

Welcome to the Behavioral Health Refresher Workshop

Troubleshooting Tips:

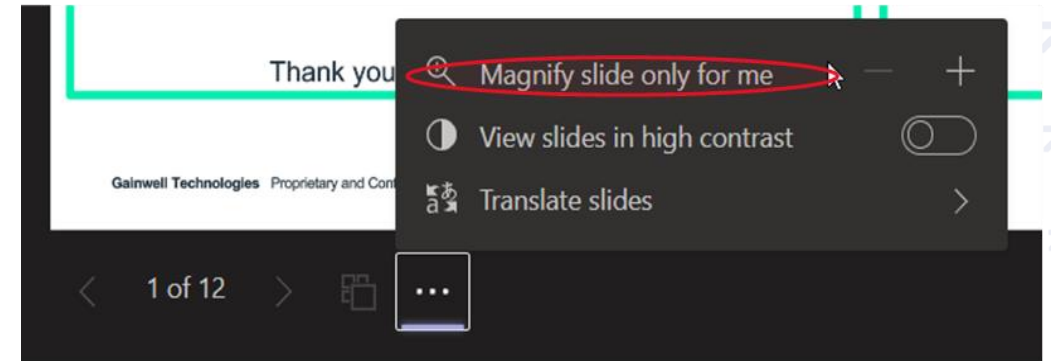
Once you have joined the Microsoft Teams meeting, please kindly follow these communication rules:

- Please ensure your camera is off.
- Please mute your mic until the end for questions.
- Be sure to select “Chat” as documents or links used during the meeting will be posted here.
- You may also use the “Chat” or the “Raise Hand” feature to ask the speaker a question.

Thank you for your participation!

Troubleshooting Tips:

While content is being shared, in the lower left-hand side of the screen, click the (...) and an option to ‘Magnify slide only for me’ appears allowing you to zoom in or out.



Or it may appear with this option next to the speaker's name, allowing you to Zoom In or Out:





2025 Behavioral Health Refresher

Presented by:
The Department of Social Services and Gainwell
Technologies

Presenter: Nick Michaels

October 2025

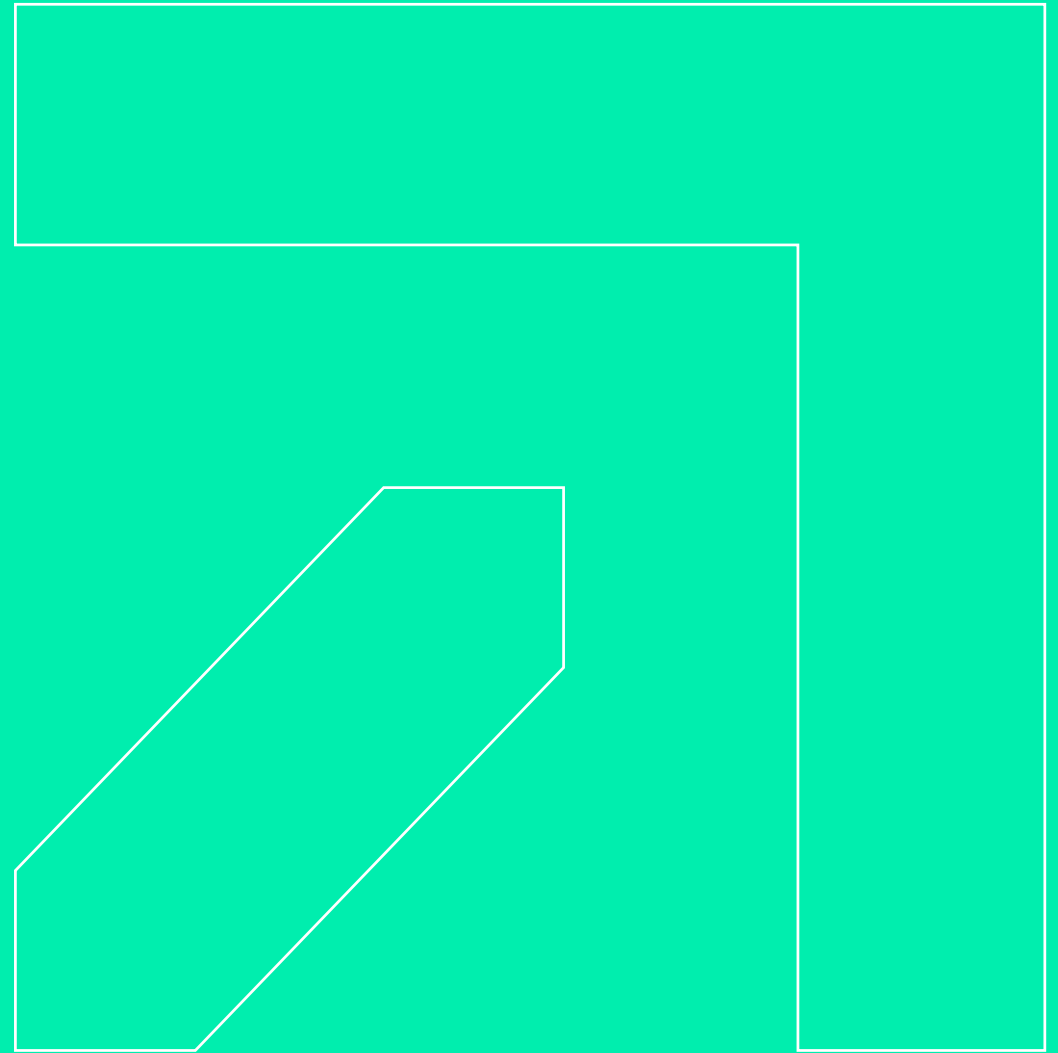


Agenda

Re-Enrollment
Clerk and Demographic Maintenance
Performing Provider Requirement
E-Delivery
Eligibility Verification
Prior Authorization
Behavioral Health Web Claim Submission
Provider Manuals
Claim Resolution Guide
Provider Fee Schedule
Attestations
Provider Bulletins
Telehealth
FAQs
Resources and Contacts



Re-Enrollment



Re-enrollment

Re-enrollment Period:

- Providers are required to re-enroll every 5 years (Clinicians and Behavioral Health Groups)
- The following are some of the providers that are required to re-enroll every two years:
 - Behavioral Health Clinics
 - BCBAs
- Most providers will receive a reminder letter via e-Delivery (some by USPS) when they are due for re-enrollment six (6) months prior to the end of their current contract
- If the provider has not successfully re-enrolled three (3) months prior to the end of their current contract, another letter will be sent
- Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP)
- Re-enrollment is required to continue to participate in CMAP.

The complete list of enrollment periods can be found by using the following link:

[Ct Enrollment Criteria Matrix](#)

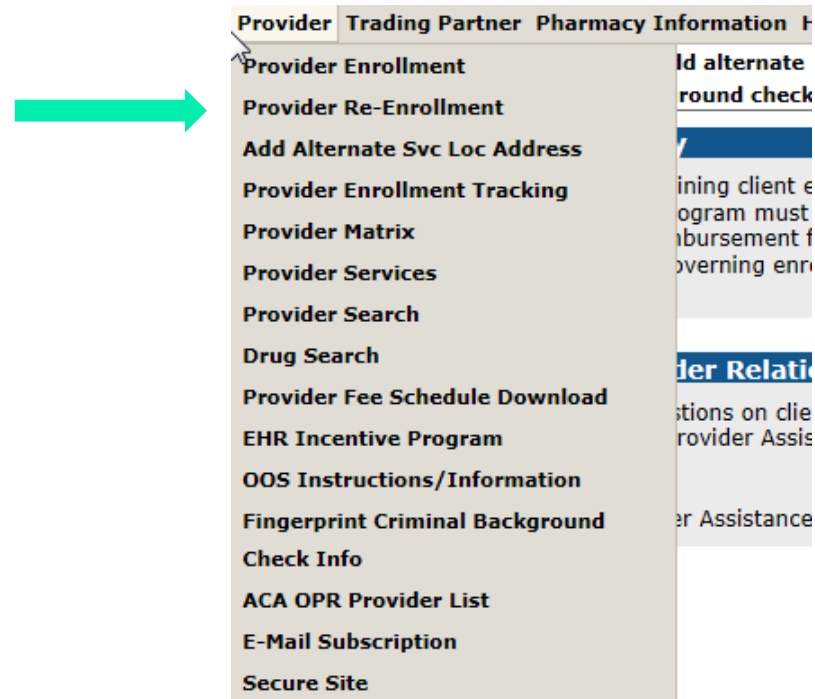
Re-enrollment via the Enrollment/Re-enrollment Wizard on the CMAP Web site, www.ctdssmap.com, is required.

Re-enrollment

The Department of Social Services (DSS) requires most providers to enroll / re-enroll on our Web site www.ctdssmap.com.

- Most of the required information is automatically populated based on the provider's previous contract information.
- Online re-enrollment cannot be initialized until an *Application Tracking Number (ATN)* is received from the Gainwell Technologies Provider Enrollment Unit.

From the *Provider* drop-down menu; select *Provider Re-Enrollment*.



Re-enrollment

Re-enrollment Due Dates:

Providers with Secure Web portal access can view their re-enrollment due date once logged in!

- Individual providers and Organizations can view their re-enrollment due date on the Home page.
- Organization providers can view their re-enrollment due date, as well as the re-enrollment due date of their members by accessing the “Maintain Organization Members” panel.

This allows individual providers and Organizations to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Claims Eligibility Prior Authorization Hospice Trade Files MAPIR Messages **Account**
home **account home** account maintenance account setup change password clerk maintenance demographic maintenance reset password log out

Welcome, P0042

Provider ID: NPI

Provider AVRS ID:

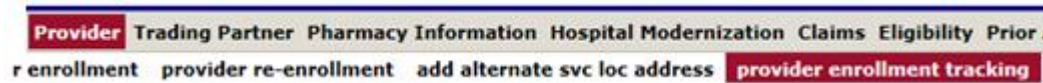
Reenrollment Due Date: 10/18/2028



Zip Code: 06010 - 5106

Re-enrollment

To check the status of an enrollment / re-enrollment application, select *Provider Enrollment Tracking* from either the *Provider* submenu or the *Provider* drop-down menu.



Enter your *ATN* and *Business OR Last Name* and click *search*

A screenshot of the 'Enrollment Tracking Search' form. It has a blue header with the text 'Enrollment Tracking Search'. Below the header, there are two input fields: 'ATN*' with the value '305929' and 'Business OR Last Name*' with the value 'SMITH'. To the right of the input fields are two blue buttons: 'search' and 'clear'.

- In this example DSS is conducting the final review of an application that was submitted by Mr. Smith.

A screenshot of the search results table. The table has a blue header with the text 'Search Results'. The table has four columns: 'ATN', 'Name', 'Date Received', and 'Status'. The first row of data shows a redacted ATN, a redacted Name, the date '07/31/2024', and the status 'DSS Conducting Final Review'.

ATN	Name	Date Received	Status
[REDACTED]	[REDACTED]	07/31/2024	DSS Conducting Final Review

Re-enrollment

It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.

Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.

Providers who are dis-enrolled will not be able to do the following until re-enrollment is completed:

- Get new referrals to services
- Receive Prior Authorization
- Bill or receive payment for services rendered

Reinstatement of contracts w/out a finalized application violates ACA policies.

Providers with Secure Web portal access can view their re-enrollment due date on the Home page of their Secure Web portal once logged in, as well as access the actual letter with the re-enrollment ATN #. This allows providers to track their re-enrollment due dates prior to receiving their notice to re-enroll.

Re-enrollment

Performing Providers:

- Billing groups need to associate their **performing providers** to the group since performing providers are enrolled / re-enrolled independent of the groups they belong to.
- The performing providers re-enroll according to their re-enrollment due date which may be different from the group.
- The re-enrollment letter will only be sent to the address that's on file with Medicaid. There is only one letter sent and if the performing provider belongs to more than one group/clinic it may go to the last organization that enrolled the provider.
- Organizations/Groups can view the re-enrollment due dates of their members by accessing the “**Maintain Organization Members**” from the “**Demographic Maintenance panel**”.
- This allows organizations/groups to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Re-enrollment

Adding Alternate Service Location Addresses

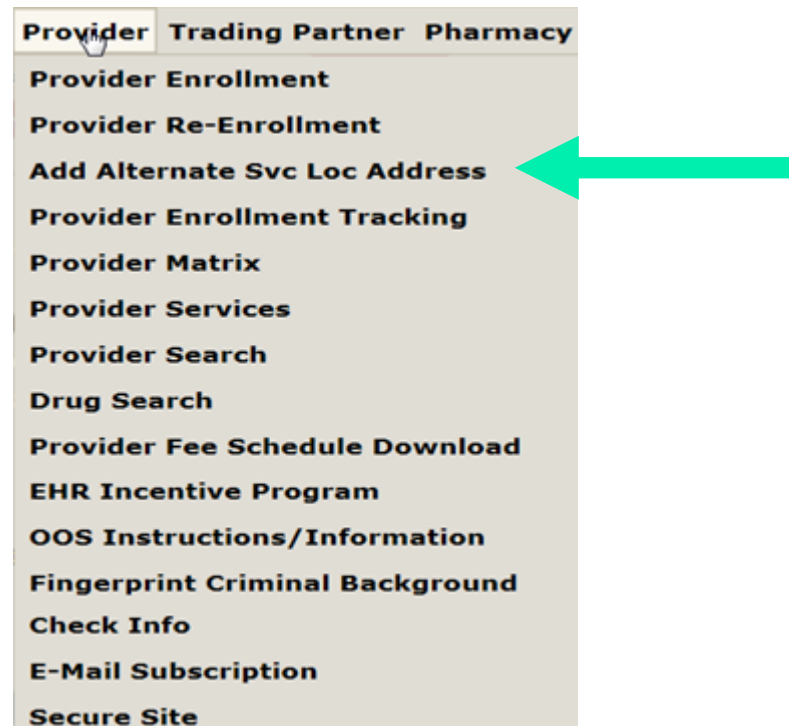
- [Provider Bulletin 2018-19](#): Web Portal Enhancement – Alternate Service Location Addresses
- Enrollment/Re-enrollment Wizard allows billing providers to submit an application for the purpose of adding alternate service location(s).
- A new alternate service location address application must be submitted when a provider is expanding the number of practice locations.
- More than one new practice location may be submitted in one application.

Caution: Do not use this application to: Change an existing address(es) of a practice or add a practice location to an AVRS ID that already exists under another billing AVRS ID registered to that provider

Re-enrollment

Adding Alternate Service Location Address

- To begin a new add alternate service location address application, navigate to the www.ctdssmap.com Web site and log into your Secure Web portal account. Once logged in, select Provider > Add Alternate Svc Loc Address.



Re-enrollment

Adding Alternate Service Location Address

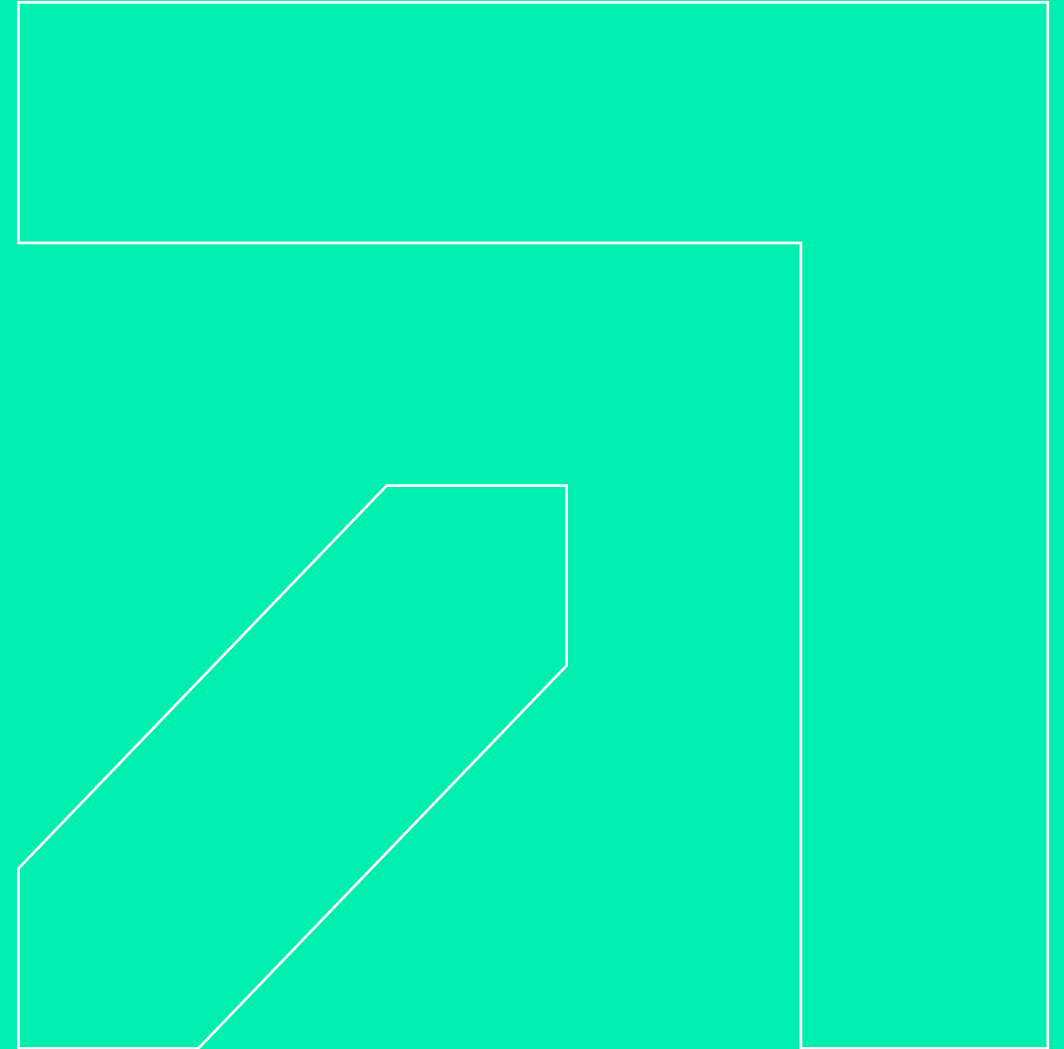
Who can submit an Add Alternative Service Location Address application?

- A new clerk role, Submit Applications, has been created to allow master users to designate clerks to submit the add alternate service location address application.
- A master user is required to add the Submit Applications role to the clerk(s) that will be responsible for updating their organization's service locations.

To assign the Submit Applications role, a master user will sign into their Secure Web portal account, select Clerk Maintenance, enter the clerk ID to which the role will be assigned, and assign the role of Submit Applications.



Clerk & Demographic Maintenance



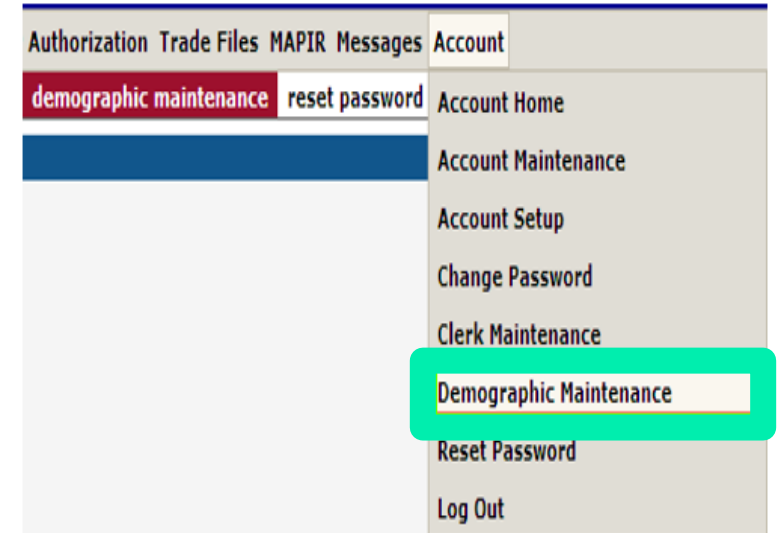
Demographic Maintenance

The **Demographic Maintenance** section of the **Secure Site** allows you to alter and maintain demographic information:

- Home, Mail to, Pay to, Service Location, Alternate Service Locations and Enrollment addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Maintain Organization Members
- Add/Update Vehicle Registration Information (Ambulance Providers)

Access this section by selecting **Demographic Maintenance** from either the Account submenu or the Account drop-down menu.

Caution: It is the responsibility of a provider to update any demographic changes in a timely manner. **Failure to do so might result in denied claims or delayed reimbursement.**



Demographic Maintenance

The Demographic Maintenance page displays the Provider Information panel as well as a submenu.

Clicking the submenu options will open a panel with related information:

- Base Information Service Location
- Location Name Address
- EFT Account
- Service Language
- Maintain Organization Members
- Provider Certification

Provider Information			
Provider ID	008123972 MCD	Address	55 HARTLAND ST
AVRS ID	008123972		
Usage	Service Location	City	EAST HARTFORD
Provider Type	86 - Behavioral Health Clinician Groups	County	Hartford
Provider Specialty	115 - Licensed Clinical Social Worker	State/Zip	CT 06108-0000
Phone	860-255-3900		

[Location Name Address](#) > [EFT Account](#) > [Service Language](#) > [Maintain Organization Members](#) > [Provider Certification](#)

Demographic Maintenance – Address Updates

Specify different mailing, payment, service location, home office, and enrollment addresses.

Location Name Address [X]

Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
Mail to	DOE, JOHN	15 MAIN STREET	WILLIMANTI	CT	06614	4008	(203)555-5555	5555	Y
Pay to	DOE, JOHN	250 OAK AVENUE	WILLIMANTI	CT	06614	0001	(203)555-5555	5555	Y
Service Location	DOE, JOHN	15 MAIN STREET	WILLIMANTI	CT	06614	4008	(203)555-5555	5555	Y
Enrollment	DOE, JOHN	123 STEELE STR	WILLIMANTI	CT	06614	0001	(203)555-5555	5555	Y

Type changes below.

Name Type Business Name Personal Name

Name

Title [v]

Usage [v]

Country [v]

Address 1*

Address 2

City

State [v]

Zip*

Apply Changes To:

- Svc Loc
- Pay To
- Mail To
- Enrollment

Phone*

Fax

Handicap Accessible? [v]

EMail

Demographic Maintenance – EFT Updates

The **EFT Account** panel allows you to add and maintain bank accounts into which reimbursements from CMAP will be electronically deposited.

- Click **“add”**; enter the appropriate information; and click **“save”**

Location Name Address > **EFT Account** > Service Language > Maintain Organization Members

EFT Account

Click here to open Provider EFT Enrollment instructions.

Financial Institution Name	Financial Institution Routing Number	Provider's Account Number with Financial Institution	Type of Account at Financial Institution	Last Change Date	EFT Status
BANK OF AMERICA, N.A.			Checking		Active

Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (*)

Provider Name*

Account Number Linkage to Provider Identifier*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

Provider Identifiers*

Provider Federal Tax Identification Number (TIN)
OR Employer Identification Number (EIN)

Demographic Maintenance – EFT Updates

****This action will place the provider in a *pre-notification* status****

EFT Account X

[Click here to open Provider EFT Enrollment instructions.](#)

Financial Institution Name	Financial Institution Routing Number	Provider's Account Number with Financial Institution	Type of Account at Financial Institution	Last Change Date	EFT Status
TD BANK NA	011100111		Checking		Active

Select row above to update -or- click Add button below.

Required fields are indicated with an asterisk (*)

Provider Name*

Account Number Linkage to Provider Identifier*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

Provider Identifiers*

Provider Federal Tax Identification Number (TIN)
OR Employer Identification Number (EIN)

OR

National Provider Identifier (NPI)

Other Identifiers

Assigning Authority

Trading Partner ID

Financial Institution Information

Financial Institution Name

Financial Institution Address

Street

City

State/Province

ZIP Code/Postal Code

Financial Institution Routing Number

Financial Institution Routing Number(rekey)*

Type of Account at Financial Institution

Provider's Account Number with Financial Institution

Provider's Account Number with Financial Institution(rekey)*

Reason for Submission New Enrollment Change Enrollment Cancel Enrollment

Authorized Signature

Demographic Maintenance – Maintain Organization Members

Re-Enrollment due dates are visible on the Maintain Organization panel.

All Current Historical Organization Member ID Member Business/Last Name Member First Name

Organization Member ID ▲	ID Type	Organization Member Name	Effective Date	End Date	Reenrollment Due Date
1414141414	NPI	BOYLE, DR. DAWN	06/01/2012	10/08/2012	06/05/2014

Total Count: 3 Current Count: 2 Historical Count: 1

Select row above to update -or- click Add button below.

- To add a new member, click the add button.
- To separate a member from your organization, click on the existing member row, then enter the end date of their affiliation with your organization. This date cannot be in the past.

Organization Member ID [Search] Effective Date

Organization Member Name End Date

Reenrollment Due Date

This panel allows the Master User to:

- Search current or historical members using the search button
- Add new members by entering their Organization Member ID (NPI) as well as Effective Date
- Terminate member affiliation by selecting their line and entering an End Date
- View re-enrollment due dates of members

Demographic Maintenance – Provider Certification

SUD Residential Certification Letter Upload Instructions – [DSS Important Message](#)

To upload your Certification, select your Certification(s) from the “Certification Type” dropdown menu and use the specific effective and end dates as stated on your certification letter.

Provider Information			
Provider ID	008123972 MCD	Address	55 HARTLAND ST
AVRS ID	008123972		
Usage	Service Location	City	EAST HARTFORD
Provider Type	86 - Behavioral Health Clinician Groups	County	Hartford
Provider Specialty	115 - Licensed Clinical Social Worker	State/Zip	CT 06108-0000
Phone	860-255-3900		

Location Name Address > EFT Account > Service Language > Maintain Organization Members > **Provider Certification**

Location Name Address > EFT Account > Service Language > **Provider Certification**

Provider Certification

[Click here to open the Certification and Document Upload Guide for instructions on how to complete this panel by the service you offer.](#)

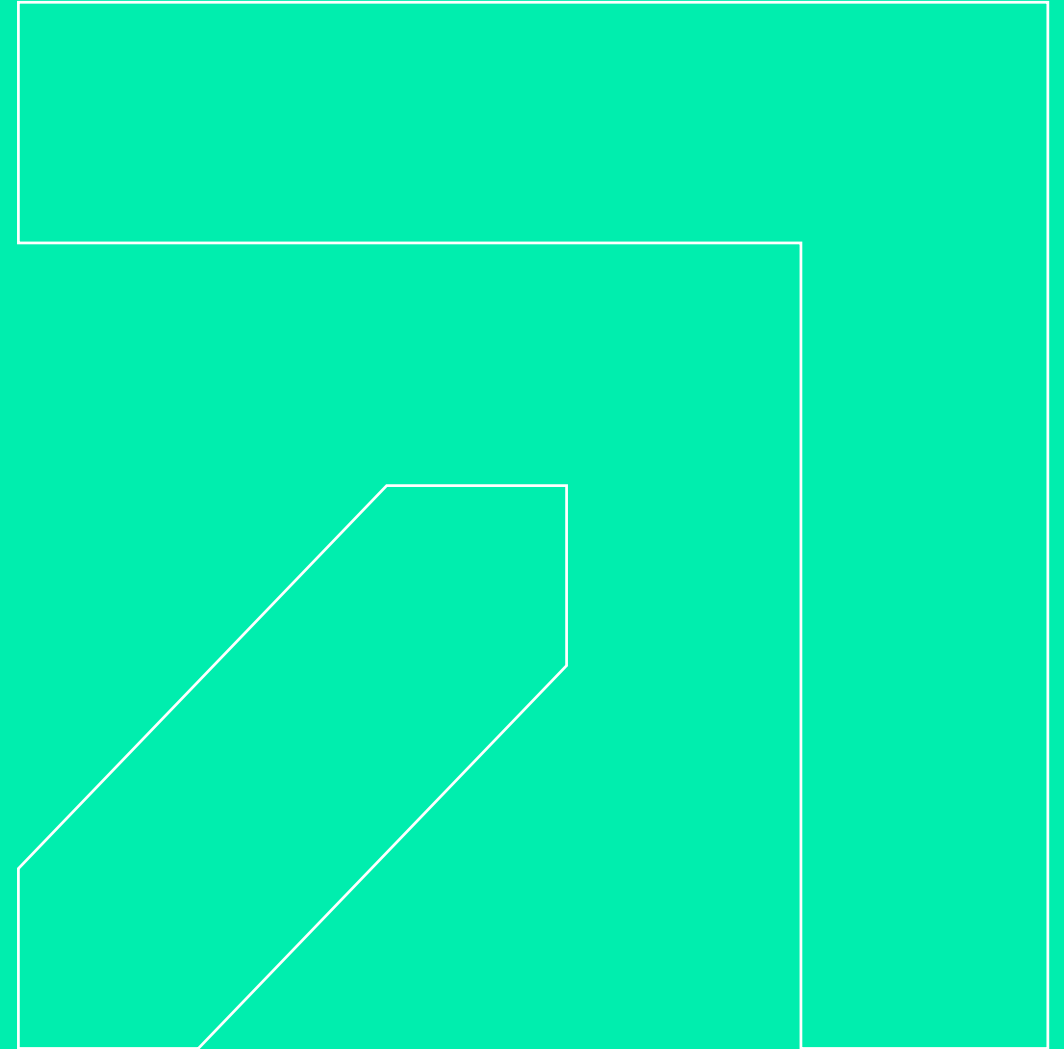
- If you are adding a new certification record, click the Add button and then click the Save button for each certification.
- If you are changing a certification, select the row to populate the fields below. Only the End Date can be updated. Once complete, click the Save button.
- Once a record is added or updated, go to the Provider Upload panel to upload documents.

*** No rows found ***

Select row above to update -or- click Add button below.

Certification Type Effective Date
End Date

Performing Provider Requirement for Clinics and Behavioral Health FQHC's



Performing Provider Requirement for Behavioral Health Clinics

PB 2024-11

Effective for dates of service June 1, 2024, and forward, the Department of Social Services (DSS) is implementing new system changes **requiring all performing providers** employed by or contracting with a Behavioral Health and/or Enhanced Care Clinic and rendering services to HUSKY Health members (HUSKY A, B, C and D) to **(1) be enrolled in the Connecticut Medical Assistance Program (CMAP) and (2) to be associated to that clinic for the claim date of service.**

- If the performing provider is not already actively enrolled in CMAP, effective immediately, providers must use the Gainwell Technologies Provider Enrollment Wizard located at www.ctdssmap.com to enroll.
- Providers that were previously enrolled in CMAP but are not currently active must contact the Provider Assistance Center to request a re-enrollment Application Tracking Number (ATN) to initiate the application process.

Performing Provider Requirement for Behavioral Health FQHC's

PB 2025-48

Effective for dates of service February 1, 2026, and forward, the Department of Social Services (DSS) is implementing new system changes requiring all performing providers employed by or contracting with a **Behavioral Health Federally Qualified Health Centers (FQHCs)** rendering services to HUSKY Health members (HUSKY A, B, C and D) to (1) be enrolled in the Connecticut Medical Assistance Program (CMAP) and (2) to be associated to that clinic for the claim date of service.

- If the performing provider is not already actively enrolled in CMAP, effective immediately, providers use the Gainwell Technologies Provider Enrollment Wizard located at www.ctdssmap.com to enroll.
- Providers that were previously enrolled in CMAP but are not currently active must contact the Provider Assistance Center to request a re-enrollment Application Tracking Number (ATN) to initiate the application process.

Performing Provider Requirement for Behavioral Health FQHC's

PB 2025-48

Claims with dates of service November 1, 2025, through January 30, 2026, that are submitted without the performing provider's NPI, will pay and post one of the following Explanation of Benefits (EOB) code(s):

- 1007 – The Performing Provider is Not on File
- 1008 – Performing Provider Must Have an Individual Number

This post and pay period will allow claims to bypass system edits that would normally cause claims to deny for the following EOB code(s):

- 0231 – Performing Provider is Missing
- 1011 – Performing Provider Number Not a Valid Format
- 1010 – Performing Provider is Not a Member of the Billing Provider Group

Performing Provider Requirement for Behavioral Health Clinics and FQHC's

BH Clinic and FQHC claims that do not include a valid performing providers NPI number, or if the performing provider NPI is not associated to the billing provider number, will receive claim denials with the following Explanation of Benefit (EOB) code(s):

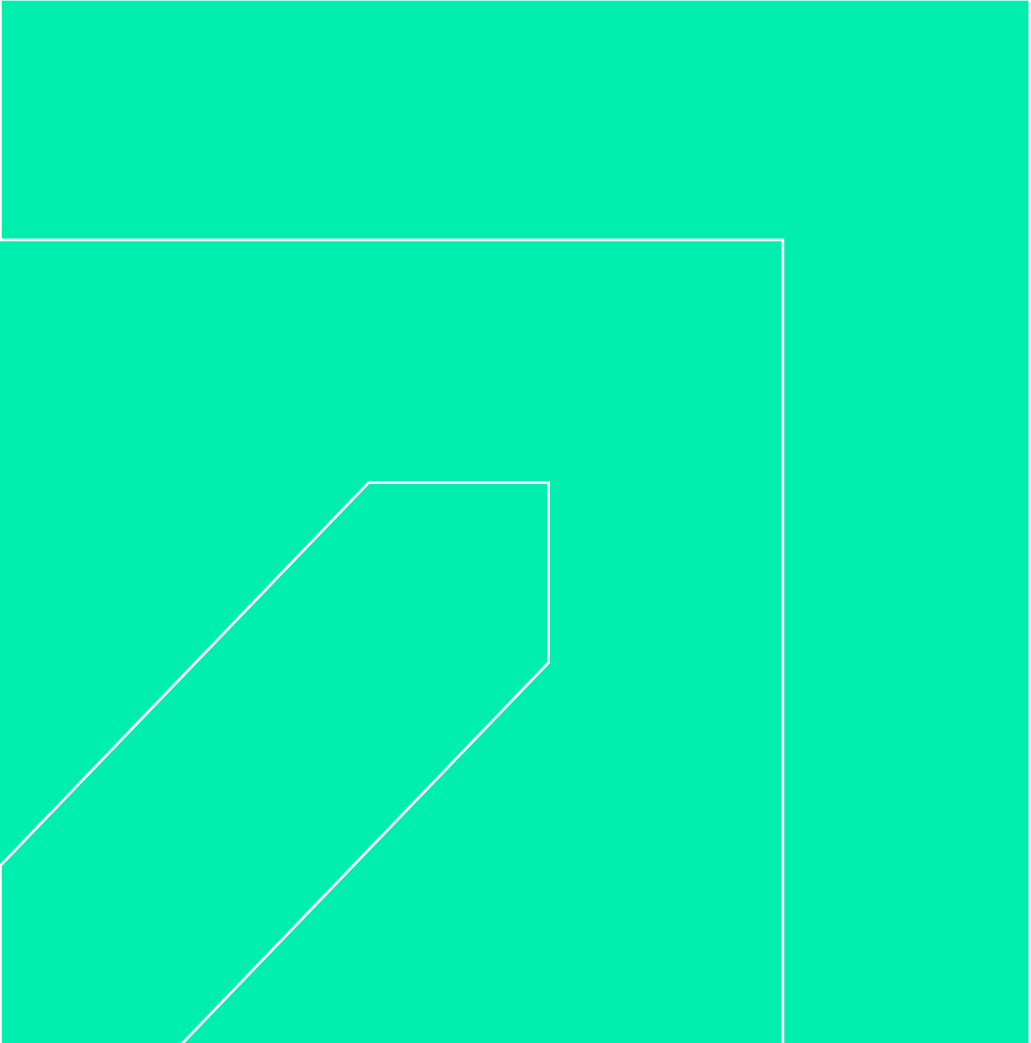
- 0231 - Performing Provider is Missing EOB code
- 1007 - The Performing Provider is Not on File
- 1008 - Performing Provider Must Have an Individual Number
- 1010 - Performing Provider is Not a Member of the Billing Provider Group
- 1011 - Performing Provider Number Not a Valid Format
Performing provider

Performing provider's NPI should be entered in the following sections of an electronic claim:

837P - Health Care Claim Professional

- NPI Segment ID = NM109
- NPI Loop ID = 2420
- Qualifier = 82

eDelivery and eMessages



E-Delivery

- A user can download their letters by selecting **Trade Files** and then Download from the menu items.
- Select **E-Delivery** from the Transaction Type field.
- A user can also sort their letters by title, date available and date downloaded.

The screenshot shows a web application interface for 'Trade Files'. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, Trade Files (highlighted), MAPIR, Messages, Account. Below this is a sub-menu with 'home', 'download' (highlighted), 'upload', and 'claim level detail'. The main content area has a 'File Download Search' section with a 'Transaction Type' dropdown menu set to 'E-Delivery' (highlighted with a red box). To the right of the dropdown are 'search' and 'clear' buttons. Below the search section is a red 'REMINDER: DOWNLOAD WEB FILE RETENTION' section with a list of bullet points regarding file retention periods. At the bottom, there is a table titled 'Current Files Available for Download' with columns for File Name, Title, Date Available, and Date Downloaded. The first row of the table is highlighted, and the 'Date Downloaded' cell is highlighted with a red box.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims Eligibility Prior Authorization Hospice **Trade Files** MAPIR Messages Account

home **download** upload claim level detail

File Download Search

Transaction Type **E-Delivery** search clear

REMINDER: DOWNLOAD WEB FILE RETENTION
Web file retention periods vary based on the type of file being downloaded.

- Remittance Advices (RA) in PDF format, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the www.ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Drug Rebate files will be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

It is recommended all electronic files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by such data as client ID, ICN or Explanation of Benefits (EOB) Codes.

All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.

Files are listed in order of the date they become available.

File Name	Title	Date Available	Date Downloaded
000322230_PRV-9137-R_1179846_379798_20190220.pdf	OOS License Verification Request Letter	02/20/2019	02/21/2019

E-Delivery

Notification

- Email notification will be sent to the email address associated with the primary account holder and clerk's Secure Web portal account
- Email sent daily for letters posted the day prior
- Only one email generated, even if multiple letters posted the previous day
- If a clerk is associated to multiple master users, the email will indicate the master user(s) to which the posted letters apply

Sample Email text:

From: ctdssmap@gainwelltechnologies.com

Subject: CMAP E-Delivery Alert – Letter(s) Available

REMINDER: It is important that all users keep their data updated, including their contact email information, as well as clerk data.

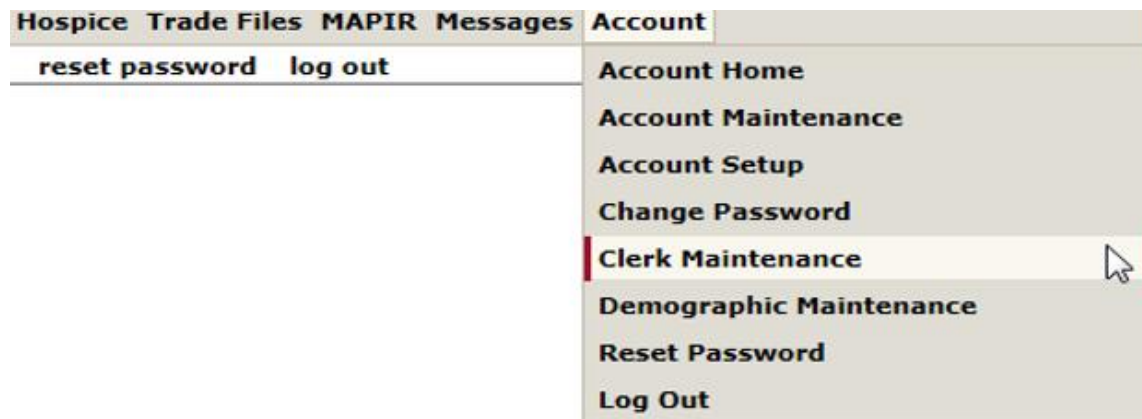
E-Delivery

Clerk Maintenance

A clerk can access e-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:

- the existing role of Trade Files (has been re-named Trade Files Includes E-Delivery)
 - allows access to download all files
- a new role of Trade Files E-Delivery Only – allow access to e-Delivery letters only

Access the Clerk Maintenance section of the Secure Site by selecting “Clerk Maintenance” from either the Account submenu or the Account drop-down menu.



E-Delivery

The following screenshot displays the two roles that can be assigned to a clerk that include e-Delivery: (Clerks can be assigned either role, but not both)

- Trade files includes E-Delivery
- Trade files E-Delivery Only

Connecticut Department of Social Services
Making a Difference

Help
Thursday, February 28, 2019

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Claims Eligibility Prior Authorization Hospice Trade Files MAPIR Messages Account

home account home account maintenance account setup change password clerk maintenance demographic maintenance switch provider reset password log out

Clerk Maintenance

User ID	Contact First Name	Contact Last Name
CLERK01	Dawn	Test
CLERK02	Dawn	Test
CLERK05	Dawn	Test
CLERK06	Dawn	Test
CLERK08	Dawn	Test
CLERK31	Test	Clerk

Type data below for new record.

remove clerk add clerk

User ID*
Contact First Name*
Contact Last Name*
Phone Number*
Password*
Confirm Password*
AVR ID
AVR Pin
Confirm AVR Pin

Assigned Roles

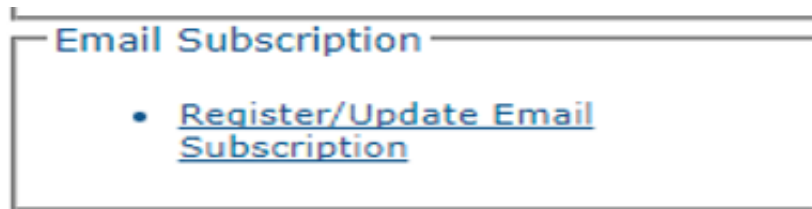
Available Roles

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

submit cancel

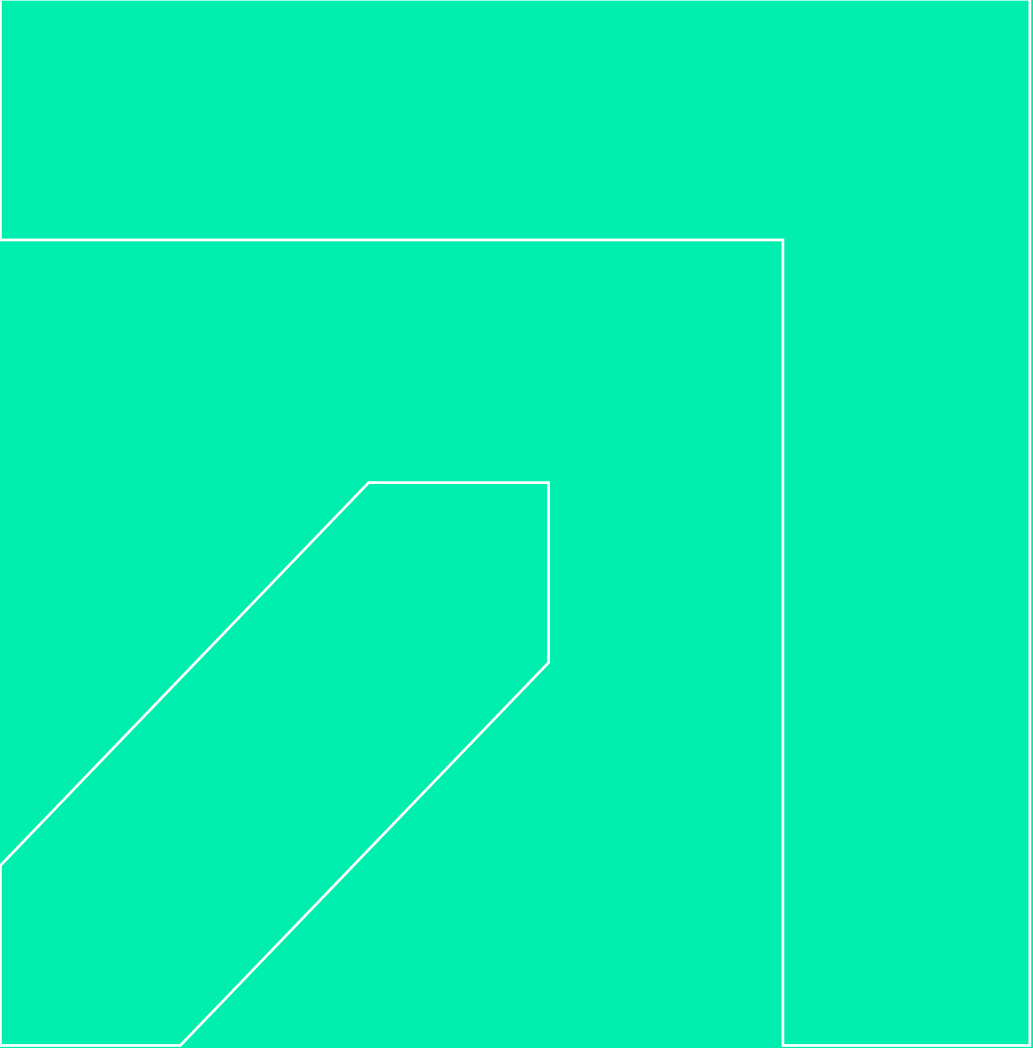
Registering for & Receiving E-Messages

Providers can register/subscribe for provider/topic specific publications by clicking on “Register/Update Email Subscription” from the www.ctdssmap.com home page.



- Providers are able to receive eMessages via email to the email address of their choosing.
- eMessaging replaces provider bulletins, newsletters, provider workshop invitations being sent via USPS.
- Multiple users from each provider’s office may sign up to receive eMessages.
- Providers are able to update their eMessage subscription with addition provider types or topics.
- Refer to Provider Bulletin [PB15-23](#) for additional information.

Eligibility Verification



Eligibility Verification

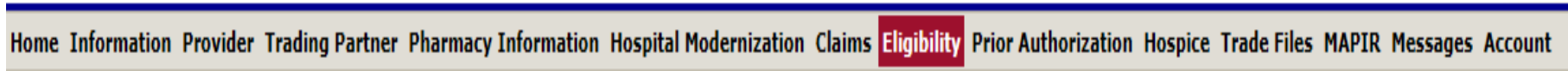
DSS recommends that providers verify a client's eligibility on the date of service *prior to performing said service* because eligibility can change at any time.

Eligibility verification can be performed in the following ways:


- Internet Web site at www.ctdssmap.com
- Automated Voice Response System (AVRS)
- Point of Sale (POS) Device
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
- Via e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

Eligibility Verification

To verify a CMAP client's eligibility through the secure site – click on the *Eligibility* tab on the main menu.



Enter enough data to satisfy at least one of the *valid search combinations*; click *search*



Valid Search Combinations

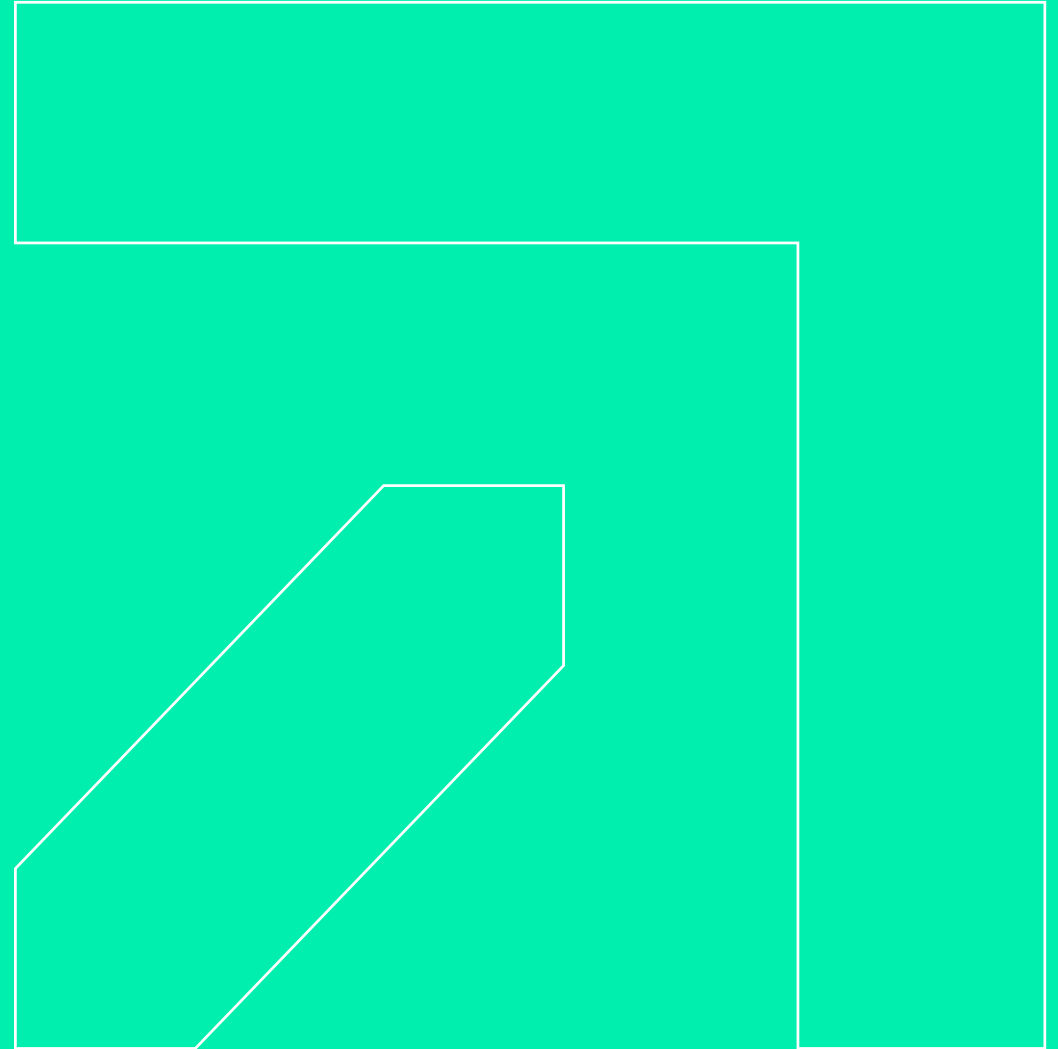
- Client ID + SSN
- Client ID + Birth Date
- Birth Date + SSN
- Full Name + SSN
- Full Name + Birth Date

[Eligibility Response Quick Reference Guide](#)

Eligibility Verification Request			
Client ID	<input type="text"/>	Last Name	DOE <input type="text"/>
SSN	666-55-4444 <input type="text"/>	First Name, MI	JOHN <input type="text"/> <input type="text"/>
Birth Date	<input type="text"/>	From DOS*	08/22/2022 <input type="text"/>
Service Type Code 1	30 - Health Benefit Plan Coverage <input type="text"/>	To DOS*	08/22/2022 <input type="text"/>
Service Type Code 2	<input type="text"/>	Service Type Code 3	<input type="text"/>
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>
Service Type Code 4	<input type="text"/>	Service Type Code 5	<input type="text"/>
Service Type Code 5	<input type="text"/>	<input type="button" value="search"/>	
<input type="button" value="clear"/>			

****When entering a full name as part of your search, a middle initial is required if present in their CMAP profile****

Prior Authorization Information



Prior Authorization Information (PB 2022-77)


Carelon Behavioral Health accepts prior authorization requests for:

- Behavioral Health Services (ASD included)
- Spravato
- [PB 2022-77](#) – Removal of PA for select Services
- [Fee Schedule](#)

www.ctbhp.com (Carelon Behavioral Health)

Go to “For Providers” > Log in -> enter
Prior Authorization Request
Via ProviderConnect

Phone: 1-877-55-CTBHP

	Connecticut Department of Social Services Medical Assistance Program www.ctdssmap.com	Provider Bulletin 2022-77 October 2022
---	---	---

TO: Hospital Behavioral Health Outpatient, Behavioral Health Clinics, Enhanced Care Clinics, Behavioral Health FQHCs, Medical Clinics, Physicians, APRNs and Behavioral Health Clinicians

RE: Removal of Prior Authorization for Select Behavioral Health Services

Effective for dates of service September 1, 2022, and forward, the Department of Social Services (DSS) is removing Prior Authorization (PA) on the following procedure codes:

90785	90791	90792	96116	96121	96130
96131	96132	96133	96136	96137	T1017

Outpatient Hospitals

Hospitals must continue to refer to both CMAP Addendum B and the Clinic and Outpatient Hospital fee schedule for reimbursement.

As required by 17b-262-971(c) of the Regulations of Connecticut State Agencies Concerning Outpatient Hospital Services, outpatient hospital behavioral health services are considered an all-inclusive rate and professional fees will not be reimbursed separately for medically necessary services rendered in POS/FTC 19 (off campus-outpatient hospital) or 22 (on campus-outpatient

Accessing CMAP Addendum B:

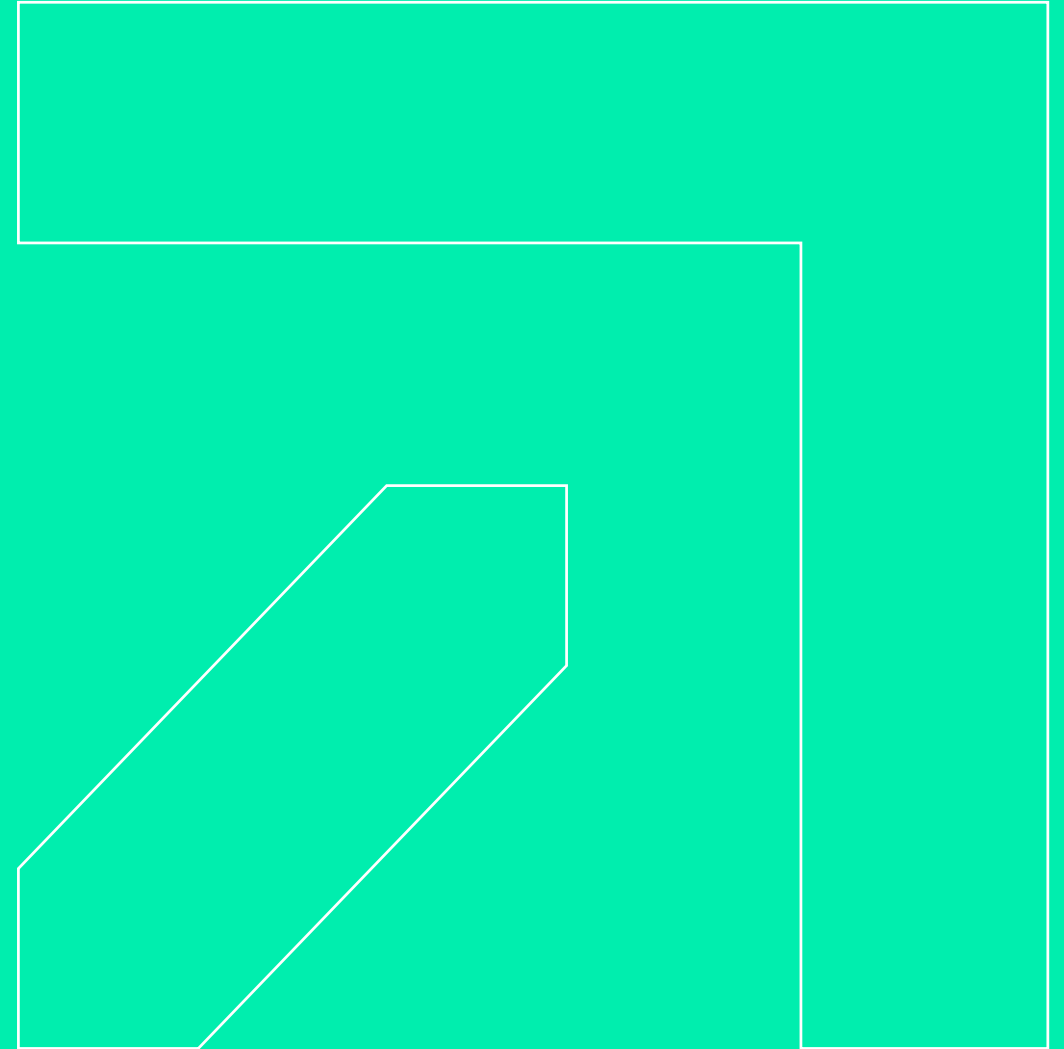
CMAP’s Addendum B can be accessed via the www.ctdssmap.com Web site by selecting the “Hospital Modernization” Web page. CMAP’s Addendum B (Excel) is located under “Important Messages–Connecticut Hospital Modernization”.

Accessing the Fee Schedule:

The updated fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance (CMAP) Web site: www.ctdssmap.com. From this Web page, go to “Provider”, then to “Provider Fee Schedule Download”, then click on your specific fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select “Open”.

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

Behavioral Health Web Claim Submission



Professional Web Claim Submission

Professional claims can be submitted through the Secure Web site by signing into www.ctdssmap.com. Once on the secure site, select “Professional” from the claims drop-down menu.



The screenshot shows the top navigation bar of the CMAP website. The navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Telehealth Information, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, and Hospice. Below the navigation bar, there is a large blue "WELCOME" graphic with the text "TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM". To the right of the graphic, a dropdown menu is open, showing options for Claim Inquiry, Professional, Institutional, Dental, and Claim History for Specific Services. A green arrow points to the "Professional" option. On the left side of the page, there are two sections: "Information" with links for Publications, Links, Important Information, RA Banner Announcements, HIPAA, and Regional Office Locations; and "Provider" with links for Provider Services, Provider Search, Provider Enrollment, and CQC Instructions/Information.

Claim types that can be submitted through the secure Web site:

- Primary and Secondary/Third Party Liability (TPL) claims
- Re-submission and adjustments for non-crossover claims, if they are within timely filing
- Recoup/Void a claim at any time regardless of timely filing

Professional Web Claim Submission

Connecticut Department of Social Services
Making a Difference

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization **Claims** Eligibility Prior Authorization Hospice

home claim inquiry **professional** institutional dental claim history for specific services

Quick Links

- [Internet Claims Submission FAQ](#)
- [Instructions for submitting Professional claims](#)
- [Claim Resolution Guide](#)

Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	<input type="text"/>	To Date	<input type="text"/>
AVRS ID	<input type="text"/>	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	<input type="text"/> \$0.00
First Name, MI	<input type="text"/>	Total Paid	<input type="text"/> \$0.00
Date of Birth	<input type="text"/>	TPL Amount	<input type="text"/> \$0.00
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text"/> \$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	<input type="text"/> No
Referring Physician	<input type="text"/> [Search]	837 Version	<input type="text"/> 5010
SSN	<input type="text"/>		
Accident Related	<input type="text"/> No		
Accident Date	<input type="text"/>		

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident

Diagnosis

Diag-Sequence	Diagnosis	Description
Code Set	<input type="text"/> ICD 10	
Principal	<input type="text"/> [Search]	Other 1 <input type="text"/> [Search]
Other 3	<input type="text"/> [Search]	Other 4 <input type="text"/> [Search]
Other 6	<input type="text"/> [Search]	Other 7 <input type="text"/> [Search]
		Other 8 <input type="text"/> [Search]

[add more](#)

- **The Internet Claims Submission FAQ** document contains relevant information that will guide you through the process of submitting a claim via the web.
- **The Claim Resolution Guide** contains a list of common denial codes and resolution methods.

Professional Web Claim Submission

- Perform the following steps to easily submit a new claim:
- Select Professional claim type from the Claims drop down box
- A blank claim will appear
- At a minimum, enter data into all required fields (identified by an asterisk after the field name)

Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	<input type="text" value="NPI"/>	To Date	<input type="text"/>
AVRS ID	<input type="text"/>	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text" value=""/>
Last Name	<input type="text"/>	Total Charges	<input type="text" value="\$0.00"/>
First Name, MI	<input type="text"/>	Total Paid	<input type="text" value="\$0.00"/>
Date of Birth	<input type="text"/>	TPL Amount	<input type="text" value="\$0.00"/>
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Medical Record Number	<input type="text"/>	Medicare Crossover	<input type="text" value="No"/>
Referring Physician	<input type="text"/> [Search]	837 Version	<input type="text" value="5010"/>
SSN	<input type="text"/>		
Accident Related	<input type="text" value="No"/>		
Accident Date	<input type="text"/>		

Professional Web Claim Submission

- Enter up to 12 Diagnosis codes on a professional claim, click the add more button to enter more than 9.
- Do not include periods in diagnosis codes. Example: F41.1 must be entered in as F411.

Diagnosis		
Diag-Sequence ▲	Diagnosis	Description
Code Set	ICD 10 ▼	
Principal	<input type="text"/>	[Search]
Other 1	<input type="text"/>	[Search]
Other 2	<input type="text"/>	[Search]
Other 3	<input type="text"/>	[Search]
Other 4	<input type="text"/>	[Search]
Other 5	<input type="text"/>	[Search]
Other 6	<input type="text"/>	[Search]
Other 7	<input type="text"/>	[Search]
Other 8	<input type="text"/>	[Search]

[add more](#)

Professional Web Claim Submission

New Claim

Required fields for the detail panel of the claim:

- From Date of Service (DOS)
- To Date of Service (DOS)
- Procedure
- Units
- Facility Type Code / Place of Service
- Charges

Groups and Clinics must enter the rendering/performing provider NPI on the claim.

Certain behavioral health providers require to bill with a modifier.

Once all of the required fields are entered, click on the *Add* button.

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1			1.00	\$0.00		\$0.00

Type data below for new record.

Item	<input type="text" value="1"/>	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Calc Allowed Amt	<input type="text" value="\$0.00"/>
Rendering Physician	<input type="text"/> [Search]	Medicare Paid Amount	<input type="text" value="\$0.00"/>
SSN	<input type="text"/>	Medicare Deductible Amount	<input type="text" value="\$0.00"/>
Referring Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	<input type="text" value="\$0.00"/>
Ordering Provider	<input type="text"/> [Search]	Diagnosis Code Pointer	<input type="text"/>
		National Drug Code	<input type="text"/>
		NDC Quantity	<input type="text" value="0"/>
		NDC Unit of Measurement	<input type="text"/>

delete

Professional Web Claim Submission

Modifiers – The following providers must bill with the corresponding modifiers.

Provider Type / Specialty	Modifier
License Clinical Social Worker (LCSW)	AJ
Licensed Marital and Family Therapists (LFMT)	HO
Licensed Professional Counselors (LPC)	HO
Licensed Alcohol and Drug Counselors (LADC)	HO

Professional Web Claim Submission

TPL									
Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A	060	BC/BS OF CONNECTICUT	\$0.00						

Type data below for new record.

Client Carriers: 060 - BC/BS OF CONNECTICUT ▼

Carrier Code: 060 [Search] Relationship: ▼

Plan Name: BC/BS OF CONNECTICUT Last Name: _____

Policy Number: _____ First Name, MI: _____

Paid Amount*: _____ Date of Birth: _____

Paid Date*: _____

Adjustment Reason Code: _____ [Search] _____ [Search] _____ [Search]

Adjustment Amount: _____ \$0.00 _____ \$0.00 _____ \$0.00

[delete](#) [add](#)

Professional Web Claim Submission

TPL Claims

Medicaid is the Payer of last resort. The three-digit Carrier Code of the Other Insurance (OI) is required to be submitted on the claim when OI is primary.

- The three-digit code can be found on the client eligibility verification screen under TPL (Third Party Liability) Information

		TPL
Carrier Code ▲	Carrier Name	
060	BC/BS OF CONNECTICUT	
K50	PRIME THERAPEUTIC	

Provider should initiate a separate request to the other payer or plan to determine level of coverage

- It can also be found on the claim submission screen under the TPL panel in the “**Client Carriers**” field.

Professional Web Claim Submission

The final step is to submit the claim and you will see the claim status within a minute.

Claim Status Information	
Claim Status	Not Submitted yet



Claim Status Information	
Claim Status	PAID
Claim ICN	
Paid Date	
Paid Amount	\$110.77
Applied Income	\$0.00
Client Contribution	\$0.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

Professional Web Claim Submission

Void

Perform the following steps to void or completely recoup a paid claim:

- Select Claim Inquiry
- Enter the paid claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the Search button
- Once the claim is retrieved, click the **void** button at the bottom of the claim page
- The void will process immediately and return a message that the claim has been successfully adjusted / voided with a new ICN



Professional Web Claim Submission Adjustment

Perform the following steps to adjust a paid claim:

- Select Claim Inquiry
- Enter the paid claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the search button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the **adjust** button at the bottom of the claim page
- The adjustment will process immediately and return a status of Paid, Denied, or Suspended

Claim Status Information	
Claim Status	Adjusted / Voided
Claim ICN	
Paid Date	
Paid Amount	\$110.77
Applied Income	\$0.00
Client Contribution	\$0.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

Professional Web Claim Submission

Web Claim Adjustment Limitations

Timely Filing

Claims that are over the Timely Filing guidelines cannot be adjusted, unless the adjustment is submitted to pay the same or less than the original claim. Otherwise, claim adjustments outside of the timely filing limit will be fully recouped.

Medicare Crossovers

Crossover claims cannot be adjusted. They must be voided, copied and then submitted as new claims.

Special Handled Claims

Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by Gainwell Technologies and are, therefore, **not** able to be adjusted via the www.ctdssmap.com Web site

*****Note: Provider claims that are submitted to Gainwell Technologies for special handling, such as timely filing overrides are excluded from the Elimination of Paper Claims mandate.*****

Professional Web Claim Submission

Copy

Paid claims may be copied and submitted as a new claim

- This feature is helpful for reoccurring services



copy claim

Perform the following steps to easily copy a paid claim for submission as a new claim

- Select Claim Inquiry
- Enter the paid claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the search button
- Once the claim is retrieved, click the copy button at the bottom of the claim page
- Make the necessary changes to the claim
- Click the submit button at the bottom of the claim page
- The new claim will process immediately and return a status of Paid, Denied or Suspended

Professional Web Claim Submission

Resubmit

Resubmission - Perform the following steps to easily resubmit a denied claim:

- Select Claim Inquiry
- Enter the denied claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the search button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the re-submit button at the bottom of the claim page
- The new claim will process immediately and return a status of Paid, Denied or Suspended



re-submit

Professional Web Claim Inquiry

What Can I Do With These Claims?

Paid claims allow you to:

- Cancel any alterations you have made
- Adjust the claim
- Void the claim
- Copy the claim and use it as a template to create a new claim
- Create a brand new claim

Denied claims allow you to:

- Resubmit the claim (with or without making changes)
- Cancel any alterations you have made
- Create a brand new claim

Suspended claims allow you to:

- Create a brand new claim

cancel

adjust

void

copy claim

new claim

re-submit

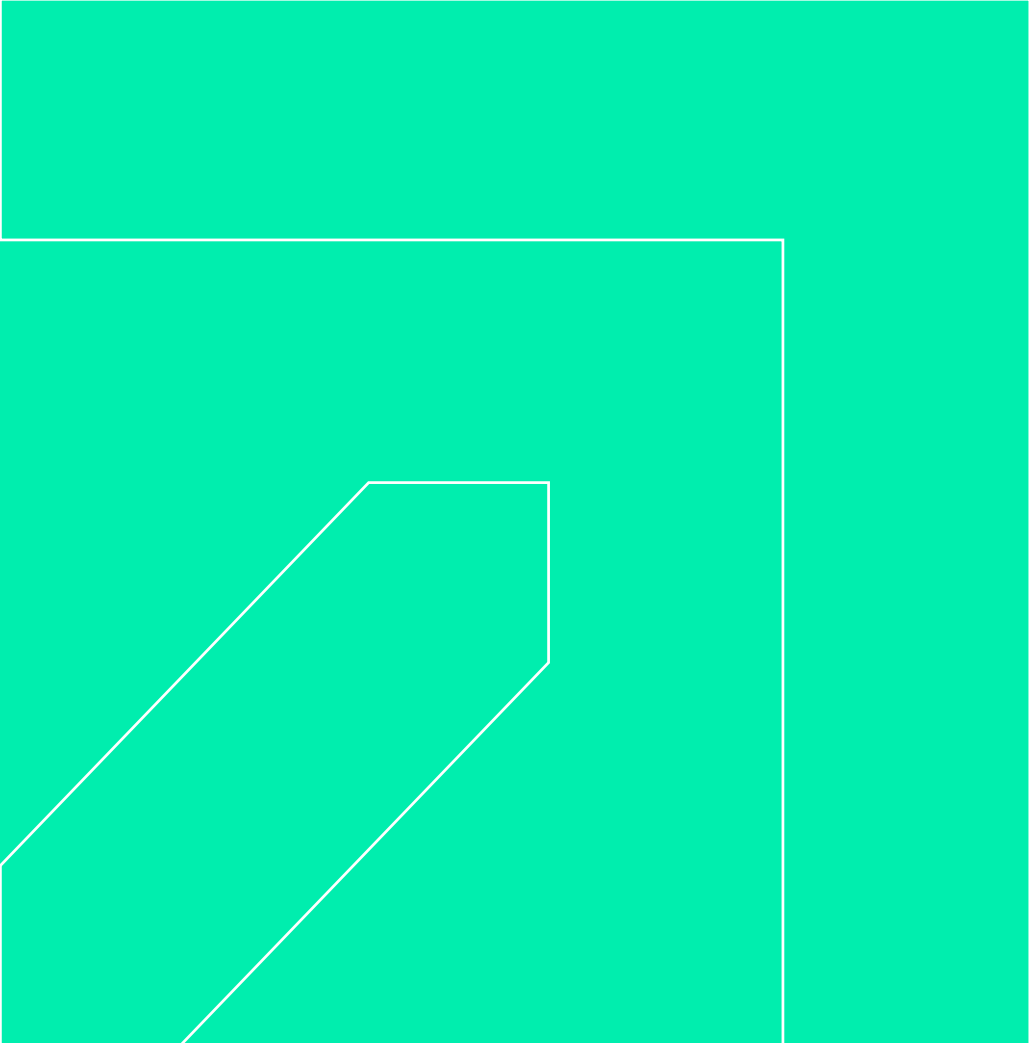
cancel

new claim

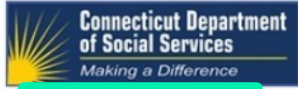
Intermission



Provider Manuals



Provider Manuals



Home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit V
 Home publications link hipaa messages archive



Information

Bulletin Search

Year Provider Type



Number Title

Provider Manuals	
Chapter	
1	Introduction
2	Provider Partici
3	Provider Enrollr

- From your Home Page, select Information and then Publications from the drop down.
- Provider Manuals are in the second panel.

Provider Manuals	
Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information
	Additional Chapter 5 Information <ul style="list-style-type: none"> • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation
	<input type="text" value="Select a provider type"/> View Chapter 7

Provider Manuals

8	Provider Specific Claims Submission Instructions <input type="text" value="Select a provider type"/>  View Chapter 8
9	Prior Authorization
10	Web Portal / AVRS
11	Other Insurance and Medicare Billing Guides <input type="text" value="Select a claim type"/>  View Chapter 11
12	Claim Resolution Guide

Chapters 1 - 4

Chapter 1 – Introduction

Provides information on the Connecticut Medical Assistance Program, DSS and Gainwell Technologies responsibilities/resources and the Provider Manual organization.

Chapter 2 – Provider Participation Policy

Provides Connecticut Medical Assistance Program Regulations for provider participation.

Chapter 3 – Provider Enrollment/Re-Enrollment

Provides information on provider eligibility in regards to provider enrollment and re-enrollment, and specific program enrollment information for the HUSKY Health Program (HUSKY A, HUSKY B, HUSKY C, HUSKY D), Connecticut Behavioral Health Partnership (CT BHP), Connecticut Dental Health Partnership (CTDHP), and the Connecticut AIDS Drug Assistance Program (CADAP).

Chapter 4 – Client Eligibility

Provides information regarding client eligibility in the Medical Assistance Program, client eligibility verification, and client third party liability.

Chapters 5 - 8

Chapter 5 – Claim Submission Information

Provides information on general claim processing and billing requirements.

Chapter 6 – Electronic Data Interchange Options

Provides information on electronic claim submission and electronic remittance advices.

Chapter 7 – Specific Policy/Regulation

Provides the Connecticut State Regulations or Program regulatory policy for specific providers. See drop down menu for your provider type.

Chapter 8 – Provider Specific Claims Submission Instructions

Provides information on provider specific billing requirements and instructions. See drop down menu for your provider type

The screenshot shows a web browser window with a 'Provider Manuals' table. The table has columns for 'Chapter' and a description. A dropdown menu is open over the table, listing various provider types. A red arrow points to the 'View Chapter 7' link in the table row for Chapter 7.

Chapter	Description
1	
2	
3	
4	
5	
6	
7	View Chapter 7
8	View Chapter 8
9	Prior Authorization
10	Web Portal / AVRS
11	View Chapter 11
12	Claim Resolution Guide

Forms

Authorization/Certification Forms

- [17-Alpha Hydroxyprogesterone Caproate Pharmacy Referral Form](#)

Chapters 7

Chapter 7 – Behavioral Health Clinicians

Sec. 17b-262-917. Service Limitations

The department shall pay for covered services only in accordance with the treatment plan and with the following additional limits: (1) Only one diagnostic interview in any twelve-month period per licensed behavioral health clinician per client; (2) only one unit of individual counseling or individual psychotherapy per client, per day; (3) only one unit of family counseling or family psychotherapy per client, per day; (4) only one unit of group counseling or group psychotherapy per client, per day; (5) group psychotherapy sessions shall include a maximum of twelve participants per group session, to the extent clinically appropriate, regardless of each participant's payment source, and the provider shall document the number of participants in each session in the client's chart; (6) family, group and multiple-family group psychotherapy sessions shall be at least forty-five minutes in length, and the provider shall document the length of time of each session in the client's chart.

Chapters 9-12

Chapter 9 –Prior Authorization

Provides information on how to obtain Prior Authorization for designated services

Chapter 10 – Web Portal / Automated Voice Response (AVRS)

Provides information on the self-service features for the provider for both the Automated Voice Response System (AVRS) and the Web Portal functions with interChange. This will serve as a standalone self-service manual that will provide the comprehensive features available to the provider such as claims inquiry/submission, PA inquiry/submission, Web enrollment and re-enrollment, etc.

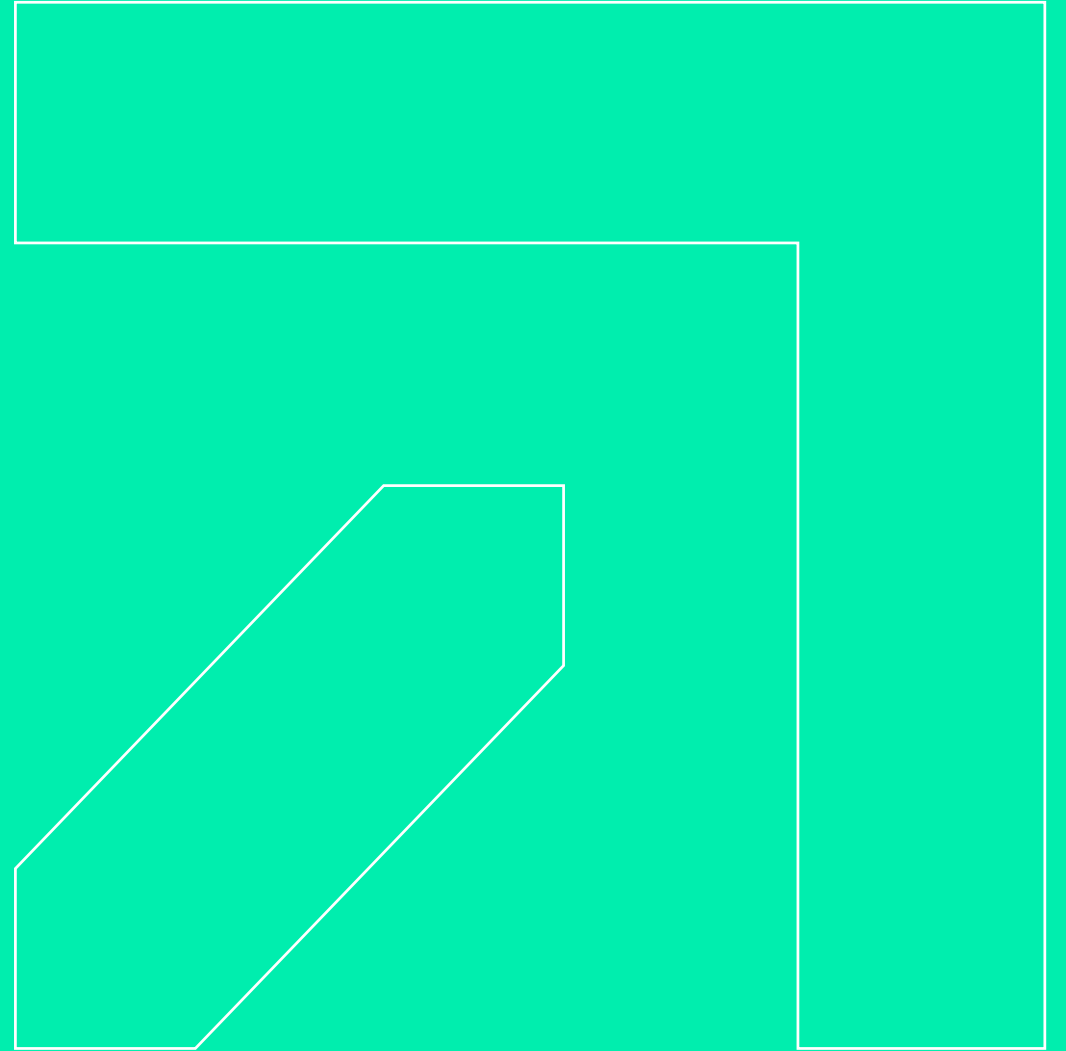
Chapter 11 – Other Insurance/Medicare Billing Guides

Provides information on other insurance and Medicare billing.

Chapter 12- Claim Resolution Guide

Provides descriptions of the most common claim errors and, if applicable, information to resolve the error conditions.

Claim Resolution Guide



Frequent Claim Denials

Explanation of Benefits (EOB) code 4140: “The Services Submitted are not Covered Under the Client’s Benefit Plan” and EOB code 4250: “No Reimbursement Rule for the Associated Provider Type/Provider Specialty.”

The provider should verify client eligibility to determine if services are covered under the client’s benefit plan for their provider type and specialty.

If the services are covered under client’s benefit plan, client eligibility could have been updated at some point.

- Providers should re-submit the claim for processing.
- If the claim still denies, the provider will need to contact the Provider Assistance Center (PAC) to review the claim.

Frequent Claim Denials

EOB code 4149: “Billing Provider not Authorized to Bill for Submitted Procedure Code.”

Cause

- The provider is not authorized to bill for that procedure code.

Resolution

- If the procedure billed is not on the provider's fee schedule for the date of service, the service is not payable.
- If the procedure billed is present on the provider's fee schedule, contact the Provider Assistance Center to request an update to the procedure code in question.

Frequent Claim Denials

EOB Code 4821: “Facility Type is Restricted for Procedure under Provider Contract.”

Cause

- The provider provided services in an invalid place of service. A behavioral health clinician or psychologist billed for an invalid facility type code for their provider specialty.
- Example: The provider bills with a facility type code of 22 “Outpatient Hospital.” In this case, the service would deny with EOB 4821.

Resolution

- Verify the facility type code; if billed incorrectly, correct and re-submit the claim.
- If the facility type code is correct, then the claim denied appropriately.

Frequent Claim Denials

EOB Code 1010: “Performing Provider is Not a Member of the Billing Provider Group.”

Cause

- The rendering provider billed on the claim is not associated to the billing group.

Resolution

- The provider group needs to associate the rendering provider to their behavioral health group.
- Once the performing provider is associated to the group, re-submit the claim.

Frequent Claim Denials

EOB code 5925: “CCI column 1 code or mutually exclusive code was billed on the same date as previous column 2 code.”

EOB code 5926: “CCI column 2 code or mutually exclusive code was billed on the same date as previous column 1 code.”

Cause

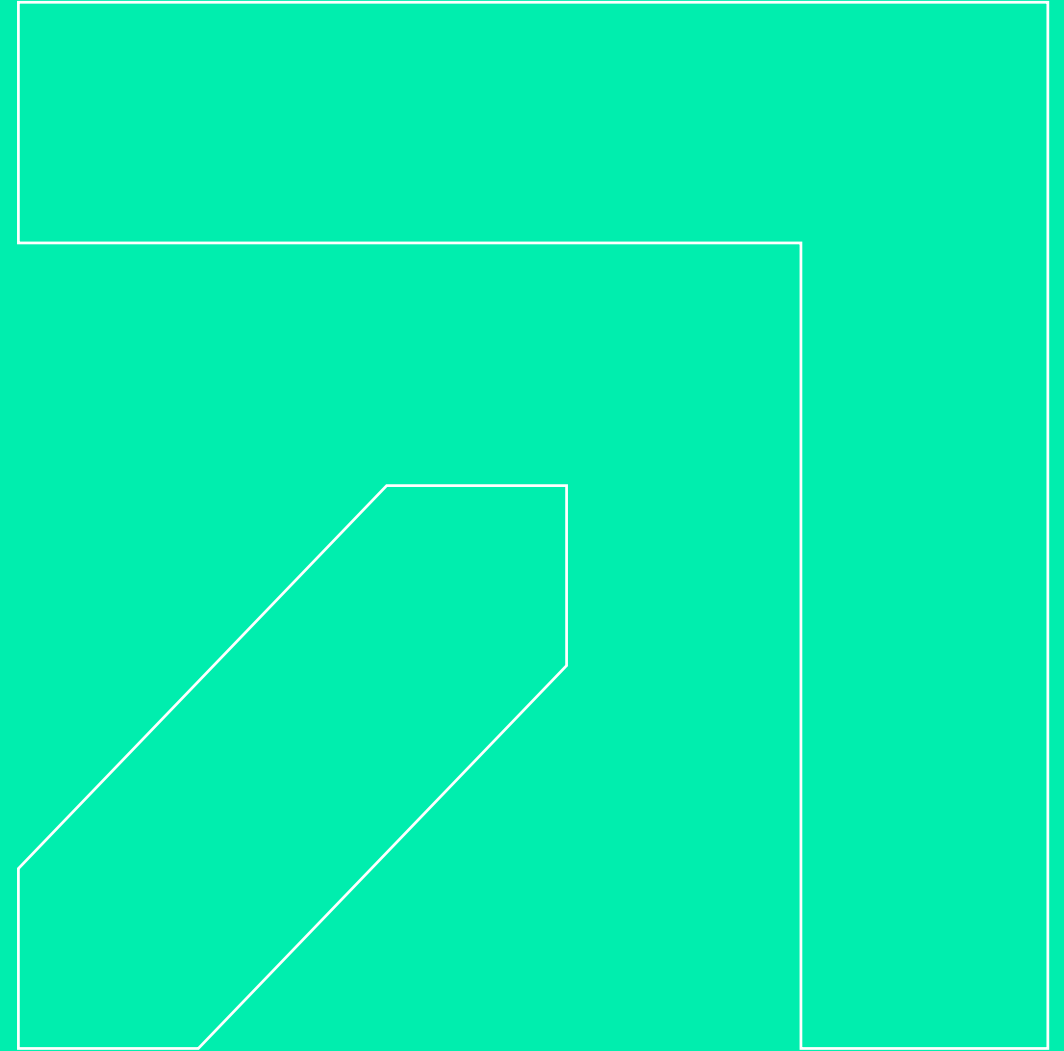
- A claim containing a CCI column 1 or 2 code or mutually exclusive code was submitted for the same date of service as a previously paid CCI column 1 or 2 code.

Resolution

- Verify the procedure code and date of service information on the claim. If the data was keyed incorrectly, make the necessary corrections and resubmit the claim. If the data was keyed correctly, the claim is not payable based on a previously paid claim.

For detailed information regarding the National Correct Coding Initiative, please review Provider Bulletins PB [2011-12](#), PB [2011-41](#), and PB [2012-40](#).

Provider Fee Schedules



Provider Fee Schedules


CMAP fee schedules are available for download from the Web site.

- Select *Provider Fee Schedule Download* from the *Provider* drop-down menu

- You must read and accept the *End User License Agreement* prior to downloading the fee schedule; click *I Accept*

The screenshot shows the website header with the logo "Connecticut Department of Social Services" and the tagline "Making a Difference". The navigation menu includes "Home", "Information", "Provider", "Trading Partner", "Pharmacy Information", and "Hospital". The "Provider" dropdown menu is open, listing options such as "Provider Enrollment", "Provider Re-Enrollment", "Provider Enrollment Tracking", "Provider Matrix", "Provider Services", "Provider Search", "Drug Search", "Provider Fee Schedule Download", "OOS Instructions", "Fingerprint Criminal Background Check Info", "E-mail Subscription", and "Secure Site". The "Provider Fee Schedule Download" option is highlighted. To the right of the dropdown menu, there are input fields for "Type" and "Title". Below the dropdown menu, there is a table with a cell containing the number "4" and a link labeled "Client Elig".

Provider Fee Schedules



Connecticut Department of Social Services
Making a Difference

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization

home provider enrollment provider re-enrollment provider enrollment tracking prov
fingerprint criminal background check info e-mail subscription secure site

***** Click here for the Fee Schedule Instructions *****

Provider Fee Schedule Download

- Acquired Brain Injury Case Management [CSV](#)
- Acquired Brain Injury DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Fiduciary [CSV](#)
- Acquired Brain Injury II DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Service Provider [CSV](#)
- Acupuncture [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Autism Waiver Fiscal Intermediary [CSV](#)
- Autism Waiver Service Provider [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)
- Clinic - Dialysis [CSV](#)
- Clinic - Family Planning / Abortion [CSV](#)
- Clinic - Medical [CSV](#)
- Clinic - Rehabilitation [CSV](#)
- Community First Choice - Assessments [CSV](#)
- Community First Choice - Services [CSV](#)
- Connecticut Housing Engagement and Support Services [CSV](#)
- CT Home Care [CSV](#)
- DDS Specialized Services NF Fee Schedule [CSV](#)
- Dental Adult [XLSX](#)
- Dental DOS Prior to 09/01/2016 [CSV](#)
- Dental Pediatric [XLSX](#)
- Free-Standing Substance Use Disorder (SUD) Residential Treatment Facilities [CSV](#)
- Home Health [PDF](#)

- Provider Fee Schedules are listed by provider type and specialty.
- Click the corresponding link to download the appropriate fee schedule.

Provider Fee Schedule Instructions

- Fee Schedule Formats
- Special Indicators
- Table Listing
- [Fee Schedule Instructions \(Live Link\)](#)

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernizat
home provider enrollment provider re-enrollment provider enrollment tracking pro
provider fee schedule download oos instructions/information fingerprint criminal bac

***** Click here for the Fee Schedule Instructions *****

Provider Fee Schedules

Behavioral Health Clinicians and Clinics fee schedule

Provider Fee Schedule Download

- Acquired Brain Injury [CSV](#)
- Acquired Brain Injury II [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)

Provider Fee Schedule Download

- Acquired Brain Injury [CSV](#)
- Acquired Brain Injury II [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)

Provider Fee Schedule

Autism Spectrum Disorder (ASD) provider fee schedule.

Provider Fee Schedule Download

- [Acquired Brain Injury CSV](#)
- [Acquired Brain Injury II CSV](#)
- [Ambulatory Detoxification CSV](#)
- [Autism Spectrum Disorder CSV](#)
- [Behavioral Health Clinician CSV](#)
- [Chiropractor CSV](#)
- [Clinic - Ambulatory Surgical Center CSV](#)
- [Clinic - Chemical Maintenance CSV](#)
- [Clinic - Clinic and Outpatient Hospital Behavioral Health CSV](#)

Provider Fee Schedule

Autism Specialist provider fee schedule

Autism Spectrum Disorder 7/1/2025								
Procedure	Proc description	Mod1	Rate Type	Max Fee	Effective Date	End Date	QTY	PA
97153	Adaptive behavior treatment by technician using an establi		ASD	12.17	11/17/2021	12/31/2299	72	Y
97153	Adaptive behavior treatment by technician using an establi		ASK	14	7/1/2024	12/31/2299	72	Y
97156	Adaptive behavior treatment by professional with family us		ASK	21.2	7/1/2025	12/31/2299	4	Y
97158	Adaptive behavior treatment by professional with group usi		ASD	2.97	11/17/2021	12/31/2299	16	Y
97158	Adaptive behavior treatment by professional with group usi		ASK	3.08	7/1/2024	12/31/2299	16	Y
H0031	Mental health assessment by non-physician		ASD	84.8	11/17/2021	12/31/2299	10	Y
H0031	Mental health assessment by non-physician		ASK	87.98	7/1/2024	12/31/2299	10	Y
H0032	Mental health service plan development by non-physician		ASD	84.8	11/17/2021	12/31/2299	3	Y
H0032	Mental health service plan development by non-physician		ASK	87.98	7/1/2024	12/31/2299	3	Y
H0032	Mental health service plan development by non-physician	TS	ASD	58.51	11/17/2021	12/31/2299	3	Y
H0032	Mental health service plan development by non-physician	TS	ASK	60.7	7/1/2024	12/31/2299	3	Y
H0046	Mental health services not otherwise specified		ASD	21.2	11/17/2021	12/31/2299	24	Y
H0046	Mental health services not otherwise specified		ASK	22	7/1/2024	12/31/2299	24	Y
H2014	Skills training and development per 15 minutes		ASD	14.69	11/17/2021	12/31/2299	75	Y
H2014	Skills training and development per 15 minutes		ASK	15.24	7/1/2024	12/31/2299	75	Y
T1016	Case management each 15 minutes		ASK	11.33	7/1/2025	12/31/2299	12	

Rate type descriptions can be found under the Fee Schedule Instructions under Table								
_____2.								

Procedure H0032 without modifier TS has a quantity limit of 1.								

- Rate Type “ASD” – Autism Spectrum Disorder
- Rate Type “ASK” - Autism Spectrum Disorder for Kids (20 years old and under)
- Modifier “TS” – Follow up Service

Provider Fee Schedule

Behavioral Health Clinicians fee schedule

Behavioral Health Clinician 7/1/2024							

For all HUSKY Health Benefit Plans T1016 is only payable for clients under							
_____the age of 19 through 6/30/2024 and under the age of 21 from 7/1/2024 forward.							

Procedure	Description	Mod1	Rate Type	Max Fee	Effective Date	End Date	PA
0373T	Adapt bhv tx ea 15		BHC	24.16	11/17/2021	12/31/2299	Y
90785	Psytx complex inte		BHC	2.68	11/17/2021	12/31/2299	
90785	Psytx complex inte		BHK	2.78	7/1/2024	12/31/2299	
90791	Psych diagnostic		BHC	107.38	11/17/2021	12/31/2299	
90791	Psych diagnostic		BHK	111.41	7/1/2024	12/31/2299	
90791	Psych diagnostic		BHT	51.15	5/31/2023	12/31/2299	
90791	Psych diagnostic		FBH	51.15	11/17/2021	12/31/2299	
90791	Psych diagnostic		FBK	53.07	7/1/2024	12/31/2299	
90791	Psych diagnostic		THK	53.07	7/1/2024	12/31/2299	
90791	Psych diagnostic	U5	BHC	524.16	11/17/2021	12/31/2299	
90791	Psych diagnostic	U5	BHK	524.16	7/1/2024	12/31/2299	

- Modifier U5 – Autism Services

Provider Fee Schedule

Behavioral Health Clinicians fee schedule (footer section)

H0046	Mental health service nos		MPH	19.6	7/1/2016	12/31/2299	Y
H2014	Skills Training and Developme		MPH	13.57	2/1/2016	12/31/2299	Y
T1016	Case management		MPH	10.5	1/1/2012	12/31/2299	

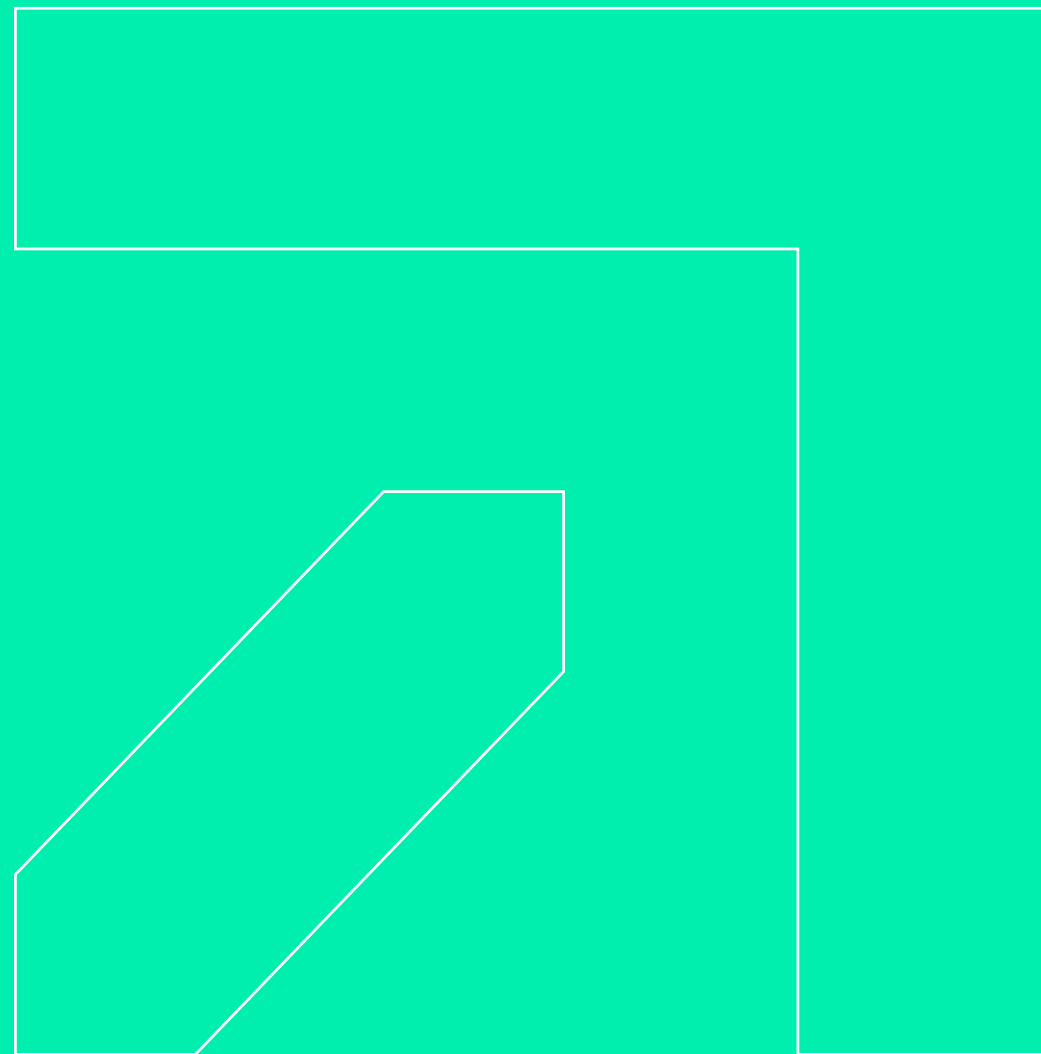
Please contact Beacon Health Options at 1-877-552-8247 for all prior authorizations							

Effective 10/1/2014 claims billed with facility type code (FTC) of 31 or 32 _____ will be paid at a unique rate and identified on the fee schedule with a _____ new rate type of FTD or FTM							

Effective 1/1/15; codes 0359T; H0031; H0032 and H2014 are covered for ages 0 -20. _____ Code 0359T can only be provided by the following providers: 33/115 or 86/115. _____ Codes H0031; H0032 and H2014 can all be provided by: 33/115; 33/119; 33/121; _____ 86/115; 86/119; or 86/121.							

For Procedure code 97153; Behavioral Health Clinicians are reimbursed 70% of the _____ Department's rate on file of \$16.07. When calculating the reimbursement rate _____ the system uses the following method \$16.07 X 70% = \$11.249; \$11.249 X # of _____ units billed.							

Attestations



Behavioral Health Attestation

- On July 6th, 2023, letters were sent in a phased approach rolling out the new required attestation process to all behavioral health providers. This attestation is required of all licensed, enrolled behavioral health providers (type 33) independently practicing or working under a behavioral health group, hospital, FQHC or clinic (if the provider only works for FQHC, hospital, or clinic they are exempt)
- The attestation is also required of behavioral health group (type 86) owners. The attestation requirement applies both to services rendered personally by an independently licensed behavioral health clinician (licensed psychologists, LCSWs, LMFTs, LPCs, LADCs) and also to services provided by an associate licensed behavioral health clinician (licensed master social workers (LMSWs), licensed marital and family therapy associates (LMFT-As), and licensed professional counselor associates (LPC-As) working within such clinician's scope of practice under the supervision of an applicable qualified independent licensed behavioral health clinician who is authorized under state law to supervise each applicable category associate licensed practitioner.
- This attestation confirms that the provider acknowledges and agrees to abide by the requirements set forth in applicable laws, regulations, the provider enrollment agreement, and other Connecticut Medical Assistance Program (CMAP) requirements.

Behavioral Health Attestation

- As a reminder: An e-Delivery account is required to receive the letters for this new requirement. Please refer to [PB2019-15](#) Implementation of Electronic Delivery of Letters - Replacement to the Mailing of Connecticut Medical Assistance Program Letters to sign up for your e-Delivery account.
- Prior to signing the attestation, providers are required to do one of the following tasks:
- Recorded training presented by Gainwell and Carelon. A link to the slides and training is available on the Carelon website after the live training has finished.
 - [Slides \(live link\)](#)
- Recorded training presented by Gainwell and Carelon [CT Medical Assistance Program Independent Practice Licensed Behavioral Health Clinicians Training \(vimeo.com\)](#) or review the slides and watch the taped training before signing and submitting the attestation.

Behavioral Health Attestation

EOB Denials

Non-compliance letters were issued on and after August 1, 2024, in a phased approach, notifying providers that their claims will be denied going forward until their attestation is completed. Claims denied due to attestation non-compliance will be denied for the following Explanation of Benefit (EOB) codes:

- 1043 BH Billing Provider Attestation Needs to be Signed
- 1046 BH Rendering Attestation Needs to be Signed
- 1047 BH Billing Provider Attestation not valid on claim date of service
- 1059 BH Rendering Attestation not valid on claim date of service

Behavioral Health Attestation

Check your providers! Unattested Behavioral Health Clinician Report

- In support of this attestation requirement, DSS and Gainwell Technologies created a report of clinicians who have not completed the required attestations. This is especially helpful for Behavioral Health Groups to verify their providers' status and completion of their attestations. Behavioral health groups can utilize the filter to search their Group AVRS ID(s) to obtain a list of affiliated performing providers who have not attested. An individual provider may review their own AVRS ID to verify their own status as well. This report updates every Monday afternoon.
- To access the report, providers must log in to their Secure Web Portal. To review the report, from the Home Page, please select the “Unattested Behavioral Health PT 33 Provider List” link located in the Quick Link section. The Quick Link section can be found on the right side of the Home Page after you sign in (screen shot below).



Behavioral Health Attestation

Attestation Summary Page

Behavioral Health Attestation Summary

This panel provides a current summary of the submitted Behavioral Health Attestation(s) for the clinician and/or owner(s) associated to the NPI and AVRS ID listed below:

Provider Name: LE [redacted]
NPI: [redacted]
AVRS ID: 00802 [redacted]
Initial Letter Notification Date: [redacted]

Overall Attestation Status: Complete

(If no Initial Letter Notification Date, letter has not yet been sent but attestation may still be submitted at any time.)

- If the Overall Attestation Status above is 'Complete' no further action is required. The clinician and/or all applicable owner(s) have signed the Behavioral Health Attestation. You may Exit the wizard now.
- If the Overall Attestation Status above is 'Incomplete' then the clinician and/or owner(s) with this status must still complete this Behavioral Health Attestation Wizard. See the Attestation Status field for the Type of Submitter(s) listed below. (if all are complete no further action is needed, the Overall Attestation Status will be updated the next day).
- Based on either your organization affiliation and/or your service location of record with CMAP, if the Overall Attestation Status above is 'Optional' no further action is required. You may exit the wizard now or proceed with the attestation.
- If the Overall Attestation Status above is 'Claims Denied' then the clinician and/or owner(s) have not completed this Behavioral Health Attestation Wizard with in the required 75-day time-period from the Initial Letter Notification Date above and claims will be denied until all attestations have been completed for any clinician and/or owner below with an Attestation Status of Incomplete. **Once all attestations are completed claims will pay.**

Type Of Submitter	Name	Attestation Status
Clinician	[redacted]	Complete
Owner	[redacted]	Complete
Owner	[redacted]	Complete

Exit

This is an important tool for BH Groups to verify their owner's attestation status. The Master User for the Group must confirm that all owners on file have completed individual owner attestations for their BH Group.

Attestation Web Account Set-up

Information Required for Account Set Up

As a new provider, you should have received your log-in information via your enrollment confirmation. Web and AVRS PIN letters arrive separately.

If you have never set up your Web Account and do not have the letters mentioned above, you will need to contact the Provider Assistance Center at 1-800-842-8440.

AVRS ID / Initial Web User ID

AVRS PIN / Web PIN

- You will need to have the Initial Web User ID and Web PIN on hand when you first access the Secure Site.

Web Account Welcome Page

www.ctdssmap.com/

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit Verification

home site map about

Information

- Publications
- Links
- Important Information
- RA Banner Announcements
- HIPAA
- Regional Office Locations

Provider

- Provider Services
- Provider Search
- Provider Enrollment
- DOS Instructions/Information
- Fingerprint Criminal Background Check Info
- Provider Training
- Secure Site

Trading Partner

- Trading Partner Enrollment
- Trading Partner Documents
- Provider Electronic Solutions Billing Instructions

Pharmacy

- Pharmacy Information

Email Subscription

- Register/Update Email Subscription

Electronic Visit Verification


- EVV Implementation Overview


Site Details


- Site: B


WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM Web site, PROVIDED BY GAINWELL TECHNOLOGIES ON BEHALF OF THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES. THIS SITE PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM. THIS SITE CONTAINS WEALTH OF RESOURCES FOR PROVIDERS INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REGULATIONS, PLUS INFORMATION ON ELECTRONIC DATA INTERCHANGE AND THE AUTOMATED ELIGIBILITY VERIFICATION SYSTEM.

Information 

Provider 

Trading Partner 

Pharmacy 

Important Messages

[Hospital Monthly Important Message \(Posted 9/16/24\)](#)

[Attention Family Planning Clinic, School Based Health Clinic, Ambulatory Surgical Center, Rehabilitation Facility, Medical Clinic, Medical FQHC & Tribal Services Medical \(FQHC\), Behavioral Health Clinic, and Enhanced Care Clinic \(ECC\) Providers: Recent Recoupment of Claims \(Posted 9/13/24\)](#)

[Attention Home Health Providers, Acquired Brain Injury \(ABI\), Autism, Connecticut Home Care \(CHC\), Mental Health \(MH\), and Personal Care Assistant \(PCA\) Waiver Service Providers: URGENT Transition from Sandata Mobile to Sandata Mobile Connect effective September 4, 2024 \(Posted 8/27/24\)](#)

[Attention Home Health Care Agencies and Access Agencies providing home services and supports to Medicaid members: In-Home Safety Enhancements Updates \(Posted 8/21/24\)](#)

[Attention Board Certified Behavioral Analysts, Behavioral Health Clinics, Rehabilitation Clinics, Medical Clinics, School-Based Health Clinics, Outpatient Hospitals, Physicians, Physician Assistants, Advance Practice Registered Nurses, Psychologists and Behavioral Health Clinician Providers: Reimbursement Rate Increases for Select Behavioral Health Services for Children \(Posted 8/20/24\)](#)

[Attention Home and Community Based Services \(HCBS\) Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments \(VBP\) \(Posted 8/19/24\)](#)

[Attention Home Health Providers: Claim Denials for Electronic Visit Verification \(EVV\) Mandated Non-Waiver Home Health Services \(Posted 8/19/24\)](#)

[Attention Home Health Agency \(HHA\) Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments \(VBP\) \(Posted 8/19/24\)](#)

[Attention Home Health Care Agencies and Access Agencies providing in home services and supports to Medicaid members: Applications for In-home Safety enhancements will be available beginning 08/07/2024 \(Posted 8/5/24\)](#)

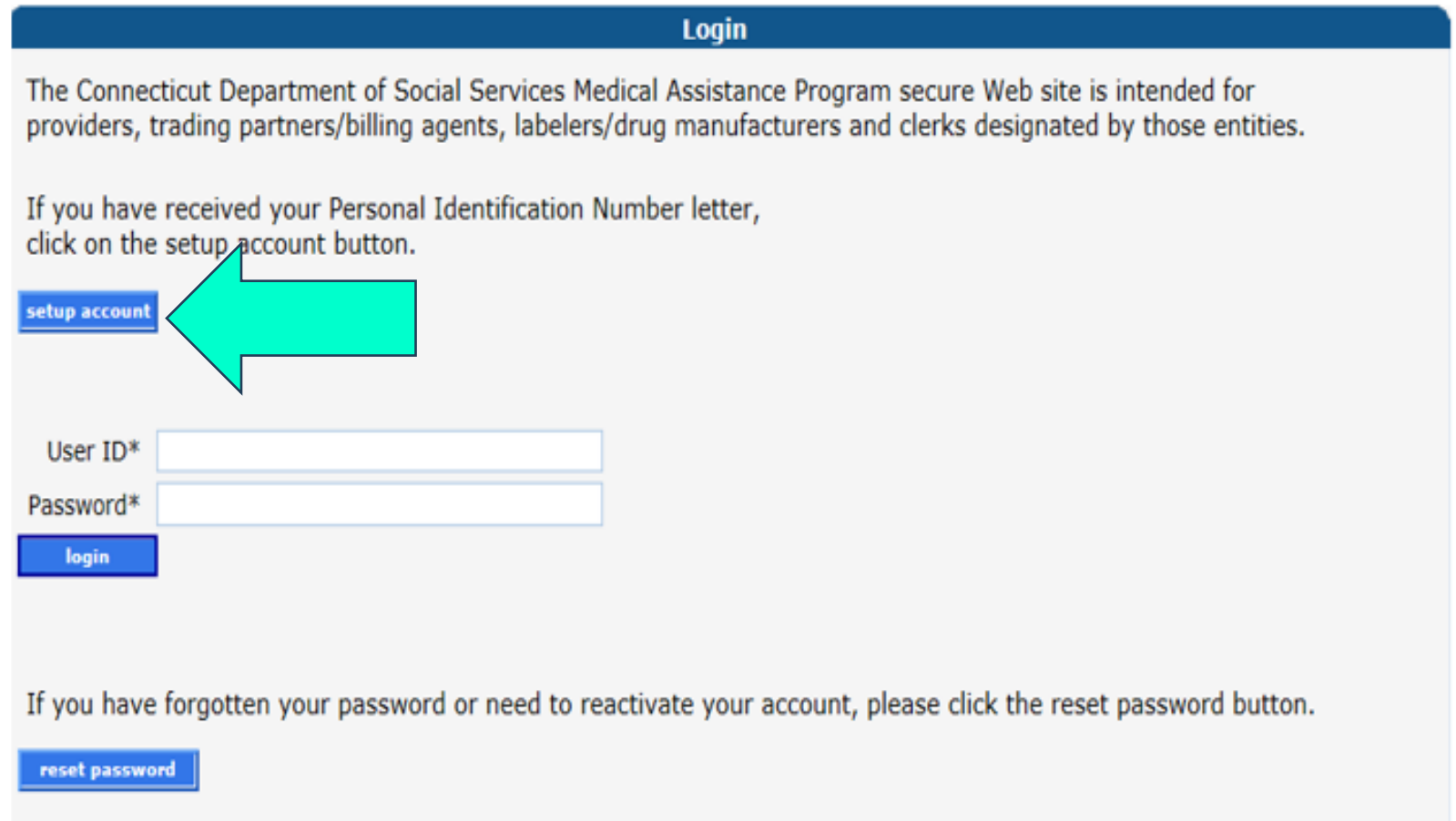
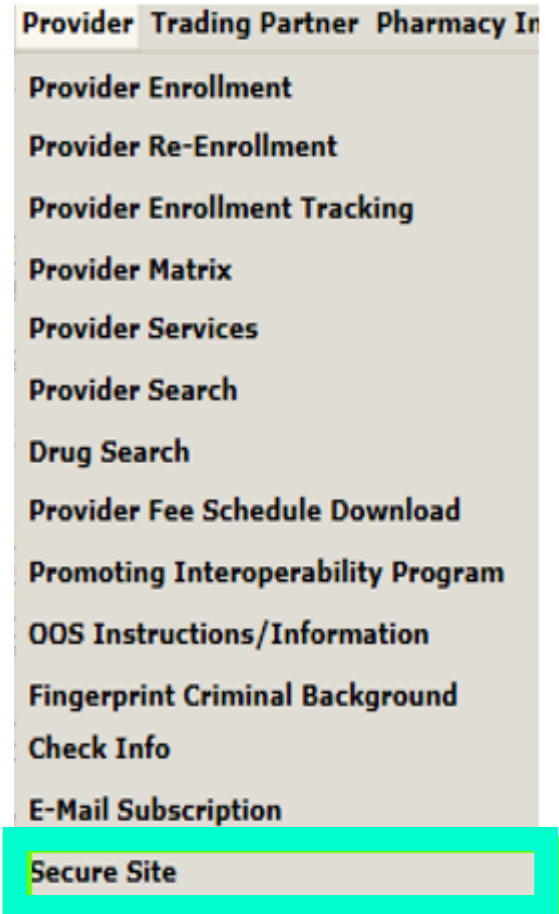
[Attention CTBHP Behavioral Health Providers Enrolled in Independent Practice and Group Practices, Psychologists, Licensed Marital and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Alcohol and Drug Counselors: REMINDER Attestation Completion Deadline is August 1, 2024, for Behavioral Health Groups and Clinicians \(Posted 7/31/24\)](#)

[Attention Outpatient Hospitals: CMAP Addendum B Updated \(July 1, 2024\) \(Posted 7/24/24\)](#)

Web Account Set Up

Setting Up Your Secure Site Account

Select “Secure Site” from either the Provider panel on the left or the Provider drop-down menu. Click “setup account”.



Web Account Set Up

Enter the provided Initial Web User ID/AVRS ID and PIN in the appropriate fields; click “setup account”.

This will allow you to create a unique user ID and password once initial set up is completed.

Account Setup

Initial Web User ID* 001111111

Personal Identification Number* AB12C3de4

Please note User ID and Personal Identification Number are case sensitive.

Click [here](#) to find answers to the most frequently asked questions (FAQs) regarding Web account set up.

setup account

Web Account Set Up

On the Account Setup screen, fill in the fields with the appropriate information.

Before clicking submit, be sure to write down the chosen User ID, Password, and secret question(s) and answer(s) and keep them in a secure location.

***** Your User ID can NEVER be changed. It is suggested you choose a generic username related to your practice/agency.*****

Passwords expire after 60 days and will need to be reset if it becomes inactive and/or expires

The screenshot shows a web account setup form with the following fields and annotations:

- Top left: "Click [here](#) to find answers to the most frequently asked questions (FAQs) regarding Web account set up." The word "here" is enclosed in a red box, and a red arrow points to it from the right.
- Top right: "Click 'here' for help to Web account set-up questions." A red arrow points to the left towards the "here" link in the text above.
- Below the top text: "Required fields are indicated with an asterisk (*)." followed by a list of fields: User ID*, Contact Last Name*, Contact First Name*, Phone Number*, 1st Secret Question*, 1st Answer*, 2nd Secret Question*, and 2nd Answer*.
- Right side of the form: Password*, Confirm Password*, EMail*, and Confirm EMail*.
- Bottom right: "Complete the fields, read the security agreement and click the 'I agree' box prior to hitting the submit button." in red text.
- Bottom left: "Security Agreement" section with a scrollable text area containing legal terms and a checkbox labeled "I Agree" which is enclosed in a red box.
- Bottom right: "submit" and "cancel" buttons, with the "submit" button enclosed in a red box.

Web Account Set Up

You have successfully set up your www.ctdssmap.com Secure Site account. Proceed to the Behavioral Health Attestation Page and complete your attestation.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit Verification Claims Eligibility Prior Authorization Hospice Trade Files
Messages **Behavioral Health Attestation** Account Portal Admin

password expires in 60 day(s) on 00/00/0000 at 00:00 [Change Password](#)

Welcome, **Provider Account User ID**
Provider ID **Enrollment NPI or AVRS**

Reenrollment Due Date: **05/01/2024** ★ ★
Zip Code: 06226 - 3606

Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Quick Link

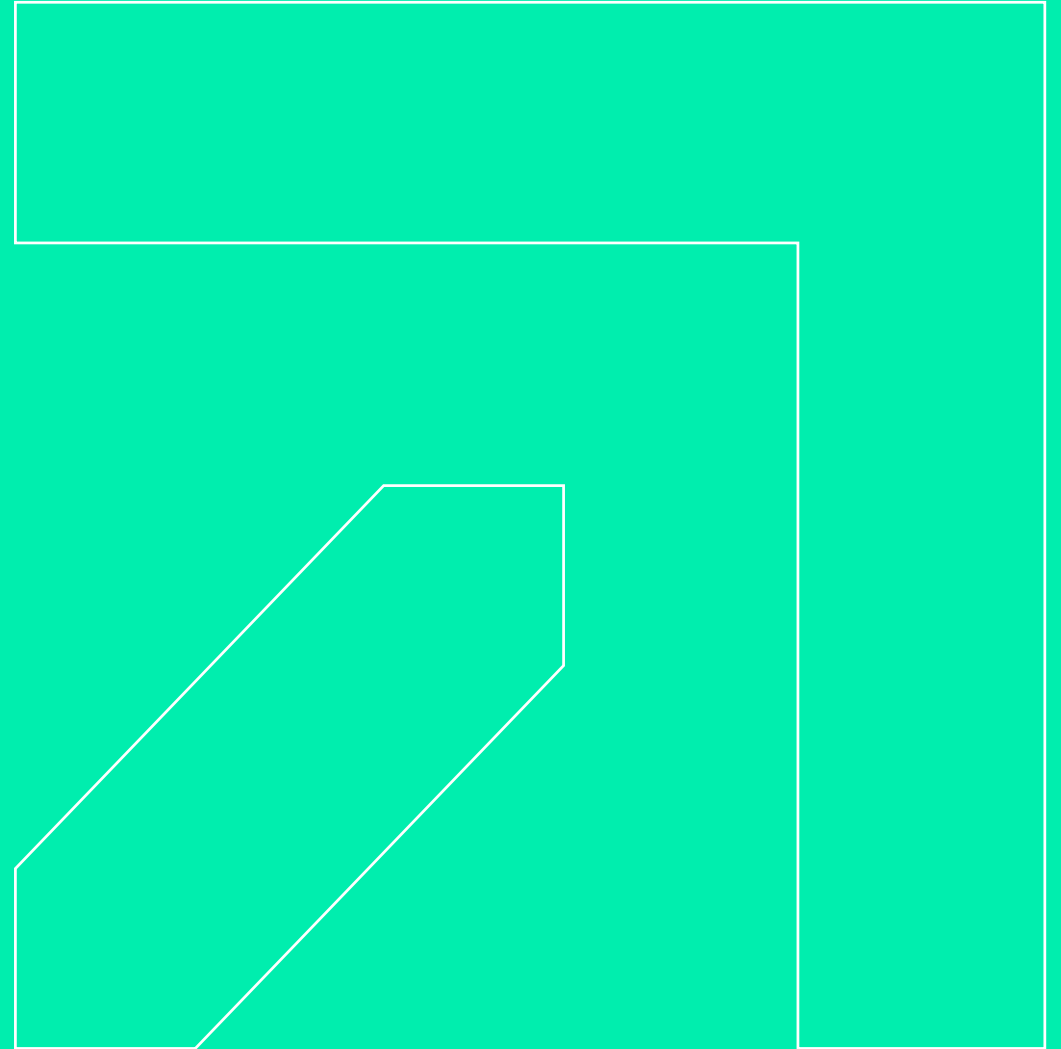
- [Check E-messages](#)
- [Claim Status Inquiry](#)
- [Client Eligibility Verification](#)
- [Prior Authorization Inquiry](#)
- [Download Remittance Advices](#)
- [ACA Ordering/Prescribing/Referring Provider List](#)

Email Subscription

- [Register/Update Email Subscription](#)

****Please Note: Please keep an eye on your re-enrollment due date. Re-Enrollment due dates are very important because if you do not get your re-enrollment in by the due date you will be disenrolled and you will not be able to submit claims for payment for dates of service beyond that date.**

Provider Bulletins and Important Updates



Provider Bulletins

Access the Publications page by selecting Publications from either the Information box on the left-hand side of the home page www.ctdssmap.com or from the Information drop-down menu.

Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type.

- When searching by provider title, you can search by any word as long as that word is in the title of the bulletin.



home **Information** Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit Verification
home **publications** links hipaa messages archive



Information

Bulletin Search	
Year	23 ▾
Provider Type	Behavioral Health Clinician ▾
Number	<input type="text"/>
Title	covid <input type="text"/>

		Search Results
Bulletin Number ▾	Title	Published Date
PB23-32	Discontinuation of the Optional COVID-19 Testing Group - Effective May 12, 2023	04/13/2023
PB23-31	Sunsetting Provider Bulletins Issued in Response to the COVID-19 Public Health E...	05/02/2023

Important Updates for Behavioral Health

- [PB 2024-39](#) - Effective for dates of service July 1, 2024, and forward, DSS has increased the reimbursement rates of select behavioral health services (including family therapy services) for HUSKY Health members ages, 20 years old and under.
- The applicable behavioral health fee schedules will be updated in the near future.
- SUD Residential Providers Certification Letter Upload Instructions - [Important Message](#)
- BCBA Licensure Requirement for Enrollment in Connecticut Medical Assistance Program – [Important Message](#)

Important Updates for Behavioral Health

- [PB 2025-30](#) - Updates to Autism Spectrum Disorder Services
- [PB 2025-48](#) - Performing providers **required** for Behavioral Health FQHC's. Non enrolled providers must enroll.
- [PB 2025-49](#) – Claim submissions of services provided by a non-licensed provider

• PB 2025-30 - Updates to Autism Spectrum Disorder Services

- Effective for dates of services, July 1, 2025, and forward, the Department of Social Services (DSS) will be adding the following procedure codes to the Autism Spectrum Disorder (ASD) fee schedule

Procedure Code	Modifier	Description	Prior Authorization Required
97156		Parent Training without Child	Yes
97156	U2	Parent Training with Child	Yes
T1016		Case Management, 15 minutes	Yes, after 96 units/24 hours

- 97156 (U2) - Parent Training and Parent Training with Child, should only be billed for the training and transferring of skills to the parents of a HUSKY Health member with an Autism diagnosis. **Up to 4 hours** per week, no rolling over.
- T1016 - Case Management, 15 minutes should be billed for the provider's attendance at any Planning and Placement Team (PPT) meetings, discharge planning, etc. for a HUSKY Health member with an Autism diagnosis. First 24 hours are without auth.

Important Updates for Behavioral Health

- [PB 2025-49](#)
- If you choose to include the non-licensed provider on the claim, they must have an NPI, and it should be entered in the **rendering physician** field on the claim.
- The non-licensed provider can be billed as the rendering provider if they are enrolled under National Plan and Provider Enumeration System (NPPES) and have a valid National Provider Identifier (NPI) and behavioral health taxonomy.
- The supervising provider that is supervising the non-licensed provider needs to be entered under the supervising provider field.

Rendering provider's NPI should be entered into the following sections of an electronic claim:

837P – Health Care Claim Professional

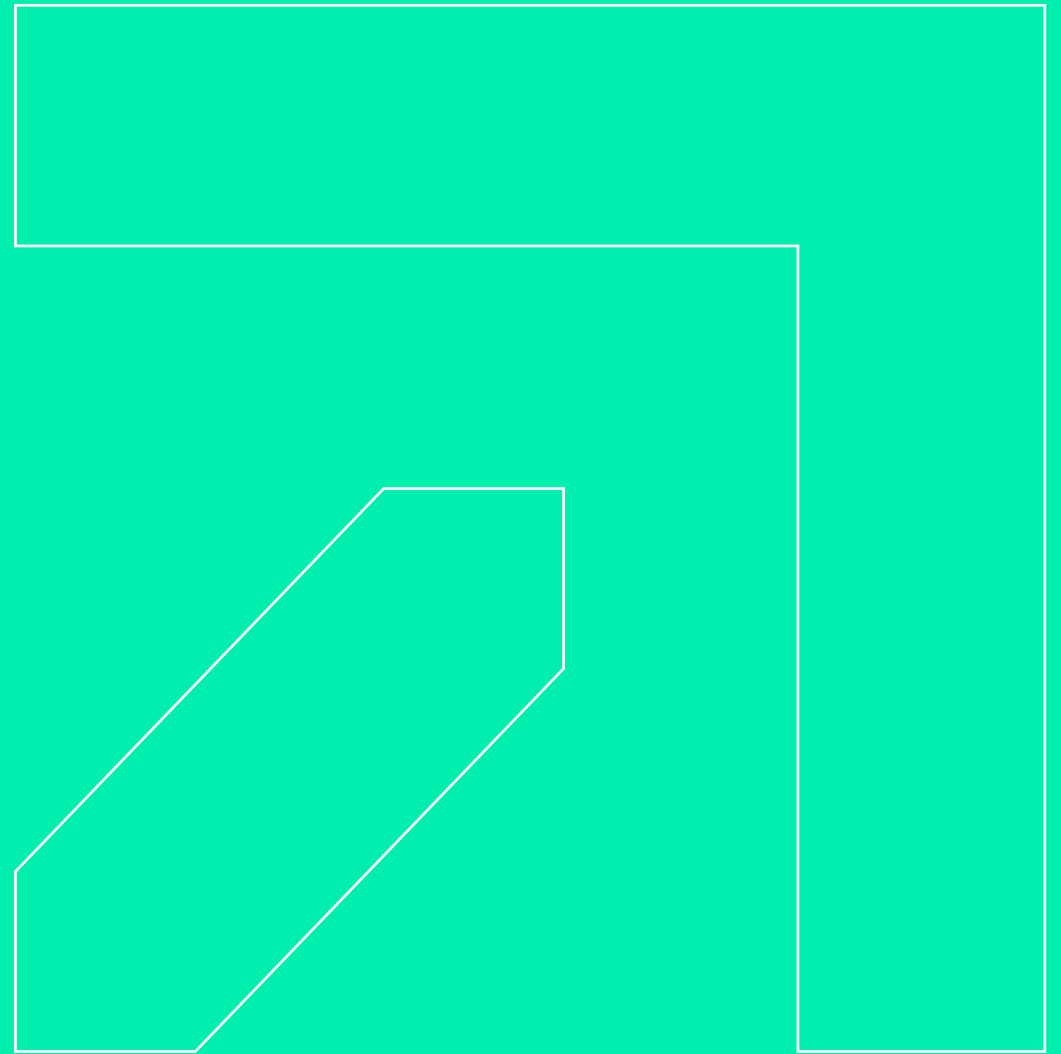
- NPI Segment ID = NM109
- NPI Loop ID = 2420
- Qualifier = 82

Supervising provider's NPI can be entered into the following sections of an electronic claim:

837P – Health Care Claim Professional

- NPI Segment ID = NM109
- NPI Loop ID = 2420D
- Qualifier = DQ

Telehealth



REVISED Guidance for Services Rendered via Telehealth

PB 2023-38 and

- Providers must adhere to the following guidelines when billing telehealth services
 - In a method as determined by providers, informed consent must be obtained in writing (electronic consent is acceptable) from each HUSKY Health member before providing telehealth services and annually thereafter. DSS is not requiring the use of a specific form and providers may use their own form or format for obtaining informed consent. In addition, the provider must ensure each HUSKY Health member is aware they can optout or refuse telehealth services at any time.
 - If the HUSKY Health member is a minor child under age 18, a parent or legal guardian must be present for services to the same extent as it would be required for comparable in-person services unless exempted by state or federal law. In addition, informed consent for telehealth services must be obtained by the parent or legal guardian prior to the provision of such services and obtained annually thereafter Providers must develop and implement procedures to verify provider and patient identity.

PB 2024-78 - Updates to Telehealth – January 2025 Updates.

Telemedicine Services

Telehealth Information tab

- [CMAP Telehealth Table](#)

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization **Telehealth Information** Electronic Visit Verification

Telehealth Overview

In accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, the Department of Social Services (DSS) provides reimbursement for select services when performed via telehealth under the Connecticut Medical Assistance Program (CMAP). Telehealth services include synchronized audio-visual (telemedicine) two-way communication services and, where specified by DSS, audio-only two-way synchronized communication services delivered via telephone. In developing the CMAP Telehealth policy, DSS consulted with practicing clinicians to determine clinically appropriate policy, limitations and criteria. DSS' telehealth policy was developed to support the HUSKY Health member's ability to access clinically appropriate, clinical effective services while maintaining the highest quality of care. The health, safety, and experience of the HUSKY Health member are central drivers of CMAP's policy. Notwithstanding federal or state statutes, the Department reserves the right to update and/or amend the telehealth policy going forward based on relevant research on this topic and/or based on feedback the Departments solicits from HUSKY members and providers.

This web page has been developed for providers to refer to for the latest telehealth updates including, Important Messages (IMs), Frequently Asked Questions (FAQs), and the CMAP Telehealth table, which provides a complete list of procedure codes approved to be rendered via telehealth. Providers are encouraged to monitor this Web page for updates. DSS will publish IMs to notify providers if updates are made to the Telehealth Table. Providers must also refer to PB 2023-38: Revised Guidance for Services Rendered via Telehealth for additional telehealth guidance. All provider bulletins, fee schedules and FAQs can be found on the CMAP Web site, www.ctdssmap.com. Providers should carefully review CMAP's Telehealth Table for the full list of approved procedure codes and, when applicable, the Revenue Center Codes (RCCs), that are eligible via telehealth. Only the codes listed on the table are allowed to be provided via telehealth. Therefore, if a code is NOT listed on table, the code is NOT eligible for payment when rendered via telehealth. Providers must refer to the Effective Date/End Date and Policy Guidelines columns detailing any specific policy criteria and/or limitations for each procedure code. Please see the bottom of Telehealth Table for proper use of modifiers for telehealth services. Providers should refer to this table periodically to ensure use of the most recent version. Providers must continue to refer to their applicable reimbursement methodology and/or fee schedule to ensure that the service identified as being eligible to be rendered as a telehealth service is payable for their specific provider type and for the reimbursement rate.

[CMAP Telehealth Table](#)

[Telehealth FAQ](#)

Quick Login

User ID*

Password*

[Login](#)

[Logging in for the first time?](#)

[Forgot your password?](#)

Helpful Information & Publications

- [Provider Bulletins and Policy Transmittals](#)
- [Provider Training](#)
- [Provider Manuals](#)
- [CT Provider Fee Schedule](#)

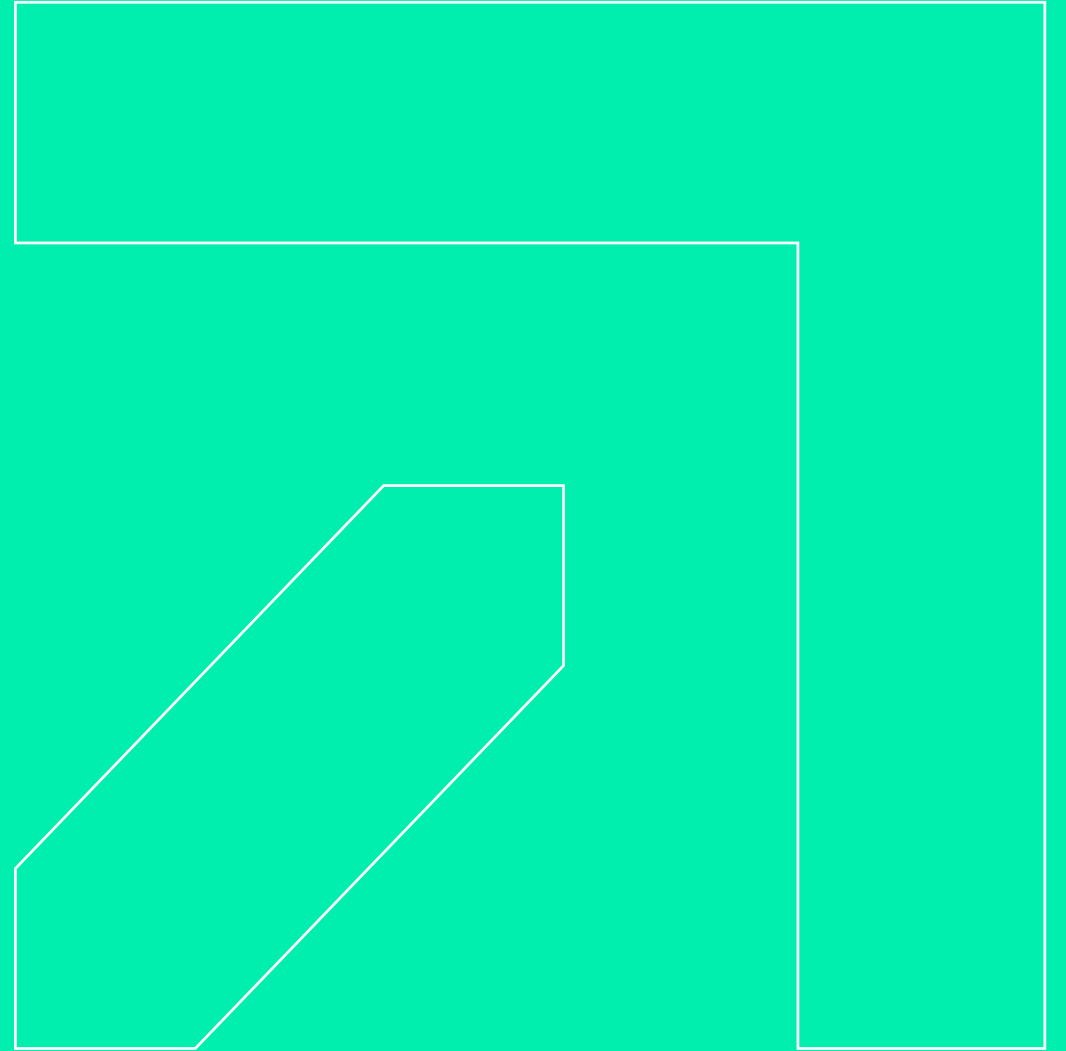
Contact Us

- toll free at 1-800-842-8440
- 1-877-413-4241 (fax)

Email Subscription

- [Register/Update Email Subscription](#)

FAQs



Frequently Asked Questions

- **Can a provider be located out of state and provide services to Medicaid members via telehealth?**
 - An enrolled CMAP provider located out of state or in a border state must maintain an approved service location to perform eligible telehealth services even when the practitioner is not physically in person at one of the enrolled CT or border service locations at the time of service, so long as the provider remains in CT or the border state, or in the limited case of an approved out of state service that is not available in CT and comply with all state and federal regulations
- **Can two different providers bill for a services on the same day for the same member?**
 - Yes. If services were provided to the same member by different providers, that is allowed to be billed.

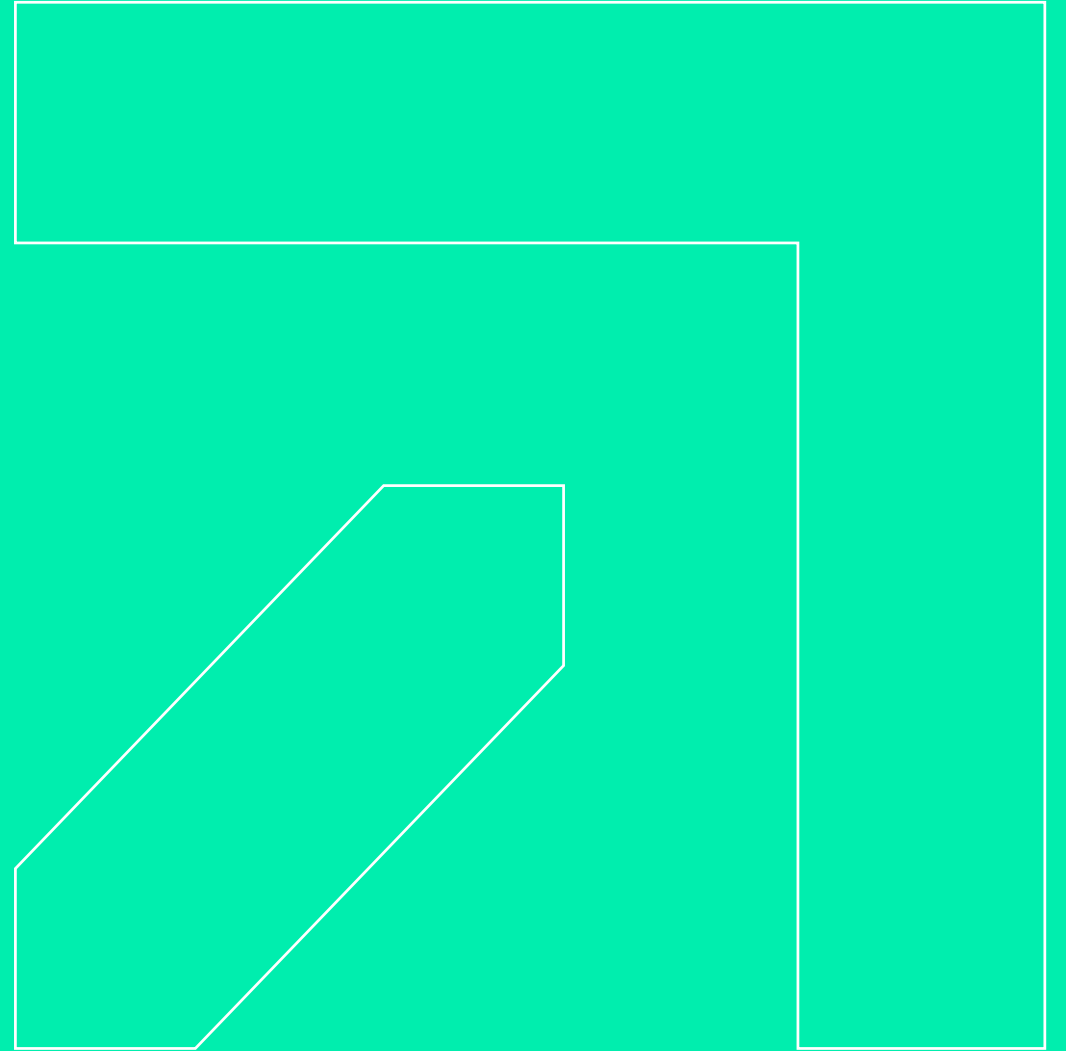
Frequently Asked Questions

- **Can a family and individual therapy session be billed on the same day? Can IOP and individual therapy be billed on the same?**
 - a. Yes, family and individual therapy can be billed on the same day as they are distinct services.
 - b. Yes, individual therapy and IOP can be billed on the same day as they are distinct and separate services.
- **Where can I find the billable procedure codes?**

Billable procedure codes are available at www.ctdssmap.com under Provider, then selecting Provider Fee Schedule Download. Scroll to 'I accept' at the bottom of the page, Behavioral Health Clinicians fee schedule is available as Behavioral Health Clinician CSV.
- **When should treatment plans be updated?**

Treatment plans should be updated at least every six months to accommodate the needs of the member and documented progress. Updates include new detailed information added pertaining to treatment, frequency, goals and objectives.

Resources



Resources

CTDSSMAP Web Site/Secure Web Portal:

www.ctdssmap.com

Provider Manual:

Chapter 7: Specific Policy/Regulation

Chapter 8: Provider Specific Claims Submission Instructions

Chapter 10: Web Portal/AVRS

Chapter 11: Other Insurance and Medicare Billing Guides

Chapter 12: Claim Resolution Guide

[CT GOV Website](#)

[CHN](#)

[Carelon Behavioral Health](#)

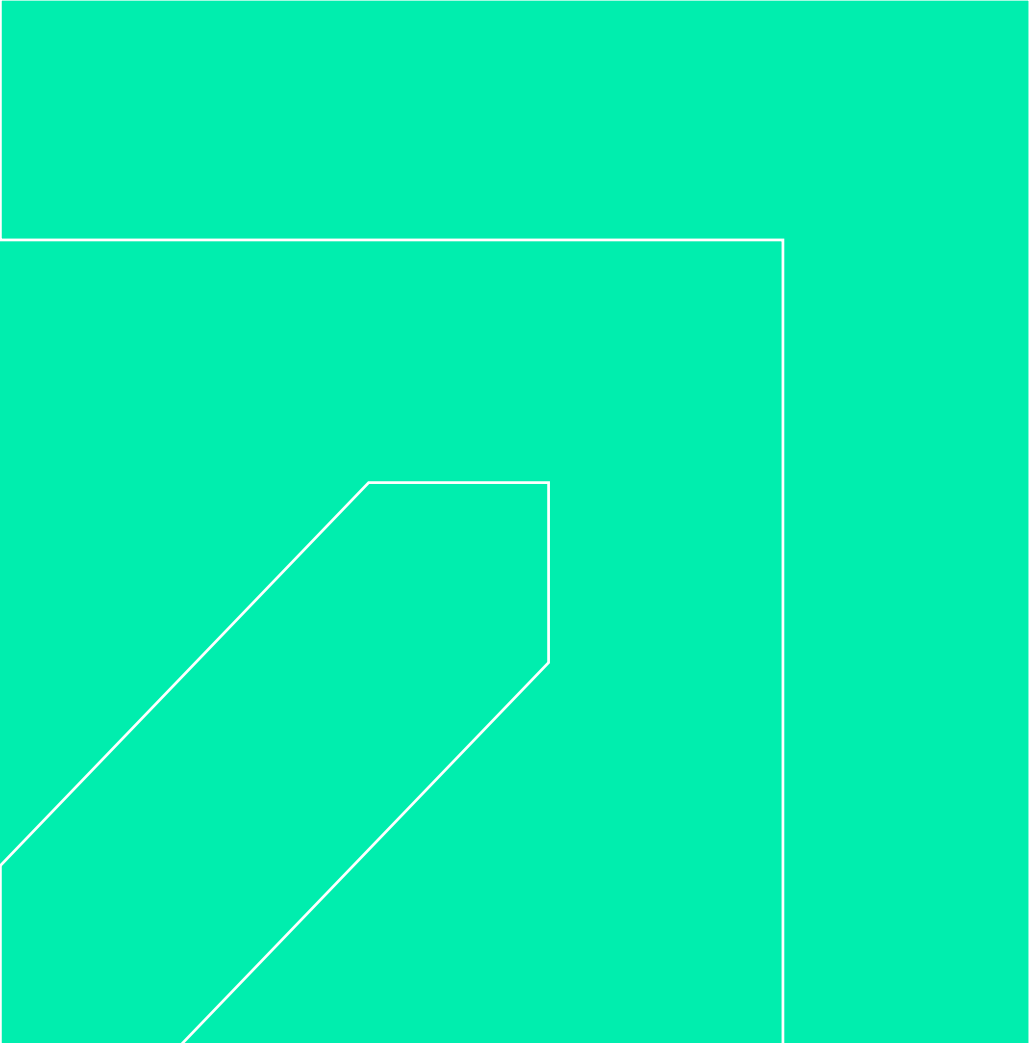
[CMS Medicaid NCCI Edit Files](#)

[Internet Claims FAQ](#)

[DSS Audit Protocols](#)

[Eligibility Response Quick Reference Guide](#)

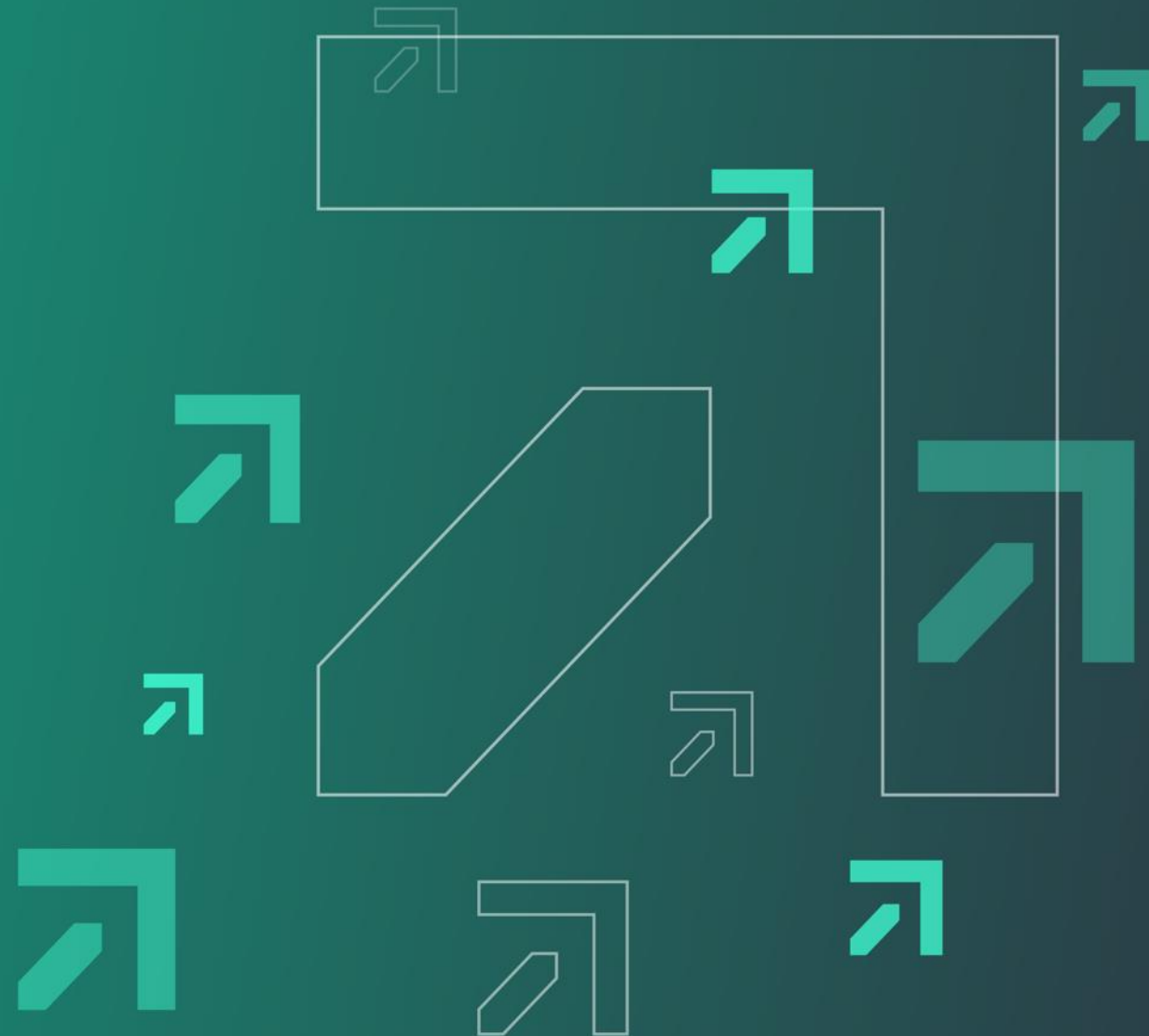
Contacts



Contacts

- **Gainwell Technologies Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
 - CTDSSMAP
 - ctdssmap-provideremail@gainwelltechnologies.com.
 - **Gainwell Technologies Pharmacy Prior Authorization Assistance Center (PPAAC)**
 - 1-866-409-8386 – In the office Monday thru Friday, 7:00 AM – 9:00 PM (EST), and Saturday, 9:00 AM – 4:00 PM (EST), on-call service available outside of office hours.
- **Gainwell Technologies Electronic Data Interchange (EDI) Help Desk**
 - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
- **Carelon**
 - 1-877-552-8247– Monday through Friday, 9 a.m. to 7 p.m. (EST)

Thank you!



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