

Welcome to the Dental Refresher Provider Workshop Training – January, 2025

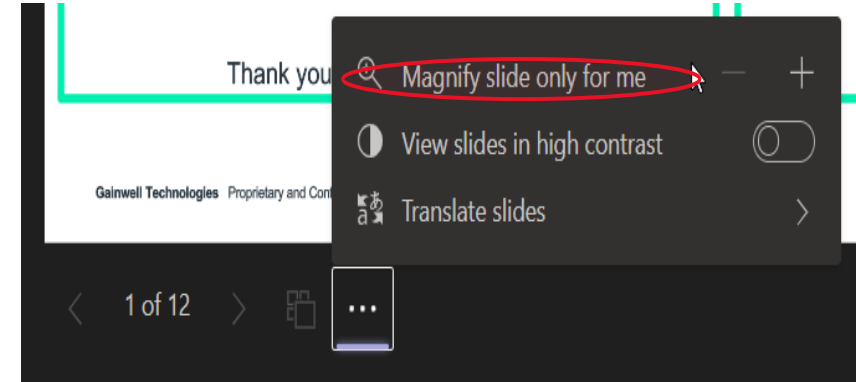
Once you have joined the Microsoft Teams meeting, please follow these communication rules:

- 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.

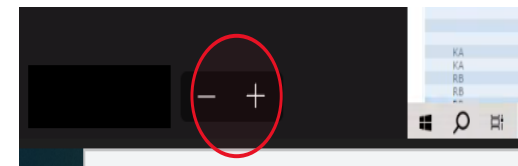
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While content is being shared, in the lower left-hand side of the screen, click the (...) and an option to ‘Magnify slide only for me’ appears allowing you to zoom in or out.



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Connecticut Medical Assistance Program: Dental Refresher

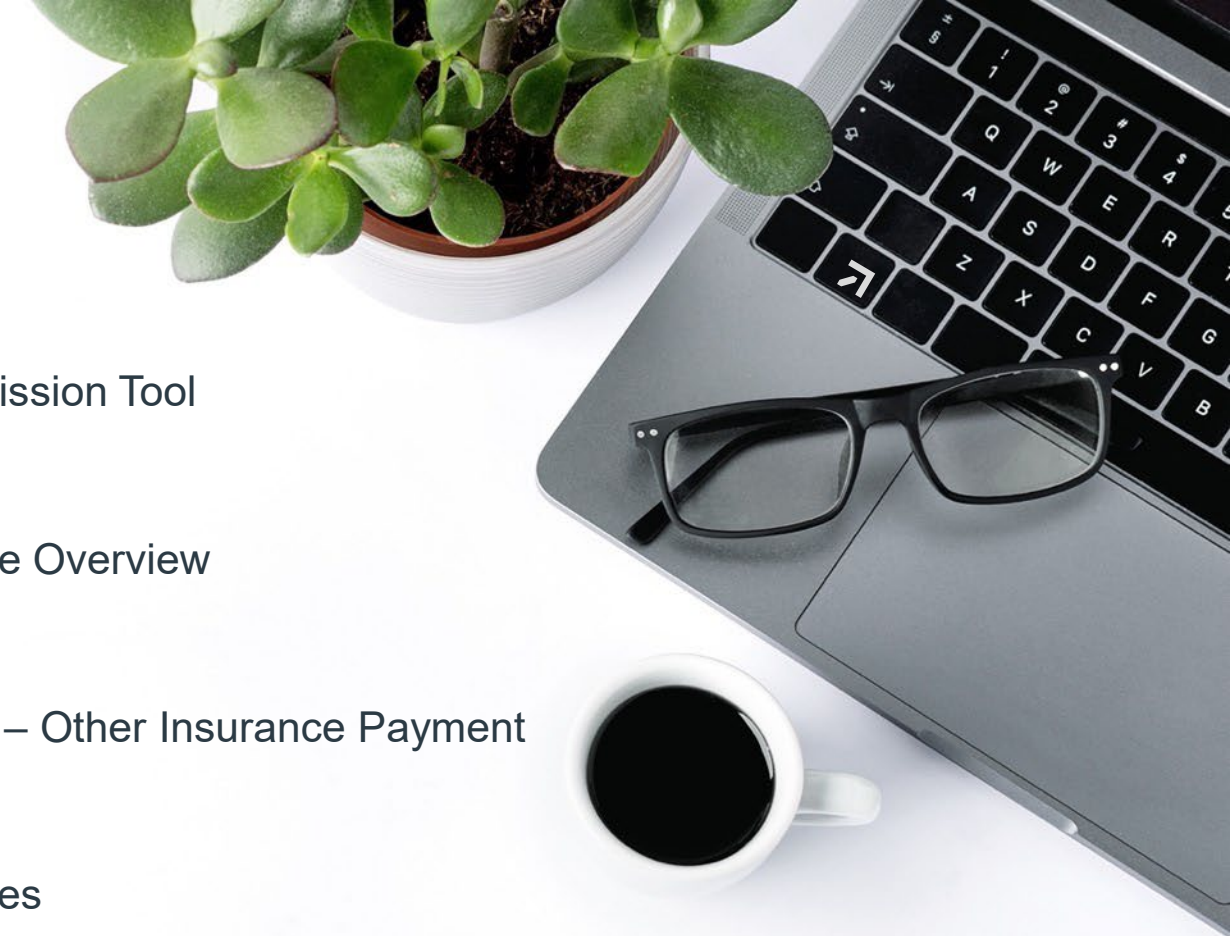
Presented by: Susan Pausmer

The Department of Social Services and
Gainwell Technologies
January 16 and 27, 2025



Training Topics

- 1 2024 Updates
- 2 Provider Re-enrollment
- 3 Web Site Maintenance
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2024 Updates



Updates

Clarifying Billing Guidance for Periodontal Services [Provider Bulletin 24-08](#)

This provider bulletin (PB) will supplement guidance found in [PB 2023-69](#) “UPDATED: Addition of Periodontal Benefits and clarify the dental examination parameters and requirements for the submission of prior authorization requests for Periodontal Services.

- **D0150 Comprehensive Oral Evaluation**, New or Established Patient. This CDT code is to be used by a general dentist or dental specialist when evaluating a patient comprehensively. For patients aged 21 years and over, CDT code D0150 may be billed once per HUSKY Health member per their lifetime. For new patients, or established patients who have had a significant change in their health conditions or other unusual circumstances, an additional comprehensive oral evaluation can be requested through the prior authorization process.
- **D0180 Comprehensive Periodontal Evaluation** – new or established patient. This CDT code is billed when the patient is showing signs or symptoms of periodontal disease. The comprehensive Periodontal Evaluation must include evaluating the condition of the gingivae and oral tissues, whether bleeding is present or not and recorded depths and bleeding on probing for all six aspects for each tooth surface. Along with the periodontal charting, the patient should be evaluated and documented for tooth mobility grades, plaque scores, description of the location and severity both supra sub-gingival calculus deposits, recession, and attachment loss if present, all oral disease states, and medical history inclusive of amount of alcohol consumption, illicit drug use, drugs that cause xerostomia or gingival hyperplasia, history including tobacco, “vaping” and cannabis use and oral tobacco.
- **As noted in the [PB 2023-69](#), if your office or clinic is not going to perform the scaling and root planing and/or debridement procedure(s), you should not perform or bill for the comprehensive periodontal evaluation.**

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:

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

Updates

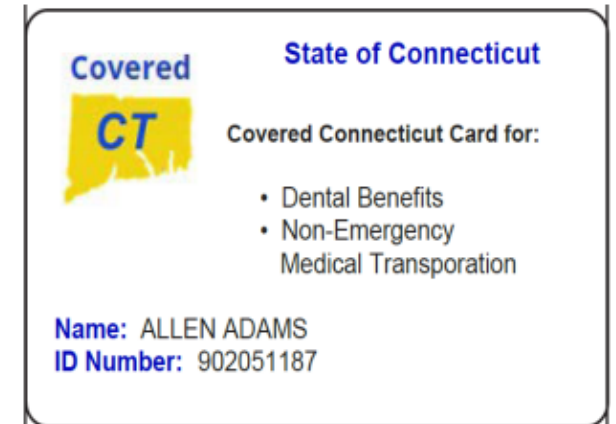
Dental Claim Form Field Update Reminder [Provider Bulletin 22-64](#)

- The purpose of this provider bulletin is to remind all dental providers that the place of service is required on all dental claims. 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.

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



Updates

Billing Updates for Dental T1015 Encounter Codes [Provider Bulletin 22-45](#)

Periodic Dental Services:

Any non-emergency periodic dental service, including, but not limited to, (1) an examination, (2) prophylaxis, and (3) radiographs, including bitewings, complete series and periapical imaging, if warranted, shall be completed in one visit. A second visit to complete any service normally included during the course of a non-emergency periodic dental visit shall not be eligible for reimbursement unless (A) medically necessary, and (B) such medical necessity is clearly documented in the patient's dental record.”

Restorative Services:

Quadrant Dentistry Multiple single or two surface restorations should be performed during one dental visit and not performed separately within a quadrant in multiple visits.

Sextant Dentistry: If quadrant dentistry is not required, the oral cavity may be broken into six sextants. Multiple two, three or four surface fillings are appropriate for sextant dentistry. Services that require multiple visits to complete (endodontics, crowns, and full & partial dentures) will still be authorized for the appropriate number of FQHC encounter visits required to complete the procedure.

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 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. The website also features a logo for the Connecticut Medical Assistance Program (CMAP) 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.

Provider Re-enrollment

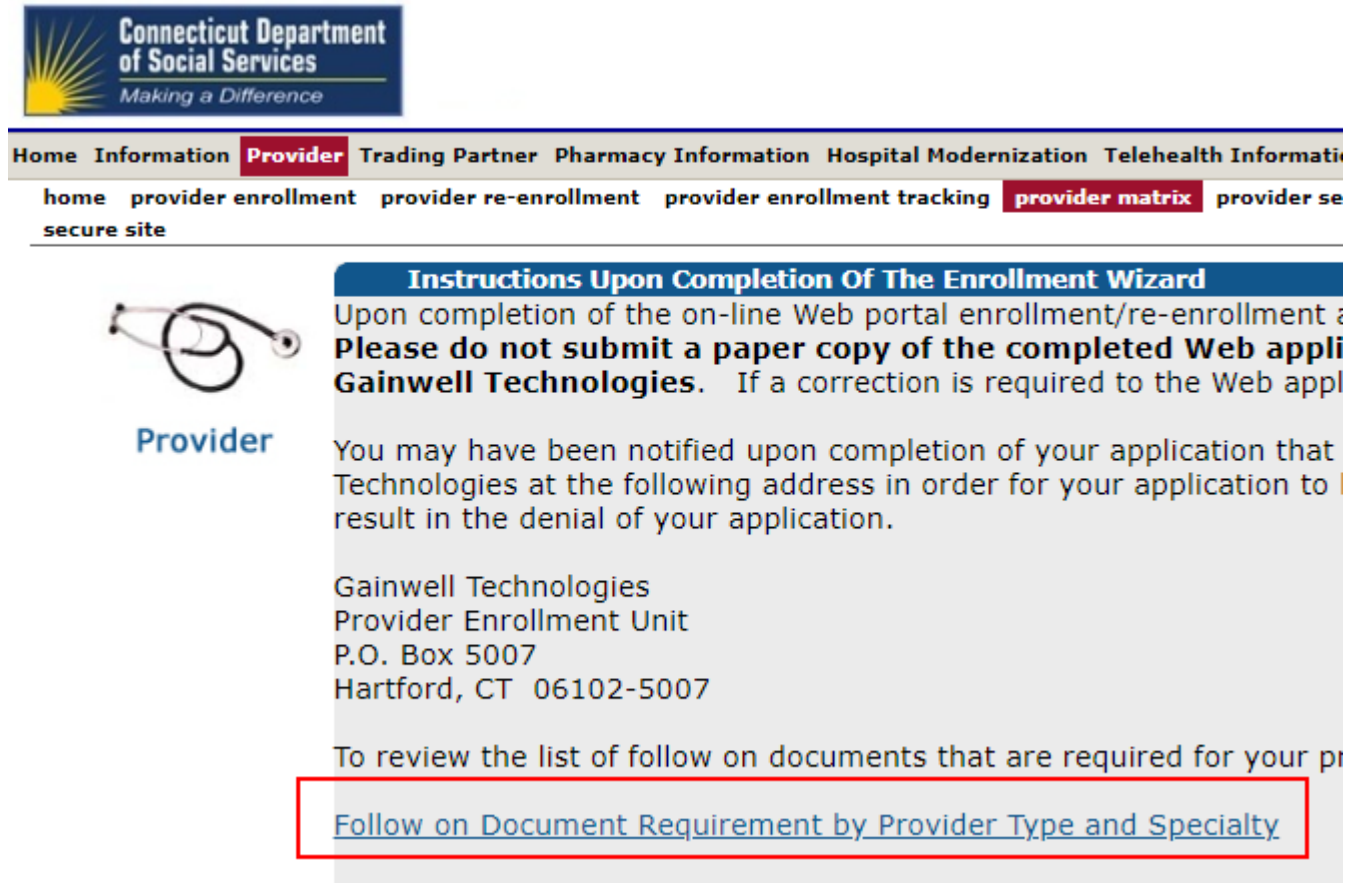
Follow On Documents:

- 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 by clicking **Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty** link.

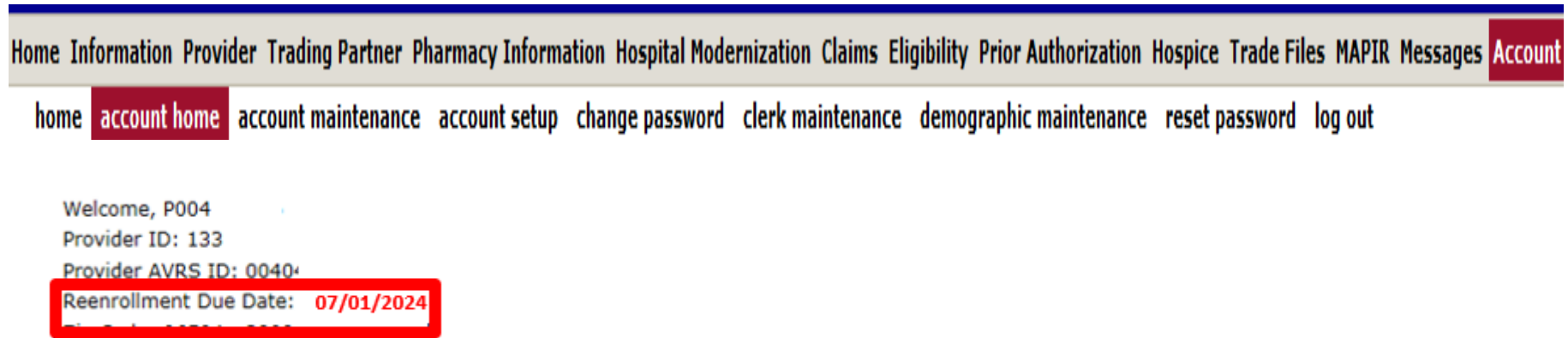


The screenshot shows the Connecticut Department of Social Services website. The header includes the logo and the text "Connecticut Department of Social Services Making a Difference". The navigation menu includes "Home", "Information", "Provider", "Trading Partner", "Pharmacy Information", "Hospital Modernization", 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 "Provider" icon and the text "Provider". To the right, there is a section titled "Instructions Upon Completion Of The Enrollment Wizard" with the following text: "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. result in the denial of your application. Gainwell Technologies Provider Enrollment Unit P.O. Box 5007 Hartford, CT 06102-5007 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. The 'Account' link is highlighted in red. Below the navigation bar, there is a secondary menu with the following links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The 'account home' link is highlighted in red. Below the secondary menu, there is a user information section with the following text: Welcome, P004, Provider ID: 133, Provider AVRS ID: 0040, and Reenrollment Due Date: 07/01/2024. The 'Reenrollment Due Date: 07/01/2024' text 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
				Demographic Maintenance
				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

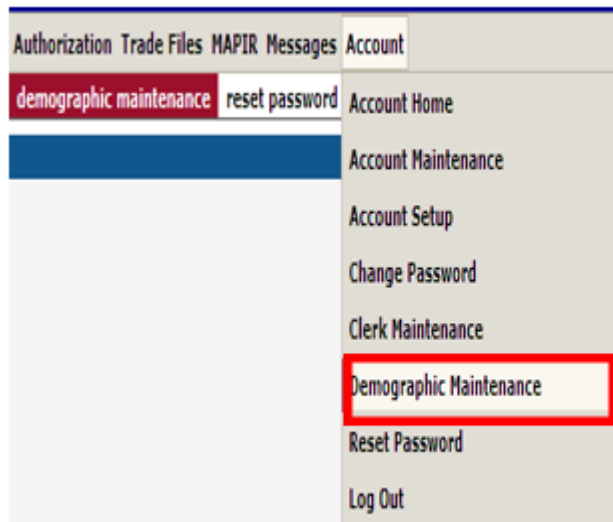


Demographic Maintenance

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 a '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, 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.

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: []

City: FARMINGTON

State: CT

Zip: 06032

Contact Name: []

Contact Phone: (860)255-3900

Fax: []

E-mail: []

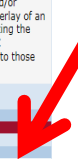
Confirm EMail: []

Address Indicator: Valid

Handicap Accessible?: No

Buttons: 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 (*)					
Provider Name*			<u>Account Number Linkage to Provider Identifier*</u>		
<input type="text"/>			Provider Tax Identification Number (TIN)		<input type="text"/>
			OR		
<u>Provider Identifiers*</u>			National Provider Identifier (NPI)		
Provider Federal Tax Identification Number (TIN) OR Employer Identification Number (EIN)		<input type="text"/>	<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”

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

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

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

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

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

Organization Member ID [Search] Effective Date

Organization Member Name End Date

Reenrollment Due Date

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 for 'All', 'Current', and 'Historical' (selected), along with input fields for 'Organization Member ID', 'Member Business/Last Name', and 'Member First Name'. A 'search' button is located to the right of these fields, and a 'clear' button is below it. Below the search area is a table with the following data:

Organization Member ID ^A	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

Below the table, the following counts are displayed: Total Count: 3, Current Count: 2, and Historical Count: 1. A message reads: 'Select row above to update -or- click Add button below.' Below this message are two instructions:

- 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.

The 'add' button is circled in green. Below the instructions are input fields for 'Organization Member ID' (with a search icon), 'Effective Date', 'Organization Member Name', 'End Date', and 'Reenrollment Due Date'. At the bottom right, there are 'save' and 'cancel' buttons.

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 ^A	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

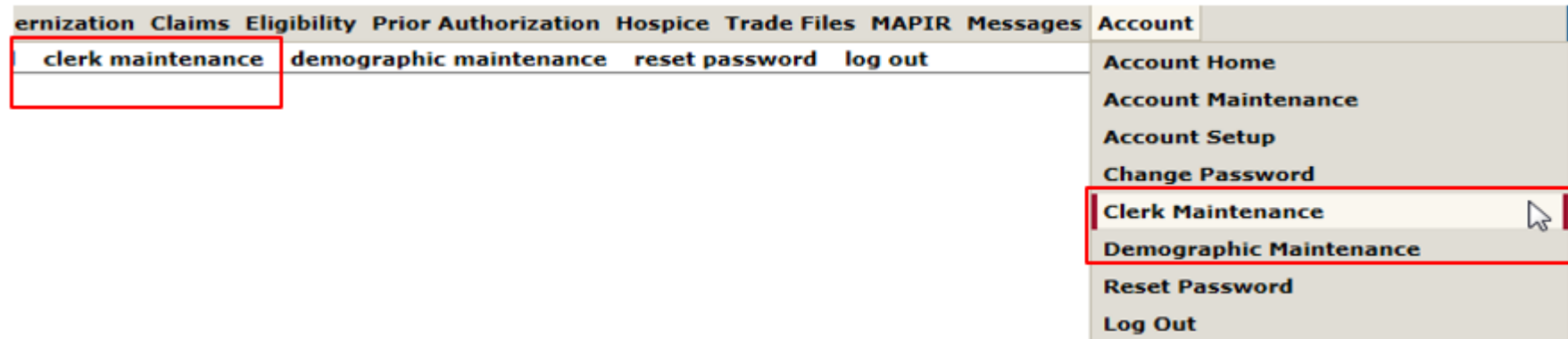
To remove or end a provider's affiliation with your group:

- 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. Primary account user (*Master User assigns User IDs and passwords for their clerks*)
- Assign the clerk their roles
- Click **submit** when finished

The screenshot shows the 'Clerk Maintenance' form. At the top, there is a header with 'User ID', 'Contact First Name', and 'Contact Last Name'. Below this, there is a red bar with 'A CLERK32' and a prompt 'Type data below for new records.' There are two buttons: 'remove clerk' and 'add clerk'. The form fields are: 'User ID*' (CLERK32), 'Contact First Name*' (Test), 'Contact Last Name*' (Clerk), 'Phone Number*' ((111)222-3333), 'Password*' (masked with dots), 'Confirm Password*' (masked with dots), 'AVR ID', 'AVR Pin', and 'Confirm AVR Pin'. There are also 'submit' and 'reset password' buttons on the right.

The screenshot shows the role assignment interface. On the left, there is a label 'Clerk Roles (Internet Only)'. In the center, there is a list of 'Assigned Roles' with four items: 'Claim Inquiry/Submission/Adjustment', 'Client Eligibility Verification', 'PA Inquiry/Submission', and 'Trade Files Includes E-Delivery'. On the right, there is a list of 'Available Roles' with two items: 'Submit Applications' and 'Trade Files E-Delivery Only'. Between the two lists are four navigation buttons: '<', '<<', '>', and '>>'. 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.
- Set up your clerk by using the same User ID for each web account.
- 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

Switch Provider

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.

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

switch to

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
- Automated Voice Response System (AVRS)
- 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, by logging in under Dental Providers

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.

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 a link for 'Eligibility Response Quick Reference Guide'. The main form is titled 'Eligibility Verification Request' and 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/ 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 1	Message 2	Message 3	Message 4
Husky A. For Behavioral Health Services, call BHP at 877-552-8247.	01/01/2025	01/15/2025	01/15/2025	Next Re-enrollment date is 01/31/2025			

Deductible Information

Service Information	Effective Date	End Date	Base Deductible Amount	Remaining Amount
Husky A			\$0.00	

Out of Pocket Information - Includes Deductible and Coinsurance

*** No rows found ***

Service Type Codes - Medicaid Services

Service Type Code	Service Type Information	Copay	Coinsurance
1	Medical Care		
33	Chiropractic	\$0.00	0%
35	Dental Care		
4	Diagnostic X-Ray	\$0.00	0%
40	Oral Surgery	\$0.00	0%
42	Home Health Care	\$0.00	0%
45	Hospice	\$0.00	0%
47	Hospital	\$0.00	0%
48	Hospital - Inpatient	\$0.00	0%
5	Diagnostic Lab	\$0.00	0%

1 2 3 Next >

Service Type Codes - MCO Services

*** No rows found ***

Service Type Codes - Not Covered

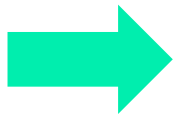
*** No rows found ***

Additional Benefit Information

*** No rows found ***

Limit Information

Description	Service Type Codes	Effective Date	End Date	Annual Maximum	Remaining Balance	Message
Dental Annual Benefit Maximum	35	01/01/2025	12/31/2025	\$1,000.00	\$1,000.00	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.



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 contact HMS:

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

Dental Fee Schedules



Dental Fee Schedules

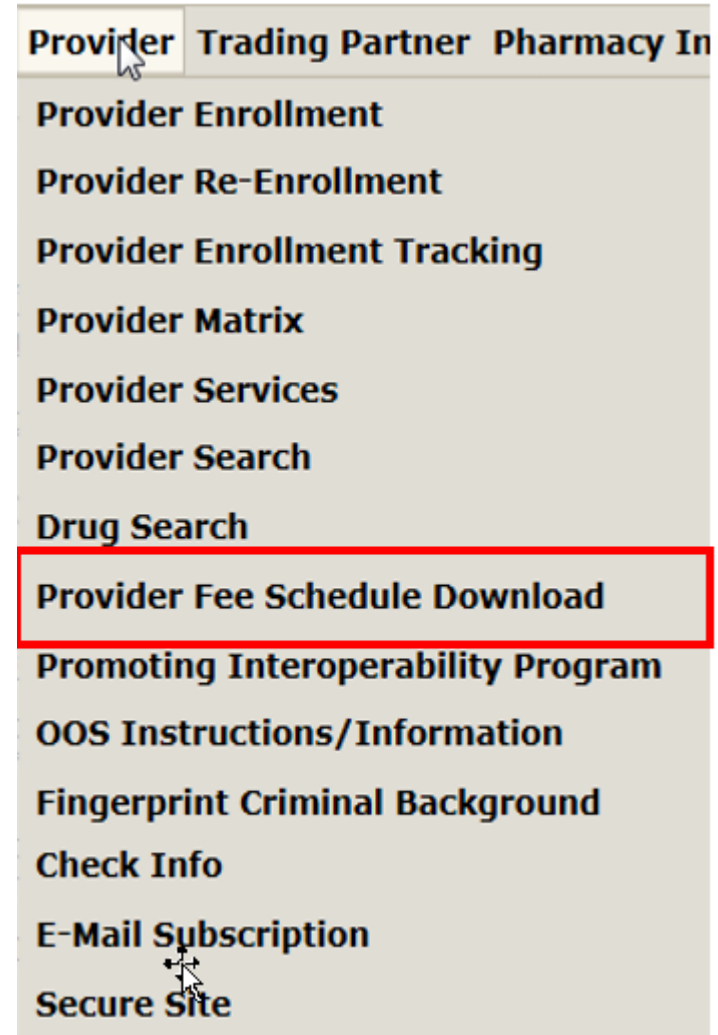
The CMAP dental fee schedule is split into two separate fee schedules effective for dates of service (DOS) September 1, 2016 and forward.

- 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.

- 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 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:

1/1/2025 Pediatric Dental Fee Schedule				Last Updated		12/12/2024									

This fee schedule lists the fees for a client under the age of 21.															

Proc Cd	Mod	Proc description	Max Fe	Husky I	Effective Da	End Date	PGM	Endoc	270 Oral &	276 Oral &	293 Period	275 Prosth	295 Dental	296 Pediat	274 Genera
12011		Repair of wound (2.5 centimeters or less)	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 centimeters)	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 centimeters)	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 centimeters)	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 centimeters)	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 centimeters)	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12018		Repair of wound (over 30.0 centimeters)	63.93	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12031		Repair of wound (2.5 centimeters or less)	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 centimeters)	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12041		Repair of wound (2.5 centimeters or less)	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 centimeters)	127.41	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
12051		Repair of wound (2.5 centimeters or less)	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 centimeters)	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 centimeters)	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 centimeters)	102.29	NA	9/1/2016	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR
14040		Tissue transfer repair of wound (10 sq ce)	511.48	NA	9/1/2016	12/31/2299		PA	PA	PA	PA	PA	PA	PA	PA
14041		Tissue transfer repair of wound (10.1 to	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:

		1/1/2025 Adult Dental Fee Schedule				Last Updated		12/12/2024																	

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

										270		276		293		275		295		296		274		271	
Proc Cd	Mod	Proc description	Max Fe	Husky I	Effective D	End Date	PGM	Endod	Oral &	Oral &	Period	Prosth	Dental	Pediat	Gener										
12011		Repair of wound (2.5 centimeters	29.26	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12013		Repair of wound (2.6 to 5.0 centir	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12014		Repair of wound (5.1 to 7.5 centir	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12015		Repair of wound (7.6 to 12.5 cent	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12016		Repair of wound (12.6 to 20.0 cen	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12017		Repair of wound (20.1 to 30.0 cen	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12018		Repair of wound (over 30.0 centir	42.40	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12031		Repair of wound (2.5 centimeters	67.85	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12032		Repair of wound (2.6 to 7.5 centir	84.51	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12041		Repair of wound (2.5 centimeters	67.85	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12042		Repair of wound (2.6 to 7.5 centir	84.51	NA	7/1/2022	12/31/2299		PR	PR	PR	PR	PR	PR	PR	PR										
12051		Repair of wound (2.5 centimeters	67.85	NA	7/1/2022	12/31/2299		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 to determine which procedure codes require PA or PR.
- Providers should refer to the CTDHP Web site 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 provider Web portal.

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

- Access the 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.
 - 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, under **Prior Authorization** select **Prior Authorization Search**.

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

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

home **prior authorization search** care plan pharmacy prior authorization

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" value="v"/>
Search Pharmacy PAs only	<input type="checkbox"/>	PA Assign - Sub	<input type="text" value="v"/>
Requested Eff Date	<input type="text"/>	Procedure	<input type="text"/> [Search]
Requested End Date	<input type="text"/>	Revenue Code	<input type="text"/> [Search]
Authorized Eff Date	<input type="text"/>	Proc/Mod List	<input type="text"/>
Authorized End Date	<input type="text"/>	Procedure Code List	<input type="text"/> [Search]

Records

Prior Authorization Inquiry

PA Inquiry result

Base Information										
Prior Authorization Number	2010018002									
Client ID	0034			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.

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 active, 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 the warning, there is a welcome message: 'Welcome, P004' followed by provider details: 'Provider ID: 19 NPI', 'Provider AVRS ID: 004', 'Reenrollment Due Date: 01/27/2008', and 'Zip Code: 06752 - 1031'. Below the provider details, there is a message: '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: 'Category', 'Subject', 'Message', 'Sent Date', 'Effective Date', and 'End Date'. The table contains one row: 'Notification', 'Web Claim Submission is Here!', 'Web claim submission is now...', '12/22/2009', '12/22/2009', and '12/31/2299'. Below the table, there is a section titled 'Secure Mailbox' with the message: '*** No rows found ***'.

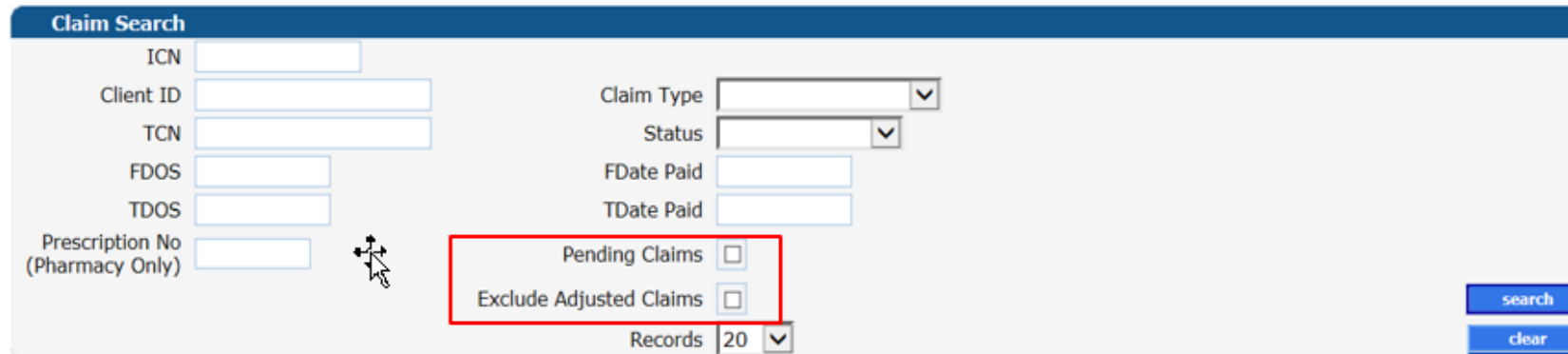
Global Messages					
Category	Subject	Message	Sent Date	Effective Date	End Date
Notification	Web Claim Submission is Here!	Web claim submission is now...	12/22/2009	12/22/2009	12/31/2299

*** 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. 04/01/2024, 4/10/2024 and 04/24/2024, when you do a claim inquiry you need to search for the entire date range. If you search for just 04/10/2024, 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:

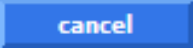
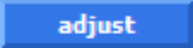
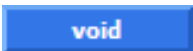
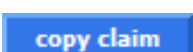
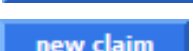
- ICN:
- Client ID:
- TCN:
- FDOS:
- TDOS:
- Prescription No (Pharmacy Only): 
- Claim Type: 
- Status: 
- FDate Paid:
- TDate Paid:
- Pending Claims:
- Exclude Adjusted Claims:
- Records: 20 

Buttons:


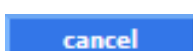
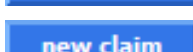
Web Claim Inquiry

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 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	\$0.00
Date of Birth	<input type="text"/>	TPL Amount	\$0.00
Patient Account #	<input type="text"/>	Total Paid Amount	\$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*	005 <input type="text"/>
Emergency	<input type="text"/> 
Accident	<input type="text"/> 
 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 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.

Remittance Advice Overview



Remittance Advice Overview

All claims processed by Gainwell Technologies are reported to the provider by cycle on a Remittance Advice (RA)

- RAs are available electronically via the secure Provider Web site at www.ctdssmap.com. RAs are available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper RA version
- The PDF version of the RA is found under Trade Files, Download, Transaction Type on drop down menu Remit Advice (RA) - PDF

The screenshot displays the CTDSSMAP website interface. At the top, there is a navigation bar with tabs for Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Telehealth Information, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, and Trade Files. Below this, there are sub-tabs for Behavioral Health Attestation, Account, and Portal Admin. The main content area is titled 'File Download Search' and features a 'Transaction Type' dropdown menu. The dropdown menu is open, showing a list of file types: 1099s, BH Attestation, Billing/Reversal, CRF Payment Agreement, CSV, Claim Payment/Advice, Claim Status Response, Drug Rebate File Transfer, E-Delivery, Eligibility Response, Enrollment/Maintenance, Functional Ack, Interchange Ack, PA Revers/Inq/Req Only, PCCM Reports, PDP/MAPD Reports, Premium Payments, Prior Authorization, and Remit. Advice (RA) - PDF. To the right of the dropdown, there are 'search' and 'clear' buttons. Below the search area, there is a 'REMIT. ADVICE' section with a warning: 'Warning: Type of file being downloaded. The ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download on the ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available. Historical files are available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available. E-Delivery files are available for approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available. 1099 files are available for approximately three (3) years, at which time they will be removed and will no longer be available. It is recommended that files be downloaded when they become available and be stored by the Provider, Trading Partner, Labeler or clerk of those entities, in electronic format for easy storage and search access by the Provider, Trading Partner, Labeler or clerk of those entities. All file retention schedules are subject to change. Changes to file retention schedules will be posted on this page.' At the bottom of the page, there is a footer that reads 'Files are listed in order of the date they become available. Current Files Available for Download'.

Remittance Advice Overview

- The PDF RA via the secure Provider Web site will be available to providers on the check date indicated on the financial cycle schedule. The cycle schedule may be downloaded from the Web site portal under Provider > Provider Services. The provider will have access to their last ten (10) RAs
- The ASC X 12N 835 Payment/Advice via the Secure Provider Web site will be available the Wednesday following each claims processing cycle. The last ten (10) 835 Payment/Advices will be available
- Gainwell Technologies encourages providers to save a copy of their ASC X12N 835 Payment/Advice and/or their PDF RAs to their local computer system for future access, since **only the last ten (10) RAs are maintained on the Gainwell Technologies Web site. RAs older than the last ten (10) will not be available**

Remittance Advice Overview

Banner page

REPORT: CRA-BANN-R Date: 09/12/2023
 RA#: 8290235 PAGE: 1

interChange MMIS
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 PROVIDER **BANNER MESSAGES**

PAYEE ID NPI
 ISSUE DATE
 TAXONOMY
 P. AVRS ID

Attention All Providers. PROVIDER FILE MAINTENANCE: In order to maintain the accuracy and completeness of the Connecticut Medical Assistance Program (CMAP) network, we are requesting all providers update their provider file on a regular basis. The information that you provide is presented in the on-line provider directory at www.ct.gov/husky. Thousands of members statewide rely on the accuracy of this source of information to find a suitable health care provider. Inaccurate addresses, phone numbers, and names may affect a member's ability to contact you. To update your provider profile, the main account administrator can log into their secure Web account from the www.ctdssmap.com Web site and click on the "Demographic Maintenance" tab. Once on the Demographic Maintenance page, the provider can select from options listed as links below the Demographic Maintenance header panel. For instance, you can update your address* if you happen to move to a new location; all you have to do is click on the "Location Name Address" link, select the address to be

Claim Information (Paid, Dental)

REPORT: CRA-DNPD-R Date: 12/24/2024
 RA#: 8635178 PAGE: 2

interChange MMIS
 MEDICAID MANAGEMENT INFORMATION SYSTEM
 PROVIDER REMITTANCE ADVICE
 DENTAL CLAIMS **PAID**

PAYEE ID NPI
 ISSUE DATE
 TAXONOMY
 P. AVRS ID

FP	--ICN-- -PATIENT NUM-	RENDERING PROVIDER	SERVICE DATES FROM THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PAID AMOUNT	
1			120624 120624	298.00	134.26	0.00	0.00	134.26	
	PL SERV	PROC CD	TOOTH	SURFACE QUAD	DATE SVC PERF	BILLED AMOUNT	ALLOWED AMOUNT	CLIENT RESP	DETAIL EOB
	11	D0160			120624	150.00	49.00	0.00	9918 0258
	11	D0330			120624	148.00	85.26	0.00	9918 0258

Remittance Advice Overview

Claim Adjustments

REPORT: CRA-DNAD-R
RA#: 8635178

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
DENTAL CLAIM ADJUSTMENTS

Date: 12/24/2024
PAGE: 10

EAST LYME, CT 06333-1727

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI

FP	--ICN--	RENDERING	SERVICE DATES	BILLED	ALLOWED	TPL	CO-PAY	PAID				
1	-PATIENT NUM-	PROVIDER	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT				
			120524 120524	298.00	134.26		74.00	60.26				
PL	SERV	PROC CD	TOOTH	SURFACE	QUAD	DATE SVC	BILLED	ALLOWED	CLIENT	DETAIL	EOBS	
11		D0160				120524	150.00	49.00	0.00	9907	9918 0258	
11		D0330				120524	148.00	85.26	0.00	9907	9918 0258	
TOTAL DENTAL ADJUSTMENT CLAIMS:				0.00	79.00	2,574.00	0.00	-1,087.32				
TOTAL NO. OF ADJ:		6										

-----ACCOUNTS RECEIVABLE-----									
A/R	SETUP	RECOUPED	ORIGINAL	TOTAL	REASON	APPLICANT/	APPLICANT/	LIAB DATE/	
NUMBER/ICN	DATE	THIS CYCLE	AMOUNT	-RECOUPED-	--BALANCE--	CODE	CLIENT NO.	CLIENT NAME	PGM YEAR
	12/21/2024	1,062.32	1,062.32	1,062.32	0.00	8400			
	12/21/2024	74.00	74.00	74.00	0.00	8400			
-----1099 ADJUSTMENTS-----									
TRANSACTION	SETUP	ADJUSTMENT	REASON						
NUMBER	DATE	AMOUNT	CODE						
NO 1099 ADJUSTMENTS									

Remittance Advice Overview

Claim Information - Denied

REPORT: CRA-DNDN-R
RA#: 8389032

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
DENTAL CLAIMS DENIED

Date: 01/23/2024
PAGE: 17

[REDACTED]

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI

[REDACTED]

--ICN--	RENDERING	SERVICE DATES	BILLED	TPL						
-PATIENT NUM-	PROVIDER	FROM THRU	AMOUNT	AMOUNT						
CLIENT NAME: [REDACTED]		CLIENT NO.: [REDACTED]								
96133		122123 122123	410.84	0.00						
PL SERV	PROC CD	TOOTH	SURFACE	QUAD	DATE	SVC	BILLED	CLIENT		
						PERF <th>AMOUNT</th> <th>RESP</th> <th>DETAIL</th> <th>EOBS</th>	AMOUNT	RESP	DETAIL	EOBS
11	T1015				122123		160.84	0.00	0899	
11	D2391				122123		250.00	0.00	0261	0266

Remittance Advice Overview

Accounts Receivable

-----ACCOUNTS RECEIVABLE-----									
A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE	APPLICANT/ CLIENT NO.	APPLICANT/ CLIENT NAME	LIAB DATE/ PGM YEAR
39 [REDACTED]	2/21/2024	1,062.32	1,062.32	1,062.32	0.00	8400	[REDACTED]	[REDACTED]	
39 [REDACTED]	2/21/2024	74.00	74.00	74.00	0.00	8400	[REDACTED]	[REDACTED]	
-----1099 ADJUSTMENTS-----									
TRANSACTION NUMBER	SETUP DATE	ADJUSTMENT AMOUNT	REASON CODE						
NO 1099 ADJUSTMENTS									

EOB Code Descriptions

REPORT:	CRA-EOBM-R	interChange MMIS	Date:
RA#:	8389032	MEDICAID MANAGEMENT INFORMATION SYSTEM	01/23/2024
		PROVIDER REMITTANCE ADVICE	PAGE: 22
EOB CODE DESCRIPTIONS			
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
EOB CODE	EOB CODE DESCRIPTION	PAYEE ID	[REDACTED]
0261	Tooth number is missing.	ISSUE DATE	[REDACTED]
0266	INCORRECT NUMBER OF TOOTH SURFACE CODES BILLED	TAX ID	[REDACTED]
0899	DENTAL FQHC PROCEDURE NOT PAYABLE	P. / ; ID	[REDACTED]
3003	Prior authorization is required for payment of this service.		
5011	Duplicate tooth surface or billing provider of a paid or pending claim.		
6251	FQHC PERIODIC DENTAL VISIT MUST BE PERFORMED IN A SINGLE VISIT		
6430	4 PERIAPICAL RADIOGRAPHS ALLOWED PER 12 MONTHS FOR CLIENTS 21 AND OVER.		
9916	PRICING ADJUSTMENT - UCC RATE PRICING APPLIED.		
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED		

Remittance Advice Overview

Summary

	---NEW DAY CLAIMS---		---CURRENT CYCLE TOTALS BY FUND PAYER---		---TOTAL ALL CLAIMS---	
	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT
Medicaid	4	7,334.16	0	0.00	4	7,334.16
HUSKY B-3	0	0.00	0	0.00	0	0.00
HUSKY B 1 and 2	0	0.00	0	0.00	0	0.00
CADAP	0	0.00	0	0.00	0	0.00
CommPACE	0	0.00	0	0.00	0	0.00
SAGA	0	0.00	0	0.00	0	0.00
Chester Oak	0	0.00	0	0.00	0	0.00
MLIA	0	0.00	0	0.00	0	0.00
Tuberculosis	0	0.00	0	0.00	0	0.00
Family Planning	0	0.00	0	0.00	0	0.00
-----CLAIMS DATA-----						
	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	4	7,334.16	85	364,340.27	250	1,102,851.68
POS. CLAIMS ADJUSTMENTS	0	0.00	2	2,020.83	5	3,117.85
TOTAL CLAIMS PAYMENTS	4	7,334.16	87	366,361.10	255	1,105,969.53
CLAIMS DENIED	6		25		58	
CLAIMS IN PROCESS	0	1	0		0	
-----EARNINGS DATA-----						
PAYMENTS:						
CLAIMS PAYMENTS		7,334.16		366,361.10		1,105,969.53
PAYOUTS		716.38		716.38		716.38
ACCOUNTS RECEIVABLE:						
CLAIM SPECIFIC:						
CURRENT CYCLE		(0.00)		(0.00)		(0.00)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(326.69)		(685.18)
NON-CLAIM SPECIFIC		(0.00)		(0.00)		(1,289.88)
NET PAYMENT		8,050.54		366,750.79		1,104,710.85
LOSS ADJUSTMENTS		0.00		0.00		0.00
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		
NON-CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		
OTHER FINANCIAL:						
MANUAL PAYOUTS		0.00		0.00		
CHECK VOIDS		(0.00)		(0.00)		(0.00)
NET EARNINGS		8,050.54		366,750.79		1,104,710.85

Remittance Advice Overview

Summary

	---NEW DAY CLAIMS---		---POSITIVE ADJUSTMENTS---		---TOTAL ALL CLAIMS---	
	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT	NUMBER	PAID AMOUNT
Medicaid	2,022	294,967.21	1	14.01	2,023	294,981.22
HUSKY B-3	3	379.63	0	0.00	3	379.63
HUSKY B 1 and 2	41	5,577.61	0	0.00	41	5,577.61
CADAP	0	0.00	0	0.00	0	0.00
ConnPACE	0	0.00	0	0.00	0	0.00
SAGA	0	0.00	0	0.00	0	0.00
Charter Oak	0	0.00	0	0.00	0	0.00
MLIA	310	45,263.10	0	0.00	310	45,263.10

	CURRENT		MONTH-TO-DATE		YEAR-TO-DATE	
	NUMBER	AMOUNT	NUMBER	AMOUNT	NUMBER	AMOUNT
CLAIMS PAID	2,376	346,187.55	5,557	809,655.63	29,311	4,268,250.86
POS. CLAIMS ADJUSTMENTS	1	14.01	13	118.02	142	222.03
TOTAL CLAIMS PAYMENTS	2,377	346,201.56	5,570	809,773.65	29,453	4,268,472.89
CLAIMS DENIED	301		750		6,745	
CLAIMS IN PROCESS	0		0		0	

	CURRENT		MONTH-TO-DATE		YEAR-TO-DATE	
	NUMBER	AMOUNT	NUMBER	AMOUNT	NUMBER	AMOUNT
PAYMENTS:						
CLAIMS PAYMENTS		346,201.56		809,773.65		4,268,472.89
PAYOUTS		0.00		0.00		0.00
ACCOUNTS RECEIVABLE:						
CLAIM SPECIFIC:						
CURRENT CYCLE		(730.05)		(730.05)		(730.05)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(876.06)		(7,880.14)
NON-CLAIM SPECIFIC		(0.00)		(0.00)		(0.00)
NET PAYMENT		345,471.51		808,167.54		4,259,862.70
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		(0.00)
NON-CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		(0.00)
OTHER FINANCIAL:						
MANUAL PAYOUTS		0.00		0.00		0.00
CHECK VOIDS		(0.00)		(0.00)		(0.00)
NET EARNINGS		345,471.51		808,167.54		4,259,862.70

Note: For additional information about the ASC X12N 835 Payment/Advice, refer to Chapter 6, section 6.4 “Electronic Remittance Advice”. For additional information about PDF RAs, refer to Chapter 5, section 5.9 “Provider Remittance Advice and Electronic Funds Transfer (EFT)”

Secondary Claim – Other Insurance Payment



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 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 displays 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." containing a form with the following 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 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 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 Obstetrics & Gynecology, Family Practice Physicians, Physician Assistants, APRNs and Women's Health APRNs, Certified Nurse Midwives and Doulas: Frequently Asked Questions \(FAQ\): Connecticut Maternity Bundle Billing and Claims \(Posted 12/30/24\)](#)

[Attention Connecticut General Hospitals, Private Psychiatric Hospitals, Chronic Disease Hospitals, Children's General Hospitals, and Pediatric Inpatient Psychiatric Services: Pediatric Inpatient Psychiatric Services: Interim Rate-Add Ons and Change to Medically Necessary Discharge Delay Reimbursement Methodology Public Notice \(Posted 12/19/24\)](#)

[Hospital Monthly Important Message \(Posted 12/16/24\)](#)

[Attention All Providers: Telehealth Updates for January 2025 \(Posted 12/4/24\)](#)

[Attention Outpatient Hospitals and Outpatient Chronic Disease Hospitals: Prior Authorization Required for Specific J-codes \(Posted 11/8/24\)](#)

[Attention Home Health Care Agencies \(HHA\) and Access Agencies \(AA\) providing in home services and supports to Medicaid members: Announcing Round 2 In- Home Safety Enhancement Applications \(Posted 11/7/24\)](#)

[Attention Substance Use Disorder \(SUD\) Ambulatory Providers: SUD Ambulatory Certification Letter Upload Instructions and Billing Reminder - Updated November 7, 2024 \(Posted 11/7/24\)](#)

[Attention Home Health, Connecticut Home Care \(CHC\), Personal Care Assistant \(PCA\), Acquired Brain Injury \(ABI\), Autism and Mental Health \(MH\) Waiver Service Providers: 1. UPDATE Regarding Claim Denials for Electronic Visit Verification \(EVV\) Mandated Services for Dates of Service July 1, 2024 and forward \(Posted 11/7/24\)](#)

[Attention Outpatient Hospitals: CMAP Addendum B Updated October 1, 2024 \(Posted 10/30/24\)](#)

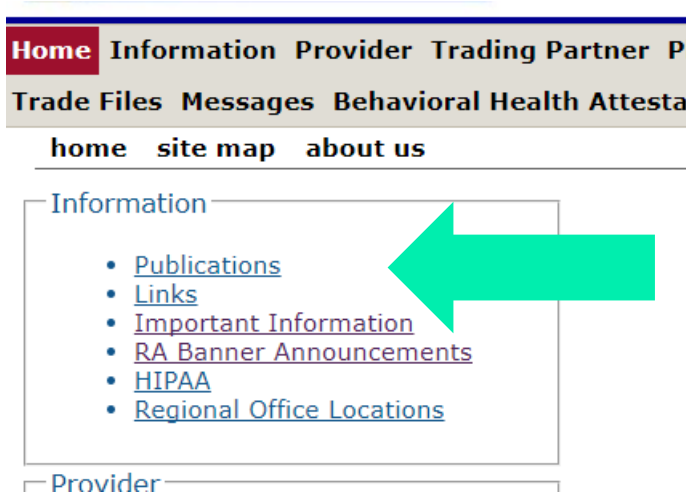
[Attention Inpatient Hospitals: 3M Grouper and DRG Calculator for ICD-10-CM Updates \(Posted 10/30/24\)](#)

[ATTENTION Obstetrics & Gynecology and Family Practice Physicians and APRNs, Women's Health APRNs and Certified Nurse Midwives: Register for the HUSKY Maternity Bundle Provider Forum \(Posted 2/12/24\)](#)

[Attention All Providers: Revised CT Medical Assistance Program \(CMAP\) Telehealth Table - Updated the end date to 2024 \(Posted 12/27/23\)](#)

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) 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 Web site.

Provider Bulletins

Provider Bulletins – Searching by Provider Type



Help
Site: C
Login

Tuesday, December 31, 2024 at 2:46:01 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

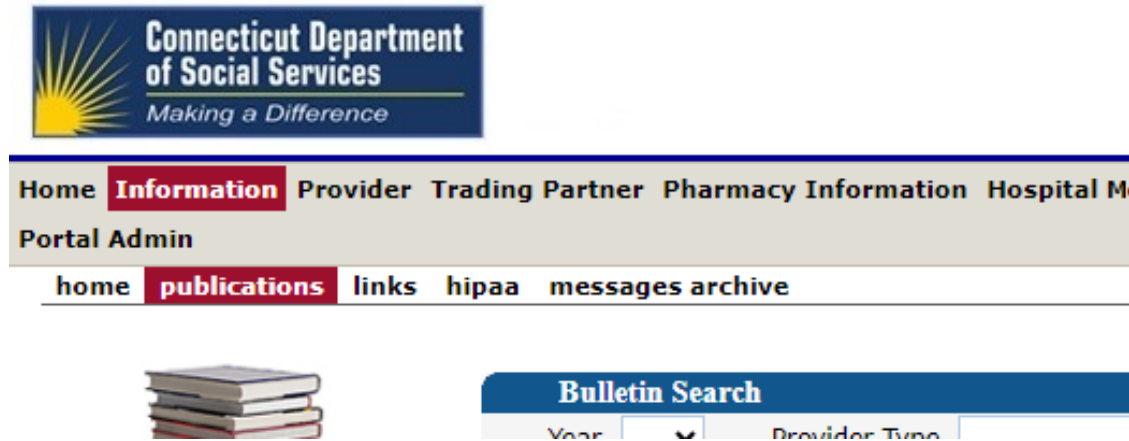
clear

Search Results

Bulletin Number	Title	Published Date
PB24-78	Updates to Telehealth - January 2025 Updates	12/24/2024
PB24-63	Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL...	12/02/2024
PB24-63	January 1, 2025 Changes to the Connecticut Medicaid Preferred Drug List (PDL)	12/02/2024
PB24-63	Pharmacy Web PA Tool	12/02/2024
PB24-63	Reminder About the 5-day Emergency Supply	12/02/2024
PB24-65	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/20/2024
PB24-52	Pharmacy Coverage for at home COVID Test kits	10/01/2024
PB24-52	Updated COVID-19 Vaccine Administration Guidance and Reimbursement	10/01/2024
PB24-60	Pharmacy Local Fax Number Discontinuation	10/01/2024
PB24-41	Confirmation of Receipt of Prescriptions Covered Under the Connecticut Medical A...	07/03/2024
PB24-34	Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL...	05/29/2024
PB24-34	July 1, 2024 Changes to the Connecticut Medicaid Preferred Drug List (PDL)	05/29/2024
PB24-34	Pharmacy Web PA Tool	05/29/2024
PB24-34	Reminder About the 5-day Emergency Supply	05/29/2024
PB24-33	Coverage of Over-the-Counter Formula and Nutritional Supplements for clients Enr...	05/28/2024

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 on the left features a sunburst icon and the text "Connecticut Department of Social Services" with the tagline "Making a Difference". The navigation menu includes "Home", "Information" (highlighted in red), "Provider", "Trading Partner", "Pharmacy Information", and "Hospital M". Below this is a secondary menu with "Portal Admin", "home", "publications" (highlighted in red), "links", "hipaa", "messages", and "archive". To the right of the navigation is a "Bulletin Search" section with a dropdown menu for "Year" and a "Provider Type" field.



The screenshot shows a section titled "Provider Newsletters" with a list of links:

- [December 2024 interChange Newsletter](#)
- [September 2024 interChange Newsletter](#)
- [June 2024 interChange Newsletter](#)
- [March 2024 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
-----	-------------

	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.
--	---

Chapter 12 - Claim Resolution Guide

EOB	Description
	<p data-bbox="392 372 1684 421">0610 Tooth Number/Tooth Surface combination invalid</p> <p data-bbox="392 508 545 556">Cause</p> <p data-bbox="392 565 2068 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="392 696 647 745">Resolution</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 PB 14-62.</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 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
- 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
- www.ctdhp.org

CTDHP Client Services to assist clients in finding dentist.

- 1-855-283-3682

Time for Questions



Thank you

