Connecticut interChange MMIS

Provider Manual

Chapter 8 – Behavioral Health Clinicians Claim Submission Instructions

January 23, 2024

Connecticut Department of Social Services (DSS)
55 Farmington Avenue
Hartford, CT 06105

Gainwell Technologies
55 Hartland Street
East Hartford, CT 06108

Amendment History

Version	Version Date	Reason for Revision	Section	Page(s)
1.0	02/03/2011	Initial Release – moved Behavioral Health Clinician claim submission instructions from Chapter 8 Clinical Services to this new Chapter 8.	All	All
1.1	05/31/2011	Updates made as a result of the Behavioral Health Expansion Project and HIPAA 5010 implementation.	8.1 8.2 8.4 8.5 8.6	2-3 5 9 11, 19-22 24
1.2	06/05/2012	Updates made as a result of ASO transition and HIPAA 5010 implementation.	8.1 8.4 8.5 8.6	2 8 10, 18-19, 21 23
1.3	11/26/2012	Updated as a result of name change for Psychologist fee schedule.	8.6	23
1.4	10/02/2013	Added OPR Edits	8.5	16
1.5	12/30/2013	Updated to include new version of CMS 1500 form and billing instructions, also updated to reflect shut down of ConnPACE and Charter Oak programs.	8.1 8.5 8.6	2 9, 11-13, 19 23-26 & 31-33
1.6	04/01/2014	Deleted section that contained billing instructions for the old version of the CMS 1500 form (08/05). Instructions for the new version of the form (02/12) confirm that claims submitted in the CMS-1500 old version of the form on or after April 1, 2014 will be returned to the provider.	8.5 8.6	11-22 24
1.7	05/05/2014	Updated to reflect delay in ICD-10 implementation.	8.5	18
1.8	07/29/2014	Removed references to Charter Oak Program. Updated for expansion of Coverage Provided by Licensed Behavioral Health Clinicians in	8.1 8.4	2-3 9

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Version	Version Date	Reason for Revision	Section	Page(s)
		Independent Practice. Updated field 9d for Medicare billing instructions, also added modifier U3 and U4.	8.5	11, 15, 20, 22
1.9	01/01/2015	Updated to include Autism Spectrum Disorder Services.	8.1 8.6	3 25
2.0	09/08/2015	Updated ICD-10 references.	8.5 8.6	18 25
2.1	11/01/2015	Updated HP references/logo with the Hewlett Packard Enterprise references/logo.	8.1 8.4 8.5	2 9 15
2.2	11/13/2015	Updated modifier section of claim submission with modifiers 25 and 59.	8.5	20
2.3	05/06/2016	Updated client plan of coverage for Autism Spectrum Disorder, updated the modifier section to include the following modifiers TS, 22 and 52 and updated to include Autism Spectrum Disorder fee schedule.	8.1 8.5 8.6	3 20 25
2.4	08/11/2016	Updated as a result of the elimination of paper claims.	8.1 8.4 8.5	2 9 11
2.5	12/01/2016	Additional updates made as a result of elimination of paper claims. Updated to remove references to ICD-9.	8.1 8.4	2 11, 12, 19
2.6	4/20/2017	Hewlett Packard Enterprise to DXC Technology Updates	All	All
2.7	10/01/2020	Updated to replace DXC Technology references/logo with Gainwell Technologies references/logo.	All	All
2.8	1/23/2024	As of January 1, 2024, Medicare will implement two provider types that can enroll and bill Medicare independently for services: LPCs and LMFTs.	8.1 8.4	3 12

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Table of Contents

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.1 Overview

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Chapter 8, Behavioral Health Clinicians, contains the provider specific claim submission instructions for the following providers in the Connecticut Medical Assistance Program (CMAP):

Behavioral Health Clinician

- Psychologist
- Licensed Clinical Social Worker
- Licensed Marital & Family Therapist
- Licensed Alcohol & Drug Counselor
- Licensed Professional Counselor

This chapter covers claim submission information and procedures, specific claim submission instructions and references to both the Connecticut Medical Assistance Program Web site and the Connecticut Behavioral Health Partnership Web site to access providers' respective fee schedules.

The information in Chapter 8 is important for all behavioral health clinician providers. It is important to note, however, that paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers.

Providers should refer to Chapter 6, Electronic Data Interchange Options. Providers interested in submitting claims through the internet should refer to Chapter 10 for internet claim submission instructions. Claim Submission Help Text for the internet claim submission feature is also located on the claim submission panel by clicking on the Quick Links in the upper left corner of the Web page, and/or by clicking on HELP in the upper right corner of the Web page.

Connecticut Behavioral Health Partnership

The Connecticut Behavioral Health Partnership (CT BHP), a joint initiative between the Department of Social Services, the Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS), provides behavioral health services to HUSKY Health Program clients (HUSKY A, HUSKY B, HUSKY C – previously referred to as Medicaid, HUSKY D – previously referred to as Medicaid LIA), and DCF funded clients. Providers must submit behavioral health claims for services provided to HUSKY Health Program and DCF funded clients to Gainwell Technologies for processing. Providers can access the list of covered services from the Providers page of the CT BHP website www.ctbhp.com under "For Providers", "Covered Services", and selecting Covered Services/Rates.

Please Note:

Effective July 1, 2014, services provided by Psychologists, Licensed Clinical Social Workers, Licensed Marital & Family Therapists, Licensed Alcohol & Drug Counselors, and Licensed Professional Counselors in independent practice are covered for HUSKY A, HUSKY B, HUSKY C, and HUSKY D members regardless of the age of the individual.

Services before July 1, 2014 provided by Licensed Clinical Social Workers, Licensed Marital & Family Therapists, Licensed Alcohol & Drug Counselors, and Licensed Professional Counselors for HUSKY C and HUSKY D members were only covered if the client was under the age of 21. Clients that were 21 or above were not covered except as described in the Dually Eligible section below. Services provided to HUSKY A and HUSKY B members by Licensed Clinical Social Workers, Licensed Marital & Family Therapists, Licensed Alcohol & Drug Counselors, and Licensed Professional Counselors have been covered regardless of the member's age since January 1, 2006.

Autism Spectrum Disorder

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

The Connecticut Medical Assistance Program provides services to HUSKY A, C, or D individuals under 21 for whom evidence based autism therapy services have been deemed medically necessary. Autism treatment services require a comprehensive diagnostic evaluation which can be done by a licensed psychologist, or licensed clinical social worker. They also require a more focused behavioral assessment to determine which specific interventions are most appropriate. These behavioral assessments must be done by a qualified licensed practitioner or a Board Certified Behavior Analyst (BCBA) working within his/her scope of practice. Intervention or Therapy services must all be done under the supervision of a qualified licensed practitioner or a BCBA working within his/her scope of practice. The supervising practitioner is the billing provider. The Behavioral Health Clinician and Psychologist fee schedules contain the applicable codes.

To be eligible, providers must have experience providing ASD therapy services to children with ASD. Eligible providers include: licensed psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists.

Dually Eligible:

For individuals who are dually eligible for Medicare and Medicaid, the Department will consider claims for Medicare coinsurance and deductible up to the Medicaid fee schedule amount. If the provider is not eligible to enroll in Medicare, Medicaid covered services will be paid for by Medicaid but the provider must maintain documentation from Medicare or its agent indicating that the provider is not eligible to enroll with Medicare.

As of January 1, 2024, Medicare will implement two provider types that can enroll and bill Medicare independently for services: Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). Once enrolled in Medicare, LPCs and LMFTs will be able to bill Medicare Part B and be reimbursed for approved services in accordance with Medicare reimbursement rates.

For additional information on general provider requirements please refer to the www.ctdssmap.com Web site, under information, publications, provider manual chapter 2 “Provider Participation policy”.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.2 Prior Authorization

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Prior Authorization (PA) is required for Behavioral Health Services. Please refer to Chapter 9 of the Provider Manual for full Prior Authorization requirements, contact information and related forms.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Information

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Information regarding the State of Connecticut's Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is located in Chapter 5, Claim Submission Information.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

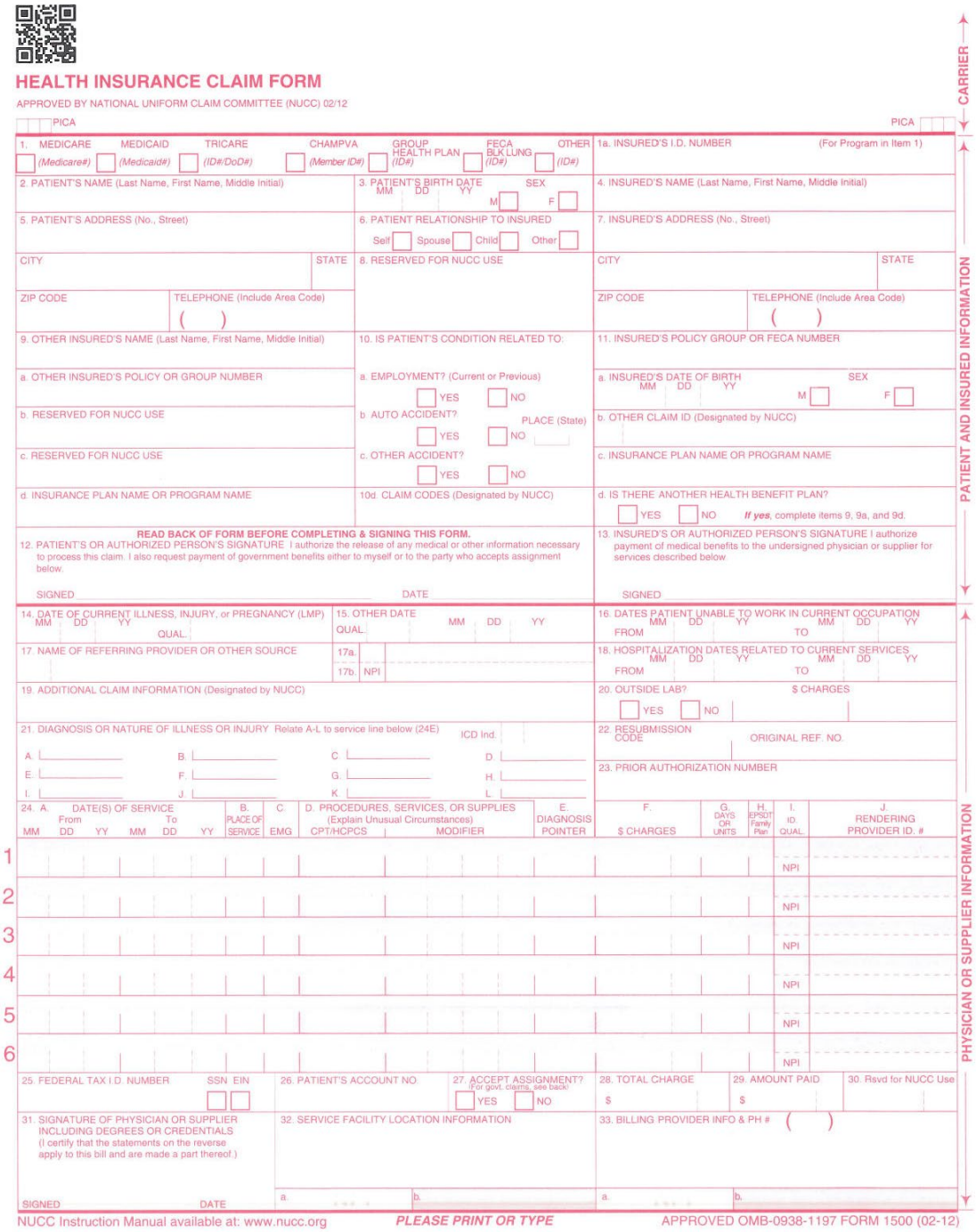
8.4 Behavioral Health Claim Submission Instructions

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Electronic Claim Submission References	As a reminder, providers are required to submit claims electronically, unless the claims meet the exception criteria outlined below. Providers should use the following resources for electronic claim submission information: • Chapter 6, Electronic Data Interchange Options, for electronic claim submission options located at www.ctdssmap.com by selecting Information > Publications • Chapter 10, AVRS/Web Portal, for internet claim submission instructions located at www.ctdssmap.com by selecting Information > Publications • Implementation Guide found at www.wpc-edi.com • Companion Guide located at www.ctdssmap.com by clicking on the Trading Partner tab, then the EDI tab for format and code set information • Chapter 7 for Connecticut Medical Assistance Program for regulations and policy guidelines. Please note that, while the instructions below are intended to instruct providers on how to submit paper claims, this section can be reviewed by all providers to gain insight on claim requirements, such as permissible modifiers.
Connecticut Behavioral Health Partnership (CT BHP)	Refer to Chapter 5, General Claim Submission Instructions, Section 8, for additional information regarding behavioral health claim submission.
Paper Claims Exception Criteria	Paper claims are only permitted if they must be special handled, or if they are claims from out-of-state providers. Please note that the only version of the form that is accepted is the CMS-1500 Health Insurance Claim Form Version 02/12.
How to Obtain CMS-1500 Claim Form	Providers submitting paper claims must use original red CMS-1500 claim forms, as these claims will be electronically scanned. Original red CMS-1500 claim forms are obtained from private printing vendors.
Where to Send Completed CMS-1500 Claim Form	Mail completed CMS-1500 claim forms to: Gainwell Technologies P.O. Box 2991 Hartford, CT 06104
CMS-1500 Required Fields for Claim Submission	In the section below, there are directions for completion of each field on the CMS 1500 and fields not required are noted. Only black ink should be used when completing the claim form. Do not use highlighter on claims or attachments.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

****CMS-1500 Health Insurance Claim Form (version 02/12)**



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Please reference the following chart for information on required fields for submission of the CMS-1500 Health Insurance Claim Form (version 02/12).

CMS 1500 Required Fields

Paper Claim Field No. and Name		Description
1.	TYPE OF CLAIM	Not required.
1a.	INSURED'S I.D. NUMBER	Enter the client's 9-digit Connecticut Medical Assistance Program ID number exactly as it appears on the CONNECT Card or as obtained from the Automated Eligibility Verification System (AEVS). **NOTE:** If submitting a claim for Medicare or Medicare HMO coinsurance and/or deductible, enter the client's Medicare number in Field 1a.
2.	PATIENT'S NAME	Enter the client's name (last name, first name, middle initial). **NOTE:** The client's name should be spelled the same way as communicated by eligibility on the www.ctdssmap.com Web site or AEVS.
3.	PATIENT'S BIRTH DATE	Not required.
	SEX	Not required.
4.	INSURED'S NAME	Not required.
5.	PATIENT'S ADDRESS	Not required.
6.	PATIENT RELATIONSHIP TO INSURED	Not required.
7.	INSURED'S ADDRESS	Not required.
8.	RESERVED FOR NUCC USE	Not required.
9.	OTHER INSURED'S NAME	Not required.
9a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter the client's 9-digit Connecticut Medical Assistance Program ID number when submitting a claim for Medicare coinsurance and deductible. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Professional claim type.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
9b.	RESERVED FOR NUCC USE	Not required.
9c.	RESERVED FOR NUCC USE	Not required.
9d.	INSURANCE PLAN NAME OR PROGRAM NAME	**Medicaid is always the payer of last resort.** 1) Non Medicare Other Insurance If the client has other insurance coverage and a payment was received, enter the 3-digit other insurance carrier code, paid amount, and payment date. Enter the total amount paid by the other insurer(s) in Field 29 of the CMS-1500 claim form. If a denial was received from the other insurer, enter the 3-digit other insurance carrier code(s) followed by “Not Applicable” or “N/A” followed by the denial date. A response from each and every other insurance policy the client has must be indicated in this field. **The other insurance Explanation of Benefits (EOB), indicating a payment or denial, does not need to be attached to the claim, unless required to override timely filing.** Refer to Chapter 5, Section 6 for additional information on timely filing. A complete listing of insurance carrier codes can be accessed/downloaded from the Web site www.ctdssmap.com, by selecting Information, then Publications. The 3-digit insurance code(s) may also be obtained through the AEVS. If the 3-digit code for a specific insurance carrier does not appear on the list, the provider should enter "999", along with the paid amount and payment date in Field 9d. Refer to Chapter 4, Section 3 for information on accessing the AEVS. Providers unable to obtain a response from a documented carrier listed on the client’s eligibility file should refer to the subrogation procedures in Chapter 5, Section 3. A copy of the Third Party Billing Attempt Form is accepted in lieu of an EOB. 2) Medicare Insurance (Dually Eligible) As of January 1, 2024, Medicare will implement two provider types that can enroll and bill Medicare independently for services: Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). Once enrolled in Medicare, LPCs and LMFTs will be able to bill Medicare Part B and be reimbursed for approved services in accordance with Medicare reimbursement rates.

| Paper Claim Field No. and Name | Description |

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

9d.	INSURANCE PLAN NAME OR PROGRAM NAME (Continued)	**The Explanation of Medicare Benefits (EOMB), indicating a payment from Medicare or the Medicare HMO, must be attached to the paper claim.** Please note that: • Providers must submit one paper claim attached to one EOMB. • Claims with multiple EOMBs attached to one claim or multiple claims attached to one EOMB will not be processed and will be returned to the provider. • The following information must be exactly the same on the paper claim and on the EOMB: Patient name, detail dates of service, procedure codes and modifiers (if any), units, and billed amounts (each line). • The number of lines submitted on the claim must have corresponding lines on the EOMB. • Columns that indicate Medicare billed amount, allowed amount, paid amount, coinsurance and deductible must appear on the EOMB. • When submitting a paper coinsurance and/or deductible claim for Connecticut Medical Assistance Program payment, providers must submit the claim information on an original (red) paper claim form. *When Medicare Indicates a Denial* If the client has Medicare and a denial was received: • Indicate either “Medicare N/A”, “MPB N/A” or “Medicare HMO N/A”. Indicate the date of the EOMB in field 9d. (If the provider has a letter from Medicare/CMS stating they are not eligible to enroll in Medicare and that letter is dated within one year from the date of service on the claim, indicate the date of that letter in place of the EOMB date. To request this letter, providers must submit a request in writing to National Government Services (NGS) at PO Box 7052, Indianapolis, Indiana 46207-7052. In lieu of the Medicare ‘Not Eligible To Enroll’ denial letters for clinic services requested through NGS, providers may submit a copy of the list of suppliers not eligible to participate in Medicare as valid Medicare denial documentation. The list is documented in the Medicare Provider Integrity Manual, Publication # 100-8, under Chapter 10, Section 10.2.7 which is located on the CMS Web site, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c10.pdf. A copy of this page must be stored in the client’s file for audit purposes and does not need to be submitted with the claim to Gainwell Technologies. The Medicare denial date submitted on the claim would represent the date the documentation was printed. Each year the provider must validate this list to ensure it continues to be valid documentation for future claims.)

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name	Description
9d. INSURANCE PLAN NAME OR PROGRAM NAME (Continued)	• Field 29 must be blank. **The Explanation of Medicare Benefits (EOMB), indicating a denial from Medicare or the Medicare HMO, should not be attached to the paper claim.** Refer to Chapter 5, Section 3 for more information on third party claim submission requirements. **NOTE:** For subrogation procedures, refer to Chapter 5, Section 3. A copy of the Third Party Billing Attempt Form is accepted in lieu of an EOB. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Professional claim type.
10. IS PATIENT'S CONDITION RELATED TO:	**NOTE:** If "Yes" is indicated in 10a, 10b, or 10c, enter the date in MM/DD/YY format in Field 14.
10a. EMPLOYMENT? (Current or Previous)	Enter an "X" in the appropriate box.
10b. AUTO ACCIDENT? PLACE (State)	Enter an "X" in the appropriate box. If "Yes" is indicated, enter the state where the accident occurred.
10c. OTHER ACCIDENT?	Enter an "X" in the appropriate box.
10d. CLAIM CODES (Designated by NUCC)	Not required.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required.
11a. INSURED'S DATE OF BIRTH SEX	Not required.
11b. OTHER CLAIM ID (Designated by NUCC)	Not required.
11c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
11d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	Not required.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date in MM/DD/YY format for the illness or injury identified in 10a, 10b, or 10c.
	QUAL.	Not required.
15.	OTHER DATE QUAL	Not required.
	DATE	Not required.
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	If applicable, enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. • **DN** Referring Provider • **DK** Ordering Provider • **DQ** Supervising Provider Enter the qualifier to the left of the vertical, dotted line. This provider is required to be enrolled in CMAP.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
17a. 17a.	UNLABELED FIELD	Not required.
17b.	NPI	If applicable, enter the referring/ordering physician's NPI.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not required.
19.	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Not required.
20.	OUTSIDE LAB? $ CHARGES	Not required.
21.	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24 E) ICD Ind	Enter 0 as the ICD-10-CM indicator. **NOTE**: When billing for Family Therapy, the behavioral health clinician must enter in this field the diagnosis of the patient (child or adult) who is receiving treatment services.
	A. – L.	Enter the ICD-10-CM diagnosis code. No more than 12 ICD-10-CM diagnosis codes can be listed.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
22.	RESUBMISSION CODE ORIGINAL REF. NO.	Not required.
23.	PRIOR AUTHORIZATION NUMBER	Not required.
24A.	DATE(S) OF SERVICE	Enter the "from" and "to" date(s) of service in MM/DD/YY format. **NOTE:** The “to” date of service is not required if submitting claims for one date of service. When the same service is performed on consecutive dates, enter the first date of service in the “from” field and the last date of service in the “to” field. The number of units entered in Field 24G must be equal to the number of days spanned by the “from” and “to” dates. The same procedure must have been performed on each of the dates spanned. If services were not performed on consecutive days, the procedures must be itemized on separate lines.
24B.	PLACE OF SERVICE	Enter the Place of Service (POS) code for the location where services were performed. Use the following POS code(s) when submitting claims for Connecticut Medical Assistance Program services: Code Description 11 Office 12 Home 31 Skilled Nursing Facility 32 Nursing Facility 49 Independent Clinic 50 Federally Qualified Health Center 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 99 Other Place of Service

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
24C.	EMG	Not required.
24D.	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	Enter the appropriate procedure code for the service performed. Refer to the Fee Schedule for procedure code(s) covered in the Connecticut Medical Assistance Program.
	MODIFIER	Two (2) digit alphanumeric modifiers are used in conjunction with procedure codes for informational purposes. Enter the appropriate modifier if applicable. **HUSKY Health and DCF Funded Health Plan Services:** AJ – Clinical Social Worker HO – Masters Degree Level * *Used for LMFT, LPC, and LADC clinicians TS – Follow-Up Service U3 – Medicaid Care Level 3 State Defined (Connecticut has defined this as **Positive** developmental behavioral health screen.) U4 - Medicaid Care Level 3 State Defined (Connecticut has defined this as **Negative** developmental behavioral health screen.) U5 – Autism Services 22 – Unusual Procedural Services (Expended Scope) 25 - Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service 52 – Reduced Services (Reduced Scope) 59 - Distinct procedural service **NOTE:** On claims for Medicare coinsurance and/or deductible, the Medicare procedure codes and modifiers must be entered, if any. Modifiers must match the Medicare EOMB when they are the primary payer. **NOTE:** Only the following modifiers can be used to bypass the National Correct Coding Initiative (NCCI) edits, if applicable: 25 and 59.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
24E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 on the new (version 02/12) claim form. When multiple services are performed, the primary reference letter for each service should be listed first. The reference letter(s) should be A – L or multiple letters as applicable. Alpha characters only are accepted.
24F.	$ CHARGES	Enter the usual and customary charge for the procedure indicated. **NOTE**: When the same services were performed on consecutive days, enter the total charges for all services performed within these consecutive days.
24G.	DAYS OR UNITS	Enter the number of days or units for each service provided. **NOTE:** When submitting claims for consecutive days, the number of units must be equal to the number of days billed in Field 24A.
24H.	EPSDT FAMILY PLAN	H = EPSDT F = Family Planning X = Both EPSDT and Family Planning R = Service is related to EPSDT referral T = Service is related to EPSDT and Family Planning referral
24I.	ID. QUAL.	This field is only required for Behavioral Health Clinicians when the billing provider is an enrolled group. Enter the three character taxonomy qualifier (PXC) in field 24I.
24J.	RENDERING PROVIDER ID. #	This field is only required for Behavioral Health Clinicians when the billing provider is an enrolled group. Enter the performing provider's taxonomy in the shaded area of field 24J and the performing provider's NPI in the un-shaded area of field 24J. The taxonomy on the claim must be the correct taxonomy as submitted on the provider's enrollment application. The performing provider listed on the claim in Field 24J must be enrolled as a member of the billing provider group.
25.	FEDERAL TAX ID NUMBER	Not required.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
26.	PATIENT'S ACCOUNT NO.	Enter the patient's account number. Providers have the option of submitting up to 12 alphanumeric characters for their own accounting purposes. For electronic claims it can be up to 38 characters.
27.	ACCEPT ASSIGNMENT?	Not required.
28.	TOTAL CHARGE	Enter the total dollar amount, which is the sum of the charges from each line in Column 24F.
29.	AMOUNT PAID	Enter the **total** amount paid, if any, by the other insurance carrier. Enter the other insurance carrier code(s), payment amount and paid date in Field 9d. Refer to Chapter 5, Section 3 for further third party liability requirements. **NOTE**: Do not enter previous Connecticut Medical Assistance Program or Medicare payments for coinsurance or deductible claims in this field. Do not enter HUSKY B copays in this field. For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop down box, select the Professional claim type.
30.	Rsvd for NUCC Use	Not required.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Enter the signature of the billing provider or designated agent. Enter the date of signature on the claim. For computer generated forms, print the words "computer-generated" in this field. **NOTE:** A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	If the service was performed in a location other than the provider's office, enter the name and address of the facility where the services were performed.
32a.		Not required.
32b.		Not required.
33.	BILLING PROVIDER INFO & PH #	Enter the billing provider's name, address, zip + 4 code and telephone number. If submitting a claim as a group practice, enter the group name and address. PLEASE NOTE: To avoid claim denials, please enter a nine digit zip code in this field.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Paper Claim Field No. and Name		Description
		The address must be the address provided upon enrollment in the Medical Assistance Program.
33a.		Enter the ten digit National Provider Identifier of the billing provider. If submitting a claim as a group practice, enter the group's NPI.
33b.		Enter the three digit ID Qualifier "PXC" and taxonomy of the billing provider. The taxonomy on the claim must be the correct taxonomy as submitted on the provider's enrollment application.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

8.5 Fee Schedule

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.

Overview

Fee schedules can be accessed on the Connecticut Medical Assistance Program Web site www.ctdssmap.com.

To access your fee schedule from the Connecticut Medical Assistance Program Web site Home Page:

1. Click on Provider
2. Click on Provider Fee Schedule Download
3. Review the End User License Agreements and select either:
   - I Accept
   - I Do Not Accept

   In order to access the fee schedule, you must accept the end user license agreements.
4. If your provider specialty is Clinical Social Worker, Alcohol and Drug Counselor, Marital and Family Therapist, or Professional Counselor, you will need to select Behavioral Health Clinician for access to your fee schedule. If your provider specialty is Psychologist, you will need to select Psychologist for access to your fee schedule. If your provider specialty is Board Certified Behavior Analyst, you will need to select Autism Spectrum Disorder for access to your fee schedule.

Select the Fee Schedule Instructions quick link for detailed instructions on accessing and using the fee schedule. Table 10 in the document lists the ICD-10-CM diagnosis codes related to the Behavioral Health Benefit Plan.

Please note that special fee schedule foot notes exist with specific procedure code restrictions for some services, such as Autism Spectrum Disorder (ASD) services.

The Behavioral Health Partnership fee schedule lists required co-pays for HUSKY B clients.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.