Connecticut Medical Assistance Program Dental Refresher Workshop

Presented by
The Department of Social Services & DXC Technology

DXC Proprietary and Confidential

Training Topics

- 2020 Updates
- Provider Re-enrollment
- Demographic Maintenance
- Clerk Maintenance
- Client Eligibility
- Dental Fee Schedules
- Prior Authorization
- Program Limitations
- Web Claim Submission
- Provider Resources
  - Claim Resolution Guide
  - Provider Bulletins
  - Contact Information
- Time for Questions

August 20, 2020

2020 Updates

COVID-19 Updates for Dental Providers – 2020 Updates

The Department of Social Services (DSS) is temporarily changing the prior authorization (PA) requirements for specified services effective for dates of service April 1, 2020 until DSS has notified providers that the state has deemed COVID-19 to no longer be a public health emergency (the "Temporary Effective Period").

During the Temporary Effective Period, PA will be waived for the following dental procedures:

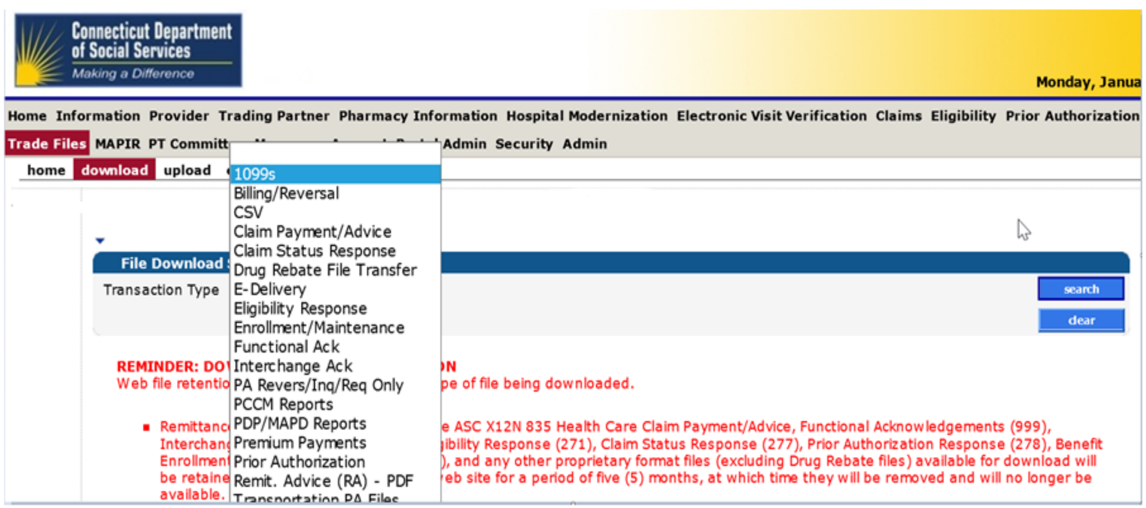
- D3310 Endodontic therapy, anterior tooth (excluding final restoration)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
- D3330 Endodontic therapy, molar (excluding final restoration)

Please refer to Provider Bulletin PB 2020-33 for further information.

1099s available on the secure Web portal – 2020 Updates

Providers are now able to download their 1099s from their secure portal on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com. The retention period for 1099s on the secure Web portal account is three (3) years. The functionality to download the 1099s is available for all Master Users and any clerk accounts that have access to download PDF Remittance Advice files.

- Log into secure Web account from www.ctdssmap.com
- Select Trade Files >Download. Click on the 1099s selection located at the top of the drop-down menu and then click on Search.



Provider Re-enrollment

Provider Re-enrollment

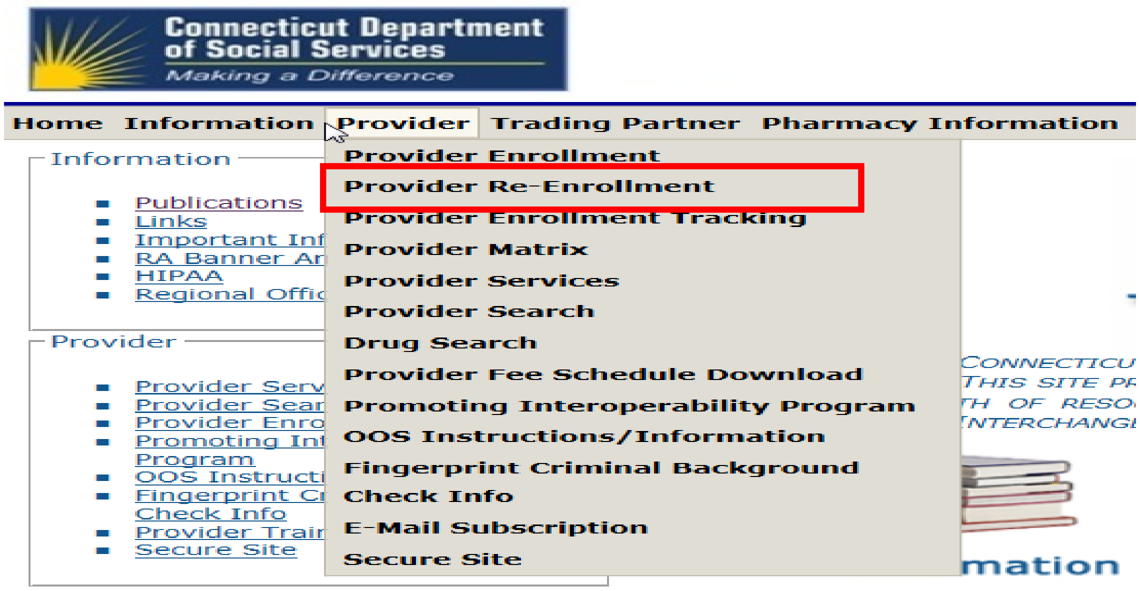
The Department of Social Services (DSS) requires dental providers to enroll / re-enroll on our Web site www.ctdssmap.com.

- A majority of the required information on a re-enrollment application 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 DXC Technology Provider Enrollment Unit. The notice with the ATN is either emailed to the provider's contact email on file or mailed, if the provider has not established a secure Web account, to the provider's "Enrollment Address" on record six months prior to the re-enrollment date.

Provider Re-enrollment

Select *Provider Re-Enrollment* from the *Provider* drop-down menu.



Re-enrollment Period: Dental providers are required to **re-enroll every 2 years mandated by the federal regulations.**

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

Provider Re-enrollment

Re-enrollment Notification and Process:

- Dental providers will receive a reminder email/letter when they are due for re-enrollment six (6) months prior to the end of their current contract (Reference **Provider Bulletin 2014-52**).

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

- If the provider has not successfully re-enrolled three (3) months prior to the end of their current contract, another email/letter will be sent.

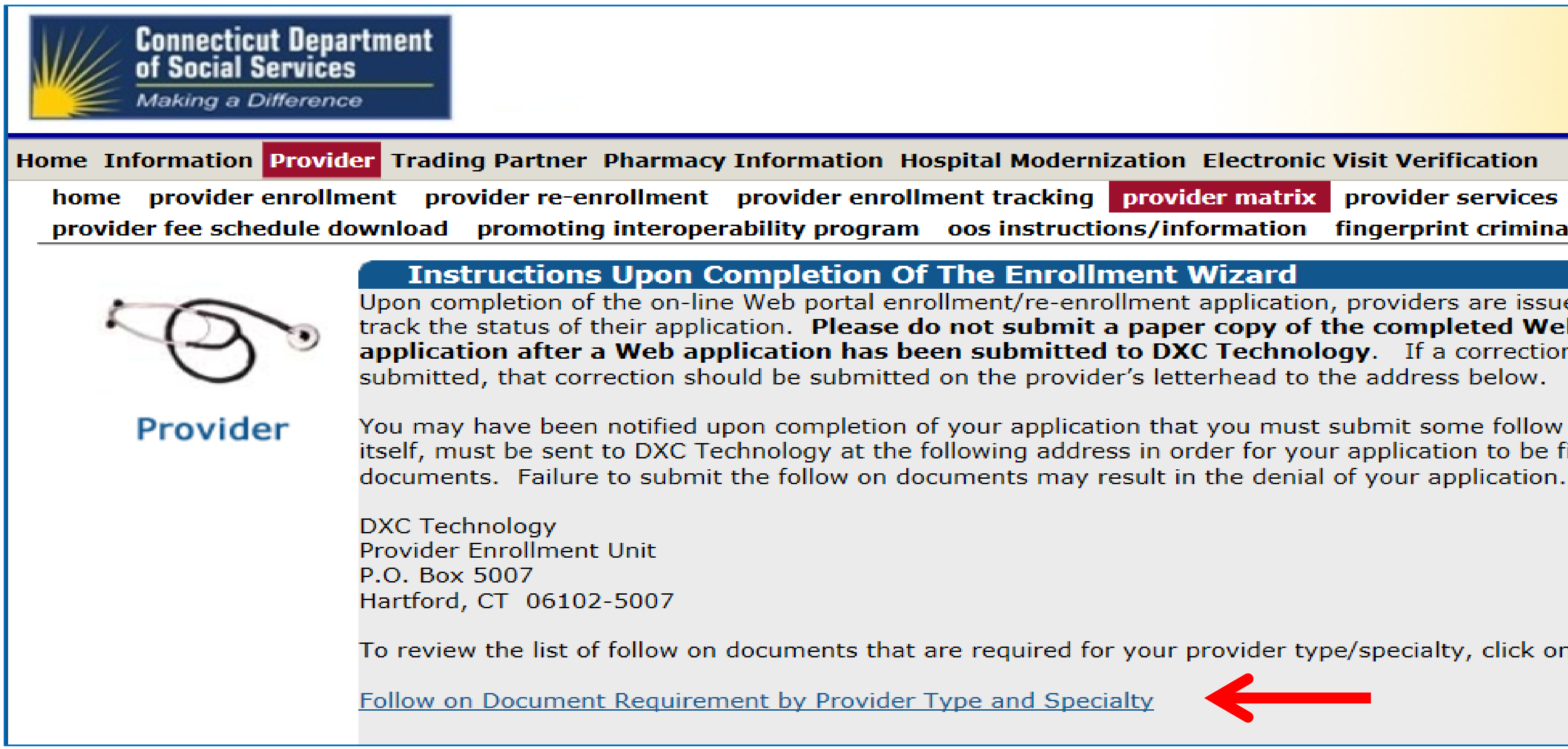
Provider Re-enrollment

Follow on Documents:

- Once the enrollment/re-enrollment application is submitted, providers are notified of any “follow on” documents that need to be mailed to DXC Technology’s Enrollment Unit.
- The document requirements vary by provider specialty.
- The enrollment/re-enrollment application is not considered complete until all the required documents have been received.
- **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.**

Provider Re-enrollment

Follow on Documents: Providers can access the follow on document requirements from www.ctdssmap.com by clicking Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty.



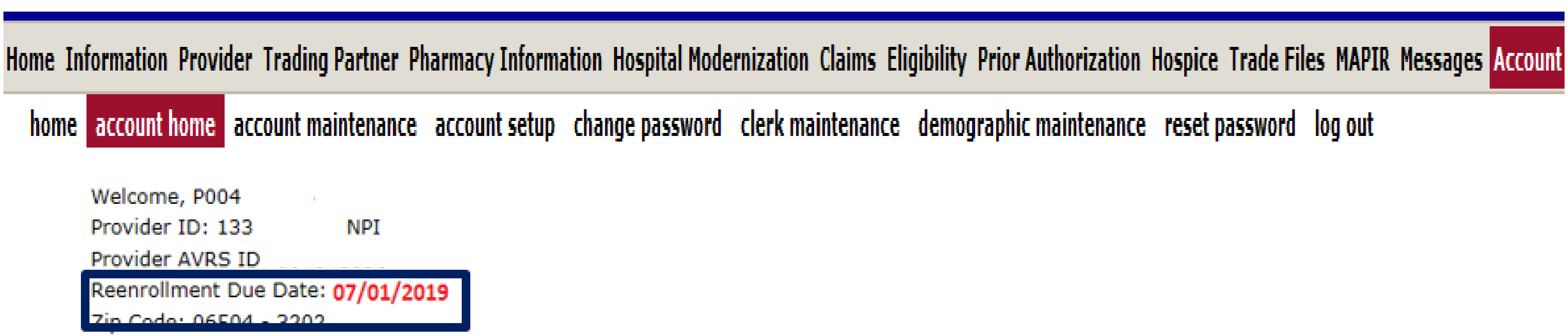
Provider Re-enrollment

Re-enrollment Due Dates:

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

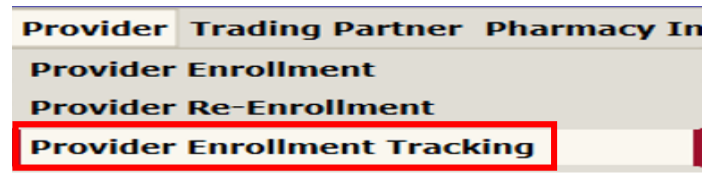
- Individual providers can view their re-enrollment due date on the Home page.
- Organizations can view their re-enrollment due date, as well as the re-enrollment due date of their members by accessing the "Maintain Organization Members" panel.

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

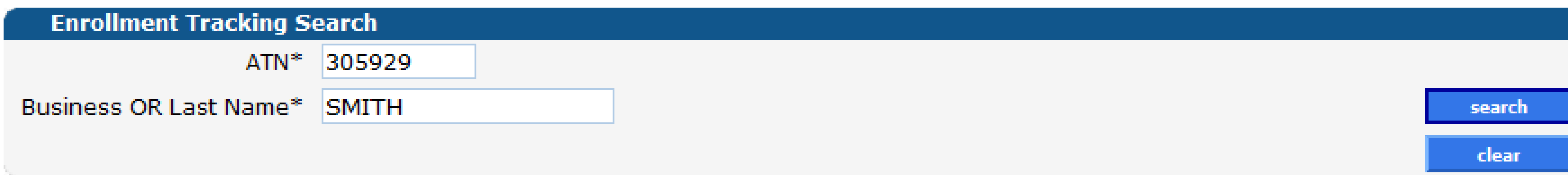


Provider Re-enrollment

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*



- In this example DSS is conducting initial review of the application that was received on July 31, 2020.

Search Results	
Date Received	Status
07/31/2020	DSS Conducting Initial Review

Provider 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 to which they belong.
- Each performer will 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 one address if the performing provider belongs to more than one group.
- Organizations/Groups can view the re-enrollment due dates of their members by accessing the “Maintain Organization Members” from the “Demographic Maintenance panel.”
- This feature allows organizations/groups to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Provider Re-enrollment
Adding Alternate Service Location Addresses

Billing providers can submit an application for the purpose of adding alternate service location(s) using the online Enrollment/Re-enrollment Wizard. (Reference **Provider Bulletin 2018-19**).

This functionality eliminates the need for providers to contact DXC Technology to first obtain an ATN.

A new alternate service location address application must be submitted when a provider is expanding the number of practice locations.

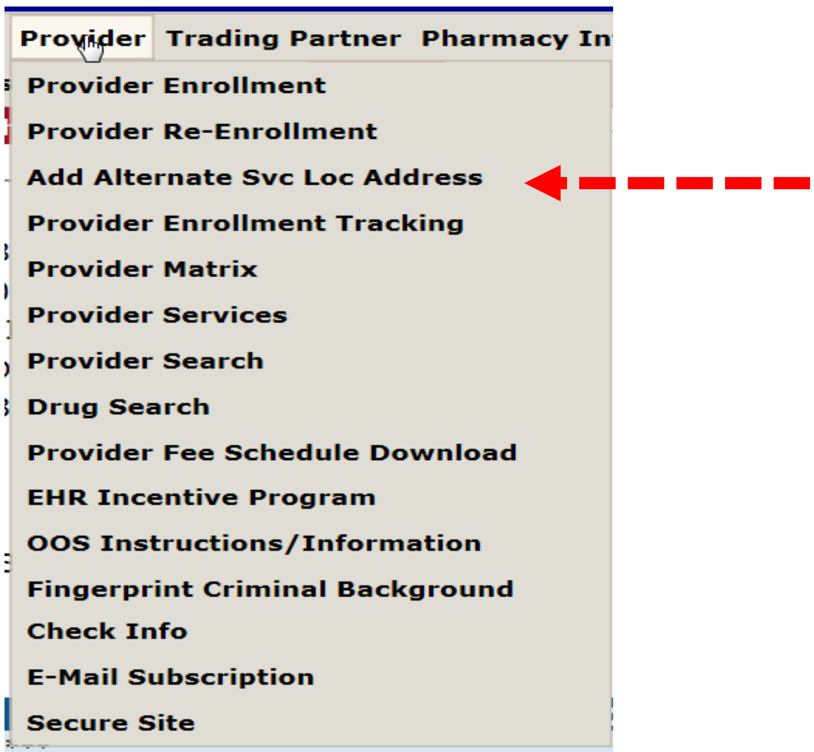
More than one new practice location may be submitted in one application.

Caution: Do not use this application to:

- Change an existing address(es) of a practice;
- Add a practice location to an Automated Voice Response System (AVRS) ID that already exists under another billing AVRS ID registered to that provider.

Provider Re-enrollment
Adding Alternate Service Location Addresses

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.



Provider Re-enrollment
Adding Alternate Service Location Addresses

Who can submit an Add Alternative Service Location Address application?

In addition to the provider (i.e. the master user) being able to submit this new application, a new clerk role, Submit Applications, has been created to allow providers/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.

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

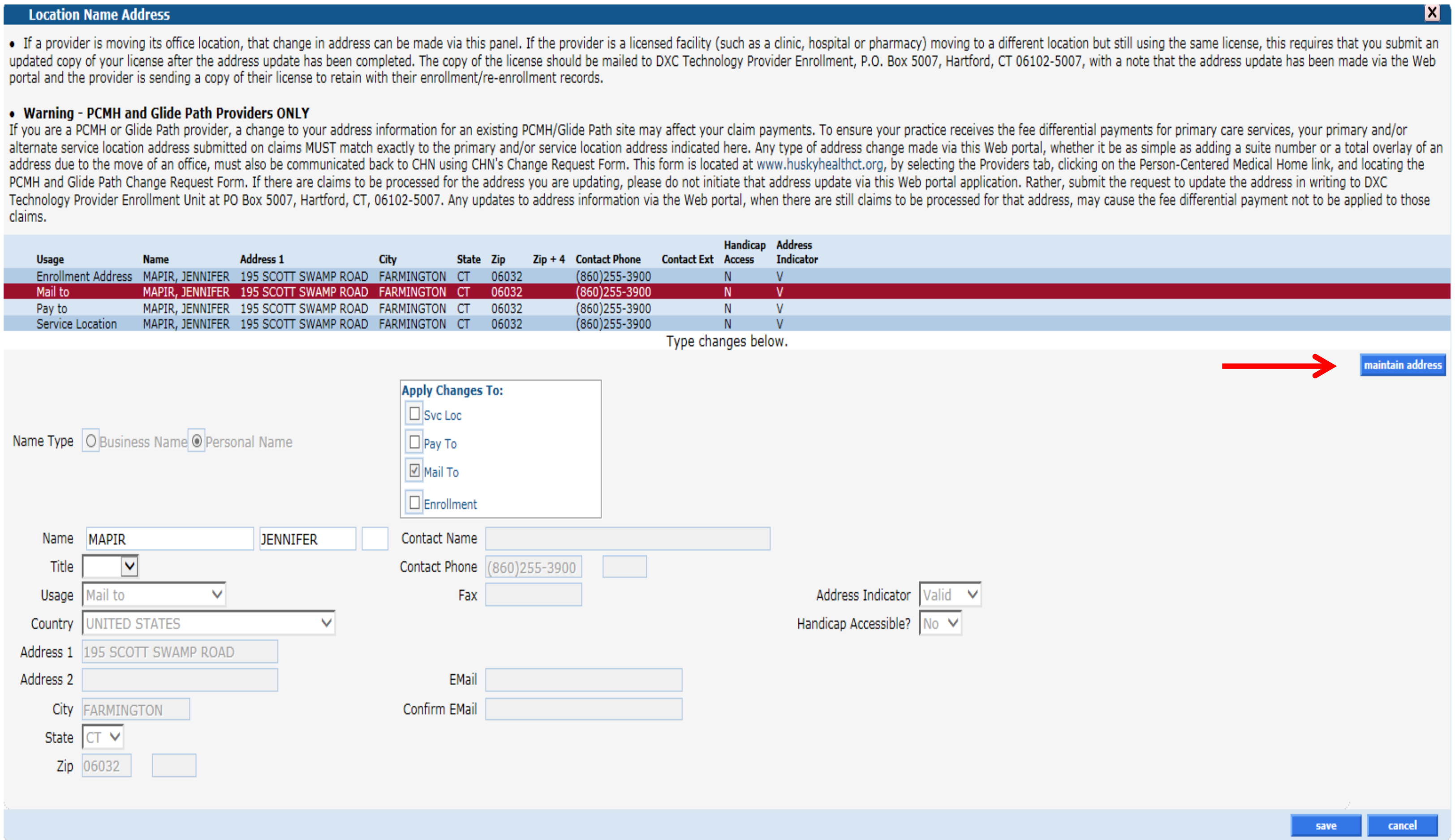
Demographic Maintenance

Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes **Provider Addresses, Electronic Funds Transfer (EFT) and Maintain Organization Members.** The main account administrator must log on to their account and click on the “Demographic Maintenance” tab. See Chapter 10 of the Provider Manual for more information.

Demographic Maintenance – Address Updates

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



Location Name Address

- If a provider is moving its office location, that change in address can be made via this panel. If the provider is a licensed facility (such as a clinic, hospital or pharmacy) moving to a different location but still using the same license, this requires that you submit an updated copy of your license after the address update has been completed. The copy of the license should be mailed to DXC Technology Provider Enrollment, P.O. Box 5007, Hartford, CT 06102-5007, with a note that the address update has been made via the Web portal and the provider is sending a copy of their license to retain with their enrollment/re-enrollment records.

- **Warning - PCMH and Glide Path Providers ONLY**

If you are a PCMH or Glide Path provider, a change to your address information for an existing PCMH/Glide Path site may affect your claim payments. To ensure your practice receives the fee differential payments for primary care services, your primary and/or alternate service location address submitted on claims MUST match exactly to the primary and/or service location address indicated here. Any type of address change made via this Web portal, whether it be as simple as adding a suite number or a total overlay of an address due to the move of an office, must also be communicated back to CHN using CHN's Change Request Form. This form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the PCMH and Glide Path Change Request Form. If there are claims to be processed for the address you are updating, please do not initiate that address update via this Web portal application. Rather, submit the request to update the address in writing to DXC Technology Provider Enrollment Unit at PO Box 5007, Hartford, CT, 06102-5007. Any updates to address information via the Web portal, when there are still claims to be processed for that address, may cause the fee differential payment not to be applied to those claims.

Usage	Name	Address 1	City	State	Zip	Zip + 4	Contact Phone	Contact Ext	Handicap Access	Address Indicator
Enrollment Address	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Mail to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Pay to	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V
Service Location	MAPIR, JENNIFER	195 SCOTT SWAMP ROAD	FARMINGTON	CT	06032		(860)255-3900		N	V

Type changes below.

maintain address

Apply Changes To:
- [ ] Svc Loc
- [ ] Pay To
- [x] Mail To
- [ ] Enrollment

Name Type: ○ Business Name ◉ Personal Name

Name: MAPIR JENNIFER

Title:

Usage: Mail to

Country: UNITED STATES

Address 1: 195 SCOTT SWAMP ROAD

Address 2:

City: FARMINGTON

State: CT

Zip: 06032

Contact Name:

Contact Phone: (860)255-3900

Fax:

EMail:

Confirm EMail:

Address Indicator: Valid

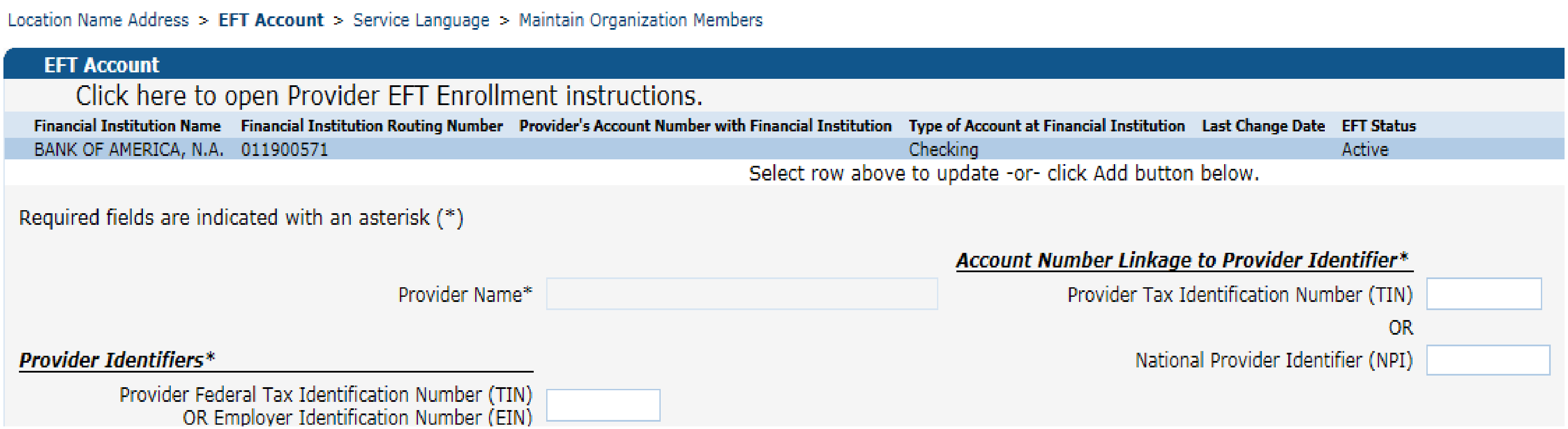
Handicap Accessible? No

save cancel

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.	011900571		Checking		Active

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

Required fields are indicated with an asterisk (*)

Account Number Linkage to Provider Identifier*

Provider Name*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

Provider Identifiers*

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

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

Demographic Maintenance – Maintain Organization Members

Group providers must associate all their individual providers to the group through the group’s secure Web portal account.

Failure to associate providers to their group practices could cause claim denials

When enrolling or attaching a performing provider to a group, the provider must be the same specialty as the group that they are being tied to.

- Example:
    - A Dental group with an Endodontist Specialty (270) cannot have a Pediatric Dentist Specialty (274) attached to it.

Demographic Maintenance – Maintain Organization Members

To add a new member:

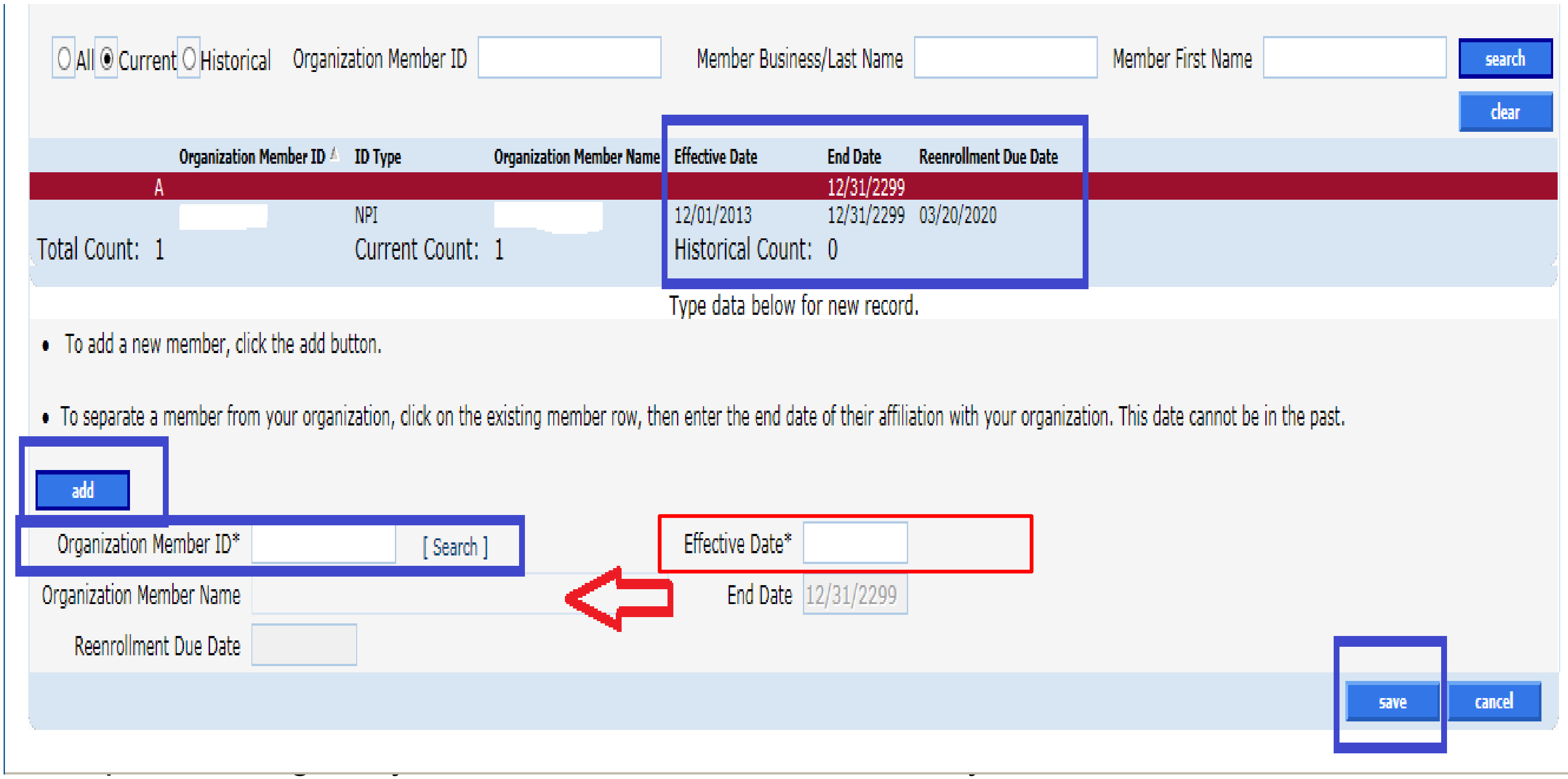
Click the Add button.

- **Enter the practitioner's NPI under Organization Member ID field.**
  - ➢ It should auto-populate with the provider's name.
- **Enter the effective date you want the individual provider association to begin. The effective date can be up to 6 months prior to the date you are adding the member.**
  - ➢ The end date will be automatically populated with the date 12/31/2299.

Click Save.

Demographic Maintenance – Maintain Organization Members

Add a new member:



Demographic Maintenance – Maintain Organization Members

To remove or end a provider's affiliation with your group:

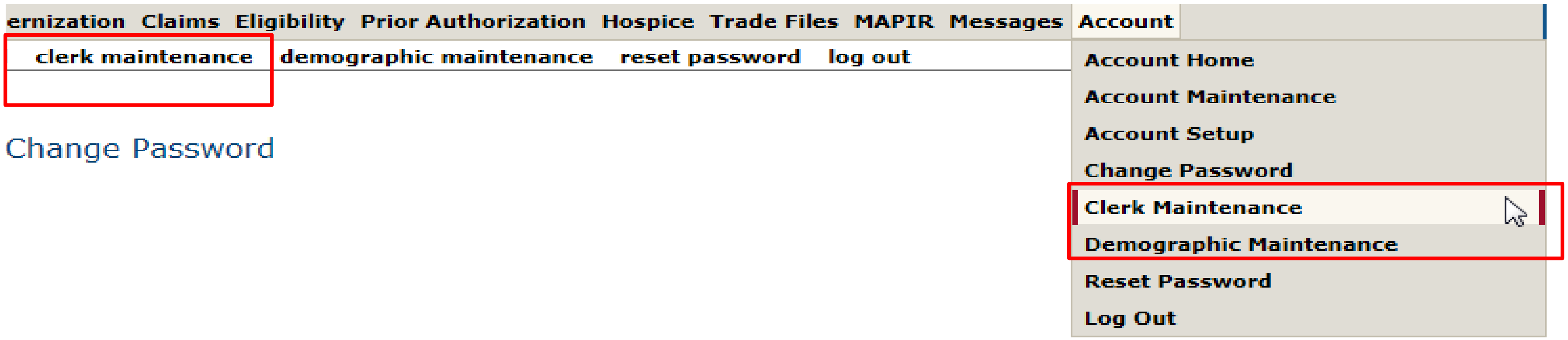
Click on the existing member.

- **Enter the end date of their affiliation with the group in the end date field.**
  - The end date cannot be a date in the past.

Click Save.

Clerk Maintenance

Clerk Maintenance



The Clerk Maintenance grants Web access to staff members allowing them to perform functions based on their job responsibilities:

- Client eligibility verification
- Claim Inquiry/Submission/Adjustment
- Prior Authorization inquiry
- Trade files includes E-Delivery
- Trade files E-Delivery Only)
- Submit Applications

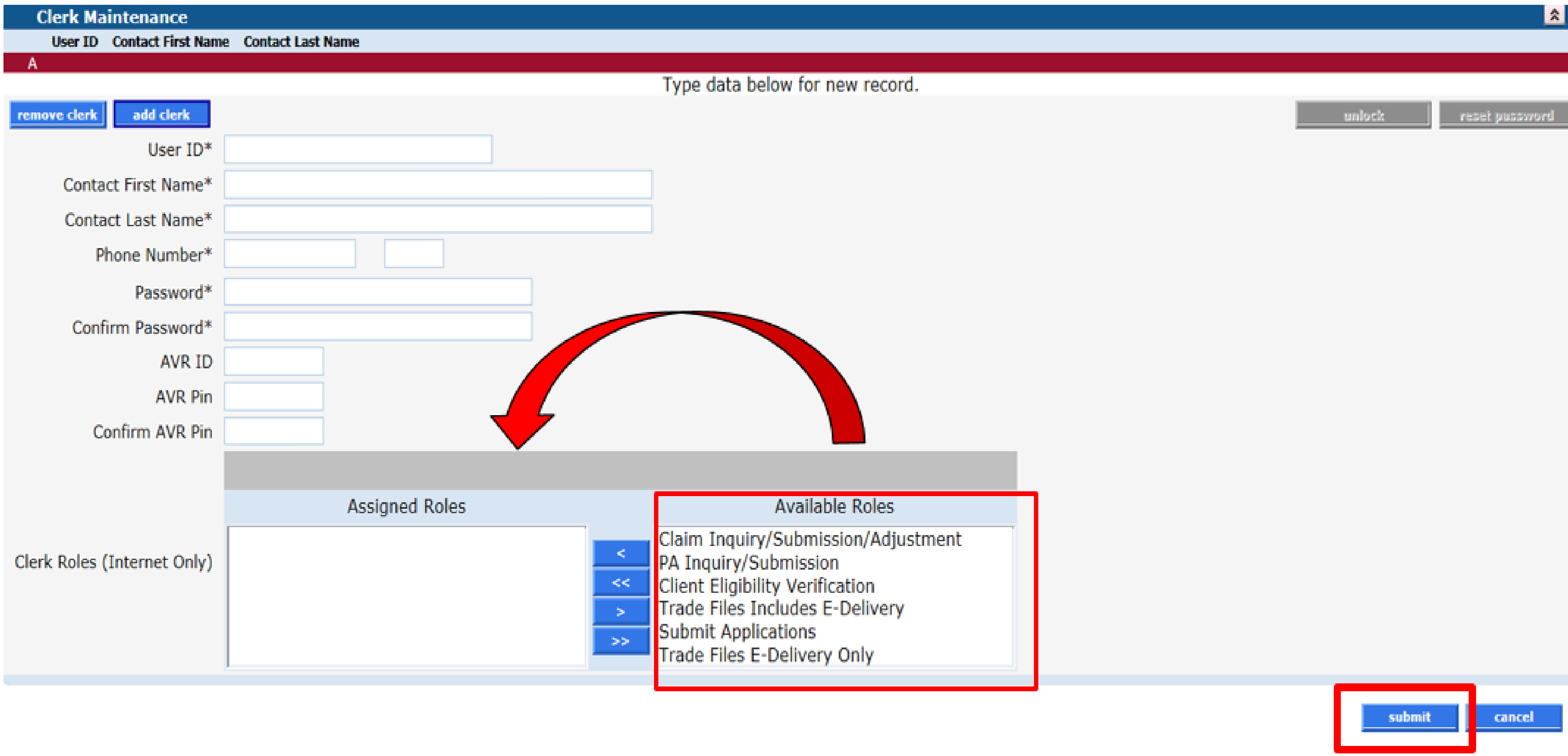
The primary account holder is responsible for maintaining clerk accounts within their organization. This includes adding clerks, changing the role(s) for clerks, removing clerks, and resetting passwords.

Clerk Maintenance

To create a new clerk account, click ‘add clerk’

Fill in the required fields.

Assign the clerk their roles, then click “submit.”

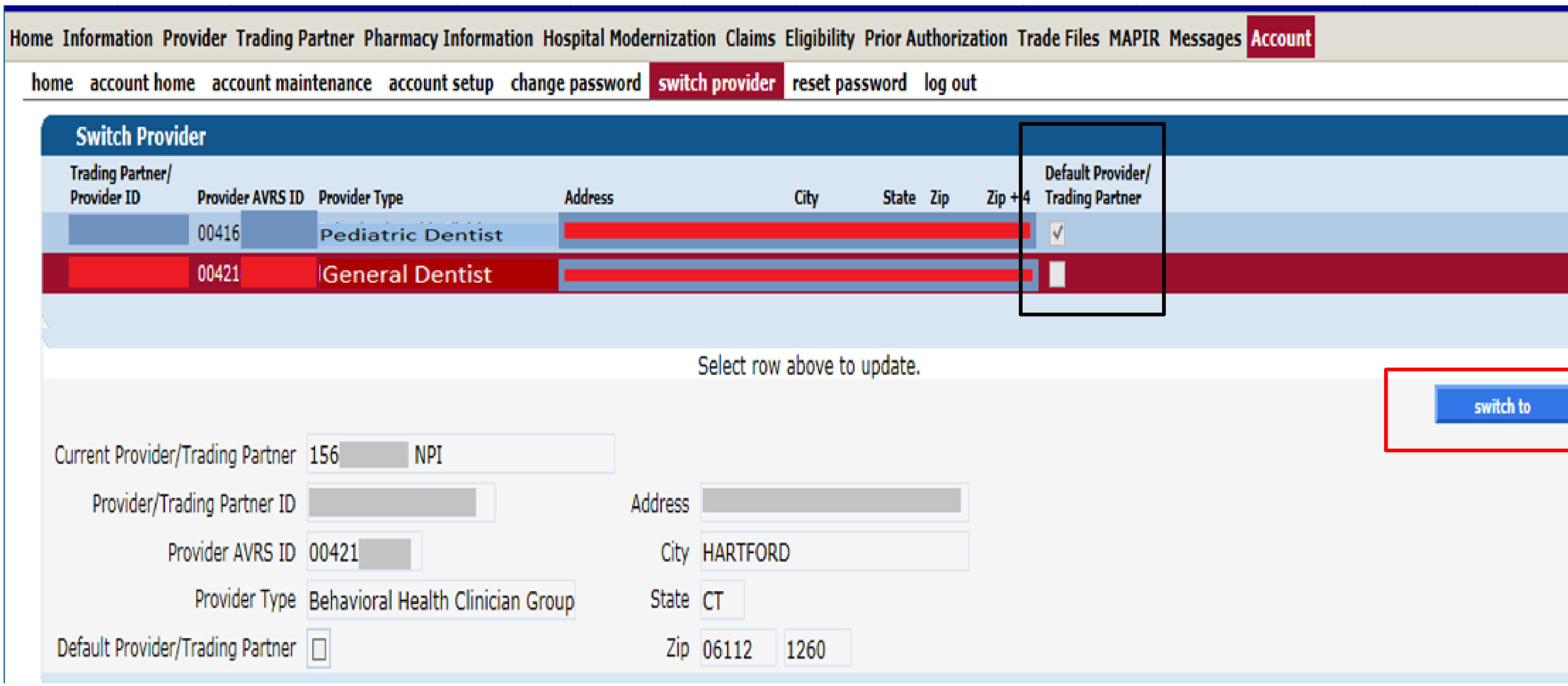


Clerk Maintenance

Switch Provider

The switch provider function is available to clerks that have been associated to multiple provider Web accounts.

When logged into the secure site the clerk can select Switch provider and click on a row for the provider they want to switch to.



Client Eligibility

Client Eligibility - Verification

DSS recommends that providers verify a client's eligibility on the date of service *prior to performing the 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
- On the CTDHP Web site www.ctdhp.com, under Provider Partners

Client Eligibility - Verification

Search by Service Type Codes

From the Web site at www.ctdssmap.com providers have the option to search up to five (5) different service type codes. The service type codes allow providers to verify the client's eligibility benefit coverage for specific services.

- The first service type code field defaults to 30 – Health Benefit Plan Coverage. If the provider searches by that default selection, it will return with all the service type codes that are covered for the client's benefit plan.

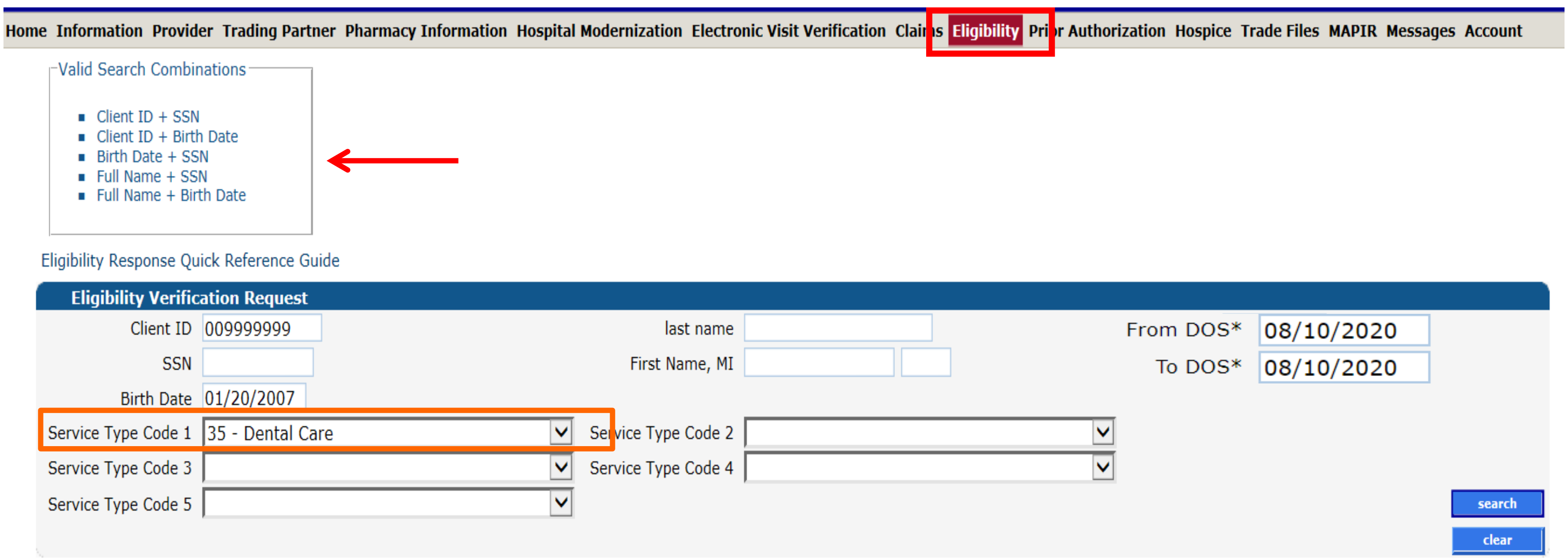
- The specific service type code for Dental providers is "35" for "Dental Care."

Client 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.

- When entering a full name as part of your search, a middle initial is required if present in the client's CMAP profile.



Client Eligibility - Verification

Eligibility Verification Response

Eligibility Verification Response

Verification Number 191720000P

Response Text: Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information

Client ID	009999999	Last Name	CAREY
SSN	###-##-####	First Name, MI	BABYC
Birth Date	01/20/2007	Street	1 MAIN ST
Gender	M	City, State, Zip	TORRINGTON, CT 06790

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Husky D. For Behavioral Health Services, call BHP at 877-552-8247.	08/01/2020	08/10/2020	08/10/2020	

Deductible Information

*** No rows found ***

Out of Pocket Information - Includes Deductible and Coinsurance

*** No rows found ***

Service Type Codes - Medicaid Services

Service Type Code	Service Type Information	Copay	Coinsurance
35	Dental Care		

Service Type Codes - MCO Services

*** No rows found ***

Service Type Codes - Not Covered

*** No rows found ***

Limit Information

*** No rows found ***

TPL

*** No rows found ***

Managed Care Provider

*** No rows found ***

Lockin

*** No rows found ***

Medicare

*** No rows found ***

Client Eligibility - Verification

- **The Dental Annual Benefit Maximum** for adult clients will be displayed under the "Limit Information" panel. Providers will be able to see the "Annual Maximum" and the "Remaining Balance" if any claims have been processed against the benefit limit for the client.

Limit Information						
Description	Service Type Codes	Effective Date	End Date	Annual Maximum	Remaining Balance	Message
Dental Annual Benefit Maximum	35	01/01/2019	12/31/2019	$1,000.00	$0.00	Claims not yet received or not yet processed may reduce available benefits. Eligibility verification and confirmation of coverage or remaining benefits is not a guarantee of payment.

- **HUSKY B copay** amounts will not show on the eligibility screen, providers should refer to the dental fee schedule.
- **Third Party Liability (TPL):** If the client has private insurance in addition to HUSKY, this information will display in the TPL Panel. The provider should initiate a separate request to the other payer or plan to determine the level of coverage.

TPL	
Carrier Code	Carrier Name
788	CONNECTICARE INC
A12	EXPRESS SCRIPT

Client Eligibility – Third Party Liability (TPL) Update

To correct or update TPL information:

You must obtain a TPL form from the following options:

- Print out the form located on the Web site at www.ctdssmap.com under **Information → Publications → Forms →Third Party Liability Forms → TPL Information Form.**

- Call Health Management System, Inc. (HMS) 1-866-277-4271. HMS staff will mail or fax the form to the provider.

- E-mail requests can be made to ctinsurance@hms.com and the form will be e-mailed back to the provider.

Client Eligibility – TPL Update

Submit completed forms via:

- Mail to:

  Health Management Systems, Inc.
  Attn: CT Insurance Verification Unit
  5615 High Point Dr.
  Suite 100
  Irving, Texas 75038

- Fax to HMS with the HIPAA compliant cover letter to 214-560-3932.

- Scan the completed forms and submit through e-mail to ctinsurance@hms.com.

Dental Fee Schedules

Dental Fee Schedules

The CMAP dental fee schedule is split into two separate fee schedules effective for dates of service (DOS) September 1, 2016 and forward.

The fee schedules are separated by the reimbursement rates for adults and children (clients under the age of 21).

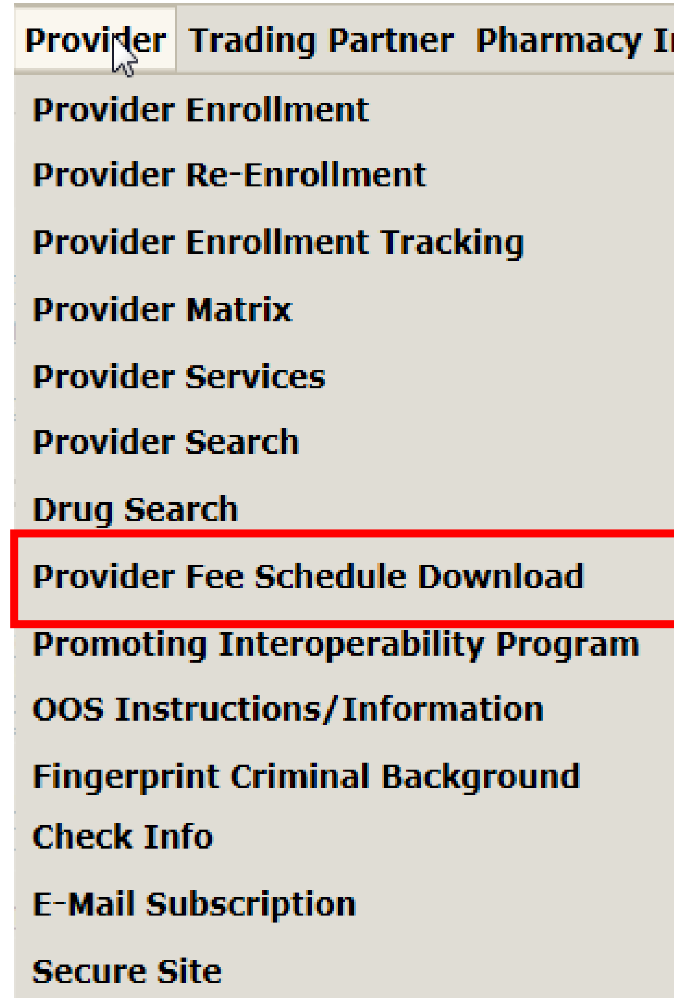
Prior to DOS September 1, 2016, DSS had one fee schedule which listed the pediatric rate; the adult rate was 52% of the pediatric rate.

Dental Fee Schedules

CMAP *fee schedules* are available for download from the Web site www.ctdssmap.com.

- 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.*



Dental Fee Schedules

- Provider Fee Schedules are listed by provider type and specialty.
- For the dental adult fee schedule click on the CSV link next to:
  - ➢ Dental Adult
- For the dental pediatric fee schedule click on the CSV link next to:
  - ➢ Dental Pediatric
- For the consolidated dental fee schedule prior to DOS September 1, 2016, click on the CSV link next to:
  - ➢ Dental DOS Prior to 09/01/2016

*** 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
- Ambulatory Detoxification 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
- CT Home Care CSV
- DDS Specialized Services NF Fee Schedule CSV
- Dental Adult CSV
- Dental DOS Prior to 09/01/2016 CSV
- Dental Pediatric CSV
- Home Health PDF
- Hospice CSV

Dental Fee Schedules

Example of the Dental Pediatric fee schedule:

	1/1/2020 Pediatric Dental Fee Schedule				Last Updated 5/5/2020										
	--														
	This fee schedule lists the fees for a client under the age of 21.														
Proc Code	Mod	Proc descr	Max Fee	Husky B C	Effective D	End Date	PGM Limit	Endodonti	Oral & Ma	Oral & Ma	Periodonti	Prosthodo	Dental Ane	Pediatric D	General De
								270	276	293	275	295	296	274	271
12011		SIMPLE RE	44.11	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12011		SIMPLE RE	45.01	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12013		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12013		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12014		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12014		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12015		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12015		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12016		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12016		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12017		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12017		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12018		SIMPLE RE	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12018		SIMPLE RE	65.23	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12031		INTMD WI	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12031		INTMD WI	104.38	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12032		INTMD WI	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12032		INTMD WI	130.01	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12041		INTMD WI	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12041		INTMD WI	104.38	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12042		INTMD WI	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12042		INTMD WI	130.01	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR
12051		INTMD WI	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12051		INTMD WI	104.38	NA	7/1/2005	8/31/2016		PR	PR	PR	PR	PR	PR	PR	PR

Dental Fee Schedules

Example of the Dental Adult fee schedule:

1/1/2020 Adult Dental Fee Schedule   Last Updated 5/5/2020

This fee schedule lists the fees for a client age 21 and older.

Proc Code	Mod	Proc descr	Max Fee	Husky B Cc	Effective D	End Date	PGM Limit	Endodonti	Oral & Ma	Oral & Ma	Periodonti	Prosthodo	Dental Ane	Pediatric D	General De
								270	276	293	275	295	296	274	271
12011		SIMPLE RE	23.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12013		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12014		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12015		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12016		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12017		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12018		SIMPLE RE	33.92	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12031		INTMD WI	54.28	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12032		INTMD WI	67.61	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12041		INTMD WI	54.28	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12042		INTMD WI	67.61	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12051		INTMD WI	54.28	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12052		INTMD WI	54.28	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12053		INTMD WI	67.61	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12054		INTMD WI	54.28	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
14040		ADJACENT	271.4	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
14041		ADJACENT	390.14	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
14060		ADJACENT	378.59	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
14061		ADJACENT	468.16	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
14300		ADJACENT	542.8	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
15000		SURGICAL	312.11	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
15120		SPLIT-THIC	296.47	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
15121		SPLIT GRAI	54.63	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
15240		FULL THIC	324.5	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA

Dental Fee Schedules (Footer Section)

The footer is a great source of additional information:

Max Fee column - MP means MANUALLY PRICED

Note: T1015 MAY BE BILLED ONLY BY FQHCS - PROVIDER SPECIFIC RATE

Pgm Limits Column{^}indicates program limitations apply. See Provider Manual Chapter 7 and also the following policy transmittals PB 06-103; PB 09-25; PB 09-57; PB 11-07; PB 11-61;
_____PB 14-62; PB 14-71; PB 15-15; PB 15-27; PB 16-45; PB 18-51; PB 19-03 and PB 19-51

Pgm Limits Column{#}-indicates service is limited to private practice (non-group related) dentists and public health hygienists. See policy transmittal PB 11-61.

Effective 9/1/2018: Procedure D1354 will pay $28.42 for the first tooth and all additional teeth will pay $1.00.

PA TYPE designates:
PR means Authorization Review is required to be obtained from Connecticut Dental Health Partnership after the service has been performed
PA means Prior Authorization is required to be obtained from Connecticut Dental Health Partnership before the service is performed
An empty box means that prior authorization is NOT required
NA means that the Provider Type/Specialty cannot bill for these codes

----

Provider Type / specialty Column Designates:
PA means Prior Authorization (PA) is required for under the age of 21
<21 means Prior Authorization is required for patients under the age of 21
>21 means Prior Authorization is required for patients 21 years of age and older
21-69 means Prior Authorization is required for patients 21 years of age and older; but less than 70
Please note procedure code D3352 and D3353 are restricted to under the age of 18
PAR designates PA >21 and PR <21

The CDT Code and Nomenclature above have been obtained from Current Dental Terminology (including procedure codes; nomenclatures; descriptors and other data contained therein) ("CDT").
CDT is copyright 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply

PR means <u>Post Authorization Review</u> is required to be obtained from Connecticut Dental Health Partnership(CTDHP) **AFTER** the service has been performed.

Dental Fee Schedules

PA means Prior Authorization is required to be obtained from CTDHP **BEFORE** the service is performed.

- <21 means that Prior Authorization is required for patients under the age of 21.
- >21 means that Prior Authorization is required for patients 21 years of age and older.
- 21-69 means that Prior Authorization is required for patients 21 years of age and older, but less than 70.
- PAR means that Prior Authorization for >21 and PR for < 21.
- PA means that Prior Authorization is required for all patients.

Providers can access the dental fee schedule at www.ctdssmap.com to determine which procedure codes require PA or PR.

Providers should refer to the CTDHP Web site www.ctdhp.com and access the provider manual to determine if a procedure complies with the Medical Services Policy.

Prior Authorization

Prior Authorization

Electronic prior authorization or post procedure review requests may be submitted via the www.ctdhp.com provider Web portal.

➢ To upload a PA/PR request, follow the steps outlined below:

1. Access the www.ctdhp.com Web site and click on **"Provider Partners."**
2. Enter your Billing NPI and Tax ID numbers in the appropriate boxes and click on **"Login."**
3. A new screen will appear, click on **"Prior Authorization Upload."**
4. Follow instructions for prior authorization or post procedure review requests.

Prior Authorization

Hard copy submissions for the non-orthodontic services that require PA or PR should be submitted to:

CT Medicaid Prior-Authorizations

C/O Dental Benefit Management, Inc./BeneCare

P.O. Box 40109

Philadelphia, PA 19106-0109

Hard copy PA requests for orthodontic services should be submitted to:

Orthodontic Case Review

C/O BeneCare Dental Plans

195 Scott Swamp Road, Suite 101

Farmington, CT 06032

Prior Authorization

Allow fifteen (15) business days for the review, processing of prior authorization and post procedure review requests.

CTDHP will enter the information for the approved PAs and PRs in DXC Technology's system.

- Denied PA/PR requests **will not be entered**; however, the provider will be informed via a written response.

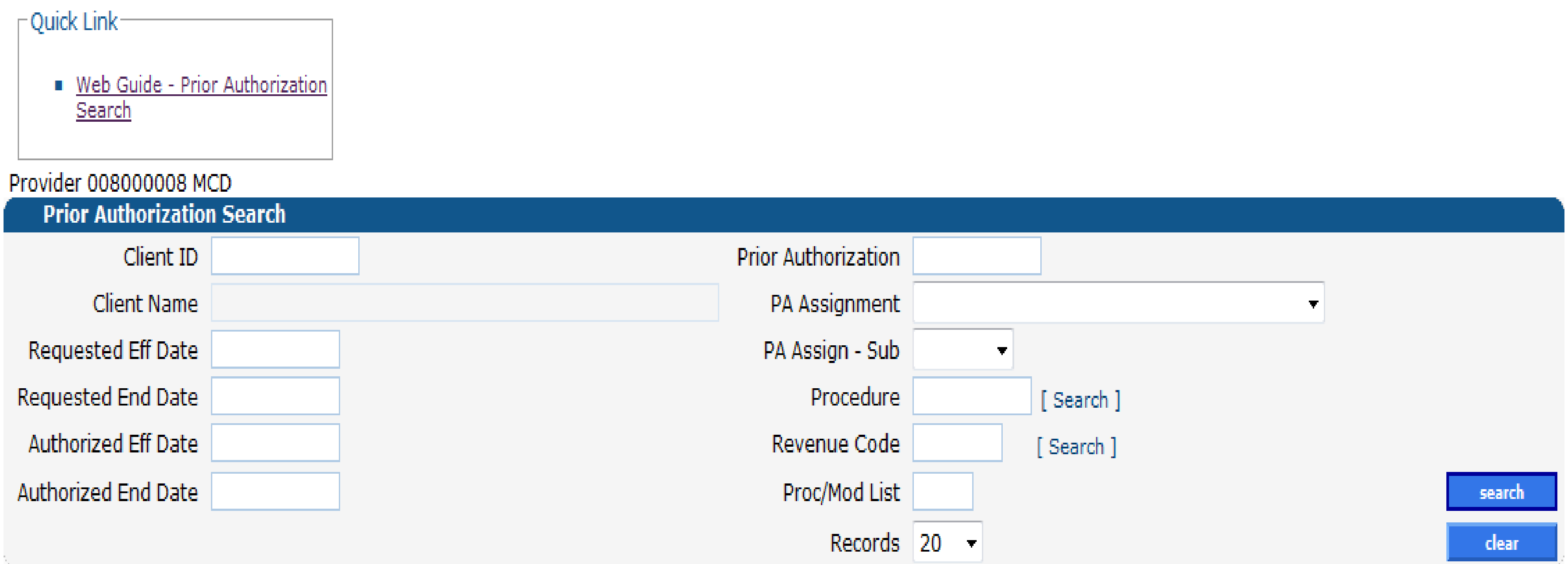
PA approval status may be verified via the CT Medical Assistance Program Web site at www.ctdssmap.com.

- The Prior Authorization (PA) Search allows providers to see if the PA or PR has been entered into the system prior to submitting their claims.

Prior Authorization Inquiry

On the provider secure Web site <u>www.ctdssmap.com</u>, under "Prior Authorization" select "Prior Authorization Search."

- ➢ Enter a client ID and click search to bring up prior authorizations for a specific client.



Prior Authorization Inquiry

PA Inquiry result

Base Information

Prior Authorization Number: 2010018002

Client ID: 003490661 | PA Assignment: DENTAL SERVICES

Last Name: NOT LEAST | First Name, MI: CHILD

Billing Provider: XXXXXXXXXX NPI | Date of Birth: 01/01/2000

Diagnosis: [Search] | Insurance: None

Estimated Date of Delivery:

Patient Condition: Fair

Line Item

Line Item	Requested Units	Requested Dollars	Authorized Units	Authorized Dollars	Status	Procedure Code	Procedure Code List	NDC	Revenue Code	Revenue Code List
01	2.000	$0.00	2.000	$0.00	Approved	D3320				

Type changes below.

Line Item: 01

Service Type Code*: Procedure Code | Tooth: [Search]

Procedure Code/List: D3320 [Search] [Search] | Quad: [Search]

Modifier 1: [Search] | Tooth Surface 1: [Search]

Modifier 2: [Search] | Tooth Surface 2: [Search]

Modifier 3: [Search] | Tooth Surface 3: [Search]

Modifier 4: [Search] | Tooth Surface 4: [Search]

Revenue Code/List: [Search] [Search] | Tooth Surface 5: [Search]

Requested Eff./End Dates*: 09/01/2009 11/30/2009 | NDC: [Search]

Requested Units/Dollars*: 2.000 $0.00 | Status: Approved

Authorized Units/Dollars: 2.000 $0.00

Authorized Eff./End Dates: 09/01/2009 11/30/2009

Used Units/Dollars: 2 $200.00

Available Units/Dollars: 0 ($200.00)

You can see the procedure code that was approved, authorized units/dollars, authorized effective/end dates, used units/dollars and available units/dollars.

Program Limitations

Program Limitations:
Dental Benefit Assignment by Client

DSS reimbursement for dental services rendered to HUSKY clients follows **client based benefit** assignment. The benefit limitations for services mirror commercial dental plan reimbursement.

All dental providers who deliver services to clients should check to ensure that each client is eligible to receive dental services by verifying the **client's eligibility status** and **dental history** before performing any treatment on a client.

Please refer to Chapter 7 of the Provider Manual and the Dental Fee Schedule for specific Program Limitations. The footer of the fee schedule lists Provider Bulletin numbers announcing various program limitations.

Program Limitations:

Dental Benefit Assignment by Client *Resources*

To verify when a procedure was last performed on a client, go to the **www.CTDHP.com** Web site and click on the link on the left hand side of the Home Page labeled **"Provider Partners"** then click on **"Provider Login."**

1) Choose the link labeled **"Client Inquiry."**
2) Enter the client's Medicaid ID number and date of birth and click **"Submit."**
3) The screen will return the client's current eligibility status for the date of the inquiry as well as a listing of all historical dental procedures performed on file for this client.

* It is important to ask clients about any recent dental visits as the claims history does not include claims yet to be submitted for services recently performed.

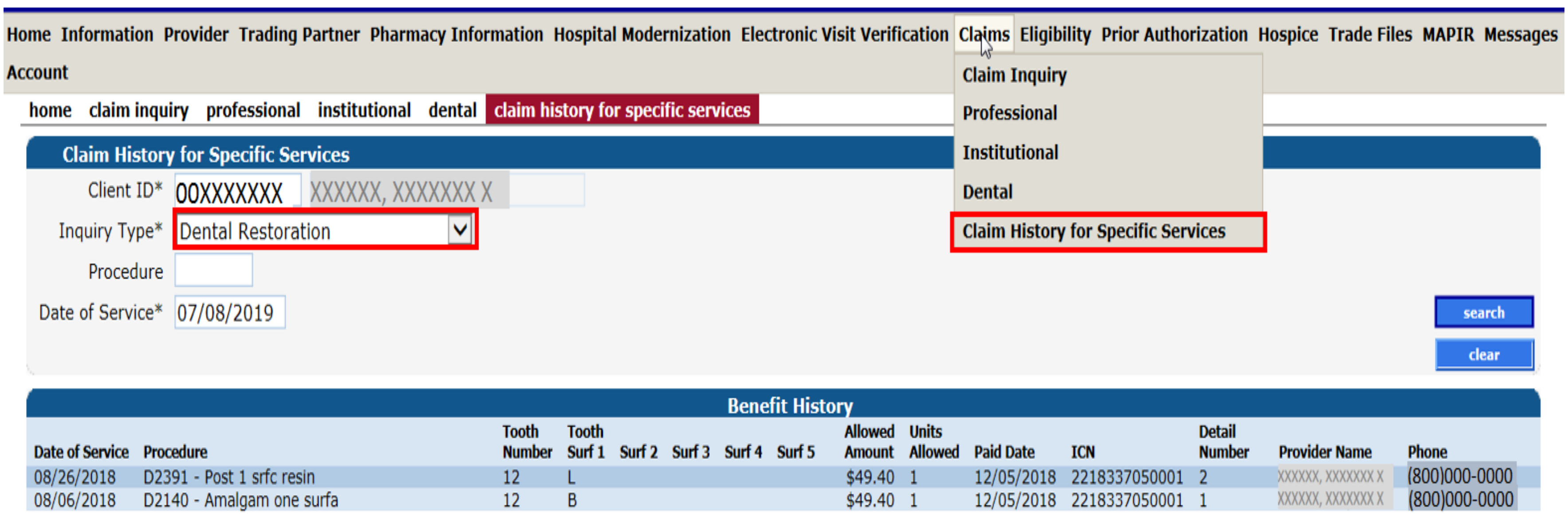
Program Limitations: Restoration Pricing

DSS reimburses providers **for the total number of surfaces restored on a single tooth per one (1) year** period regardless of the provider performing the service.

- A provider is paid for performing a restoration on surfaces Lingual and Mesial (LM) on tooth 19.
- The same or a different provider submits a second claim for the same client within one year from the previous date of service for restoration on surfaces Distal and Occlusal (DO) on the same tooth (#19).
- The second claim does not pay for a second two surface restoration; instead the second claim pays the difference between the four surface restoration and the previously paid two surface restoration and posts the Explanation of Benefit (EOB) code 9992 – Payment Amount Reflects Tooth Surface Pricing at the detail.

Program Limitations:
Restoration Pricing *Resources*

Providers can look up restoration services provided to a client within the past one year by logging into their secure portal **www.ctdssmap.com**, click on **"claim history for specific services"** from under the "Claims" link. Enter the Client ID, select **"Dental Restoration"** as the Inquiry Type, enter the Date of Service and click "Search".



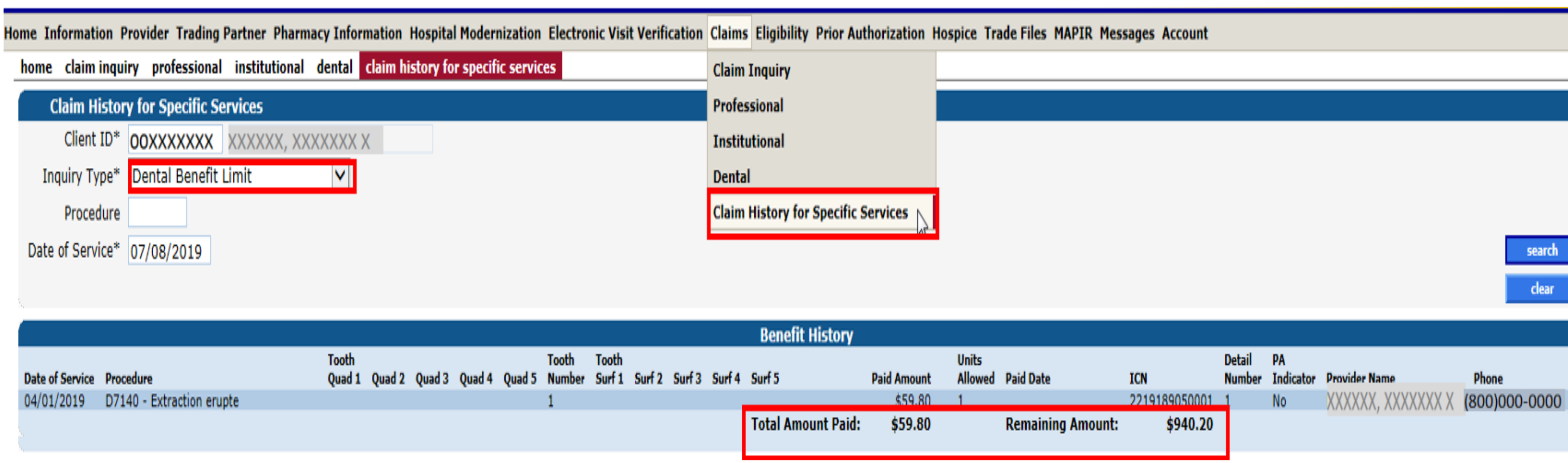
Program Limitations: Annual Adult Dental Benefit Maximum

An **annual dental benefit maximum for nonemergency dental services of $1,000** has been implemented for dental services provided to adult clients ages 21 and older enrolled in HUSKY A, C and D benefit plans for dates of service January 1, 2018 and forward. The dental benefit limit resets on January 1st of each year.

- HUSKY B benefit plan is not subject to this limit.
- The benefit limit is based on the calendar year; resets on January 1st of each year.
- For a client turning 21 years old, the benefit limit starts from the date of the 21st birthday through the end of the year.
- Emergency dental services and dentures will not be counted towards the annual dental benefit limit.
- Medically necessary services may be prior authorized beyond the annual benefit limit.

Program Limitations:
Annual Adult Dental Benefit Maximum *Resources*

Providers can look up the amount paid towards a client's annual dental benefit limit and the remaining amount, if any, within a one (1) year period by logging into their secure portal **www.ctdssmap.com**, click on **"claim history for specific services"** from under the "Claims" link. Enter the Client ID, select "Dental Benefit Limit" as the Inquiry Type, enter the Date of Service and click "Search".



Program Limitations:
Annual Adult Dental Benefit Maximum
Client Responsibility

Dental providers who submit a claim for a client nearing his or her annual benefit maximum limit, will receive a partial payment up to the annual maximum of $1000.

For a Federally Qualified Health Centers (FQHCs), the payment per encounter will be partially paid if the client is nearing his or her annual benefit maximum limit and the final encounter will exceed the maximum UNLESS additional encounters have been prior authorized.

Once the Dental Benefit Limit has been reached and a claim is submitted for the client, the detail(s) will post **EOB code 6250 – Dental Annual Benefit Limit Exceeded.** For any detail that posts EOB 6250, the Remittance Advice (RA) will list the amount for which the client is responsible.

Program Limitations:
Annual Adult Dental Benefit Maximum
Medical Necessity Threshold

Dental providers need to seek PA from CTDHP for services in excess of the annual benefit limit for adult clients when they think additional services are medically necessary prior to providing the services to the client.

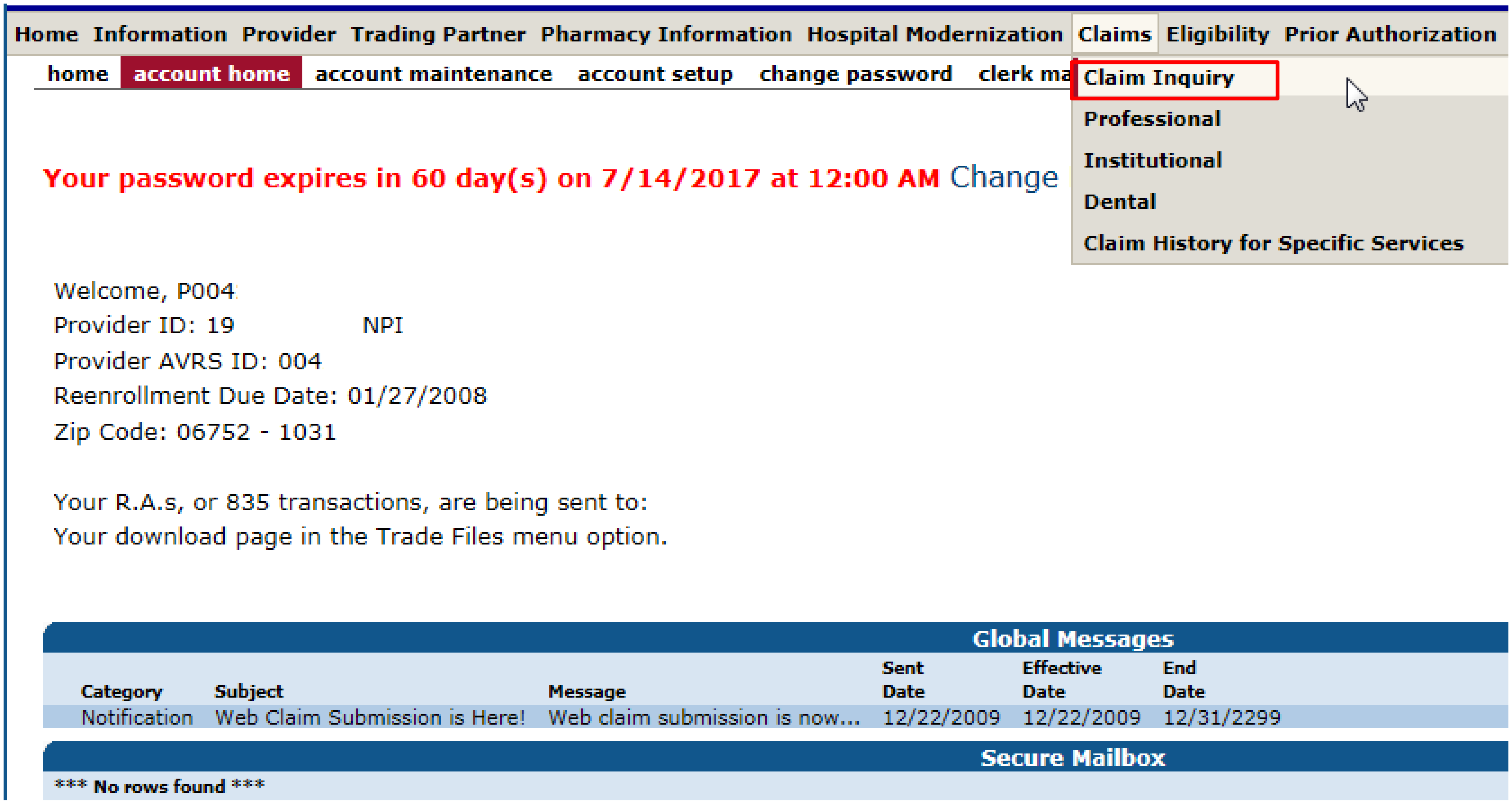
- When seeking PA for medical necessity, providers must submit the full treatment plan and all documentation, including, but not limited to, radiographs, photographs, written commentary and, as appropriate, statements from the client's primary care provider, to support medical necessity of the proposed dental treatment.
  - If PA is approved, the dental provider can submit a claim to DSS for payment.
  - If PA is denied, CTDHP will send the dental provider a denial and the member a Notice of Action (NOA).
- Dental provider may not perform the service or bill the client unless the client has knowingly signed a form/agreement that (1) explains the type of service that is not covered by Medicaid due to lack of medical necessity; (2) details the amount of money the dental provider will charge the member for the service; and (3) confirms that the client understands that he or she is consenting to paying for the services. The provider must obtain this consent before performing the procedure(s).

Please refer to Provider Bulletin PB 2019-24 for further information.

Web Claims Submission Tool

Web Claim Inquiry

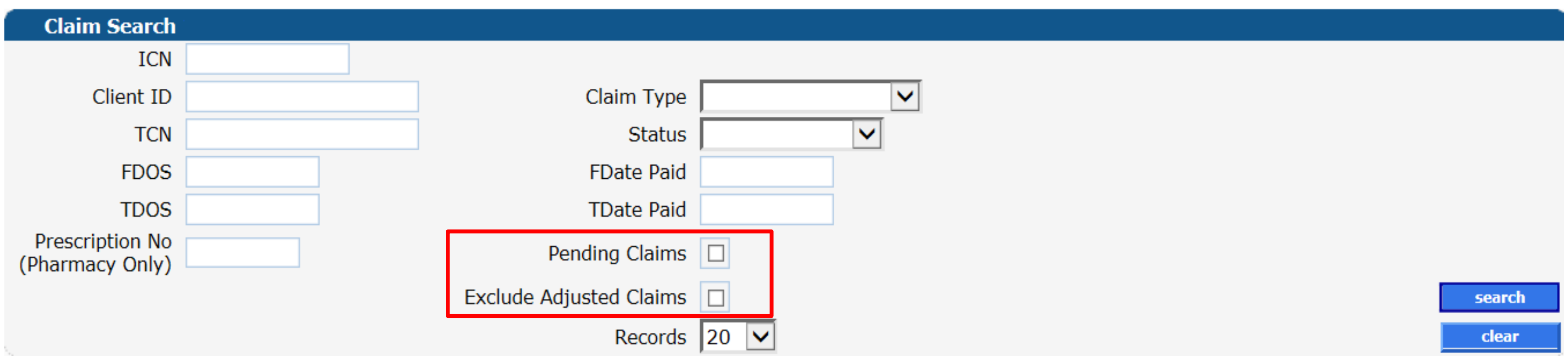
To search for a claim, select Claim inquiry from the drop down list under Claims



Web Claim Inquiry

You can view claims by:

- **Internal Control Number (ICN)**
- **Client ID and date of service (no greater range than 93 days)**
  - ➢ If you submit a one claim with multiple date of services (i.e. 03/01/2019, 3/10/2019 and 03/24/2019, when you do a claim inquiry you need to search for the entire date range. If you search for just 03/10/2019, the inquiry will not return a claim.
- **Date of payment (no greater range than 93 days)**
- **Pending claims (to see claims that haven't gone through a financial cycle yet)**
- **Exclude adjusted claims (to see only the final outcome of claims)**



Web Claim Inquiry

What can I do with these claims?

Paid claims allow you to:

- cancel   Cancel any data entry you have done to the claim after it processed
- adjust   Adjust the claim
- void   Void the claim
- copy claim   Copy the claim and use it as a template to create a new claim
- new claim   Create a brand new claim

Denied claims allow you to:

- re-submit   Resubmit the claim (with or without making changes)
- cancel   Cancel any data entry you have done to the claim after it processed
- new claim   Create a brand new claim

Suspended claims allow you to:

- new claim   Create a brand new claim

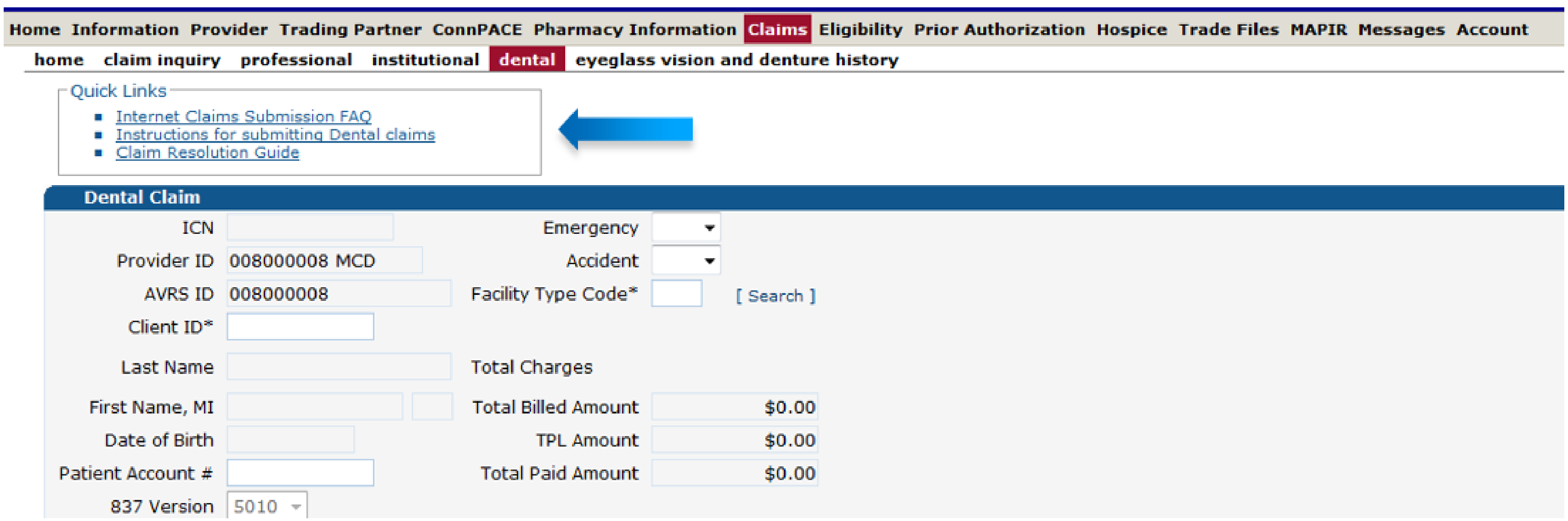
New Claim Submission

To *submit Dental Claims* using the ctdssmap.com *secure site*, click on "*Claims*" *then* "*Dental*".

The Claim page is divided into different panels. Each panel is marked with a blue line which lists the name of that panel.

All required fields in the different panels are marked with an asterisk.

Please refer to the Instructions for submitting Dental Claims available from this page for help.



New Claim Submission

Web Claims Submission – Error Messages

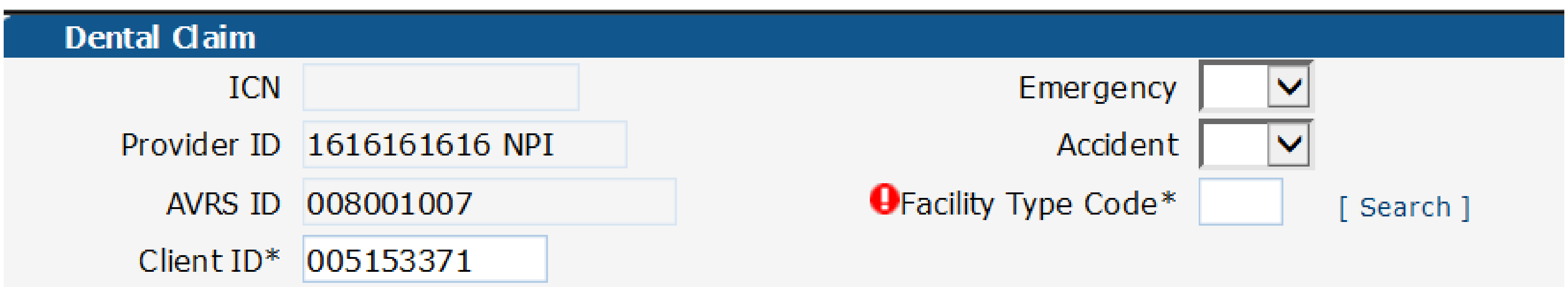
If required information is missing or is in an incorrect format, the self editing feature of Web claims generates error messages to alert the provider and will prevent the claim from being submitted until the errors have been corrected.

The following messages were generated:

Message Description	Panel	Field	Row
A valid Facility Type Code is required	Dental Claim	Facility Type Code	

Dental Claim

The error message will point to the Panel, the Field and the Row where the error has occurred.



Web Claim Adjustment

Adjustment - Perform the following steps to easily adjust a *paid* claim:

- Select *Claim Inquiry*
- Enter the paid claim ICN, found on your Remittance Advice (RA), 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.*

Web claim adjustment limitations:

- Timely Filing
  - Claims that are over the *Timely Filing* guidelines cannot be *adjusted*. If a claim outside of timely filing is adjusted, the claim will be fully recouped, unless the adjusted claim payment will be equal to or less than the original claim payment.
- Special Handled
  - Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by DXC Technology and are, therefore, not able to be adjusted via the www.ctdssmap.com Web site.

Web Claim Void

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, 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.

Web Claim Copy

Paid claims may be copied and submitted as a new claim

This feature is helpful for reoccurring services

Copy - 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 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.

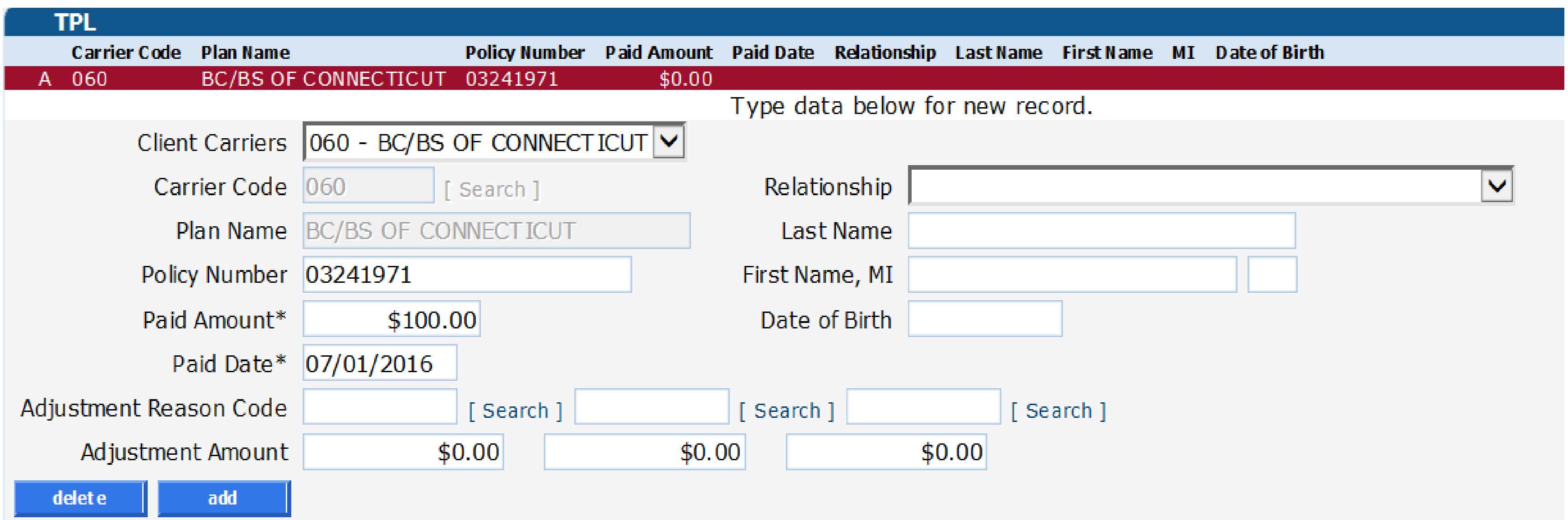
Secondary Claim – Other Insurance Payment

To ***submit*** an Other Insurance (OI) primary claim using the www.ctdssmap.com *secure site*, click on "*Claims" then "Dental"*.

Complete all fields with an asterisk at the Dental Claim Panel, Detail Panel and any additional information as it pertains to the claim.

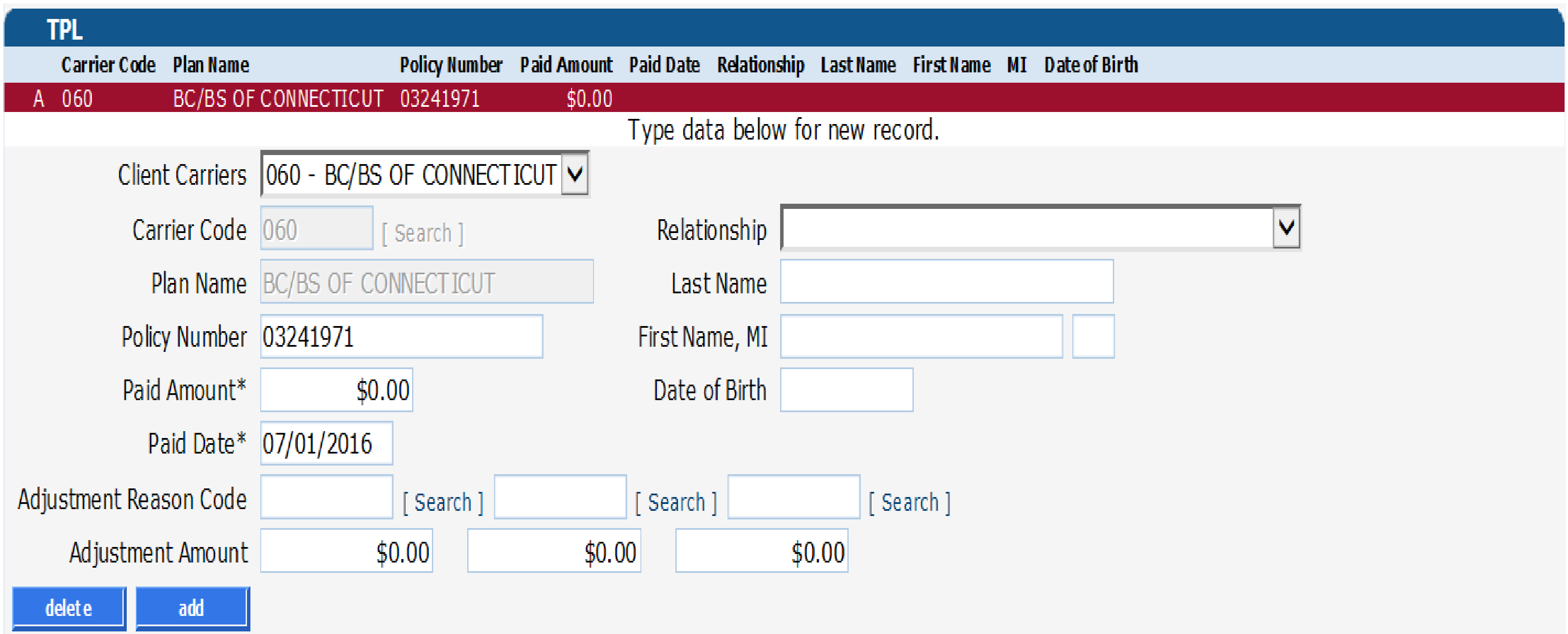
In the TPL Panel, click on the add button; in the below example, select Client Carrier Code 060, enter the TPL payment $100.00 and a paid date of 07/01/2016.

Click on the Submit button at the bottom of the page. The claim will process immediately and return with a status of Paid, Denied or Suspended.



Secondary Claim - Other Insurance Denial

If the OI denies the claim, in the TPL panel select the Carrier Code from the Drop Down Client Carriers field, enter zero in the "*Paid Amount*" field and the date of the denial in the "*Paid Date*".



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	03241971	$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: 03241971

First Name, MI:

Paid Amount*: $0.00

Date of Birth:

Paid Date*: 07/01/2016

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

Adjustment Amount: $0.00 $0.00 $0.00

delete add

Provider Resources

Claim Resolution Guide

Provider Manual Chapter 12 – Claim Resolution Guide

- This guide lists commonly posted Explanation of Benefits (EOB) codes and provides a brief explanation of the reason why claims were either suspended or denied.
- This guide provides a detailed description of the cause of each EOB code and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.
- This guide also provides tips by identifying where providers can go to find additional information to assist with correcting their claims.

Example of an EOB code:

EOB

View All Current Historical

Detail Number	EOB Code	EOB Description	Financial Payer	Benefit Plan	Status	Adjustment Amount	Adjustment Units	Origin
0	1912	BILLING PROVIDER'S TAXONOMY IS MISSING			Current	$130.00	0.000	System Generated
1	9996	REFER TO HEADER EOB			Current	$130.00	0.000	System Generated

Claim Resolution Guide

EOB	Description

1912 Billing provider’s taxonomy is missing

Cause

The billing provider’s taxonomy was not submitted on the claim. This edit will post on HIPAA 5010 claims at the header if the header billing provider identifier is submitted, and the taxonomy code for the billing provider is blank.

Resolution

With HIPAA 5010 claims, providers must now submit both the billing and the rendering taxonomies at the header. If your vendor has older edits in place which prevent the billing taxonomy from coming over on your electronic files (a possible carryover from HIPAA 4010A submissions), please contact your vendor to make the required changes for 5010 submissions to ensure that both the billing taxonomy and rendering taxonomy are populating at the header of the claim.

Add the billing provider’s taxonomy to the claim as submitted on the provider’s enrollment application, correct all other errors, and resubmit the claim.

EOB	Description

0610 Tooth Number/Tooth Surface combination invalid

Cause

This edit will set when a procedure code is billed with a required tooth number and the tooth number/tooth surface combination is not valid.

Resolution

Verify the tooth number and tooth surface submitted on the claim. If it is incorrect, correct the claim and resubmit. If the tooth number and tooth surface is correct, it is not a payable service.

A list of tooth surface/tooth number combinations can be found in Provider Bulletin PB 14-62.

EOB	Description

6250 Dental Annual Benefit Limit Exceeded

Cause

A claim is submitted for a client who has reached their annual Dental Benefit Limit. For any detail that posts EOB 6250, the Remittance Advice (RA) will list the amount for which the client is responsible.

Resolution

Before providing the service(s), the provider should verify the total of each client's accrual of services towards the annual dental benefit limit from their Secure portal account at www.ctdssmap.com by selecting "Claims" > "claim history for specific services" and selecting the "Inquiry Type" of "Dental Benefit Limit". The client may not be billed unless and until they have signed a form indicating that the proposed service is not covered because it exceeds the maximum, but they are willing to assume responsibility for payment. Such consent shall include a specific financial statement describing the service(s) for which he or she accepts responsibility. A client may also consent to partial payment for a service or procedure, if the remaining accrual amount will cover only part of the cost of the service. Again, this consent must be obtained before the procedure(s) is performed.

If the dental services are medically necessary even though the client has reached the annual dental benefit limit, the provider should request prior authorization (PA) for the service(s) through CTDHP. The full remaining treatment plan should be submitted including all supporting documentation required to substantiate reasons of medical necessity, including but not limited to radiographs, photographs, written commentary and statements of medical necessity from the member's primary care provider.

For detailed information regarding the Annual Dental Benefit Maximum policy, please refer to Provider Bulletin 2017-81.

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.

- All Provider Bulletins and Policy Transmittals are in the CTDHP provider manual and can be accessed on the “Provider Partners” section of the www.ctdhp.com Web site.

Provider Bulletins

Provider Bulletins – Searching by Provider Type

Connecticut Department of Social Services
Making a Difference

Help
Monday, August 10, 2020

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

home **publications** **links** **hipaa** **messages archive**

Information

Bulletin Search

Year: 20 | Provider Type: Dentist
Number: | Title:

search | clear

Search Results

Bulletin Number	Title	Published Date
PB20-55	1) July 1, 2020 Changes to the Connecticut Medicaid Preferred Drug List (PDL) 2...	06/18/2020
PB20-51	Electronic Claims Submission,Web Remittance Advice, Check, EFT and 835 Schedule...	05/27/2020
PB20-48	REVISED CMAP COVID-19 Response - Bulletin 32: Services Covered Under the Optiona...	05/15/2020
PB20-45	CMAP COVID-19 Response - Bulletin 29: Updated Guidance Regarding Audio-Only Tel...	05/11/2020
PB20-44	CMAP COVID-19 Response - Bulletin 30: Updated Audio-Only Behavioral Health (Tele...	05/11/2020
PB20-43	CMAP COVID-19 Response - Bulletin 28: Emergency Medicaid for Non-Citizens	04/30/2020
PB20-42	CMAP COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured ...	04/30/2020
PB20-39	CMAP COVID-19 Response - Bulletin 25: Non-Emergency Medical Transportation and N...	04/13/2020
PB20-38	CMAP COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Tel...	04/16/2020
PB20-33	CMAP COVID-19 Response - Bulletin 23: Changes to the Prior Authorization Require...	04/13/2020
PB20-15	CMAP COVID-19 Response - Bulletin 5: Elimination of Copayments for Services Rend...	03/18/2020
PB20-14	CMAP COVID-19 Response - Bulletin 4: Expanded Telemedicine and New Audio-Only (T...	03/19/2020
PB20-11	Accessing the Provider's Re-enrollment Due Date	03/16/2020
PB20-10	CMAP COVID-19 Response - Bulletin 1: Emergency Temporary Telemedicine Coverage	03/11/2020
PB20-09	New Coverage of Specified Telemedicine Services Under the Connecticut Medical As...	03/11/2020

Contact Information

Where to go for more information www.ctdssmap.com

- Important Messages
- Provider Banner Messages
- Provider Newsletters

- Provider Manual
  - Chapter 7 – Policy
  - Chapter 8 – Claim Submission Instructions
  - Chapter 10 – Other Insurance and Medicare Billing Guide
  - Chapter 12 – Claim Resolution Guide

- Dental Fee Schedules

Contact Information

DXC Technology Provider Assistance Center to assist with claims: Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays.

- 1-800-842-8440 or ctdssmap-provideremail@dxc.com
- 1-800-688-0503 (EDI Help Desk)

CTDHP Provider Relations and Network Support will assist with Prior Authorization and claim history: Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays.

- 1-888-445-6665

CTDHP Client Services to assist clients in finding dentist.

- 1-855-283-3682

Time for Questions

Questions & Answers

Thank you