

# Welcome to – Dental Refresher Workshop Training – December 14, 2023

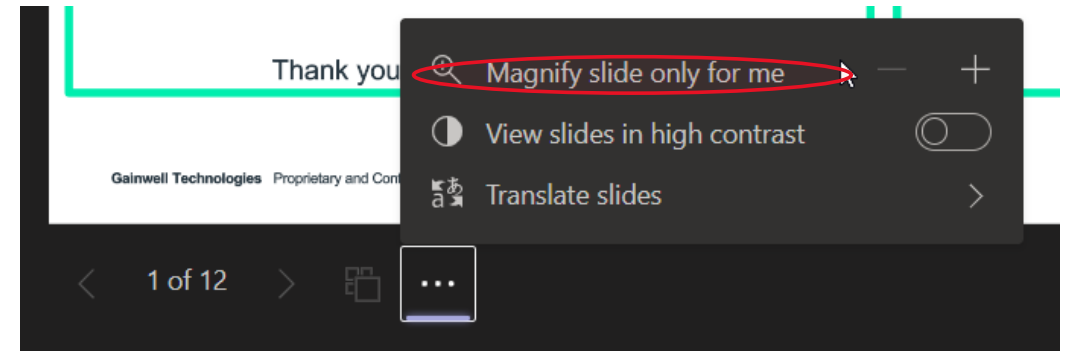
Once you have joined the Microsoft Teams meeting, please follow these communication rules:

- Please ensure your camera is off.
- Use the mute button when you are not speaking.
- Be sure to select “Show Conversation” as documents or links used during the meeting will be posted to the Meeting Chat. You may also use the meeting chat to ask the speaker a question or to comment.
- The “Raise Hand” icon or (Ctrl+Shift+K) may also be used to ask the speaker a question.

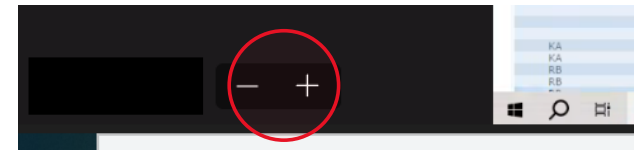
Thank you for your participation!

## 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:



# Connecticut Medical Assistance Program Dental Refresher Workshop

Presented by  
The Department of Social Services & Gainwell Technologies

# Training Topics

- 2023 Updates
- Provider Re-enrollment
- Web Site Maintenance
- Client Eligibility
- Dental Fee Schedules
- 06 Prior Authorization
- 07 Program Limitations
- 08 Web Claim Submission Tool
- 09 Provider Resources
- 10 Time for Questions



# 2023 Updates

# 2023 Updates

## Multi-disciplinary Examinations for Medical, Behavioral Health and Dental Services [Provider Bulletin 23-54](#)

- The Department of Social Services (DSS) is updating billing guidelines regarding Multi-disciplinary Examination (MDE) provided for children covered by the HUSKY Health plan who are in the custody of the State of Connecticut - Department of Children and Families (DCF)
- The MDE is a comprehensive examination with three components: 1) a medical examination, 2) a behavioral/developmental examination, and 3) a dental examination.
- MDE services are provided by DCF-contracted MDE service providers or their subcontractors. In some cases, a single agency is licensed to provide all three components of the MDE while being entitled to reimbursement for each component.
- Diagnosis code Z65.3 is not required for the dental component of the MDE. Providers should bill their usual and customary charge for each service/encounter/visit (D0191).
- Effective for dates of service, August 1, 2023, and forward, eligible dental providers that are authorized to perform the dental component of the MDE must bill as follows:

<b>Procedure Code</b>	<b>Description</b>	<b>Effective Date</b>
D0191	Assessment of the patient	8/1/2023-12/31/2299

# 2023 Updates

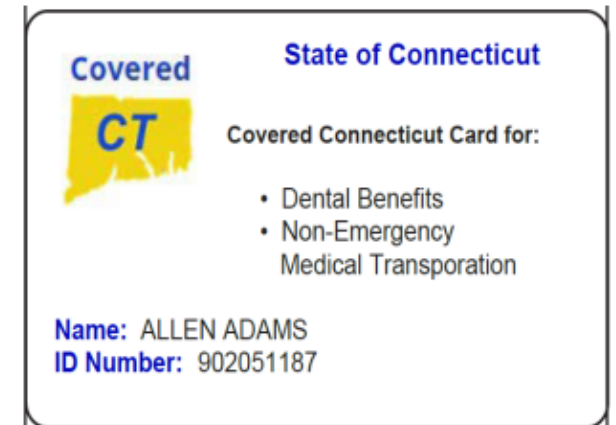
## Dental Claim Form Field Update Reminder [Provider Bulletin 22-64](#)

- The purpose of this provider bulletin is to remind all dental providers that the place of service is required on all dental claim forms in location 38. The place of service must not reflect the billing entity's location or main clinic location unless services are delivered at the site respectively.
- All dental clinics, Federally Qualified Health Centers and dentists who operate mobile vans and/or use portable equipment to deliver oral health services in a community - based setting or school are reminded to use code 15 as the place of service.

# 2023 Updates

## Covered CT Program [Provider Bulletin 22-56](#)

- Covered CT is a program that covers out of pocket costs, nonemergency medical transportation (NEMT) and dental services for certain income-eligible individuals who purchase coverage through Access Health CT (AHCT). Effective July 1, 2022.
- Available for parents, caretaker relatives, and adults (ages 19 to 64) with a household income above the limit for Medicaid but not more than 175% of the federal poverty level.
- To be on Covered CT, qualified individuals must enroll in a silver level Qualified Health Plan (QHP) through AHCT.
- The dental and NEMT benefits under Covered CT are comparable to the benefits under Connecticut Medicaid (HUSKY A, C and D). The annual \$1,000 dental maximum applies to Covered CT members over the age of 21



# 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](http://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 Gainwell Technologies Provider Enrollment Unit.

The notice with the ATN is either emailed to the provider's contact email on file or if the provider has not established a secure Web account, the ATN will be mailed to the provider's 'Enrollment Address' on record six months prior to the re-enrollment date.

# 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.*
- *Enrollment must be finalized by the due date.*
- 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

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

The screenshot shows the website for the Connecticut Department of Social Services. The navigation menu includes Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, and Telehealth Information. The 'Provider' menu is expanded, showing options like Provider Enrollment, Provider Re-Enrollment (highlighted with a red box), Provider Enrollment Tracking, Provider Matrix, Provider Services, Provider Search, Drug Search, Provider Fee Schedule Download, OOS Instructions/Information, Fingerprint Criminal Background, Check Info, E-mail Subscription, and Secure Site. A tooltip for 'Provider Re-Enrollment' is visible. The page also features a large 'W' logo and text: 'TO THE CONNECTICUT', 'THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM WEB SITE, PROVIDES IMPORTANT INFORMATION TO HEALTH CARE PROVIDERS ABOUT INCLUDING ENROLLMENT, BILLING MANUALS, BULLETINS, PROGRAM REVISIONS AND MORE. VISIT OUR WEBSITE TODAY.', a stack of books, and a stethoscope icon.

Re-enrollment Period: Dental providers are required to **re-enroll every 2 years per Federal regulations mandate**. Re-enrollment should be done via the Enrollment/Re-enrollment Wizard on the CMAP Web site, [www.ctdssmap.com](http://www.ctdssmap.com).

# Provider Re-enrollment

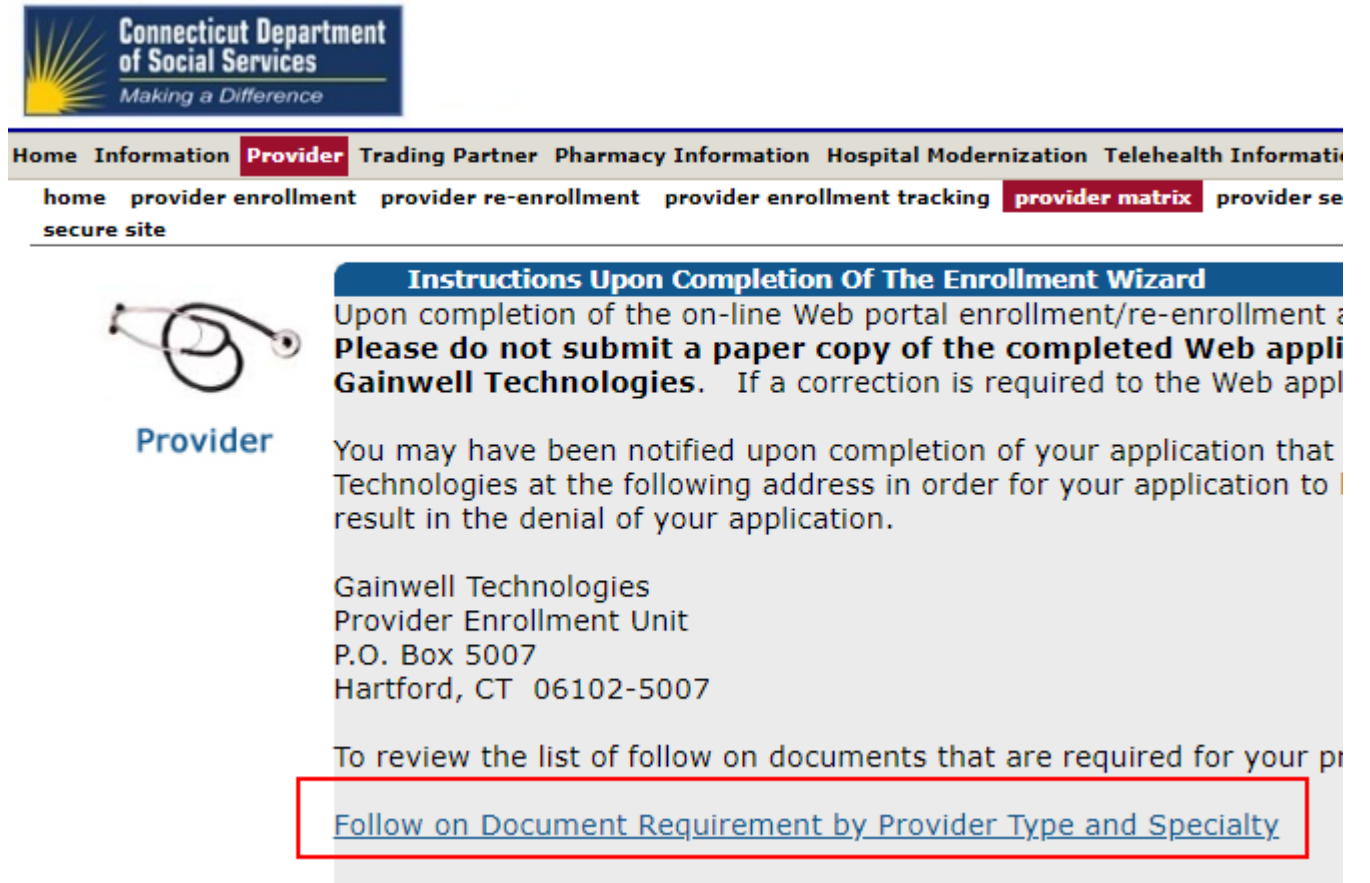
## Follow On Documents:

- Once the enrollment/re-enrollment application is submitted, providers are notified of any “Follow On” documents (FOD) that need to be mailed to Gainwell Technologies Enrollment Unit.
- The document requirements vary by provider specialty.
- The enrollment/re-enrollment application is not considered complete until all the required Follow On 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.
- ***Any provider who is not enrolled will not be able to bill for services rendered and if a performing provider is delivering care under the billing office and is not enrolled, DSS Quality Assurance will recoup the services that have been paid to date.***

# Provider Re-enrollment

## Follow On Documents:

Providers may access the Follow On document requirements from [www.ctdssmap.com](http://www.ctdssmap.com) by clicking **Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty** link.

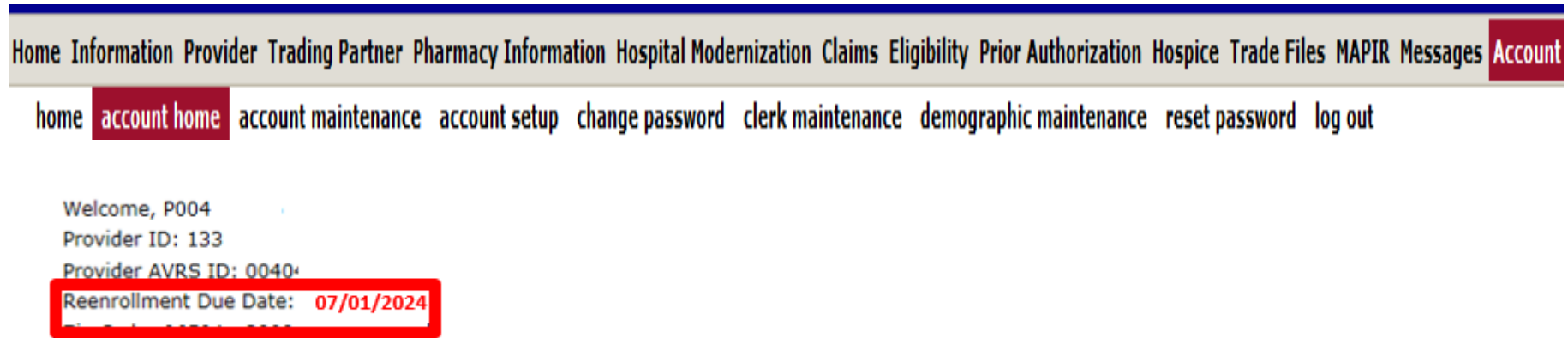


The screenshot shows the Connecticut Department of Social Services website. The header includes the logo and the text "Connecticut Department of Social Services Making a Difference". The navigation menu includes "Home", "Information", "Provider", "Trading Partner", "Pharmacy Information", "Hospital Modernization", and "Telehealth Information". The "Provider" menu is expanded, showing "home", "provider enrollment", "provider re-enrollment", "provider enrollment tracking", "provider matrix", and "provider secure site". The "Provider matrix" link is highlighted. Below the navigation menu, there is a section titled "Instructions Upon Completion Of The Enrollment Wizard". The text in this section reads: "Upon completion of the on-line Web portal enrollment/re-enrollment application, please do not submit a paper copy of the completed Web application to Gainwell Technologies. If a correction is required to the Web application, you may have been notified upon completion of your application that you should contact Gainwell Technologies at the following address in order for your application to be processed and not result in the denial of your application." The address listed is: "Gainwell Technologies, Provider Enrollment Unit, P.O. Box 5007, Hartford, CT 06102-5007". Below the address, there is a link: "To review the list of follow on documents that are required for your provider type and specialty, click on the following link: [Follow on Document Requirement by Provider Type and Specialty](#)". The link is highlighted with a red box.

# Provider Re-enrollment

## Re-enrollment Due Dates:

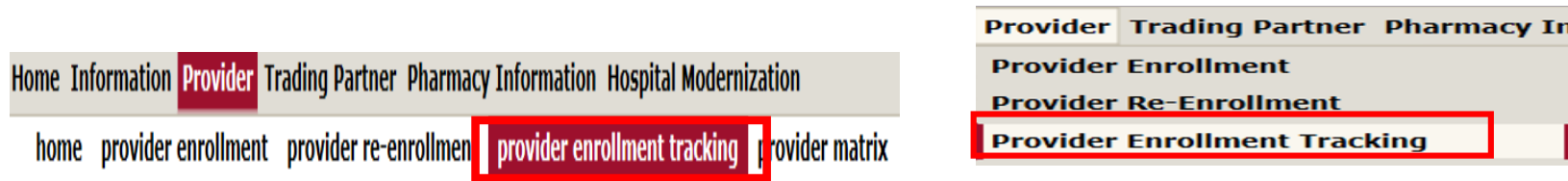
- Providers with secure Web portal access may view their re-enrollment due date once logged in.
  - Individual providers may view their re-enrollment due date on the Home page.
  - Organizations may view their re-enrollment due date, as well as the re-enrollment due date of their members by accessing 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.



The screenshot shows a web portal interface. At the top, there is a navigation bar with the following links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below this, there is a secondary navigation bar with links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. In the user information section, the text reads: Welcome, P004, Provider ID: 133, Provider AVRS ID: 0040, and Reenrollment Due Date: 07/01/2024. The date is highlighted with a red box.

# 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**

**Enrollment Tracking Search**

ATN\*

Business OR Last Name\*

In this example, DSS is conducting initial review of the application that was received on July 31, 2023.

Search Results	
Date Received	Status
07/31/2023	DSS Conducting Initial Review

# Provider Re-enrollment

## Performing Providers:

- Billing groups must associate their *performing providers* to the group since performing providers are enrolled/re-enrolled independent of the groups to which they belong.
- Each performing provider will re-enroll according to their own 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 may 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.

Authorization	Trade Files	MAPIR	Messages	Account
demographic maintenance	reset password			Account Home
				Account Maintenance
				Account Setup
				Change Password
				Clerk Maintenance
				<b>Demographic Maintenance</b>
				Reset Password
				Log Out

Provider Information			
Provider ID	1234567890	Address	15 Main Street
Organization	Sole Proprietor		Suite 2A
Usage	Service Location	City	Willimantic
Provider Type	27 - Dentist	County	Fairfield
Ownership	Yes	State/Zip	CT 06614-4008
Phone	203-555-5555		

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

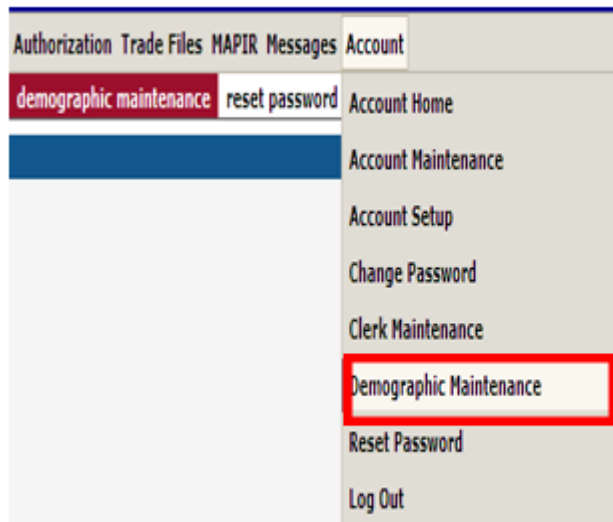
# Web Site Maintenance

# 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.



A screenshot of the 'Provider Information' form. The form contains the following fields and values:

Provider ID	1234567890	Address	15 Main Street
Organization	Sole Proprietor		Suite 2A
Usage	Service Location	City	Willimantic
Provider Type	27 - Dentist	County	Fairfield
Ownership	Yes	State/Zip	CT 06614-4008
Phone	203-555-5555		

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

# Demographic Maintenance – Address Updates

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

To update address information, simply select the applicable row from the provided list (Enrollment Address, Home Office, Mail to, Pay to, or Service Location); then click ‘maintain address’

**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](http://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  
 Mail To  
 Enrollment

Name Type:  Business Name  Personal Name

Name: MAPIR JENNIFER  
 Title: [v]  
 Usage: Mail to  
 Country: UNITED STATES  
 Address 1: 195 SCOTT SWAMP ROAD  
 Address 2: [v]  
 City: FARMINGTON  
 State: CT  
 Zip: 06032

Contact Name: [v]  
 Contact Phone: (860)255-3900  
 Fax: [v]  
 Address Indicator: Valid  
 Handicap Accessible?: No

E-Mail: [v]  
 Confirm E-Mail: [v]

**save** **cancel**

**maintain address**

Select/fill in the appropriate information (address, phone number, etc.); click ‘save’

**The following messages were generated:**

Message Description	Panel	Field
Save was Successful		

- Please Note: It is extremely important to make sure that all contact information (names, address, phone and email, etc.) is updated at all times. If there are any discrepancies in your enrollment/re-enrollment information, please be sure that the information in the demographic maintenance panel reflects updates/changes. If your demographic information is not accurate this can impact you receiving important information from DSS and Gainwell Technologies. **\*Alternate Service Location cannot be changed on the Web Portal, contact the Provider Assistance Center and they can assist with this change.**

# Demographic Maintenance – EFT Updates

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

- Click **add**
- Enter banking information in the EFT Account panel fields
- When complete, 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 (*)					
			<b><u>Account Number Linkage to Provider Identifier*</u></b>		
Provider Name*		<input type="text"/>	Provider Tax Identification Number (TIN)		<input type="text"/>
			OR		
<b><u>Provider Identifiers*</u></b>					
Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN)		<input type="text"/>			

**\*\*NOTE: 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.
- It is important to note that 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.
- There cannot be multiple provider enrollments at the same service location unless those enrollments are for the same group practice. Multiple unrelated groups or individual practices may not use the same service location. A multi-specialty practice may have the same service location.

Example:

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

# Demographic Maintenance – Maintain Organization Members

The **Maintain Organization Members** panel allows the local administrator 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”

The screenshot displays the 'Maintain Organization Members' interface. At the top, there are radio buttons for 'All', 'Current', and 'Historical'. Below these are search fields for 'Organization Member ID', 'Member Business/Last Name', and 'Member First Name', along with 'search' and 'clear' buttons. A table lists member information with columns: Organization Member ID, ID Type, Organization Member Name, Effective Date, End Date, and Reenrollment Due Date. A summary row shows 'Total Count: 3', 'Current Count: 2', and 'Historical Count: 1'. Below the table, there is an instruction: 'Select row above to update -or- click Add button below.' and two bullet points: 'To add a new member, click the add button.' and '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.' An 'add' button is present, followed by input fields for 'Organization Member ID' (with a search icon), 'Effective Date', 'Organization Member Name', 'End Date', and 'Reenrollment Due Date'. 'save' and 'cancel' buttons are at the bottom right.

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.

add

Organization Member ID [ Search ]      Effective Date

Organization Member Name      End Date

Reenrollment Due Date

save      cancel

# Demographic Maintenance – Maintain Organization Members

## To add a new member:

- Click the **Add** button.
- Enter the provider'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's association to begin.
- The end date will be automatically, populated with the date 12/31/2299.
- Click **Save**.

The screenshot displays a web interface for managing organization members. At the top, there are search filters: radio buttons for 'All', 'Current', and 'Historical' (with 'Historical' selected), and input fields for 'Organization Member ID', 'Member Business/Last Name', and 'Member First Name'. Below these are 'search' and 'clear' buttons. A table lists members with columns: Organization Member ID, ID Type, Organization Member Name, Effective Date, End Date, and Reenrollment Due Date. A row shows ID 1414141414, NPI type, and name BOYLE, DR. DAWN. Summary statistics show Total Count: 3, Current Count: 2, and Historical Count: 1. Below the table, instructions state: 'Select row above to update -or- click Add button below.' Two bullet points provide further guidance: 'To add a new member, click the add button.' and '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.' The 'add' button is highlighted with a green circle. Below it are input fields for Organization Member ID (with a search icon), Organization Member Name, Reenrollment Due Date, Effective Date, and End Date. At the bottom right are 'save' and 'cancel' buttons.

Organization Member ID <sup>A</sup>	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.

**add**

Organization Member ID  [ Search ]      Effective Date

Organization Member Name       End Date

Reenrollment Due Date

save      cancel

# Demographic Maintenance – Maintain Organization Members

## Add a new member:

All  Current  Historical

Organization Member ID  Member Business/Last Name  Member First Name

Organization Member ID <sup>A</sup>	ID Type	Organization Member Name	Effective Date	End Date	Reenrollment Due Date
A	NPI		12/01/2013	12/31/2299	03/20/2020

Total Count: 1      Current Count: 1      Historical Count: 0

Type data below for new record.

- 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 also shows the reenrollment due date for your members.

# Demographic Maintenance – Maintain Organization Members

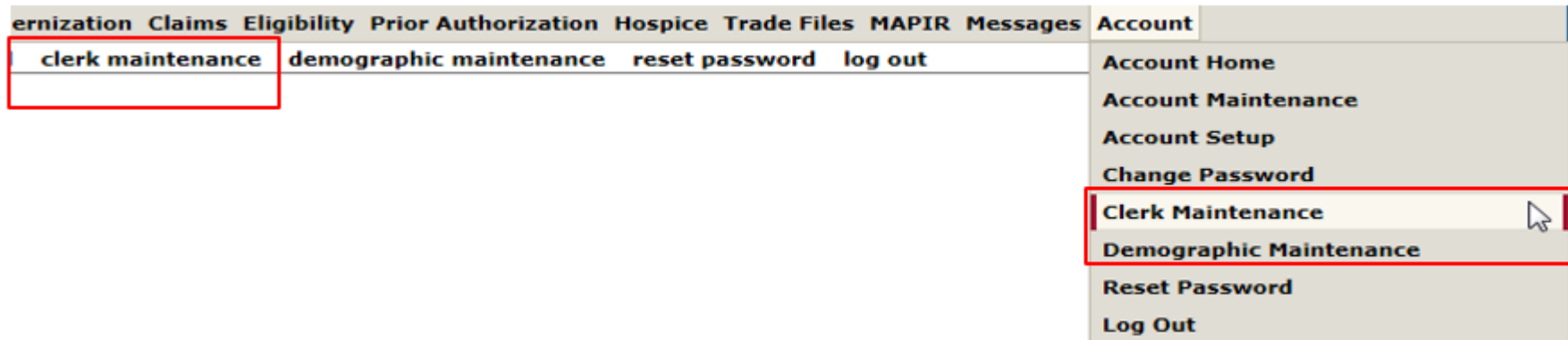
## To remove or end a provider's affiliation with your group:

- 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

The Clerk Maintenance panel can be accessed by

- Access the Clerk Maintenance section of the Secure Site by selecting clerk maintenance from either the Account submenu or the Account drop-down menu



# 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

Clerk roles can perform the following functions:

- **Claim Inquiry/Submission/Adjustment** – Allows clerks to inquire on claims, submit claims, and adjust claims through the Secure Web site. *This role cannot be limited to only claims inquiry or only claims submission*
- **PA Inquiry/Submission** - Allows clerks to inquire on PAs through the Secure Web site
- **Client Eligibility Verification** – Allows clerks to verify a client's eligibility
- **Submit Applications** – Allows clerks to submit applications to add an alternate service location address(es)
- **Trade Files Includes E-Delivery** – Allows clerks to Upload claims and retrieve claim file responses (999's), X12N transactions, retrieve electronically delivered letters, 1099s and to download Remittance Advices (RAs)
- **Trade Files E-Delivery Only** - Allows a clerk to access electronically delivered letters only, and does not provide access to trade file functions such as downloading Remittance Advices (RAs)

\*\*\*A clerk **cannot** be assigned both the “Trade Files Includes E-Delivery” and the “Trade Files E-Delivery Only” roles. \*\*\*

# Clerk Maintenance

## How to create a new Clerk Account

- Click **add clerk**
- Fill in the required fields
- Assign the clerk their roles
- Click **submit** when finished

The screenshot shows the 'Clerk Maintenance' form. At the top, there is a table with columns 'User ID', 'Contact First Name', and 'Contact Last Name'. Below the table, there are two buttons: 'remove clerk' and 'add clerk'. The 'add clerk' button is highlighted. The form contains the following fields:

- User ID\*: CLERK32
- Contact First Name\*: Test
- Contact Last Name\*: Clerk
- Phone Number\*: (111)222-3333
- Password\*: [masked]
- Confirm Password\*: [masked]
- AVR ID: [empty]
- AVR Pin: [empty]
- Confirm AVR Pin: [empty]

At the bottom right of the form, there are 'submit' and 'reset password' buttons.

The screenshot shows the 'Clerk Roles (Internet Only)' assignment interface. It features two columns: 'Assigned Roles' and 'Available Roles'. The 'Assigned Roles' column contains the following roles:

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

The 'Available Roles' column contains the following roles:

- Submit Applications
- Trade Files E-Delivery Only

Navigation buttons (<, <<, >, >>) are located between the two columns. At the bottom right, there are 'submit' and 'cancel' buttons.

# 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.

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

home account home account maintenance account setup change password **switch provider** reset password log out

Trading Partner/ Provider ID	Provider AVRS ID	Provider Type	Address	City	State	Zip	Zip +4	Default Provider/ Trading Partner
	00416	Pediatric Dentist						<input checked="" type="checkbox"/>
	00421	General Dentist						<input type="checkbox"/>

Select row above to update.

switch to

Current Provider/Trading Partner 156 NPI

Provider/Trading Partner ID Address

Provider AVRS ID 00421 City HARTFORD

Provider Type Behavioral Health Clinician Group State CT

Default Provider/Trading Partner Zip 06112 1260

# Client Eligibility

# Client Eligibility - Verification

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

Eligibility verification can be performed in the following ways:

- Internet Web site at [www.ctdssmap.com](http://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 transactions
- On the CTDHP Web site [www.ctdhp.org](http://www.ctdhp.org), by logging in under Dental Providers

# Client Eligibility - Verification

## Search by Service Type Codes

From the Web site at [www.ctdssmap.com](http://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.

The screenshot shows the 'Eligibility' tab selected in the top navigation bar. A red box highlights the 'Eligibility' tab. Below the navigation bar, a 'Valid Search Combinations' box lists five search criteria: Client ID + SSN, Client ID + Birth Date, Birth Date + SSN, Full Name + SSN, and Full Name + Birth Date. A red arrow points to this box. Below the search combinations is an 'Eligibility Verification Request' form. The form contains several input fields: Client ID (009999999), SSN, Birth Date (01/20/2007), Last Name, First Name, MI, From DOS\* (11/21/2023), and To DOS\* (11/21/2023). There are five Service Type Code dropdown menus. The first dropdown, 'Service Type Code 1', is highlighted with a red box and contains the text '35 - Dental Care'. To the right of the form is a blue 'search' button.

# 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

**Managed Care Provider**  
\*\*\* No rows found \*\*\*

**Lockin**  
\*\*\* 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:

- Call Health Management System, Inc. (HMS) at 1-866-252-0671
- Email requests may be made to [CTinsurance@gainwelltechnologies.com](mailto:CTinsurance@gainwelltechnologies.com)

# Dental Fee Schedules

# Dental Fee Schedules

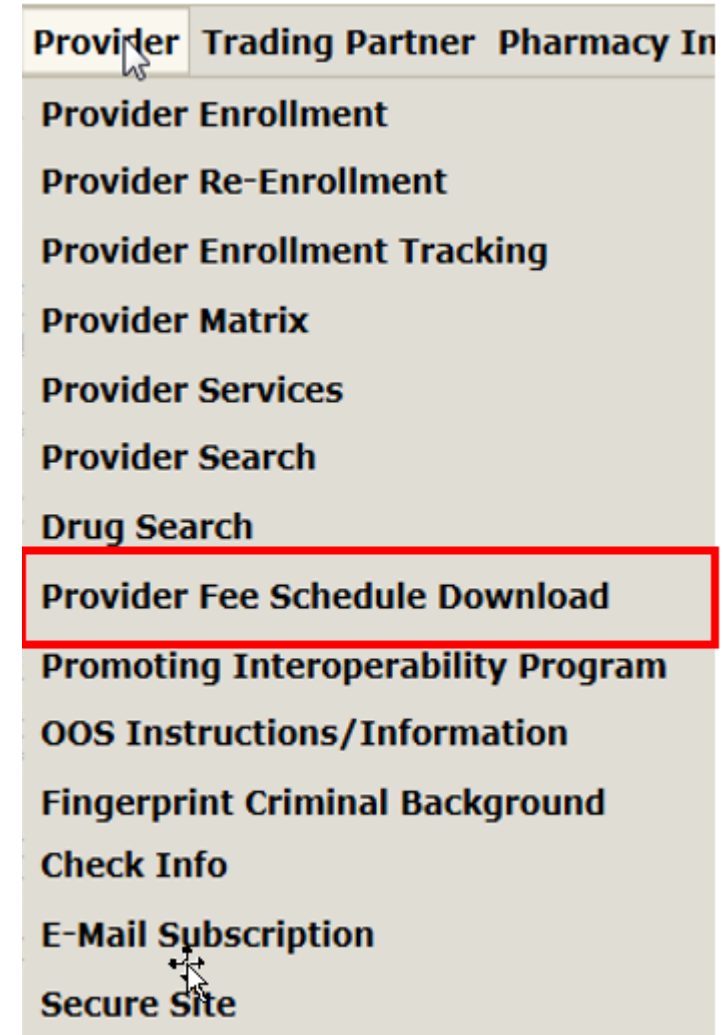
The CMAP dental fee schedule is split into two separate fee schedules effective for dates of service (DOS) September 1, 2016 and forward.

- 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 once 52% of the pediatric rate but is no longer.

# Dental Fee Schedules

CMAP *fee schedules* are available for download from the Web site [www.ctdssmap.com](http://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 **Accept**.



# Dental Fee Schedules

Provider Fee Schedules are listed by provider type and specialty.

For dental adult fee schedule, click on the CSV link next to **Dental Adult**.

For dental pediatric fee schedule, click on the CSV link next to **Dental Pediatric**.

For 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 NE 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 Pediatric Dental fee schedule:

1/1/2023 Pediatric Dental Fee Schedule							Last Updated	10/26/2023								
-----																
This fee schedule lists the fees for a client under the age of 21.																
-----																
Proc Cd	Mod	Proc description	Max Fe	Husky	Effective Da	End Date	PGM Li	270	276	293	275	295	296	274	271	
12011		Repair of wound (2.5 centimet	44.11	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12013		Repair of wound (2.6 to 5.0 ce	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12014		Repair of wound (5.1 to 7.5 ce	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12015		Repair of wound (7.6 to 12.5 ce	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12016		Repair of wound (12.6 to 20.0 c	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12017		Repair of wound (20.1 to 30.0 c	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12018		Repair of wound (over 30.0 ce	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12031		Repair of wound (2.5 centimet	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12032		Repair of wound (2.6 to 7.5 ce	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12041		Repair of wound (2.5 centimet	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12042		Repair of wound (2.6 to 7.5 ce	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12051		Repair of wound (2.5 centimet	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12052		Repair of wound (2.6 to 5.0 ce	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12053		Repair of wound (5.1 to 7.5 ce	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
12054		Repair of wound (7.6 to 12.5 ce	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	
14040		Tissue transfer repair of woun	511.48	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA	
14041		Tissue transfer repair of woun	735.25	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA	

# Dental Fee Schedules

## Example of the Adult Dental fee schedule:

1/1/2023 Adult Dental Fee Schedule										Last Updated		10/26/2023							
This fee schedule lists the fees for a client age 21 and older.																			
Proc C	Mod	Proc description	Max Fe	Husky	Effective D	End Date	PGM L	Endod	270	276	293	275	295	296	274	271			
									Oral &	Oral &	Period	Prosth	Dental	Pediat	Genera				
12011		Repair of wound (2.5 centimeters or less) of the fa	29.26	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12013		Repair of wound (2.6 to 5.0 centimeters) of the fac	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12014		Repair of wound (5.1 to 7.5 centimeters) of the fac	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12015		Repair of wound (7.6 to 12.5 centimeters) of the fa	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12016		Repair of wound (12.6 to 20.0 centimeters) of the f	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12017		Repair of wound (20.1 to 30.0 centimeters) of the f	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12018		Repair of wound (over 30.0 centimeters) of the fac	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12031		Repair of wound (2.5 centimeters or less) of the sc	67.85	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12032		Repair of wound (2.6 to 7.5 centimeters) of the sca	84.51	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12041		Repair of wound (2.5 centimeters or less) of neck	67.85	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12042		Repair of wound (2.6 to 7.5 centimeters) of neck h	84.51	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			
12051		Repair of wound (2.5 centimeters or less) of face	67.85	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR	PR			

# 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 Post Authorization Review is required to be obtained from Connecticut Dental Health Partnership(CTDHP) **AFTER** the service has been performed.

# Dental Fee Schedules

## Footer information continued...

- PA means Prior Authorization is required to be obtained from CTDHP BEFORE the service is performed for all clients.
- <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.
- Providers can access the dental fee schedule at [www.ctdssmap.com](http://www.ctdssmap.com) to determine which procedure codes require PA or PR.
- Providers should refer to the CTDHP Web site [www.ctdhp.org](http://www.ctdhp.org) 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.org](http://www.ctdhp.org) provider Web portal.

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

- Access the [www.ctdhp.org](http://www.ctdhp.org) Web site and click on **Dental Providers**.
- In drop down menu select **Provider Login**.
- Enter your Billing NPI and Tax ID numbers in the appropriate boxes and click on **Login**.
- A new screen will appear, click on **Prior Authorization Upload**.
- Follow instructions for prior authorization or post procedure review requests.

---

## Provider Login

Billing NPI Number:

Tax ID or SSN:

Login

Please sign in using the NPI number under which your office is enrolled and under which you submit claims. Your Billing NPI may be your office's Type I or Type II NPI depending upon how you are enrolled. Please use the Tax ID or Social Security Number under which you receive IRS reporting information (1099s).

# Prior Authorization

Hard copy submissions for non-orthodontic services that require PA or PR should be mailed 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 mailed 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 PR into Gainwell Technologies' 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](http://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.
  - Benecare (CTDHP) uploads the approved PA files.
  - Information is available online before notices are sent out.
  - Incomplete PA requests are pended until further information requested is submitted.

# Prior Authorization Inquiry

On the provider secure Web site [www.ctdssmap.com](http://www.ctdssmap.com), under **Prior Authorization** select **Prior Authorization Search**.

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

Quick Link

- Web Guide - Prior Authorization Search

Provider 008000008 MCD

### Prior Authorization Search

Client ID	<input type="text"/>	Prior Authorization	<input type="text"/>
Client Name	<input type="text"/>	PA Assignment	<input type="text"/>
Requested Eff Date	<input type="text"/>	PA Assign - Sub	<input type="text"/>
Requested End Date	<input type="text"/>	Procedure	<input type="text"/> [ Search ]
Authorized Eff Date	<input type="text"/>	Revenue Code	<input type="text"/> [ Search ]
Authorized End Date	<input type="text"/>	Proc/Mod List	<input type="text"/>
		Records	20 <input type="text"/>

# 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	
Procedure Code/List	D3320 [ Search ]	[ Search ]
Modifier 1	[ Search ]	
Modifier 2	[ Search ]	
Modifier 3	[ Search ]	
Modifier 4	[ Search ]	
Revenue Code/List	[ Search ]	[ Search ]
Requested Eff./End Dates*	09/01/2009	11/30/2009
Requested Units/Dollars*	2.000	\$0.00
Tooth	[ Search ]	
Quad	[ Search ]	
Tooth Surface 1	[ Search ]	
Tooth Surface 2	[ Search ]	
Tooth Surface 3	[ Search ]	
Tooth Surface 4	[ Search ]	
Tooth Surface 5	[ Search ]	
NDC	[ Search ]	
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)

This panel will display 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 benefits.
- 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.

A listing of program limitations can also be found on [www.ctdhp.org](http://www.ctdhp.org). A reference chart is located under the Dental Provider section, select Dental Providers Benefit Grid.

# Program Limitations

## Dental Benefit Assignment by Client Resources

To verify when a procedure was last performed on a client:

- Access the [www.ctdhp.org](http://www.ctdhp.org) Web site, click on **Dental Providers** then click on **Provider Login** in drop down menu.
- Log into **Provider Login** by using **Billing NPI Number** and **Tax ID** or **SSN**.
- From the gray menu on the left, click on **Client Inquiry**.
- Enter the client's Medicaid ID number and date of birth and click **Submit**.
- 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 claim 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 annually.

Example:

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; 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 may review restoration services provided to a client within the past year by logging into their secure portal [www.ctdssmap.com](http://www.ctdssmap.com).

Click on **Claims**, then from the drop-down menu select **Claim History for Specific Services**. Enter the Client ID, select **Dental Restoration** as the 'Inquiry Type', enter the Date of Service and click **Search**.

The screenshot shows the CTDSSMAP portal interface. 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, MAPIR, and Messages. Below this is an 'Account' section with a breadcrumb trail: home > claim inquiry > professional > institutional > dental > claim history for specific services. The 'Claims' menu is open, showing options: Claim Inquiry, Professional, Institutional, Dental, and Claim History for Specific Services (highlighted with a red box). The search form includes: Client ID\* (00XXXXXX), Inquiry Type\* (Dental Restoration), Procedure (empty), and Date of Service\* (07/08/2019). Search and clear buttons are present. Below the form is a 'Benefit History' table.

Date of Service	Procedure	Tooth Number	Tooth Surf 1	Surf 2	Surf 3	Surf 4	Surf 5	Allowed Amount	Units Allowed	Paid Date	ICN	Detail Number	Provider Name	Phone
08/26/2018	D2391 - Post 1 srfc resin	12	L					\$49.40	1	12/05/2018	2218337050001	2	XXXXXXXX,XXXXXXXXX	(800)000-0000
08/06/2018	D2140 - Amalgam one surfa	12	B					\$49.40	1	12/05/2018	2218337050001	1	XXXXXXXX,XXXXXXXXX	(800)000-0000

# Program Limitations

## Annual Adult Dental Benefit Maximum

- An annual dental benefit maximum (ABM) 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 1<sup>st</sup> 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 1<sup>st</sup> of each year.
- For a client turning 21 years old, the benefit limit starts from the date of the 21<sup>st</sup> birthday through the end of the year.
- Emergency Dental Services which consist of Oral Surgery and Root Canal Treatment services as well as 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 may review 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](http://www.ctdssmap.com).

Click on **Claim History for Specific Services** from under the **Claims** drop-down. Enter the Client ID, select **Dental Benefit Limit** as the 'Inquiry Type', enter the Date of Service and click **Search**.

The screenshot shows the 'Claim History for Specific Services' form in the CTDSSMAP portal. The form includes fields for Client ID, Inquiry Type (set to 'Dental Benefit Limit'), Procedure, and Date of Service (07/08/2019). A dropdown menu is open under 'Claims', with 'Claim History for Specific Services' selected. Below the form is a 'Benefit History' table with a summary row showing 'Total Amount Paid: \$59.80' and 'Remaining Amount: \$940.20'.

Benefit History																						
Date of Service	Procedure	Tooth Quad 1	Quad 2	Quad 3	Quad 4	Quad 5	Tooth Number	Tooth Surf 1	Surf 2	Surf 3	Surf 4	Surf 5	Paid Amount	Units Allowed	Paid Date	ICN	Detail Number	PA Indicator	Provider Name	Phone		
04/01/2019	D7140 - Extraction erupte						1						\$59.80	1		2219189050001	1	No	XXXXXX, XXXXXXX X	(800)000-0000		
													<b>Total Amount Paid:</b>	<b>\$59.80</b>	<b>Remaining Amount:</b>	<b>\$940.20</b>						

# 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

Provider Bulletin [2019-24](#)

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).

A dental provider may not perform the service or bill the client unless the client has knowingly signed a Treatment Consent for Payment form that

- explains the type of service that is not covered by Medicaid due to lack of medical necessity;
- details the amount of money the dental provider will charge the member for the service;
- and
- 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).

A sample "Treatment Consent for Payment" form may be viewed on the Dental Provider page under Dental Provider Toolkit, select Dental Provider Forms and Compliance on the [www.ctdhp.org](http://www.ctdhp.org) Web site.

# Web Claims Submission Tool

# Web Claim Inquiry

To search for a claim, select **Claim Inquiry** from the drop-down list under **Claims**

The screenshot shows a web application interface. At the top, there is a navigation bar with tabs for 'Home', 'Information', 'Provider', 'Trading Partner', 'Pharmacy Information', 'Hospital Modernization', 'Claims', 'Eligibility', and 'Prior Authorization'. The 'Claims' tab is selected, and a dropdown menu is open, showing options: 'Claim Inquiry' (highlighted with a red box), 'Professional', 'Institutional', 'Dental', and 'Claim History for Specific Services'. Below the navigation bar, there is a red warning message: 'Your password expires in 60 day(s) on 7/14/2017 at 12:00 AM Change'. Below this, there is a welcome message for user P004, including their Provider ID (19), NPI, Provider AVRS ID (004), Reenrollment Due Date (01/27/2008), and Zip Code (06752 - 1031). A message states: 'Your R.A.s, or 835 transactions, are being sent to: Your download page in the Trade Files menu option.' At the bottom, there is a table titled 'Global Messages' with columns for Category, Subject, Message, Sent Date, Effective Date, and End Date. The table contains one row of data. Below the table, there is a section titled 'Secure Mailbox' with the message '\*\*\* No rows found \*\*\*'.

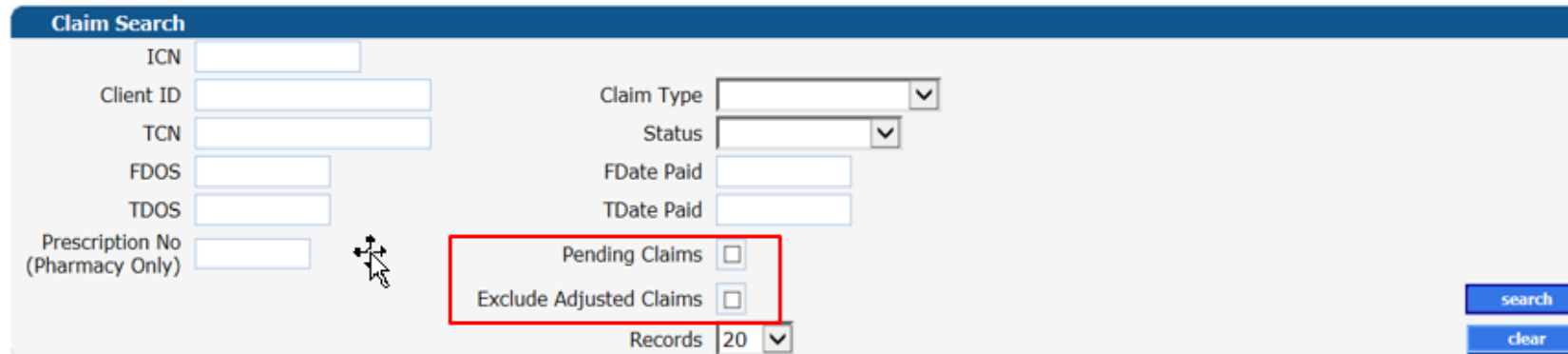
Global Messages					
Category	Subject	Message	Sent Date	Effective Date	End Date
Notification	Web Claim Submission is Here!	Web claim submission is now...	12/22/2009	12/22/2009	12/31/2299

\*\*\* No rows found \*\*\*

# Web Claim Inquiry

Providers will have the ability to view claims by:

- Internal Control Number (ICN)
- Client ID and date of service (range no greater than 93 days)
  - If you submit one claim with multiple date of services (i.e. 03/01/2023, 3/10/2023 and 03/24/2023, when you do a claim inquiry you need to search for the entire date range. If you search for just 03/10/2023, the inquiry will not return a claim.
- Date of payment (range no greater 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)



The screenshot displays a 'Claim Search' form with the following fields and options:

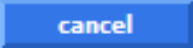
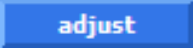
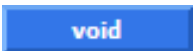
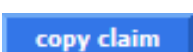
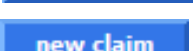
- ICN:
- Client ID:
- TCN:
- FDOS:
- TDOS:
- Prescription No (Pharmacy Only):
- Claim Type:
- Status:
- FDate Paid:
- TDate Paid:
- Pending Claims:
- Exclude Adjusted Claims:
- Records: 20

Buttons: search, clear


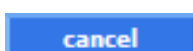
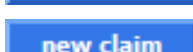
# Web Claim Inquiry

## What can I do with these claims?

– *Paid* claims allow you to:

-  Cancel any data entry you have done to the claim
-  Adjust the claim
-  Void the claim
-  Copy the claim and use it as a template to create a new claim
-  Create a new claim

– *Denied* claims allow you to:

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

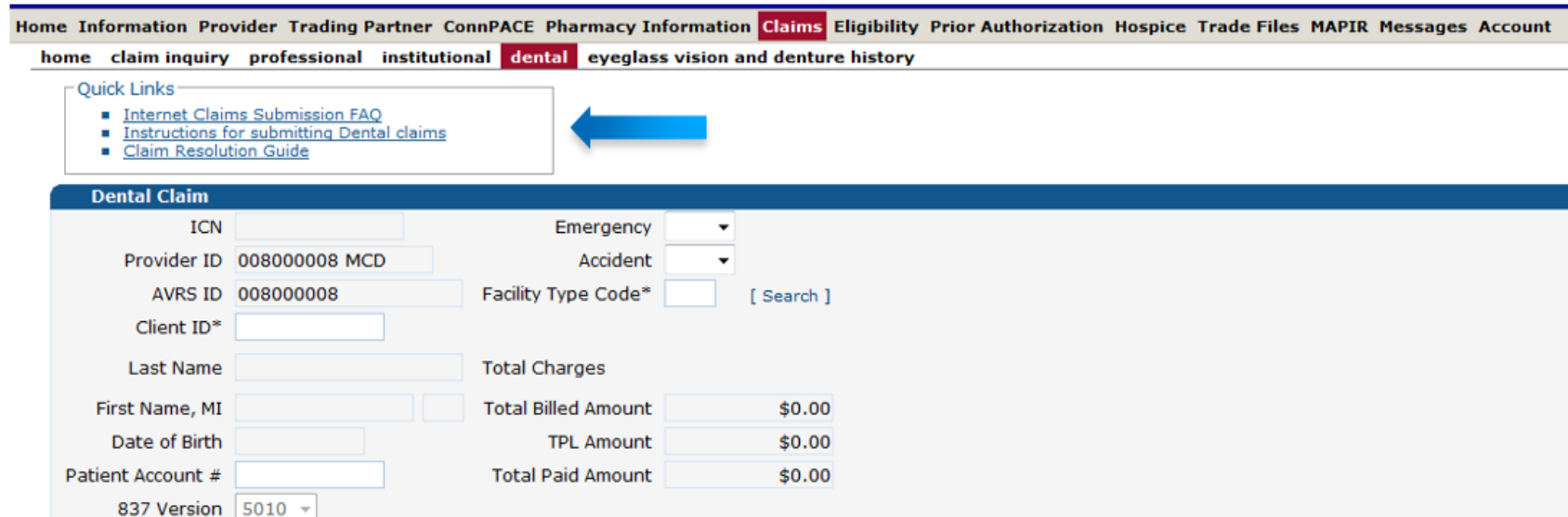
– *Suspended* claims allow you to:

-  Create a new claim

# New Claim Submission

To submit Dental Claims using the [www.ctdssmap.com](http://www.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.



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

home claim inquiry professional institutional **dental** eyeglass vision and denture history

Quick Links

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


**Dental Claim**


ICN	<input type="text"/>	Emergency	<input type="text"/>
Provider ID	008000008 MCD	Accident	<input type="text"/>
AVRS ID	008000008	Facility Type Code*	<input type="text"/> [ Search ]
Client ID*	<input type="text"/>		
Last Name	<input type="text"/>	Total Charges	
First Name, MI	<input type="text"/>	Total Billed Amount	<input type="text"/> \$0.00
Date of Birth	<input type="text"/>	TPL Amount	<input type="text"/> \$0.00
Patient Account #	<input type="text"/>	Total Paid Amount	<input type="text"/> \$0.00
837 Version	5010		

# 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.

Dental Claim	
ICN	<input type="text"/>
Provider ID	1616161616 NPI
AVRS ID	008001007
Client ID*	005153371
Emergency	<input type="checkbox"/> 
Accident	<input type="checkbox"/> 
 Facility Type Code*	<input type="text"/> [ Search ]

# 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: the follow claims cannot be adjusted:

- 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 Gainwell Technologies and are, therefore, not able to be adjusted via the [www.ctdssmap.com](http://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

# Secondary Claim – Other Insurance Payment

To submit an Other Insurance (OI) primary claim using the [www.ctdssmap.com](http://www.ctdssmap.com) secure site, click on **Claims** then **dental**.

- Complete all fields with an asterisk on the Dental Claim Panel, Detail Panel and any additional information as it pertains to the claim.
- In the TPL Panel, click the **Add** button.
- 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.

The screenshot shows the TPL interface. At the top, there is a table with the following data:

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						

Below the table, there is a section titled "Type data below for new record." with the following form fields:

- Client Carriers: 060 - BC/BS OF CONNECTICUT (dropdown)
- Carrier Code: 060 (input) [ Search ]
- Plan Name: BC/BS OF CONNECTICUT (input)
- Policy Number: 03241971 (input)
- Paid Amount\*: (input)
- Paid Date\*: (input)
- Relationship: (dropdown)
- Last Name: (input)
- First Name, MI: (input)
- Date of Birth: (input)
- Adjustment Reason Code: (input) [ Search ] (input) [ Search ] (input) [ Search ]
- Adjustment Amount: (input) \$0.00 (input) \$0.00 (input) \$0.00

At the bottom of the form, there are two buttons: "delete" and "add".

# Secondary Claim - Other Insurance Denial

If the Other Insurance 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

# Contact Information

## Where to go for additional information:

The Connecticut DSS website can be reached by navigating to [www.ctdssmap.com](http://www.ctdssmap.com) where you will be able to find and review:

- 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

# Important Messages

[www.ctdssmap.com](http://www.ctdssmap.com) contains a wealth of information for providers:

- Important Messages
  - Available on the Home page. Also available on the Information page
  - Contains urgent messages that require immediate communication to the provider community as well as links to important information regarding recent/upcoming system changes

## Important Messages

[Attention All Home Health Providers: Home Health Agencies \(HHA\) HUSKY Health Secure Provider Web Portal Sign Up \(Posted 3/14/23\)](#)

[Hospital Monthly Important Message \(Posted 3/13/23\)](#)

[Attention Home Health Providers: Alternate Electronic Visit Verification \(EVV\) Town Hall Session #3 Date & Registration Link and Previous Town Hall Recordings available on the Connecticut Medical Assistance Program \(CMAP\) Web site \(Posted 3/7/23\)](#)

[CMAP Addendum B January 2023 \(Updated 2/24/23\)](#)

[Attention Home Health Providers: Alternate Electronic Visit Verification \(EVV\) Provider - Vendor Registration and Notification of Revised Provider Bulletin 2023-07 \(Posted 2/24/23\)](#)

[Attention Behavioral Health Providers: Beacon Health Options to become Carelon Behavioral Health \(Posted 2/24/23\)](#)

[Attention Home Health Providers: Reminder for Home Health Providers and their Alternate Electronic Visit Verification \(EVV\) Vendors to Register for the Upcoming Town Hall Sessions \(Posted 2/17/23\)](#)

[Attention Outpatient Hospital Providers: Monkeypox Testing and Vaccines in the Outpatient Hospital Setting \(Posted 2/14/23\)](#)

[Attention: Behavioral Health Providers \(Posted 2/10/23\)](#)

[Attention Home Health Providers: Reminder of Electronic Visit Verification \(EVV\) Home Health Provider Survey and Upcoming Town Hall Session Dates \(Posted 2/9/23\)](#)

[Attention Home and Community-Based Waiver Providers: URGENT: ACTION REQUIRED to receive March 2% rate increase through value-based payments \(VBP\) \(Posted 2/9/23\)](#)

[Attention Home Health Providers: URGENT: ACTION REQUIRED to receive March 2% rate increase through value-based payments \(VBP\) \(Posted 2/9/23\)](#)

# Provider Bulletins

## Where to find 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](http://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 using the Title field, you are able to search 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.org](http://www.ctdhp.org) Web site.

# Provider Bulletins

## Provider Bulletins – Searching by Provider Type



Help  
Site: C  
Login

Tuesday, November 21, 2023 at 3:24:26 PM

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

home **publications** links hipaa messages archive



Information

**Bulletin Search**

Year  Provider Type

Number  Title

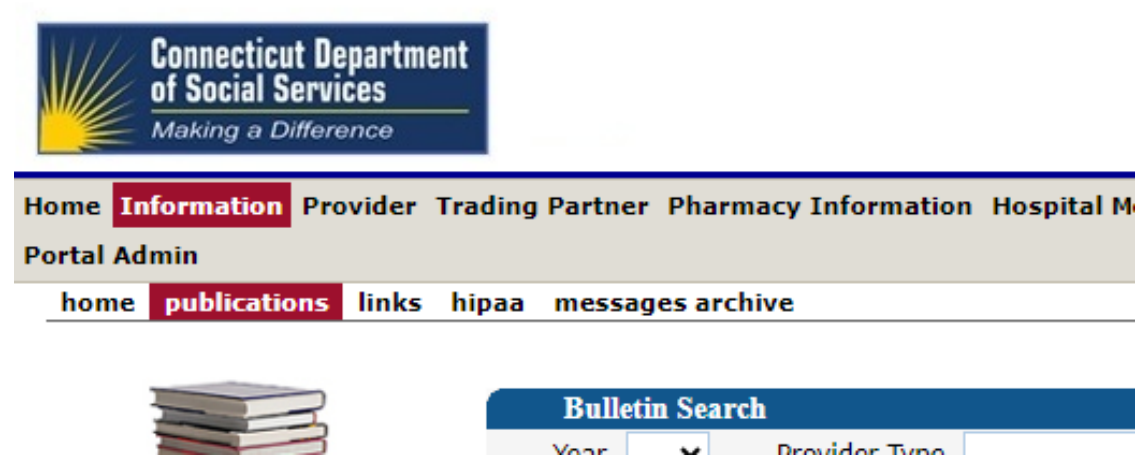
**Search Results**

Bulletin Number	Title	Published Date
PB23-68	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/07/2023
PB23-64	New Hepatitis C Policy	10/05/2023
PB23-61	Veyo Transition to MTM	09/08/2023
PB23-57	Adding Select Procedure Codes for Evaluation/Management Services to Dental Fee S...	08/15/2023
PB23-55	New Medicaid Coverage of Targeted Case Management for Integrated Care for Kids (...	07/14/2023
PB23-54	Multi-disciplinary Examinations for Medical, Behavioral Health and Dental Servic...	07/12/2023
PB23-25	Addition of Procedure Code G0330 to the ASC fee schedule	06/06/2023
PB23-25	Rate Increase of Bariatric Surgery Procedure Code 43775 to the ASC Fee Schedule	06/06/2023
PB23-40	Revised W10 Form/Inter-Agency Patient Referral Report	06/05/2023
PB23-42	Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL...	05/31/2023
PB23-42	July 1, 2023 Changes to the Connecticut Medicaid Preferred Drug List (PDL)	05/31/2023
PB23-42	Pharmacy Web PA Tool	05/31/2023
PB23-42	Reminder About the 5-day Emergency Supply	05/31/2023
PB23-41	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedu...	05/17/2023
PB23-38	REVISED Guidance for Services Rendered via Telehealth	05/11/2023
PB23-31	Sunsetting Provider Bulletins Issued in Response to the COVID-19 Public Health E...	05/02/2023
PB23-30	COVID-19 Vaccine Administration Guidance	04/13/2023
PB23-32	Discontinuation of the Optional COVID-19 Testing Group - Effective May 12, 2023	04/13/2023
PB23-34	Public Health Emergency Eligibility Unwinding	04/13/2023

# Newsletters

Located under Information tab,  
select Publications.

Scroll down to Provider  
Newsletters



The screenshot shows the top navigation bar of the Connecticut Department of Social Services website. The logo at the top left features a sunburst icon and the text "Connecticut Department of Social Services" with the tagline "Making a Difference". Below the logo is a horizontal menu with the following items: Home, Information (highlighted in red), Provider, Trading Partner, Pharmacy Information, Hospital M, and Portal Admin. A secondary menu below this includes: home, publications (highlighted in red), links, hipaa, messages, and archive. To the right of the navigation is a "Bulletin Search" section with a search bar and a dropdown menu for "Year".



The screenshot shows a section titled "Provider Newsletters" with a blue header. Below the header is a list of five items, each preceded by a bullet point:

- [September 2023 interChange Newsletter](#)
- [June 2023 interChange Newsletter](#)
- [March 2023 interChange Newsletter](#)
- [December 2022 interChange Newsletter](#)
- [Provider Newsletter Archives](#)

# Provider Manuals

## **Chapter 1 – Introduction**

- Provides information on the CT Medical Assistance Program, the Department of Social Services' and Gainwell Technologies responsibilities and resources

## **Chapter 2 – Provider Participation Regulations**

- Details the CMAP regulations for provider participation

## **Chapter 3 – Provider Enrollment**

- Provides information on provider eligibility in regard to provider enrollment and re-enrollment

## **Chapter 4 – Client Eligibility**

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

## **Chapter 5 – Claim Submission Information**

- Provides information on general claims processing, billing requirements and timely filing guidelines

## **Chapter 6 – EDI Options**

- Provides information on electronic claim submission and electronic RAs

# Provider Manuals

## **Chapter 7 – Regulations/Program Policy**

- This section contains the Medical Services Policy sections that pertain to the chosen provider type

## **Chapter 8 – Billing Instructions**

- Provides information on provider specific billing requirements and instructions

## **Chapter 9 – Prior Authorization**

- Provides information on how to obtain Prior Authorization for designated services

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

- Provides information on both the AVRS and the Web Portal functions

## **Chapter 11 – Other Insurance/Medicare Billing Guides**

- Provides claim-type specific information on other insurance and Medicare billing

## **Chapter 12 – Claim Resolution Guide**

- Provides descriptions of common EOBs and, if applicable, information to resolve the errors

# Chapter 12 - 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									
<input checked="" type="radio"/> All <input type="radio"/> Current <input type="radio"/> 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	

# Chapter 12 - Claim Resolution Guide

EOB	Description
-----	-------------

<b>1912 Billing provider's taxonomy is missing</b>
--

<b>Cause</b>
--------------

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.
---

<b>Resolution</b>
-------------------

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.
---

# Chapter 12 - Claim Resolution Guide

EOB	Description
	<p data-bbox="392 372 1684 419"><b>0610 Tooth Number/Tooth Surface combination invalid</b></p> <p data-bbox="392 508 545 555"><b>Cause</b></p> <p data-bbox="392 565 2066 651">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.</p> <p data-bbox="392 696 647 743"><b>Resolution</b></p> <p data-bbox="392 768 1989 905">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.</p> <p data-bbox="392 925 2091 968">A list of tooth surface/tooth number combinations can be found in Provider Bulletin <a href="#">PB 14-62</a>.</p>

# Chapter 12 - Claim Resolution Guide

## 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](http://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.

# Claim Resolution

## Assistance:

- Please note if you are experiencing difficulties with your claims adjudication, you should first contact the Gainwell Technologies Customer Service Center at the following:

**1-800-842-8440**

- If you require further assistance, the Customer Service Center escalate your call to the Provider Representative that handles dental claims.
- Please ask for assistance if you need help with your claims.

# Contact Information

**Gainwell Technologies 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@gainwelltechnologies.com](mailto:ctdssmap-provideremail@gainwelltechnologies.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