

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Q54: What happens if I selected the wrong specialty on my enrollment or re-enrollment application?

A: If your application has already been approved and you wish to change his/her specialty (i.e., internal medicine to cardiology), an application is not required. You may complete an NPI submission form to initiate this change. This form must be returned to Gainwell Technologies for processing. To download the NPI submission form, go to www.ctdssmap.com, click on Information, then Publications, then scroll down to the Provider Enrollment/Maintenance Forms



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section and click on the form titled National Provider Identifier (NPI) Submission Form.

If your application is still in process, please send a signed request on your letterhead asking for a change in specialty to Gainwell Technologies at: P.O. Box 5007/Hartford, CT 06102-5007; or, fax your signed request on your letterhead to 1-877-899-5401.

For procedures to check that status of your application, please refer to Q23.

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Q55: How do I know if I have to pay the Provider Enrollment Application Fee?

A: Federal law generally requires some applicants for enrollment, re-enrollment, and when adding alternate service location addresses into a Medicaid program to pay an application fee. Only certain provider types and specialties are subject to paying the application fee.

If you are one of the provider types and specialties subject to paying a fee but you have paid the fee to CMS/Medicare, or to another state's Medicaid or Children's Health Insurance Program (CHIP), or are in the process of enrolling in another state's Medicaid/CHIP program or CMS/Medicare and will pay an application fee to CMS or to the other state, you are exempt from paying the fee to the Connecticut Medical Assistance Program (CMAP).

To determine if you are subject to the fee, please go to www.ctdssmap.com. From the home page's menu bar, select Provider > Provider Matrix. On that page, click the link, Follow on Document Requirement by Provider Type and Specialty. Look up your type and specialty in the matrix and look at the last column.

Providers who have been identified as needing to pay a fee will be notified by mail. This mailing will provide instructions on how/where to submit the fee due. You may also utilize the ATN status feature on the Web to determine if your ATN is in an Awaiting Application Fee status.

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Department of Mental Health and Addiction Services (DMHAS) Performing Provider FAQ

Q1: If my performing provider application is still in process on my re-enrollment due date, will DMHAS still get paid?



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A: No, if the performing provider's re-enrollment application is not finalized by the re-enrollment due date, the provider will be dis-enrolled. While you have six (6) months to complete your re-enrollment application, you are encouraged to access the Web portal and complete it as soon as possible. Please remember that the re-enrollment application must be reviewed by DSS' Quality Assurance Unit before it can be finalized, and so appropriate time needs to be allotted within that 6 month time period for that review.

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Q2: We have 10 offices with all different NPI numbers, do I have to complete an enrollment application out for each location? Once enrolled, will I have to complete a re-enrollment application for each one?

A: There is typically only one enrollment application required per organization/line of business for the DMHAS services. Only one NPI can be submitted on that application. When the enrollment application is submitted, you will receive one AVRS ID for that NPI. When it is time to re-enroll, you will receive one letter for that one NPI/AVRS ID. On both the enrollment and re-enrollment application, providers can supply additional office location information on the Alternate Service Location Address panel that is presented in the Web portal Wizard.

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Q3: If we do not bill because our services are grant funded, do we need to enroll?

A: If you provide services that are sent through DMHAS for billing related to DMHAS Targeted Case Management (TCM) or Behavioral Health Home (BHH) programs, you will need to enroll and then subsequently re-enroll when notified as a DMHAS performing provider.

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Q4: Does the enrollment or re-enrollment include our Mental Health Waiver services?

A: If services are performed under the Mental Health Waiver (MHW) Program, you will need to enroll separately in that program, and re-enroll when notified.

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Q5: We just re-enrolled last year and that letter says we are not due to re-enroll until a future date. Or conversely, I just received a letter a month ago that I am due to re-enroll. Why am I receiving another letter?

A: Many providers, while enrolled as DMHAS performing providers, are also enrolled as clinics or state institutions (other lines of business). Each of these have their own AVRS ID and re-enrollment requirements. You will be required



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to re-enroll each AVRS ID at different points in time. You will want to be sure to take action well in advance of the re-enrollment date on each letter for each AVRS ID, as each application must complete a screening process by Gainwell Technologies and DSS' Quality Assurance Unit.

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Q6: We are already submitting direct billing for WISE and CT Home Care Program. When will this process switch over for DMHAS - during the next re-enrollment?

A: Your organization is required to re-enroll to continue providing services to DMHAS clients as a performing provider for BHH and TCM. The services will continue to be billed to Gainwell Technologies through DMHAS as they historically have been. As a result, you will not be billing these services directly to Gainwell Technologies as you do for Connecticut Home Care services and Mental Health Waiver or to Advanced Behavioral Health as you do for the WISE services.

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Q7: We have been advised that supportive housing programs will submit TCM. Should we be completing this process for Supportive Housing programs and CSP? Also, is this the same process as WISE, or is that a different re-credentialing process through DSS?

A: Re-enrollment notices are mailed to DMHAS State Operated Facilities and Private Non-Profit performing providers of services under the DMHAS Targeted Case Management (TCM) and Behavioral Health Home (BHH) Programs six (6) months prior to a provider's re-enrollment due date. If you are providing BHH or TCM program services under the Supportive Housing or Community Support Program (CSP) that are then submitted to DMHAS for claims submission, you can expect to receive a notice to re-enroll as a DMHAS performing provider. The AVRS ID under which you must re-enroll will be referenced in the letter. As a private non-profit performing provider, you should have only one AVRS ID associated to both Supportive Housing and CSP, as it relates to BHH/TCM and TCM.

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Q8: We have one NPI and two AVRS numbers as a DMHAS performing provider. Will I always need to re-enroll both?

A: If the AVRS IDs associated to your NPI are DMHAS performing provider numbers related to BHH and TCM, you will receive a letter for each of the two AVRS IDs associated to the NPI requesting that you re-enroll each one.

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Q9: How do we know if we're considered a "performing provider"?

A: If BHH and TCM services are provided to clients and claims submissions are sent to DMHAS under the Connecticut Medical Assistance Program (CMAP), rather than your agency billing services directly to Gainwell Technologies, you are considered a performing provider.

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Q10: For our CSP program, we do not prescribe medication for clients. They are served by outside physicians or APRNs. Are we still required to have a medical director-physician?

A: The current re-enrollment follow-on documents require a copy of the Medical Director's current physician license and statement accepting full professional responsibility for services; or, if this is not applicable to your organization (e.g., if you do not provide medical services to clients and do not employ the assistance of a medical director), you may supply a list of services provided, signed by the Chief Executive Officer (CEO), instead.

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Q11: If I am inputting service hours into DDaP/ DMHAS each month, am I expected to receive a letter to re-enroll?

A: Yes, you should expect that you will receive a letter to re-enroll six (6) months prior to your re-enrollment due date.

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Q12: Are there step-by-step instructions on how to fill out the re-enrollment application?

A: Please refer to the Workshop presentation for step-by-step instructions on how to fill out the re-enrollment application. To access this presentation, please go to the www.ctdssmap.com Web site. From the Home page, click Provider > Provider Services and scroll to Provider Training. Under Provider Training, click the "here" link at the end of the paragraph to open another window. Under Materials, select DMHAS Performing Provider Re-Enrollment Workshop and click on the Presentation link under the DMHAS Performing Provider Re-enrollment Workshop heading.

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