

Welcome to the Home Health Agency Provider Refresher Workshop – October 30, 2025

Our event will begin shortly...

Please review the following MS Teams points of etiquette as a participant in today's event:



01

Your microphone and video are disabled during this event as a courtesy to the presenters and other participants to minimize distractions and enhance the MS Teams experience for everyone.

02

If you cannot hear audio, click "More..." then Settings, then Device Settings in the top navigation menu to adjust your audio and video settings.

03

Use the Chat feature to submit your text questions during the event. Questions submitted here are being monitored.

04

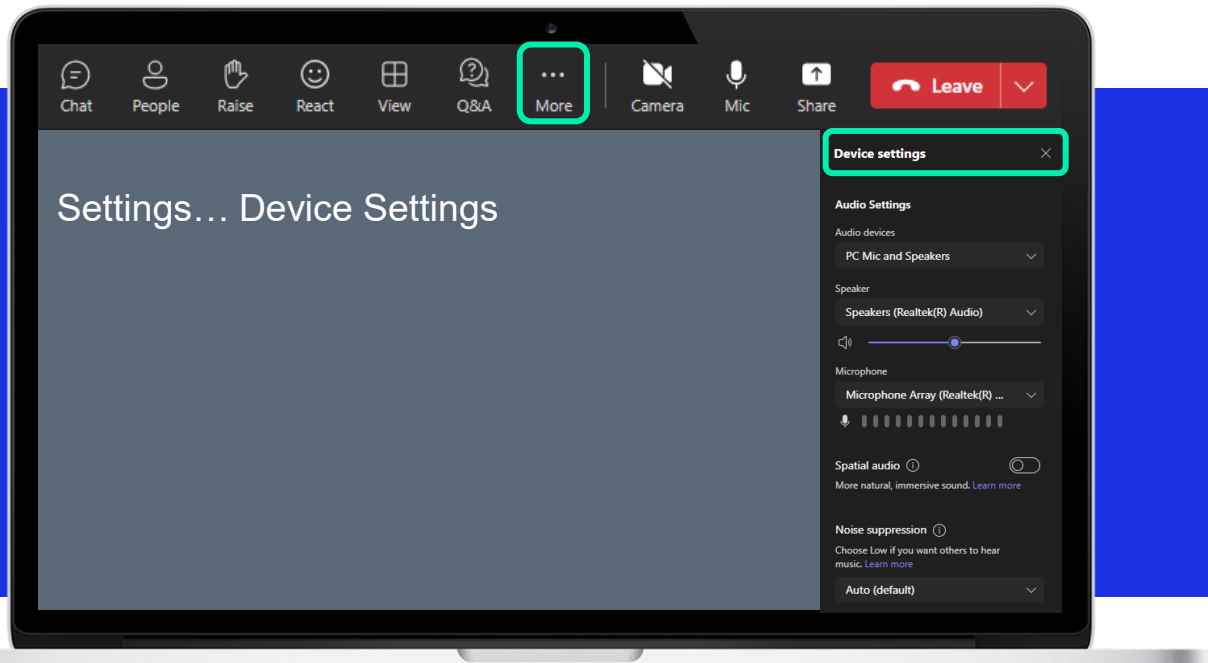
A Q&A session is included at the end of this event to answer your questions.



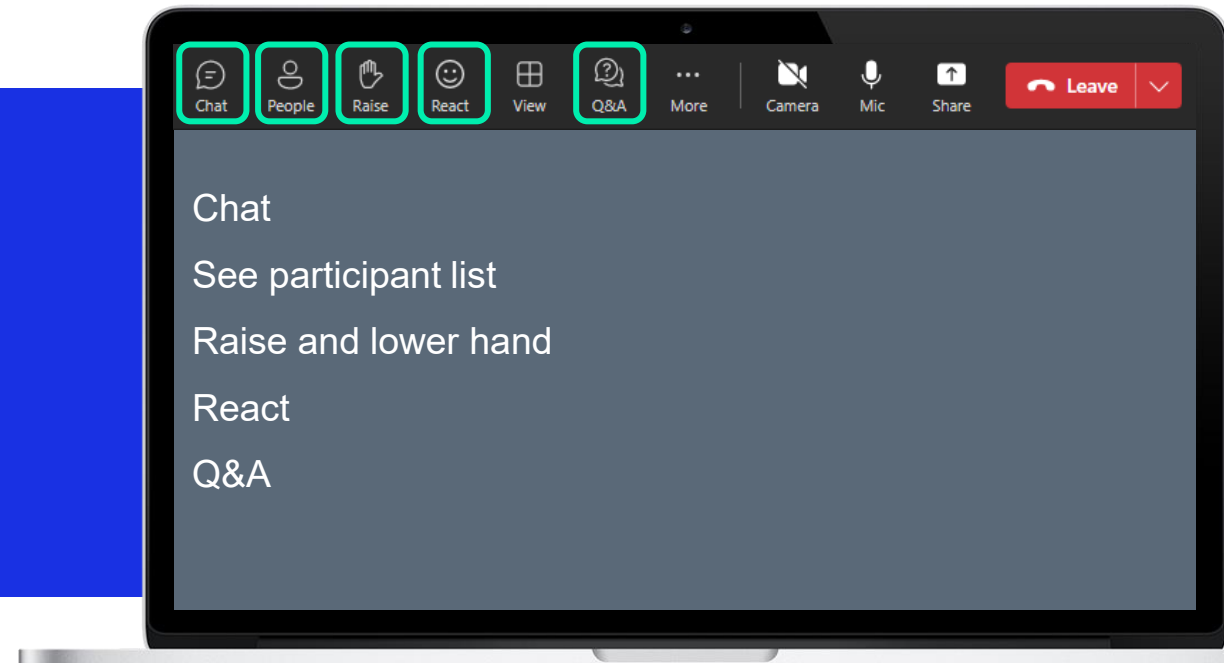
You can download the slides used in today's event from the email sent out after the event.

MS Teams Features and Functions

Manage audio and video settings



Engage with others



Home Health Agency Provider Refresher Workshop 2025

Presented by: The Department of Social Services and Gainwell Technologies for
Billing Providers

October 2025



gainwell

Agenda

- 1 2025 Updates
- 2 Electronic Visit Verification (EVV) Program Update
- 3 Provider Re-Enrollment
- 4 Demographic Maintenance
- 5 Eligibility
- 6 Prior Authorization
- 7 Claim Processing
- 8 Medicare Cost Avoidance and Home Health Audit
- 9 Claim Denial and Corrective Action
- 10 Monthly Claims Reprocessing
- 11 Remittance Advice (RA)
- 12 Information/ Resources/ Contacts/Questions/Comments



2025 Updates



2025 Updates

Effective **February 6, 2025**, and forward, Home Health providers utilizing Sandata Agency Management who are billing claims for dually eligible clients (i.e., clients eligible for both Medicare and Medicaid) via vendor software, should perform the following steps in your Santrax account listed in this link: [Electronic Visit Verification \(EVV\) Updates regarding Third Party Liability Billing](#):

- When entering patient information into your Santrax account for all clients, make sure to enter the Client Medicaid ID in the “Other ID” field under the “Agency Designations” area on the “Personal” screen. The Client Medicaid ID should also be entered on the “General” screen (i.e., “Cust. No.” field). Failure to enter the Client Medicaid ID in both areas will cause the claim to be denied in the Medicaid Management Information System (MMIS). Please reference Attachment A on the final page of this Important Message for screen prints that demonstrate entry of the ID number in two locations.
- When entering the payor information for dually eligible clients, do not enter the Medicare information into the payor area. The only payor that needs to be entered is Medicaid.
- It is essential to ensure that you are confirming all services for clients and then waiting 48 hours to send the billing file to Gainwell Technologies for adjudication. If the number of hours/units confirmed does not match the number of hours/units on the visit file, this discrepancy will result in the claim being denied with Explanation of Benefit (EOB) 3332 (“Non-Waiver Confirmed visit units are exceeded”) or EOB 3328 (“Confirmed visit units are exceeded”).
- **Please note**, the Medicare payor, correct adjustment reason code (i.e., 151, 152 or 153), and the date on which the Home Health Advance Beneficiary Notice (HHABN) was issued must be entered into your vendor software prior to billing for dually eligible clients.

2025 Updates cont.

Effective **February 10, 2025**, as previously announced by the Department of Social Services (DSS), new evidence-based service models are being added to Medicaid-funded home and community-based services (HCBS), specifically, the Acquired Brain Injury (ABI) I & II, Autism, Connecticut Home Care Program for Elders (CHCPE), and Personal Care Assistance (PCA) waiver programs. Here is a quick overview of the new models [COPE/CONFIDENT CAREGIVER AND CAPABLE](#) :

- Training and Counseling Services for Unpaid Caregivers Supporting Participants, a.k.a. Care of Older People in their Environment (COPE) and Confident Caregiver COPE is Drexel University's evidence-based model in which an Occupational Therapist (OT) and a Registered Nurse (RN) support informal caregivers of individuals with cognitive impairments, enhancing caregivers' confidence and care skills while providing a better understanding of participants' health conditions and dementia. Confident Caregiver is designed to augment the COPE program to support family members who are providing care to persons living with serious or chronic illness without cognitive impairment.
- Participant Training and Engagement to Support Goal Attainment and Independence, a.k.a. Community Aging in Place-Advancing Better Living for Elders (CAPABLE) CAPABLE is an evidence-based model developed by Johns Hopkins University in which a team consisting of an OT, RN, and handy worker collaborate with participants to improve both functional ability and home safety.

2025 Updates cont.

Important DSS Updates for COPE/Confident Caregiver and CAPABLE:

- 1) ARP 9817-funded training (Limited time opportunity) To become a certified COPE/Confident Caregiver and/or licensed CAPABLE entity, providers must complete self-paced online trainings interChange Provider Important Message offered by Drexel University and/or Johns Hopkins University.
- 2) Rate Increase OT and RN rates for COPE/Confident Caregiver and CAPABLE are now 15% higher than the traditional Medicaid OT & RN rates. This rate increase aims to offset the cost of staff training time and administrative start-up time.

Policy transmittals/provider bulletins concerning COPE/Confident Caregiver and CAPABLE are available at the Connecticut Medical Assistance Program (CMAP) website at www.ctdssmap.com

You can also click the links below for direct access.

- COPE/Confident Caregiver policy transmittal [Connecticut Department of Social Services](#)
- CAPABLE policy transmittal [Connecticut Department of Social Services](#)

Questions concerning COPE/Confident Caregiver and/or CAPABLE can be directed to the following email address: DSSCOPECAPABLEAttestation@ct.gov.

Additional information can be found in the following Provider Bulletins:

[PB25-02](#)

[PB25-03](#)

2025 Updates cont.

As of **February 18, 2025**, the Department of Social Services (DSS) would like to highlight an important enrollment requirement for all providers. **PB 2025-09**

- Providers are Required to notify DSS Enrollment and Quality Assurance (QA) of all ownership changes and updates. Failure to do so PRIOR to the change (i.e. sale, stock purchase, change in owner %) will lead to possible claims recoupment and/or denial for the period between the date of change and notification to DSS and QA. Notification can be sent to ctproviderenrollment@gainwelltechnologies.com and to Nicole Sinisgalli at DSS QA Nicole.Sinisgalli@ct.gov.
- This requirement is stated in the CT Medical Assistance Program (CMAP) Provider Agreement that all providers sign during enrollment, re-enrollment and is included in the Provider Manual (Chapter 2, Section 17b-262-526, section 9). Chapter 2 of the Provider Manual can be found on the CMAP Web site at www.ctdssmap.com, click on Information, Publications, and scroll down to Provider Manuals, click on the Chapter 2 Provider Participation Policy link.
- Providers shall notify the Department in writing of all substantial changes in information which were provided on the most recent application submitted to the Department for provider enrollment or re-enrollment in the CMAP; provider sales, board changes, stock purchases and ownership % change all qualify as substantial changes.
- **All enrollments must be finalized by the date of sale or stock exchange/sale and new ownership shall not be granted enrollment before the date of sale. Providers who fail to notify DSS and continue to bill under the old enrollment will be subject to having all claims submitted during that time frame recouped and possibly denied.**
- **AVRS ID's (Medicaid ID's) CAN NOT BE SOLD TO OR RETAINED BY NEW OWNERSHIP.**

2025 Updates cont.

Of note: The previous ownership could be held liable for any fraud, abuse or tax issues that may arise during the period that they failed to notify DSS of an ownership change and where the new ownership operated under the old AVRS ID and NPI.

Important Ownership Change Information:

FOR ALL PROVIDERS EXCEPT LONG-TERM CARE FACILITIES (LTC/ICF-IDD):

- ALL CHANGES IN OWNERSHIP BY SALE, STOCK EXCHANGE/PURCHASE OR BOARD REPLACEMENT REQUIRE A NEW PROVIDER ENROLLMENT APPLICATION.
- ALL CHANGES IN OWNERSHIP WILL REQUIRE AN ENROLLMENT THAT STARTS EFFECTIVE THE DATE OF THE BILL OF SALE.
- ALL CHANGES IN OWNERSHIP REQUIRE A NOTARIZED LETTER ON COMPANY LETTER HEAD FROM THE PREVIOUS OWNERSHIP DETAILING THE SALE AND DATE WHEN THEIR ENROLLMENT WITH CMAP/CT MEDICAID WILL END.
- CT MEDICAID ID'S (AVRS ID'S) CANNOT BE PART OF THE SALE.
- ALL NEW ENROLLMENTS DUE TO OWNERSHIP SALES OR STOCK CHANGES MUST OBTAIN A NEW NPI.

FOR LONG-TERM CARE FACILITIES (LTC/ICF-IDD) Providers:

- LTC/ICF-IID PROVIDERS MUST MAINTAIN THE SAME AVRS (MEDICARE ID) AND MUST CALL THE PROVIDER ASSISTANCE CENTER (PAC) AT 1-800-842-8440 TO OBTAIN A NEW RE-ENROLLMENT ATN

2025 Updates cont.

As of **June 1, 2025** all Third-Party Liability (TPL) Audit Letters and Reports were delivered electronically to providers who have Secure Web Accounts setup. If providers did not have a Secure Web Account, then the letters were delivered via USPS. However, ALL Providers are encouraged to setup their Secure Web accounts which allows you to access the CMAP Web site, www.ctdssmap.com.

Additional information can be found in [PB25-21](#).

As of **July 1, 2025** there was an increased to the reimbursement rates for select medication admin services.

Additional information can be found in [PB25-37](#).

2025 Update cont.

As a Reminder: The following documentation **MUST** be included with all submissions for Prior Authorization of Medical Home Health Services.

Initial Requests

- A completed CMS-485 Form – Home Health Certification and Plan of Care must accompany all initial authorization requests. The completed form must include an order signed by the licensed physician, physician assistant, or APRN responsible for the plan of care (a verbal order from the RN will continue to meet this requirement)
- Comprehensive start of care assessment

Reauthorization Requests

A current and complete CMS-485 Form – Home Health Certification and Plan of Care. The completed form must include the order signed by the licensed physician, physician assistant, or APRN responsible for the plan of care (a verbal order from the RN will continue to meet this requirement)

- Nursing reassessment
- Two weeks of nursing narrative notes (for skilled intermittent and complex nursing only)
- 15-minute task breakdown (for home health aide only)

2025 updates cont.

Effective **July 1, 2025**, prior authorization requests for home health services received without the above required documentation will be considered an incomplete request and will be cancelled and returned to the agency.

The agency must then submit a NEW request with all required documentation.

Prior Authorization Submission Process

For questions regarding the prior authorization process, please contact CHNCT at 1-800-440-5071, between the hours of 8:00 a.m. and 6:00 p.m.

Additional Information can be found in [PB 25-25](#).

Documentation Requirements for all home health authorization requests require a completed PA request via the online medical authorization web portal: <https://www.huskyhealthct.org/providers/medical-authorization.html>.

2025 updates cont.

As of **July 1, 2025** there were Changes made to Prior Authorization Process for Medical Goods and Services.

Note: These changes do not apply to PA requests submitted via fax.

PA Requests Submitted via the Medical Authorization Portal Effective July 1, 2025, Community Health Network of Connecticut, Inc. (CHNCT) is implementing changes for all PA requests submitted via the HUSKY Health Medical Authorization Portal.

The changes are as follows:

- Requests for additional information will no longer be faxed. Requesting providers will be notified that additional information is needed pertaining to their PA submission via a message in the authorization portal. The message will list the additional information needed for medical necessity review along with the due date for submitting the information. Providers may upload the information to the portal. Note: Additional information pertaining to a provider re-evaluation (appeal) request should not be attached to a denied authorization in the portal. Clinical documentation attached to a denied authorization in the portal will not be considered a request for re-evaluation. Providers should follow the re-evaluation process as outlined in their denial letter.
- Determination letters (approval and denial letters) will no longer be faxed to the requesting provider.
 - Determination letters will be available to the requesting provider in the medical authorization portal. Letters may be downloaded as needed.
 - When the ordering or prescribing provider is different than the requesting provider, a copy of the adverse determination (denial letter) will be faxed to the ordering or prescribing provider only.
- Determination status (approved, denied, or pended) is also visible in the portal.

Additional Information can be found in [PB 25-28](#)

Electronic Visit Verification (EVV) Program Update



Electronic Visit Verification (EVV) Program Update

In 2016, Section 12006 of the 21st Century Cures Act established a requirement for all states to use an Electronic Visit Verification (EVV) system. Medicaid home health care services (HHCS) were expected to use EVV by January 1, 2023. The Department of Social Services (DSS) has received approval for a Good Faith Effort (GFE) exemption request from the Centers for Medicare & Medicaid Services (CMS) to delay the EVV implementation timeline for HHCS. All providers were expected to comply with the HHCS mandate prior to January 1, 2024

DSS has approved the use of an Open Vendor EVV model for the HHCS implementation to support both Medicaid waiver and non-waiver members. This will allow home health providers the opportunity to use a third-party (“Alternate”) EVV system or the State’s existing EVV system, i.e., Santrax Agency Management to capture visit data. The changes to accept all home health visit data for HHCS from either an Alternate EVV system or the State’s existing EVV system were implemented on March 23, 2023. **All home health providers are expected to onboard and begin to submit Electronic Visit Verification (EVV) production data for Home Health Care Services (HHCS) either via the State’s EVV system (i.e., Santrax Agency Management) or an Alternate EVV solution. Moreover, home health claims without a confirmed visit resulted in a payment denial for dates of service effective January 1, 2024, and forward.**

For providers who choose to use Santrax Agency Management tasks are optional, no schedules are needed, and prior authorizations (PAs) will not be sent to a providers EVV system. This does not change the current CHN and Carelon PA request and approval process. Provider must continue to request PAs as they do now.

Electronic Visit Verification (EVV) Program Update cont.

What changes will I see in my Sandata Agency Management system?

- New modifiers and services that are used for nonwaiver home health services
- Member data will not flow automatically into a providers EVV system for Sandata Agency Management system users; manual input of these members will be necessary by providers using Sandata Agency Management system
- For providers who have 50 or more clients, there will be a one-time process that providers can use to upload initial member data prior to the HHCS implementation
- There will be some differences in visit capture methods for providers choosing to use Sandata Agency Management system:
 - Telephony** – caregivers will need to add the service and modifier to the call
 - Sandata Mobile Connect (SMC)** – when a visit is started, providers will see a full list of available services to choose from
 - Fixed Visit Verification (FVV)** – no changes noted to the FVV capture method at this time
- Providers that choose to move to the Alternate EVV solution will be able to do so but are responsible for any additional costs. To transition from Sandata to an alternate EVV provider in CT, providers must first select an Alternate EVV vendor and then register their vendor through the state's online form. The alternate vendor must complete a certification and testing process with Sandata, and the provider must then complete Sandata's aggregator training and submit a copy of their training certificate to receive production credentials.

Provider Re-enrollment

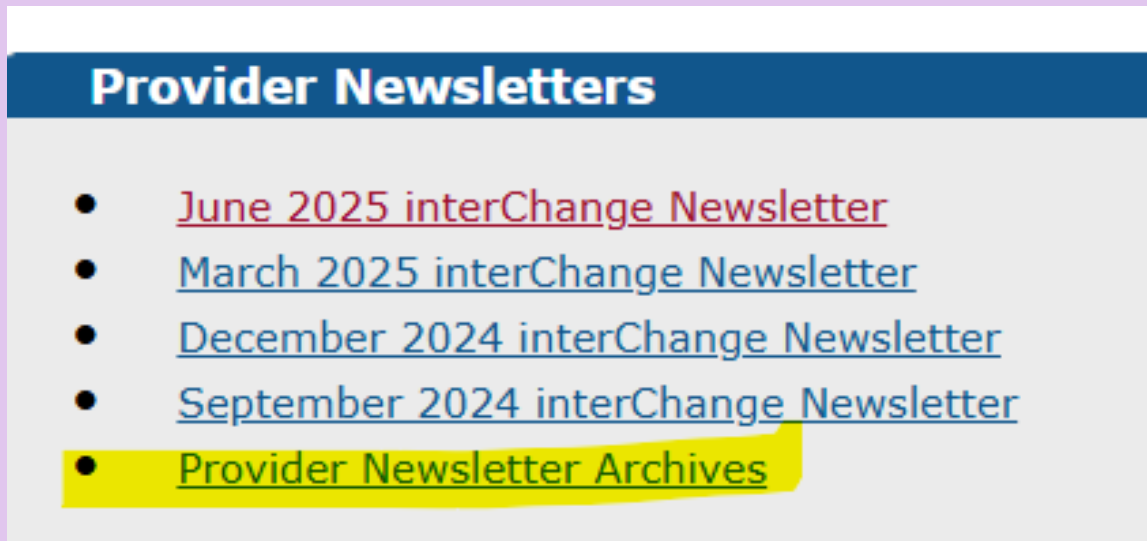


Provider Enrollment and Re-enrollment

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

- Most 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.
- Re-enrollment Period: Home Health providers are required to re-enroll every two (2) years.

Provider Enrollment and Re-Enrollment cont.

A screenshot of a webpage titled "Provider Newsletters". The page has a dark blue header with the title in white. Below the header is a list of five items, each preceded by a black dot. The first four items are underlined and colored: "June 2025 interChange Newsletter" (red), "March 2025 interChange Newsletter" (blue), "December 2024 interChange Newsletter" (blue), and "September 2024 interChange Newsletter" (blue). The fifth item, "Provider Newsletter Archives", is highlighted with a yellow background.

- [June 2025 interChange Newsletter](#)
- [March 2025 interChange Newsletter](#)
- [December 2024 interChange Newsletter](#)
- [September 2024 interChange Newsletter](#)
- [Provider Newsletter Archives](#)

- Re-enrollment Notification and Process:
- Home Health providers will receive a reminder letter via e-Delivery when they are due for re-enrollment six (6) months prior to the end of their current contract (Reference www.ctdssmap.com > Information > Publications > Provider Newsletters > Provider Newsletter Archives > **August 2020** > Important Re-Enrollment Information)

Provider Enrollment and Re-Enrollment cont.

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

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

- Providers who are dis-enrolled will **not** be able to do the following until re-enrollment is completed:
 - Get new referrals to services
 - Receive Prior Authorization
 - Bill or receive payment for services rendered.

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

Provider Enrollment and Re-enrollment cont.

Re-enrollment via the Enrollment/Re-enrollment Wizard on the Connecticut Medical Assistance Program (CMAP) Web site, www.ctdssmap.com, is required.

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

Information

- [Publications](#)
- [Links](#)
- [Important Information](#)
- [RA Banner Announcements](#)
- [HIPAA](#)
- [Regional Office Locations](#)

Provider

- [Provider Services](#)
- [Provider Search](#)
- [Provider Enrollment](#)
- [EHR Incentive Program](#)
- [Secure Site](#)

Provider Trading Partner Pharmacy Info

Provider Enrollment

- **Provider Re-Enrollment**
- **Provider Enrollment Tracking**
- **Provider Matrix**
- **Provider Services**
- **Provider Search**
- **Drug Search**
- **Provider Fee Schedule Download**
- **Promoting Interoperability Program**
- **OOS Instructions/Information**
- **Fingerprint Criminal Background**
- **Check Info**
- **E-Mail Subscription**
- **Secure Site**

Provider Enrollment and Re-enrollment cont.

Follow-on Documents:

- Once the enrollment/re-enrollment application is submitted, providers are notified of any follow-on documents that need to be mailed to Gainwell Technologies Enrollment Unit. The follow-on documents can also be found on the Web site (www.ctdssmap.com) by selecting Provider > Provider Matrix > Follow on Document Requirement by Provider Type and Specialty.
- The document requirements vary by provider type. The enrollment/re-enrollment application is not considered complete until *all* the required documents have been received.

Home Information **Provider** Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification
home provider enrollment provider re-enrollment provider enrollment tracking **provider matrix** provider services provider search drug search provider fee schedule download
promoting interoperability program oos instructions/information fingerprint criminal background check info e-mail subscription secure site



Instructions Upon Completion Of The Enrollment Wizard

Upon completion of the on-line Web portal enrollment/re-enrollment application, providers are issued an Application Tracking Number (ATN) that may be used to track the status of their application. **Please do not submit a paper copy of the completed Web application to Gainwell Technologies, or complete a paper application after a Web application has been submitted to Gainwell Technologies.** If a correction is required to the Web application after it has been submitted, that correction should be submitted on the provider's letterhead to the address below.

You may have been notified upon completion of your application that you must submit some follow on documents. Those documents only, and not the application itself, must be sent to Gainwell Technologies at the following address in order for your application to be finalized. The ATN must be included on the top of each of these documents. Failure to submit the follow on documents may 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/specialty, click on the link below and locate your type/specialty.

[Follow on Document Requirement by Provider Type and Specialty](#)

Provider Enrollment and Re-enrollment cont.

Re-enrollment Due Dates:

Providers with Secure Web portal access can view their re-enrollment due date once logged in as it is displayed on the Home page.

- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

The screenshot shows a provider 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 sub-links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. A red banner states: 'Your password expires in 60 day(s) on 00/00/0000 at 00:00 Change Password'. The main content area displays: 'Welcome, Provider Account User ID', 'Provider ID Enrollment NPI or AVRS', 'Reenrollment Due Date: 10/30/2025', and 'Zip Code: 06226 - 3606'. A large red arrow points to the date '10/30/2025'. Below this, it says: 'Your R.A.s, or 835 transactions, are being sent to: Your download page in the Trade Files menu option.' On the right side, there are two boxes: 'Quick Link' with a list of links (Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, Download Remittance Advices, ACA Ordering/Prescribing/Referring Provider List) and 'Email Subscription' with a link 'Register/Update Email Subscription'.

Provider Enrollment and Re-enrollment cont.

To check the status of a 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 as enrolled* and click *search*

A screenshot of the 'Enrollment Tracking Search' form. It has two input fields: 'ATN*' with the value '305929' and 'Business OR Last Name*' with the value 'SMITH'. There are 'search' and 'clear' buttons on the right.

In this example, the reenrollment application that was received on 04/10/2025 was completed as of 05/07/2025.

| | |
|-------------------------|------------------------|
| Status | ReEnrollment Completed |
| Last Status Date | 05/07/2025 |
| Application Type | Re-Enrollment |
| Date Received | 04/10/2025 |

Demographic Maintenance



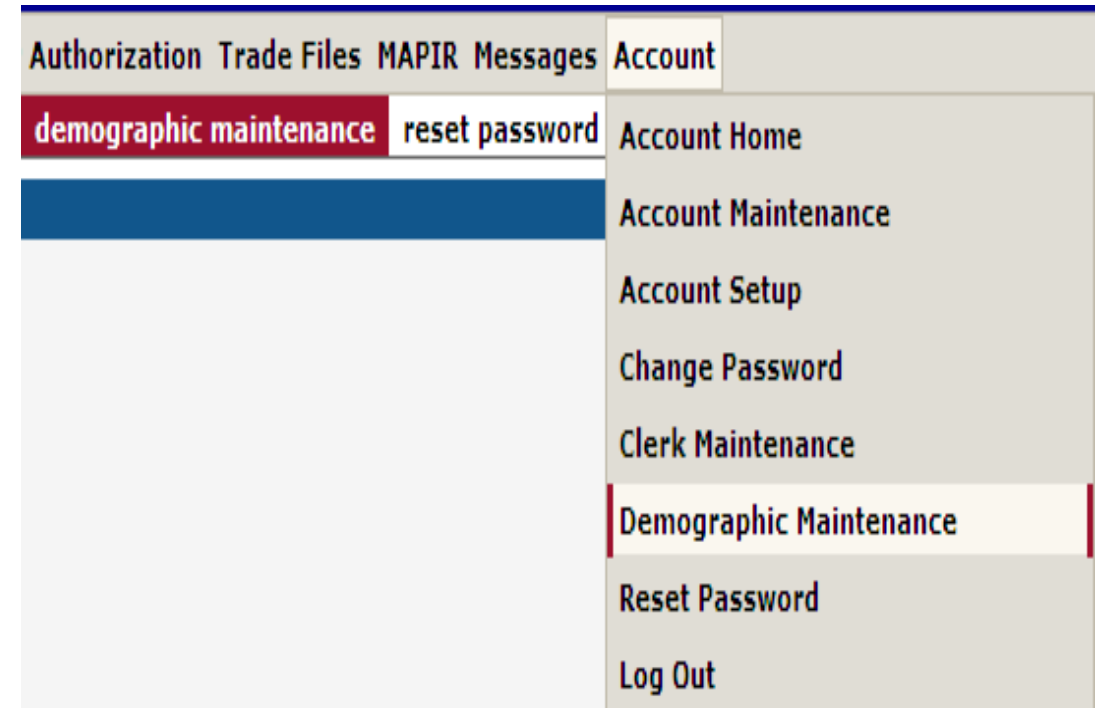
Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes **provider addresses, languages known by staff, Electronic Funds Transfer (EFT) and member of organization maintenance.** Failure to update demographic information could result in the delay of receipt of time sensitive information, information being sent to the wrong address, or delay of payments.

You can alter and update demographic information in the Demographic Maintenance section of the Secure Site:

- All address types including Mail to, Pay to, Service Location, Enrollment, and Home Office addresses
- EFT (Electronic Funds Transfer) Account (account that receives all CMAP related reimbursements)
- Maintain Organization Members

Access this section by selecting demographic maintenance from either the Account submenu or the Account drop-down menu.



Demographic Maintenance cont.

The Demographic Maintenance page displays the provider information panel as well as a submenu.

- Clicking the submenu options will open a panel with related information:
 - Base Information Service Location
 - Location Name Address
 - EFT Account
 - Service Language
 - Maintain Organization Members
 - Add/Update Vehicle Registration Information

| 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](#)

Demographic Maintenance – Location Name Address

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

| Usage | Name | Address 1 | City | State | Zip | Zip + 4 | Contact Phone | Contact Ext | Handicap Access | Address Indicator |
|--------------------|----------------------------|-------------------|------------|-------|-------|---------|---------------|-------------|-----------------|-------------------|
| Enrollment Address | AUTISM FISCAL INTERMEDIARY | 201 SOUTH PARK DR | BRIDGEPORT | CT | 06047 | 4154 | (860)746-5765 | | N | V |
| Home Office | AUTISM FISCAL INTERMEDIARY | 201 SOUTH PARK DR | BRIDGEPORT | CT | 06047 | 4154 | (860)746-5765 | | N | V |
| Mail to | AUTISM FISCAL INTERMEDIARY | 201 SOUTH PARK DR | BRIDGEPORT | CT | 06047 | 4154 | (860)746-5765 | | N | V |
| Pay to | AUTISM FISCAL INTERMEDIARY | 201 SOUTH PARK DR | BRIDGEPORT | CT | 06047 | 4154 | (860)746-5765 | | N | V |
| Service Location | AUTISM FISCAL INTERMEDIARY | 191 NORTH WEST ST | SALEM | CT | 06065 | 6065 | (860)746-5765 | | N | V |

Select row above to update.

Apply Changes To:

- Svc Loc
- Pay To
- Mail To
- Home Office
- Enrollment

Name Type Business Name Personal Name

Name

Title

Usage

Country

Address 1

Address 2

City

State

Zip

Contact Name

Contact Phone

Fax

Patient Use Phone

TDD\TTY

EMAIL

Confirm EMail

Mobile Number

Pager Number

Address Indicator

Handicap Accessible?

Demographic Maintenance – Location Name Address cont.

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

| Provider Location Name Address | | | | | | | | | | | |
|--------------------------------|------------------|---------------------|-----------|-------|---------|-------|---------|---------------|-------------|-----------------|-------------------|
| Usage | Name | Street | City | State | Country | Zip | Zip + 4 | Contact Phone | Contact Ext | Handicap Access | Address Indicator |
| Alt Service Location | HARPER, KATHLEEN | 1275 POST ROAD | FAIRFIELD | CT | | 06824 | 6015 | | | N | V |
| Alt Service Location | HARPER, KATHLEEN | 1020 MEMORY LN | HARTFORD | CT | US | 06066 | 6066 | (860)741-2333 | | N | V |
| Alt Service Location | HARPER, KATHLEEN | 1020 MEMORY LN | HARTFORD | CT | US | 06066 | 6066 | (860)741-2333 | | N | V |
| Enrollment Address | HARPER, KATHLEEN | 134 ROUND HILL ROAD | FAIRFIELD | CT | US | 06824 | 5166 | (203)254-2452 | | N | V |
| Home Office | HARPER, KATHLEEN | 134 ROUND HILL ROAD | FAIRFIELD | CT | | 06824 | 5166 | (203)254-2452 | | N | V |
| Mail to | HARPER, KATHLEEN | 134 ROUND HILL ROAD | FAIRFIELD | CT | | 06824 | 5166 | (203)254-2452 | | N | V |
| Pay to | HARPER, KATHLEEN | 134 ROUND HILL ROAD | FAIRFIELD | CT | | 06824 | 5166 | (203)254-2452 | | N | V |
| Service Location | HARPER, KATHLEEN | 134 ROUND HILL ROAD | FAIRFIELD | CT | | 06824 | 5166 | (203)254-2452 | | N | V |

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 that HHA cannot have alternate service locations. There must be a new enrollment for each service location.

Demographic Maintenance – EFT Account Information

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

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

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 |
|----------------------------|--------------------------------------|--|--|------------------|------------|
| TD BANK NA | 011100111 | 4242042420 | Checking | | Active |

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

Required fields are indicated with an asterisk (*)

Provider Name*

Account Number Linkage to Provider Identifier*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

Provider Identifiers*

Provider Federal Tax Identification Number (TIN)

OR Employer Identification Number (EIN)

OR

National Provider Identifier (NPI)

Other Identifiers

Assigning Authority

Trading Partner ID

Financial Institution Information

Financial Institution Name

Financial Institution Address

Street

City

State/Province

ZIP Code/Postal Code

Financial Institution Routing Number

Financial Institution Routing Number(rekey)*

Type of Account at Financial Institution

Provider's Account Number with Financial Institution

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

Reason for Submission New Enrollment Change Enrollment Cancel Enrollment

Authorized Signature

save cancel

Demographic Maintenance – EFT Account Information cont.

Please Note:

Any type of change in banking information whether it be the account number, or a change in financial institutions, **MUST** be updated for the EFT Account information on the demographic maintenance panel to prevent deposit discrepancies.

Also, very important to remember when any type of change to your EFT Account information is made, this causes the new information entered to go through a prenote period, so the next cycle payment will be in the form of a paper check. Once the prenote process is successful then the payments will be direct deposited into your account. Keep in mind that this entire process takes 2 or more weeks depending on whether the correct account information was entered.

Eligibility Verification



Eligibility Verification

DSS recommends that providers verify a client's eligibility on the date of service prior to performing the said service and at regular intervals

- Eligibility can change at any time

Verifying a client's eligibility:

- Secure Web portal account at www.ctdssmap.com
- Automated Voice Response System (AVRS)
- Provider Electronic Solutions (PES) software
- Point of Sale (POS) Device
 - Providers interested in using a POS device must contact a third-party vendor to obtain the device
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
- Via e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

Eligibility Verification cont.

To verify a CMAP client's eligibility through the Secure Site – click on the Eligibility tab on the main menu.

You must satisfy one of the search combinations prior to selecting submit.

Valid Search Combinations

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



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

Valid Search Combinations

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

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

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request

| | | | | | |
|---------------------|-----------------------------------|---------------------|----------------------|-----------|------------|
| Client ID | <input type="text"/> | last name | <input type="text"/> | From DOS* | 09/01/2025 |
| SSN | <input type="text"/> | First Name, MI | <input type="text"/> | To DOS* | 09/30/2025 |
| Birth Date | <input type="text"/> | | | | |
| Service Type Code 1 | 30 - Health Benefit Plan Coverage | Service Type Code 2 | <input type="text"/> | | |
| Service Type Code 3 | <input type="text"/> | Service Type Code 4 | <input type="text"/> | | |
| Service Type Code 5 | <input type="text"/> | | | | |



Eligibility Verification cont.

- Eligibility Verification Codes

| | | |
|-----------------------|--|-------------------------------------|
| 1 – Medical | 54 – Long Term Care | AD – Occupational Therapy |
| 4 – Diagnostic X-Ray | 56 – Medical Related Transportation | AF – Speech Therapy |
| 5 – Diagnostic Lab | 75 – Prosthetic Device | AL – Vision (Optometry) |
| 33 – Chiropractic | 82 – Family Planning | DM – Durable Medical Equipment |
| 35 – Dental | 86 – Emergency Services | MH – Mental Health |
| 42 – Home Health Care | 88 – Pharmacy | PT – Physical Therapy |
| 45 – Hospice | 93 – Podiatry | RT – Residential Physical Treatment |
| 47 – Hospital | 98 – Professional (Physician) Office Visit | UC – Urgent Care |

Eligibility Verification cont.

The Eligibility Verification Response window provides the search results

- In this example - the client's eligibility cannot be verified for the requested dates (Aug. 1 - Aug. 23, 2020) - **eligibility verification can only look back one year.**
- Changing the dates of the eligibility request to within the allowable one-year window creates a different result.

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request

| | | | | | |
|---------------------|-----------------------------------|---------------------|--------|-----------|------------|
| Client ID | <input type="text"/> | Last Name | DOE | From DOS* | 08/01/2020 |
| SSN | <input type="text"/> | First Name, MI | JOHN P | To DOS* | 08/23/2020 |
| Birth Date | <input type="text"/> | | | | |
| Service Type Code 1 | 30 - Health Benefit Plan Coverage | Service Type Code 2 | | | |
| Service Type Code 3 | | Service Type Code 4 | | | |
| Service Type Code 5 | | | | | |

search clear

Eligibility Verification Response

Verification Number 212350557G

Response Text: Cannot validate eligibility for dates older than 1 year

Eligibility Verification cont.

Eligibility searches cannot span multiple months

- 05/01/2025 - 06/30/2025 is **not** valid.
- 05/01/2025 - 05/31/2025 and 06/01/2025 - 06/30/2025 are valid.

Submitting a request that spans multiple months will result in an error message.



Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Telehealth Information Electronic Visit Verification Claims **Eligibility** Prior Authorization Hospice Account

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request

| | | | | | |
|---------------------|--|---------------------|--|-----------|---|
| Client ID | <input type="text"/> | Last Name | <input type="text" value="Smith"/> | From DOS* | <input type="text" value="05/01/2025"/> |
| SSN | <input type="text"/> | First Name, MI | <input type="text" value="John"/> <input type="text"/> | To DOS* | <input type="text" value="06/30/2025"/> |
| Birth Date | <input type="text"/> | | | | |
| Service Type Code 1 | <input type="text" value="30 - Health Benefit Plan Coverage"/> | Service Type Code 2 | <input type="text"/> | | |
| Service Type Code 3 | <input type="text"/> | Service Type Code 4 | <input type="text"/> | | |
| Service Type Code 5 | <input type="text"/> | | | | |

Please correct the following errors:

Eligibility verification requests must not span multiple months.

Eligibility Verification cont.

Positive eligibility responses provide detailed information.

Eligibility Verification Response

- Provides a **verification number** that should be kept on record in case the client's coverage is retroactively changed at a later date
- Reports client's eligibility status for the requested date(s) of service

Eligibility Verification Response

Verification Number 1120900015

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

Client Information

| | | | |
|------------|-------------|------------------|----------------------|
| Client ID | 009999999 | Last Name | TOM |
| SSN | 111-99-9999 | First Name, MI | TOM |
| Birth Date | 01/20/1997 | Street | 1 MAIN ST |
| Gender | M | City, State, Zip | TORRINGTON, CT 06790 |

Eligibility Verification cont.

| Eligibility Verification Response | |
|-----------------------------------|--|
| Verification Number | 160480000Z |
| Response Text | Client is eligible. Refer to Benefit Plan for specific program coverage. |

| Client Information | | | |
|--------------------|-------------|----------------|-----------|
| Client ID | 009999999 | Last Name | CAREY |
| SSN | 111-99-9999 | First Name, MI | BABYC |
| Birth Date | 01/20/2007 | Street | 1 MAIN ST |

| 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. | 04/01/2019 | 04/01/2019 | 04/30/2019 | |

| Deductible Information | | | | |
|------------------------|----------------|----------|------------------------|------------------|
| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
| Husky D | | | \$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 >

Eligibility Verification cont.

| 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% |
| 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% |
| 50 | Hospital - Outpatient | \$0.00 | 0% |

1 2 3 Next >

| Service Type Codes - MCO Services |
|-----------------------------------|
| *** No rows found *** |

| Service Type Codes - Not Covered |
|----------------------------------|
| *** No rows found *** |

| Limit Information |
|-----------------------|
| *** No rows found *** |

| TPL |
|-----------------------------|
| Carrier Code ▲ Carrier Name |
| 788 CONNECTICARE INC |
| A12 EXPRESS SCRIPT |

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

| Managed Care Provider |
|-----------------------|
| *** No rows found *** |

| Lockin |
|-----------------------|
| *** No rows found *** |

| Medicare |
|------------|
| Coverage ▲ |
| Medicare A |
| Medicare B |

Eligibility Verification cont.

Benefit Plan

- The benefit plan(s) in which the client was an active member on the date(s) of service requested

| Benefit Plan | | | | | |
|--|------------------------------|----------------|------------|-----------|-----------|
| Service Information | Benefit Month Effective Date | Effective Date | End Date | Message 1 | Message 2 |
| Husky D. For Behavioral Health Services, call BHP at 877-552-8247. | 08/01/2021 | 08/01/2021 | 08/23/2021 | | |

Service Type Codes – Gainwell Technologies

- A list of services for which the client was eligible that would be submitted for payment to Gainwell Technologies
- The Service type code field will also provide copay amounts for HUSKY B clients

| Service Type Codes - HP 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% |
| 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% |
| 50 | Hospital - Outpatient | \$0.00 | 0% |

1 2 3 Next >

Eligibility Verification cont.

Lock-in

- Some clients are locked into receiving certain health care services only from specific providers or pharmacies; those providers or pharmacies will be listed here

| » Lockin Details | | | | | |
|------------------|----------------|-------------|----------|----------------------|-------------|
| Status | Active Only | Lockin Plan | | | |
| Lockin Plan | Effective Date | End Date | Provider | Provider ID Type | Status Code |
| HOSPICE-MEDICARE | 08/14/2022 | 01/30/2023 | | National Provider ID | A - Active |

Medicare

- Types of Medicare coverage active for the client on the date(s) of service requested

| Medicare Coverage |
|-------------------|
| Medicare A |
| Medicare B |
| Medicare D |

TPL (Third Party Liability)

- Commercial / private insurance coverage other than Medicare or Medicaid under which the client may be covered

| TPL | |
|--------------|--------------------------|
| Carrier Code | Carrier Name |
| 813 | AARP HEALTH CARE OPTIONS |

Eligibility Verification – Eligibility Issues

Medicare Covered Services

- If **Medicare Covered Services** or **Qualified Medicare Beneficiary (QMB)** is present on the benefit plan and are the *only* coverage(s) on the benefit plan, the client *does not* have active Medicaid for the eligibility period being researched.
- Benefits are limited to the payment of Medicare coinsurance and deductible amounts assuming the Medicare paid amount is less than the Medicaid allowed amount.
- Charges that are denied or are not covered by Medicare will not be considered for payment under the QMB program.

| Benefit Plan | | | | | | |
|---------------------------|---------------|----------------|----------------|------------|-----------|-----------|
| Service Information | Benefit Month | Effective Date | Effective Date | End Date | Message 1 | Message 2 |
| Medicare Covered Services | | 08/01/2021 | 08/01/2021 | 08/23/2021 | | |

| Deductible Information | | | | |
|--------------------------------|----------------|----------|------------------------|------------------|
| Service Information | Effective Date | End Date | Base Deductible Amount | Remaining Amount |
| Qualified Medicare Beneficiary | | | | \$0.00 |

Eligibility Verification – Benefit Plans

HUSKY A

Coverage group for eligible children, parents, relative caregivers; pregnant women

HUSKY B

Non-Medicaid Children's Health Insurance Program (CHIP)

- Free or low-cost health insurance for children and youth up to age 19 & for families who are not income eligible for HUSKY A with income between 201% and 323% of the federal poverty level qualify under either band 1 or band 2.

HUSKY C

Previously referred to as fee-for-service Medicaid, or Adult Medicaid

- Individuals that are aged, blind, or disabled.

HUSKY D

Previously referred to as Medicaid for Low-Income Adults (MLIA) or State Administered General Assistance (SAGA)

- Individuals aged 19 through 64 who do not receive federal Supplemental Security Income or Medicare and who are not eligible for another coverage group.

Eligibility Verification – Benefit Plans cont.

Tuberculosis

Individuals not eligible for full Medicaid coverage who have active or latent TB; covers medical and pharmacy services relevant to the treatment of TB

Family Planning

Individuals of childbearing age (including minors) who are not otherwise eligible for full Medicaid coverage; provides coverage for family planning and family planning-related medical and pharmacy services

Limited Behavioral Health Services

Intensive in-home child and adolescent psychiatric services only

CHC Waiver Benefit Plans

Connecticut Home Care (CHC) Benefit Plans

- Medical and Non-Medical services for elder and disabled clients under the CHC program

Please Note: There are other waivers that provide non-medical services to HUSKY clients at risk of institutionalization, thereby enabling them to continue to live in a home and community-based setting at a cost less than that of an institution, such as Personal Care Attendant and Acquired Brain Injury Waivers.

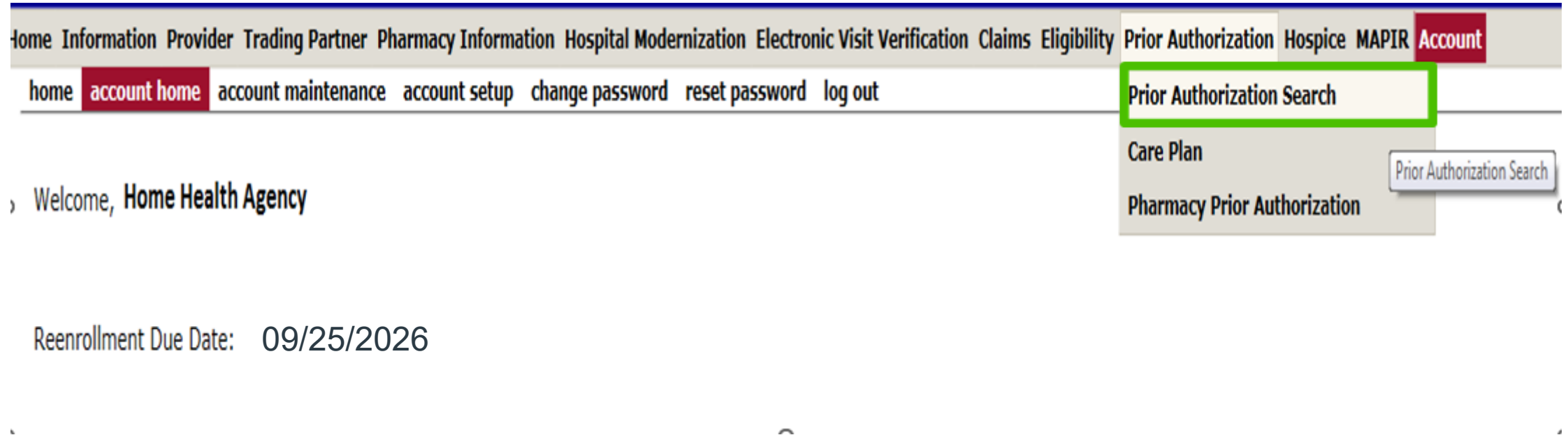
Providers will be able to find additional information about eligibility responses on our Web site. Or from our Web site, www.ctdssmap.com > Information > Publications, then scrolling down to the second to last panel, “Claims Processing Information” then clicking on Eligibility Response Quick Reference Guide

Prior Authorization



Prior Authorization – PA Search

Once on the secure site, click [Prior Authorization](#) > [Prior Authorization Search](#)



Prior Authorization – PA Search cont.

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

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

Quick Link

- Web Guide - Prior Authorization Search

Provider 001234567 MCD

Prior Authorization Search

Client ID

Client Name

Search Pharmacy PAs only

Requested Eff Date

Requested End Date

Authorized Eff Date

Authorized End Date

Prior Authorization

PA Assignment

PA Assign - Sub

Procedure [Search]

Revenue Code [Search]

Proc/Mod List

Procedure Code List [Search]

Records

It is easier to search by Client ID or PA Number, however you can search by any combination of the fields below, such as by date, procedure, or list code.

Prior Authorization – PA Search cont.

The search results by client show multiple PAs and services authorized.

Search results can include PAs authorized by procedure code, procedure code with modifier, procedure code lists, and proc/mod lists.

| Search Results | | | | | | | | | | | | | | |
|----------------|-----------|----------------------|---------------------|---------------|---------------|------------------|-----------------|---------------------|----------------------------------|--------------|-------------------|---------------|-----------------|-----------------------------|
| PA Number | Line Item | Authorized Eff. Date | Authorized End Date | Date Received | Time Received | Assignment Code | PA Assign - Sub | Billing Provider ID | Prescribing/Ordering Provider ID | Service Code | Service Code Thru | Proc/Mod List | Frequency | Status |
| 0771 | 02 | 10/28/2021 | 11/05/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | 424 | | | 1 Per Date Span | Auto Approved for Care Plan |
| 0771 | 04 | 11/01/2021 | 12/31/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | | | SN | 9 Per Date Span | Auto Approved for Care Plan |
| 0771 | 03 | 11/01/2021 | 12/31/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | G0162 | | | 6 Per Date Span | Auto Approved for Care Plan |
| 0771 | 01 | 10/27/2021 | 10/27/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | | | 36 | 1 Per Date Span | Auto Approved for Care Plan |

For ease in viewing, data can be sorted by clicking on the desired sort field, until a triangle appears. Click on the triangle to sort in ascending or descending order.

| » Search Results | | | | | | | | | | | | | | |
|------------------|-----------|----------------------|---------------------|---------------|---------------|------------------|-----------------|---------------------|----------------------------------|--------------|-------------------|---------------|-----------------|-----------------------------|
| PA Number | Line Item | Authorized Eff. Date | Authorized End Date | Date Received | Time Received | Assignment Code | PA Assign - Sub | Billing Provider ID | Prescribing/Ordering Provider ID | Service Code | Service Code Thru | Proc/Mod List | Frequency | Status |
| 0771 | 02 | 10/28/2021 | 11/05/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | 424 | | | 1 Per Date Span | Auto Approved for Care Plan |
| 0771 | 04 | 11/01/2021 | 12/31/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | | | SN | 9 Per Date Span | Auto Approved for Care Plan |
| 0771 | 01 | 10/27/2021 | 10/27/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | | | 36 | 1 Per Date Span | Auto Approved for Care Plan |
| 0771 | 03 | 11/01/2021 | 12/31/2021 | 10/29/2021 | 20:06:31 | Home Care Progra | Initial | | NPI | G0162 | | | 6 Per Date Span | Auto Approved for Care Plan |

Prior Authorization - Viewing and Understanding the PA

Services may be authorized by:

- Procedure Code – code authorized must be billed on the claim
- Procedure Code with modifier(s) – code and all modifiers authorized must be billed on the claim
- Procedure Code(s) List – any combination of the codes on the list may be billed up to the number of units authorized
- Procedure Code/Modifier(s) List – any combination of the codes with associated modifier(s) on the list may be billed up to the number of units authorized

| | |
|----|--|
| 36 | Nursing assessment/evaluation - T1001 T1001 T1001 TT |
|----|--|

| | |
|----|--|
| 39 | Skilled Services by Registered Nurse (RN) for Management and Evaluation of Plan of Care G1062 G1062 95 G1062 95 TT G0162 GT G1062 GT TT G1062 TT |
|----|--|

NOTE: Discrepancies should be reported to the Access/Case Management Agency

Prior Authorization – PA Details

Authorized services are for a **Nursing Aide Service one-time only service** to a subsequent client with billing codes **T1004 U2 TT** for **12 units = 3 hours** of authorized service with an **effective/end date of 09/30/2025** and **frequency of 12 units per calendar week**.

| Line Item | | | | | | | | | | | | | | | |
|-----------|-----------------|-------------------|------------------|--------------------|-----------------------------|----------------|-------|-------|-------|-------|---------------------|---------------|-----|--------------|-------------------|
| Line Item | Requested Units | Requested Dollars | Authorized Units | Authorized Dollars | Status | Procedure Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Procedure Code List | Proc/Mod List | NDC | Revenue Code | Revenue Code List |
| 01 | 12.000 | \$0.00 | 12.000 | \$0.00 | Auto Approved for Care Plan | T1004 | U2 | TT | | | | | | | |

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code **T1004** [Search] Nsg aide service up to 15min

Mod 1 **U2** [Search]

Mod 2 **TT** [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List [Search]

Requested Eff./End Dates* **09/30/2025** • **09/30/2025**

Requested Units/Dollars* 12.000 \$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 Auto Approved for Care

| | | |
|---------------------------|-----------------------|--------|
| Authorized Units/Dollars | 12.000 | \$0.00 |
| Authorized Eff./End Dates | 09/30/2025 09/30/2025 | |
| Used Units/Dollars | 0 | \$0.00 |
| Available Units/Dollars | 12 | \$0.00 |
| Frequency | 12 Per Calendar Week | |

Prior Authorization – PA Details cont.

This PA for Skilled Nursing services is authorized with a Procedure Code/Modifier list SN.

The services relating to these codes can be provided interchangeably up to the units authorized, unless otherwise indicated in the notes by the care manager.

| Line Item | | | | | | | | | | | | | | | |
|-----------|-----------------|-------------------|------------------|--------------------|----------|----------------|-------|-------|-------|-------|---------------------|---------------|-----|--------------|-------------------|
| Line Item | Requested Units | Requested Dollars | Authorized Units | Authorized Dollars | Status | Procedure Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Procedure Code List | Proc/Mod List | NDC | Revenue Code | Revenue Code List |
| 01 | 15.000 | \$0.00 | 15.000 | \$0.00 | Approved | | | | | | | SN | | | |

Type changes below.

Line Item 01

Service Type Code* **Procedure/Mod List**

Procedure Code [Search]

Mod 1 [Search]

Mod 2 [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List SN **Skilled Nursing**

Procedure Code List

Requested Eff./End Dates* 09/30/2025 09/30/2025

Requested Units/Dollars* 15.000 \$0.00

NDC [Search]

Status Approved

Tooth [Search]

Quad [Search]

Tooth Surface 1 [Search]

Tooth Surface 2 [Search]

Tooth Surface 3 [Search]

Tooth Surface 4 [Search]

Tooth Surface 5 [Search]

Authorized Units/Dollars 15,000 \$0.00

Authorized Eff./End Dates 09/30/2025 09/30/2025

Used Units/Dollars 0 \$0.00

Available Units/Dollars 15 \$0.00

Frequency 5 Per Calendar Week

Please Note: The Procedure Code/Modifier List is located on each of the Waiver crosswalks

Prior Authorization – PA Modifiers

- Modifiers include:
- **U2 - One Time Only Services** can be used to authorize:
 - Additional units needed on a day service is provided
 - Another day of service in an existing care plan
 - An additional frequency to an existing service

| Line Item | | | | | | | | | | | | | | | | |
|-----------|-----------------|-------------------|------------------|--------------------|-----------------------------|----------------|-------|-------|-------|-------|---------------------|---------------|-----|--------------|-------------------|--|
| Line Item | Requested Units | Requested Dollars | Authorized Units | Authorized Dollars | Status | Procedure Code | Mod 1 | Mod 2 | Mod 3 | Mod 4 | Procedure Code List | Proc/Mod List | NDC | Revenue Code | Revenue Code List | |
| 01 | 12.000 | \$0.00 | 12.000 | \$0.00 | Auto Approved for Care Plan | T1004 | U2 | TT | | | | | | | | |

Type changes below.

Line Item 01

Service Type Code* Procedure Code

Procedure Code T1004 [Search] Nsg aide service up to 15min

Mod 1 U2 [Search]

Mod 2 TT [Search]

Mod 3 [Search]

Mod 4 [Search]

Revenue Code/List [Search] [Search]

Proc/Mod List [Search]

Procedure Code List [Search]

Requested Eff./End Dates* 2/1/2019 2/1/2019

Requested Units/Dollars* 12.000 \$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 Auto Approved for Cari

Authorized Units/Doll

Authorized Eff./End Da

Used Units/Doll

Available Units/Doll

Frequer

Please Note: The U2 Modifier is only applicable to waiver members.

Prior Authorization – PA Modifiers cont.

TT - Subsequent Client can be used to authorize:

- Service for an additional client residing in the home of a client already receiving the same service
- No procedure code restrictions

If authorized:

- The **TT** modifier must be associated to the procedure code on the care plan/PA

The screenshot shows a software interface for entering procedure codes. At the top, 'Line Item 01' is displayed. Below it, a dropdown menu for 'Service Type Code*' is set to 'Procedure Code'. The main input field contains 'Procedure Code T1004' with a '[Search]' button to its right. A tooltip or search result box is visible to the right of the input, containing the text 'Nsg aide service up to 15min'. Below the main input, there are two modifier fields: 'Mod 1 U2' and 'Mod 2 TT', each with its own '[Search]' button. The 'T1004', 'U2', and 'TT' entries are highlighted with green rectangular boxes.

Prior Authorization – PA Modifiers cont.

TG – Complex Visit can be used to authorize:

- Complex nursing care greater than two (2) hours of nursing care per day
- Is billed in conjunction with PA from CHNCT
- Billed for services S9123 – Nursing care in home by Registered Nurse, per hour and S9124 - Nursing care in home by licensed practical nurse, per hour

If authorized:

- The TG modifier must be associated to the procedure code on the PA
- If used when billing S9124, must also bill with modifier TE - LPN/ LVN for complex/high tech level of care services rendered by a licensed practical nurse

For more information see PB 22-02 Updating the Reimbursement Rate for Nursing Services for Home Health Pediatric Complex/High Tech Level of Care

Claims Processing



Claims Processing

- Remember that payment for services rendered are made twice per month and, sometimes in the year, providers will encounter a 3-week cycle.
- Providers are strongly encouraged to submit enough claims prior to the 3-week cycle to meet their organization's/agency's operational needs.
- A **3-week cycle** is indicated on the "Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule" with the following identifier **"-b"** under Claim Cycle Date.
- To download the Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule navigate to www.ctdssmap.com, select Information > Publications > in the title field enter "Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule".

| 2025 Month | Claim Cycle Date | Electronic Claims Received By | Web RA Availability | Check Mail Dates | 835/EFT Dates |
|------------|------------------|-------------------------------|---------------------|------------------|---------------|
| Jul | 11-b | 10 | 15 | 16 | 16 |
| | 25 | 24 | 29 | 30 | 30 |
| Aug | 8 | 7 | 12 | 13 | 13 |
| | 22 | 21 | 26 | 27 | 27 |
| Sep | 5 | 4 | 9 | 10 | 10 |
| | 19 | 18 | 23 | 24 | 24 |
| Oct | 3 | 2 | 7 | 8 | 8 |
| | 24-b | 23 | 28 | 29 | 29 |
| Nov | 7 | 6 | 12* | 13* | 13* |
| | 21 | 20 | 25 | 26 | 26 |
| Dec | 5 | 4 | 9 | 10 | 10 |
| | 19 | 18 | 23 | 24 | 24 |

b - Denotes 3 week cycle * Denotes a 1 day delay in availability due to Monday Holiday

THIS SCHEDULE IS SUBJECT TO CHANGE WITHOUT PRIOR NOTICE
 Changes to the schedule will be published on the www.ctdssmap.com Web site.

Claims Processing – Claims Workflow

1. Check Client Eligibility - Verify client eligibility upon referral and at regular intervals thereafter. Confirm in the CMAP portal that there is a Prior Authorization (PA) in an approved status.
2. For Waiver Clients - Ensure the client is visible in Santrax/Aggregator. Activate the client profile before entering schedules. Enter schedules for services. Staff Call In/Out Requirement: Staff must call in at the start of each shift and call out at the end. If they forget, they must notify the agency immediately. Office staff may then make a manual correction to the schedule.
3. For Non-Waiver Clients - Enter the required client information into SAM: like Client Medicaid ID#, Physician information, Services the client will be receiving, Schedules are optional but can be added if desired. Staff Call In/Out Requirement: Same as for waiver clients (staff must call in/out or notify agency for corrections).
4. Confirm Visits SAM providers: Claims must remain in confirmed status for at least 24 hours before export. Aggregator providers: Claims must remain in confirmed status for at least 48 hours before export.
5. Export Claims - Once confirmation periods are met, export claims to Gainwell for billing.

Claims Processing/ Submission Information

Claims submitted to Gainwell Technologies are each assigned a unique 13-digit Internal Control Number (ICN) that is used for tracking and research

(20)(25)(005)(123)(456)

1 2 3 4 5

- 1 Claim Region** – Identifies the manner in which the claim was submitted (**20** = *Electronic Claims with No Attachments*. **The ICN Region Code List** can be found on ctdssmap.com under Information > Publications > Claims Processing Information.)
- 2 Year of Receipt** – Indicates the year in which the claim was received by Gainwell Technologies (**25** = 2025)
- 3 Julian Date of Receipt** – The Julian calendar date of receipt (**005** = *the fifth day of the year; January 5*)
- 4 Batch Number** – An internal number assigned by Gainwell Technologies to uniquely identify a batch (**123**)
- 5 Claim Number** – A sequential number assigned to uniquely identify claims within a batch (**456**)

Claims Processing / Submission Information cont.

When a claim processes through CMAP, it is subject to a series of edits that check the validity of claim data such as:

- The submitted Provider must be **actively enrolled** on the date of service.
- Client must be **eligible** on date of service.
- Procedure Code submitted must be **valid** for the Provider Type.

Each claim then passes through a series of audits:

- The claim is compared to **previously paid claims**.
- Is the current claim a duplicate of a paid claim?
- Does the billed procedure code require PA?
- Does the billed procedure code have PA?

Claims Processing – Third Party Liability (TPL) Information

Commercial / private insurance coverage other than Medicare or Medicaid under which the client is covered must be on the billed claim.

Medicaid is the payer of last resort:

- Because of this, providers must investigate the possibility of clients having other insurance coverage and pursue payment prior to submitting their claim to Gainwell Technologies
- Providers can see other insurance coverage in the eligibility verification process

Claims can potentially deny when a discrepancy in TPL data exists on the client's state profile:

- If you find that there is a discrepancy in client TPL information, please refer to the following procedure:
 - A TPL referral should be made directly to HMS to report new client health insurance, or to have a correction made to a client's existing health insurance policy. Here are the methods in which a TPL referral should be made:
 - CTDSS Eligibility Staff should send to HMS the W-1685 Medicaid Insurance Information form by FAX: 1-469-320-5117, or by scanning the form into a PDF file and sending it by secure email to: CTinsurance@gainwelltechnologies.com
 - Call HMS Phone number: 1-866-252-0671

Claims Processing – Third Party Liability (TPL) Information cont.

TPL payers must be billed prior to submitting claims to Medicaid.

TPL claims submitted to Gainwell Technologies with other insurance payment or denial must include:

- Carrier's unique three-digit carrier code
- Available through eligibility verification (Web, phone, X12N 270/271 Eligibility Benefit Inquiry / Response Transaction) and in Chapter 5 of the CMAP Provider Manual
- The Amount Paid (on a paid claim) or "0.00" for a TPL denial
- The date of payment or denial from the TPL Explanation of Benefits (EOB)
- The physical TPL EOB should not be submitted with paper claims; the provider must retain this for audit purposes
- The Subrogation Process – Available to providers who do not receive timely responses from insurance carriers to get their claim paid.

For more information on this please see Chapter 5 of the Provider Manual on the www.ctdssmap.com Web site.

Claims Processing – Third Party Liability (TPL) Information cont

An urgent TPL referral should be made to HMS to fix incorrect health insurance information that adversely affects the client's ability to receive a health care good or service, or if a TPL Good Cause situation exists where CTDSS is required to waive TPL requirements and not capture health insurance on a client's ImpaCT record, if it is anticipated that this would result in reprisal against and cause physical or emotional harm to the client or other persons. Urgent TPL referrals should be made to HMS by calling 1-866-252-0671 (8:30AM – 5:30PM), or by secure email: CTinsuranceescalation@gainwelltechnologies.com.

- HMS will make needed changes to the client's health insurance coverage and respond back to the sender within 24 hours of receipt of the urgent TPL referral.
- Routine TPL referrals, which are not urgent or TPL Good Cause-related, may be made to HMS by calling: 1-866-252-0671, or by secure email to: CTinsurance@gainwelltechnologies.com

Please contact Catherine Leaper in the Office of Quality Assurance if you have any questions regarding these TPL referral procedures (Catherine.Leaper@ct.gov, 860-424-5164).

Claims Processing – Coinsurance/Deductible Information

Medicare Coinsurance and / or Deductible Claim Submission:

- Claims for clients covered under Medicare must first be billed to Medicare.
- Crossover claims are claims that Medicare has considered and made payment on.
- Crossover claims from Medicare will be denied if TPL information is on the client's eligibility file.
- Only claims paid by Medicare will be electronically submitted to Medicaid.
- Claims that do not cross over from Medicare or are denied by Medicare can be submitted by the provider to Gainwell Technologies.
- Claims submitted do not need the Explanation of Medicare Benefits (EOMB) attached if Medicare denied the service. Enter Medicare N/A or Medicare HMO N/A and the date of Medicare's denial.
- TPL or Medicare Coinsurance and / or Deductible Reimbursement.
- Medicaid **will pay** up to the Medicaid Allowed Amount minus any Medicare or TPL payment.
- Medicaid **will not pay** if the Medicare or TPL payment is equal to or exceeds the Medicaid Allowed Amount.

A provider may not balance-bill the client, financially responsible relative, or representative of the client.

Medicare Cost Avoidance and Home Health Audit



Medicare Cost Avoidance



Home Health Agencies are required to submit claims for **dually eligible clients** to Gainwell Technologies indicating the reason an Advanced Beneficiary Notification (ABN), Form CMS-R-131 was issued to the client.



CMS has made changes to the ABN requirements, DSS is working on defining the changes and will send out a Provider Bulletin with detailed changes in the near future. Until notified of changes, providers must continue to follow the current process.



Claim Submission:



Claims for dually eligible clients who are traditional or Medicare Managed Care (A, B or A&B benefit eligible) and HUSKY eligible, must contain:

- At least one HIPAA Adjustment Reason Code (**150, 151, or 152**).
- Date the associated ABN or MCO Notice of Medicare Non-Coverage (NOMNC) was issued.
- The **issue date** of the ABN must be within **one year of the date of service**.



Note: This is not applicable to Medicare clients who are State Funded CT Home Care eligible.

Medicare Cost Avoidance cont.

Claim Denial:

If a client's care does not meet Medicare's coverage criteria and the claim does not contain one of the indicated Adjustment Reason Codes and corresponding ABN issue date, the claim will deny with:

Explanation of Benefit Code (EOB) code 2522 - "Bill Medicare First or Provide Appropriate Adjustment Reason Code and Date of ABN or NOMNC (Notice of Medicare Non-Coverage)"

Claim Auditing:

- Claims submitted with a HIPAA Adjustment Reason Code 150, 151, or 152 will be included in an Other Insurance Audit based upon a random sample of claims that contain one of the three Adjustment Reason Codes
- Audited Home Health providers will be required to submit a copy of the original signed and dated ABN associated with the selected claim under review
- Failure to provide the appropriate ABN issued contemporaneously with the date of the selected claim will result in the claim being recouped
- Providing an ABN with a different signature date than the ABN date of issue indicated on the claim will also result in recoupment of the claim

Medicare Cost Avoidance cont.

These codes can only be used for Medicare as a third-party payer. They are not valid for any other third-party payer.

| Home Health Agency Reasons to Issue Advanced Beneficiary Notice | HIPAA Adjustment Reason Code | HIPAA Adjustment Reason Code Description |
|--|------------------------------|---|
| Client determined to be not homebound; either at the start of care or after Medicare-covered services has been provided. | 150 | Payment adjusted because the payer deems the information submitted does not support this level of service. |
| Client not receiving part-time or intermittent services from start of care or following the delivery of Medicare-covered services. | 150 | Payment adjusted because the payer deems the information submitted does not support this level of service. |
| Client receiving thirty-five (35) hours per week of Medicare-covered skilled nursing and/or home health aide services combined. Medicaid being billed for additional skilled nursing and home health aide services over 35 hours/week. | 151 | Payment adjusted because the payer deems the information submitted does not support this many services. |
| Nursing, therapy and/or dependent services being provided do not meet Medicare coverage requirements, e.g. nursing visits are for medication pre-pours or the home health aide is not primarily performing hands-on personal care. | 150 | Payment adjusted because the payer deems the information submitted does not support this level of service. |
| Client's continued care determined to not be Medicare-coverable. CMS required Annual HHABN issued. | 152 | Payment adjusted because the payer deems the information submitted does not support this length of service. |

Claims Audit Criteria

- In accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, audit protocols have been published on the Department of Social Services' Web site.
- An introduction to audit protocols and an overview of the audit process can be found at: <http://www.ct.gov/dss/auditprotocols>.
- Additional resources can be found in provider bulletin [17-29](#).
- Links to audit protocols organized by provider type are located on the lower section of this Web page.

The Office of Quality Assurance

[Overview](#)

[Related Resources](#)

Provided by:

[Department of Social Services](#)

Related Resources

[Press Releases](#)

[Annual Report](#) 

[Audit Protocols](#)

[Long Term Care Audit Process](#) 

[Administrative Actions List](#)

[OIG Exclusion File](#)

[Report Fraud](#)

[Alcohol and drug abuse centers audit protocols](#) 

[Birth to Three Audit Protocol](#) 

[Dental audit protocols](#) 

[Department of Developmental Services Waiver audit protocols](#) 

[Homecare audit protocols](#) 

[Home health audit protocols](#) 

[Medical equipment audit protocols](#) 

[Outpatient hospital audit protocols](#) 

[Pharmacy audit protocols](#) 

[Physicians audit protocols](#) 

[Transportation audit protocols](#) 

[Long Term Care Audit Process](#) 

Claims Audit Criteria cont.

- The Home Health audit protocols list the most common reasons why a provider's claims may be audited.
- You can find the Audit Protocols at <https://www.ct.gov/dss/auditprotocols> > Home Health audit protocols.

DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - HOME HEALTH SERVICES
UPDATED MAY 1, 2017

Listed are the most common audit findings for Medicaid home health services, and clarification of the criteria the Connecticut Department of Social Services (the "Department") uses when it makes those findings. Disallowances for home health services under the Medicaid program are governed by policies included in the Connecticut Medical Assistance Program Provider Manual (PM), the Medicaid Provider Enrollment Agreement (PA), Provider Bulletins (PB), the Regulations of Connecticut State Agencies (Conn. Agencies Regs.), the Connecticut General Statutes (Conn. Gen. Stat.) and the Code of Federal Regulations (C.F.R.). This protocol is for services performed prior to the implementation of the Electronic Visit Verification system. Please see the protocol for homecare services for additional requirements that may apply to home health services.

| Title | Audit Criteria | Regulatory Reference |
|--|---|--|
| Billing - Failure to Utilize Third Party Liability. | The Department will disallow payment for services if there is a private insurance/third-party payor that the provider failed to bill first or did not receive a denial of payment by the third party. | Conn. Agencies Regs. § 17b-262-526(3) |
| Billing - Home Health Aide Services Provided to Multiple Clients in Same Household | If timesheets show that hands-on care services were provided to more than one client by the same home health aide during the same time period, the Department will disallow payment for the overlapping hours of home health aide services. | Conn. Agencies Regs. § 17b-262-734(b)(4) |
| Billing - Hours Paid In Excess of the Number of Hours on Timesheets | The Department will disallow payment for service if the number of hours paid exceeds the number of hours documented on the timesheet. The financial disallowance is the difference between the number of hours paid and the number of hours documented. | Conn. Agencies Regs. § 17b-262-735(c)(8) |

Claim Denials and Resolution



Claim Denials and Resolution

Denial Reasons Due to Eligibility:

- **EOB Code 2003** – Client Ineligible for dates of service
- **EOB Code 4021** – Procedure Billed is not a Covered Service under the Client's Benefit Plan. (If this is the only EOB that sets on the claim, the client does not have a Waiver benefit plan. If any other EOB is on the claim, take action on the other EOB and disregard EOB 4021)

Please Note: The system attempts to process under the HUSKY benefit plan first, if not a covered service it will set 4021 for the HUSKY benefit plan. The system will then attempt to process under the Waiver benefit plan. If the claim denies, the system will attempt to process under any other benefit plan the client may have, which too will set 4021. It is the other EOB that should be acted upon. Disregard the 4021 EOB codes

Resolution: Client eligibility file needs to be updated with a Waiver benefit plan or change in the effective dates of eligibility.

Claim Denials and Resolution cont.

- **Denial Reasons due to Care Plan not on File :**
 - **EOB Code 3015 – Care Plan Required**

Resolution: A care plan must be created by the Access Agency or DSS Autism Case Manager via batch upload or interactively online via the secure Web portal. **Contact the appropriate case manager who must add a Care Plan for the client.**

Claim Denials and Resolution cont.

- **Denial Reason due to Service not Authorized on the care Plan:**

- **EOB Code 3016** – Service not Authorized on the Care Plan.

Resolution 1: A service denied for not authorized on the care plan must be added by the Access Agency or DSS Autism Case Manager to the Care Plan.

Resolution 2: Incorrect Procedure code billed by provider. Provider must correct the claim and resubmit.

Claim Denials and Resolution cont.

- **Denial Reason due to Units Billed Exceeding Frequency :**

- **EOB Code 5151** – Units exceed the frequency units authorized on the care plan.

Resolution 1: Units of service must be added to the frequency of an existing PA by Access Agency or DSS Autism Case Manager.

Resolution 2: Units exceeded due to provider keying error. Provider should review claim(s) within the frequency span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution cont.

- **Claim Denial Reason due to PA Exhausted:**

- **EOB Code 3003** – Prior Authorization is required for payment of the service (units for the service are exhausted). This will be seen for services that are provided to non-waiver claims as well.

Resolution 1: Units of service must be added by Access Agency or DSS Autism Case Manager to an existing PA that is currently exhausted.

Resolution 2: PA exhausted may be due to provider keying error. Provider should review claim(s) within the span dates of the PA for keying errors or possible over service.

Claim Denials and Resolution cont.

- **Denial Reason Due to Modifier U2 Not Allowed:**

- **EOB Code 749 - Modifier U2 not allowed**

Cause: Prior Authorization does not contain a U2 Modifier

Resolution: Remove U2 modifier and resubmit the claim

If one-time only service, contact Access Agency or DSS Autism Case Manager who must enter a PA for service with a U2 modifier

Cause: Claim is submitted with a U2 modifier for a service that is not a valid service on the Waiver Fee schedule

Resolution: Claim must be resubmitted with the correct procedure code and the U2 modifier and must be on the Care Plan.

Claim Denials and Resolution cont.

- **Claim Denials related to EVV mandated claims submitted outside of the Santrax system:**

- **EOB Code 3327** - Confirmed visit not found

Cause: This EOB posts to a claim containing an EVV mandated service if there is no confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s).

Resolution: the visit must be confirmed in the provider's Santrax system.

NOTE: Confirmed visit data used in claims processing may take up to 24 hours for access to systematic confirmation therefore, visits must be confirmed at least 24 hours prior to claim submission.

- **EOB Code 3328** - Confirmed visit units are exhausted

Cause: This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units have been exhausted due to a previously submitted and paid claim.

Resolution: Increase the units on the confirmed visit in Santrax.

Claim Denials and Resolution cont.

Claim Denials related to EVV mandate

➤ **EOB 3331** – Non-Waiver Confirmed Visit not found

Cause: No confirmed visit in your Sandata or Aggregator account

Resolution: Reconfirm the visit, if using Sandata Agency Management (SAM) visit **MUST** be in a confirmed status for 24 hours before rebilling, if using Alt EVV visit **MUST** be in a confirmed status for 48 hours before rebilling.

➤ **EOB 3332** – Non-Waiver Confirmed Visit Units Exceeded

Cause: The number of units billed exceeds the number of units confirmed.

Resolution: Ensure the number of units billed matches the number of units confirmed.

Claim Denials and Resolution cont.

- **Claim Denials related to EVV mandated claims submitted outside of the Santrax system cont'd:**

- **EOB Code 0047** - Confirmed visit units are exceeded

Cause: This EOB posts to a claim containing an EVV mandated service where there is a confirmed visit found that contains the same client ID, provider ID, date of service, service code and modifier(s), however, the visit units on the confirmed visit are less than the units billed on the claim. This claim will pay, but it will cut back to the number of units on the confirmed visit.

Resolution: increase the units on the confirmed visit.

Please Note: EOB code 0047 may also occur if there are two visits for the same client and service on the same day and only one visit is confirmed. The second visit must be confirmed for the claim to pay the total number of units billed for the day.

Claim Denials and Resolution cont.

➤ **EOB Code 3329** - Details cannot exceed 31 days

Cause: Claims submitted from Santrax are limited to one date of service per claim detail. Claims submitted outside of Santrax may be submitted using spanned dates. These spanned dates cannot exceed the lessor of 31 days or a single month of service.

Resolution: reduce the number of days submitted on the claim detail.

Claim Denials and Resolution - Resources

- Case Managers create service orders and enter them in the Access/Case Management Agencies Care Management System.
- The Access/Case Management Agency is responsible for uploading initial care plans and changes to care plans to Gainwell Technologies, in Prior Authorization format, within seven (7) days of issuing the service order. DSS Autism Case Managers enter care plans and changes via a secure Web account directly into the PA subsystem for claims processing.
- If the provider has a PA for the services but cannot be found by doing a PA inquiry via the provider's secure Web account within seven (7) days of receipt of the service order, the provider should contact the applicable Access / Case Management Agency or DSS Autism Case Manager.

Please Note: the above are only applicable to ABI, CHC, PCA and Autism waiver members.

- For non-waiver clients Carelon or CHN should be contacted when there are any claim issues, as they are responsible for entering the PA for services.

For assistance in resolving claim denials, please refer to Provider Manual

Chapter 12 – Claim Resolution Guide.

Claim Denials and Resolution - Resources

- Providers should first verify with the care manager at the Access/Case Management Agency or the DSS Autism Case Manager responsible for the client's care plan that the client's Medicaid redetermination and financial verifications have been submitted to DSS for processing
- If the clients Medicaid redetermination and financial verifications have been submitted to DSS and the access agency cannot be of further support, the Community Options Unit, formerly the Alternate Care Unit, at DSS should be notified of the eligibility issue. Providers should send an encrypted email to Waiver.DSS@ct.gov
- The client's name, client ID, and the date service began or is scheduled to begin should be provided. Place the words "Waiver Client Eligibility Issue" in the subject line of the email

To avoid claim denials due to eligibility, providers should verify client eligibility prior to performing a service.

Monthly Claims Reprocessing for ABI, CHC, PCA, and Autism Waiver Members



Monthly Claims Reprocessing

- The Access or Case Management Agencies can make **retroactive** changes to Care Plans when claims are paid against the Prior Authorization (PA) for a CHC, PCA, Autism, or ABI Waiver client.
- Access Agencies, Case Management Agencies, and Autism Case Managers can make changes to individual care plans **without** requesting the provider recoup/void claims paid for dates of service on or after the effective date of the change.
- A Systematic Monthly Claims Reprocessing for all CHC, PCA, Autism or ABI Waiver claims occurs in the **first financial cycle of each month** to sync paid claims to the appropriate PA or PA line detail once care plan changes have been made by the Access or Case Management Agencies.

Monthly Claims Reprocessing cont.

Systematic Monthly Reprocessing:

- In the first cycle of each month, Gainwell Technologies will recoup (void) all paid claims impacted by the Access or Case Management Agency PA changes made two months prior. (*Region code 52 claims = a voided claim*).
- In the same cycle Gainwell Technologies will reprocess to deny and/or pay claims posting to the correct PA/PA line detail. (*Region 24 claims = a new day claim*).
- There is a two-month delay between the PA change and reprocessing of the claim impacted by the change.
- For example: In the first cycle of June, claims impacted by changes made in April, will be reprocessed.

Note: *Region = the first two digits of the claim Internal Control Number (ICN).*

Monthly Claims Reprocessing cont.

Impact to Provider Remittance Advice (RA)

If there is a financial impact (change in reimbursement amount up or down) between the voided claim (**region 52**) and the reprocessed claim (**region 24**):

Providers will see in the adjustment section of their RA:

- The previously paid claim ICN (**Region 20, 22, 59, 10** etc.)
- Recouped/Voided claim ICN (**Region 52**)
- **EOB Code 8236** – Claim was recouped due to PA change

Monthly Claims Reprocessing cont.

REPORT: CRA-PHAD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIM ADJUSTMENTS

Date: 10/28/2025
PAGE: 33

Home Care Agency
555 Any ST
Somewhere, CT 00000-0000

PAYEE ID
ISSUE DATE 10/28/2025
TAXONOMY -----
P. AVRS ID

| FP | --ICN-- | SERVICE DATES | BIL | ALLOWED | DEDUCT | CO-INS | TPL | CO-PAY | APPLIED | PAID | CLIENT | |
|----|--------------------|-------------------------|------|-----------|--------|--------|---------|----------|---------|--------|--------|------|
| | --PATIENT NUMBER-- | FROM | THRU | AMOUNT | AMOUNT | AMOUNT | AMOUNT | AMOUNT | INCOME | AMOUNT | CONTR. | |
| | | SERVICE DATES RENDERING | | | | BILLED | ALLOWED | | | | | |
| PL | SERV | PROC | CD | MODIFIERS | UNITS | FROM | THRU | PROVIDER | AMOUNT | AMOUNT | DETAIL | EOBS |

| | | | | | | | | | | | |
|--------------|----------------|-------------|------------|----------|---------|--------|--------|--------|--------|---------|--------|
| CLIENT NAME: | Sally Client | CLIENT NO.: | 0000000000 | | | | | | | | |
| 1 | 22000000000000 | 08/02/2025 | 08/12/2025 | (116.16) | (58.08) | (0.00) | (0.00) | (0.00) | (0.00) | (58.08) | (0.00) |
| 1 | 52000000000000 | 08/02/2025 | 08/12/2025 | 116.16 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| HEADER | EOBS: | 8236 | | | | | | | | 0.00 | |

Monthly Claims Reprocessing cont.

Impact to Provider Remittance Advice (RA)

- A new claim will be systematically created. Providers will see the new day claim on their RA.
 - Claim ICN (**Region 24**) in the paid/denied section of the RA.
 - **EOB Code 8238** – Claim Systematically Reprocessed Due to a PA/Service Order Change.

NOTE: If the reprocessed region 24 claim pays the same as the recouped region 52 claim, neither claim will appear on the paper RA.

Monthly Claims Reprocessing – Claims Reprocessed

| FP | --ICN-- | SERVICE DATES | BILLED | ALLOWED | DEDUCT | CO-INS | TPL | CO-PAY | APPLIED | PAID | CLIENT |
|---|--------------------|---------------|--------|---------|--------|--------|--------|--------|--|--------|--------|
| | --PATIENT NUMBER-- | FROM THRU | AMOUNT | AMOUNT | AMOUNT | AMOUNT | AMOUNT | AMOUNT | INCOME | AMOUNT | CONTR. |
| REPORT: CRA-PHPD-R RA#: | | | | | | | | | | | |
| interChange MMIS MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER REMITTANCE ADVISE CMS 1500 CLAIMS PAID | | | | | | | | | | | |
| Date: 10/28/2025 PAGE: 2 | | | | | | | | | | | |
| Home Care Agency 555 Any ST Somewhere, CT00000-0000 | | | | | | | | | PAYEE ID ISSUE DATE TAXONOMY P. AVRS ID | | |
| | | | | | | | | | MCD 10/28/2025 ----- | | |
| CLIENT NAME: Sally Client CLIENT NO.: | | | | | | | | | | | |
| 2400000000000 08/02/2025 08/12/2025 116.16 75.00 0.00 0.00 0.00 0.00 0.00 75.00 0 | | | | | | | | | | | |
| HEADER EOB 8238 SERVICE DATES RENDERING BILLED ALLOWED 0.00 | | | | | | | | | | | |
| PL SERV PROC CD MODIFIERS UNITS FROM THRU PROVIDER AMOUNT AMOUNT DETAIL EOB | | | | | | | | | | | |
| 12 1542P 20 08/02/2025 08/12/2025 MCD 116.16 75.00 | | | | | | | | | | | |

Monthly Claims Reprocessing cont.

Impact to provider's secure Web Portal - Claim Inquiry

Regardless of the financial impact (more, less or no \$ change):

- All **region 52** and **region 24** claims will appear on the provider's secure web account when performing a claim inquiry.
- **Region 24** claims with no financial impact (i.e., region 24 claims paid the same as voided region 52 claims) **will appear on the web only** with:

EOB code 8237 – Claim Systematically Reprocessed Due to Retro Change-Information Only.

Note: These claims will not appear on the provider's RA.

Monthly Claims Reprocessing cont.

Impact to PA Inquiry in Provider's Secure Web Portal

- Region **24 claims** identify a change made to the care plan/PA.
- Region **24 claims** with **EOB Code 8238** – “Claim Systematically Reprocessed Due to a PA/Service Order Change” confirms there has been a change which has:
 - Positively or negatively impacted you financially.
 - May impact you financially in the future.
- Providers should investigate reprocessed claims with a **negative** impact to determine if:
 - Providing appropriate level of service currently authorized.
 - Current service order matches the PA on their secure Web account.
 - Report discrepancies to the Access/Case Management Agency or DSS Autism Case Manager.

Monthly Claims Reprocessing cont.

Impact to Provider's Secure Web Portal – PA Inquiry (continued)

A PA may show negative units available, if the changes made by the Access Agency reduce the frequency number or date span to less than the total units paid on claims currently associated to the PA.

For example:

- PA authorized for 4 units per week for 4 weeks = 16 units authorized and available.
- Claims are paid against the PA = 16 units used
- Access Agency changes the PA to 4 units a week for 3 weeks = 12 units authorized due to hospitalization after the third week

Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Remittance Advice (RA)



Remittance Advice

- **Claim Cycle Schedule**

- The Claim Cycle Schedule is published twice per year to tell providers when their Medicaid claims must be submitted to Medicaid for processing and when they can expect payment and the ability to download the Remittance Advice.
- To download the Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule navigate to www.ctdssmap.com, select Information > Publications > in the title field enter “Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule”.
- The Claim Cycle Schedule can also be located by navigating to www.ctdssmap.com > Provider > Provider Services > Schedules.

| 2025 Month | Claim Cycle Date | Electronic Claims Received By | Web RA Availability | Check Mail Dates | 835/EFT Dates |
|------------|------------------|-------------------------------|---------------------|------------------|---------------|
| Jul | 11-b | 10 | 15 | 16 | 16 |
| | 25 | 24 | 29 | 30 | 30 |
| Aug | 8 | 7 | 12 | 13 | 13 |
| | 22 | 21 | 26 | 27 | 27 |
| Sep | 5 | 4 | 9 | 10 | 10 |
| | 19 | 18 | 23 | 24 | 24 |
| Oct | 3 | 2 | 7 | 8 | 8 |
| | 24-b | 23 | 28 | 29 | 29 |
| Nov | 7 | 6 | 12* | 13* | 13* |
| | 21 | 20 | 25 | 26 | 26 |
| Dec | 5 | 4 | 9 | 10 | 10 |
| | 19 | 18 | 23 | 24 | 24 |

b - Denotes 3 week cycle

* Denotes a 1 day delay in availability due to Monday Holiday

THIS SCHEDULE IS SUBJECT TO CHANGE WITHOUT PRIOR NOTICE
Changes to the schedule will be published on the www.ctdssmap.com Web site.

Remittance Advice cont.

All claims activity is reported to providers twice a month on a Remittance Advice:

- RAs provide comprehensive information about claims that are paid, denied, in process, and adjusted, and are produced based on a provider's claim activity
- Providers receive RAs electronically via the secure Provider Web site at www.ctdssmap.com
- Available in either the ASC X12N 835 Payment/Advice standard transaction format or in the Portable Document Format (PDF) which provides the paper version of the RA
- Only the last 10 RAs are maintained on the Gainwell Technologies' Web site. It is recommended that providers save a copy of their RAs to their local computer system for future access
- Click Download Remittance Advice from the Quick Link box on the account home screen or select Download from the Trade Files drop-down menu

Quick Link

- [Check E-messages](#)
- [Claim Status Inquiry](#)
- [Client Eligibility Verification](#)
- [Prior Authorization Inquiry](#)
- [Download Remittance Advices](#)

| | | | | |
|---------------|--------------------|-------|----------|---------|
| Authorization | Trade Files | MAPIR | Messages | Account |
| demographic | Download | | | it |
| | Upload | | | |
| | Claim Level Detail | | | |

Remittance Advice cont.

Select Remit. Advice (RA) – PDF from the Transaction Type menu; click Search

NOTE: 1099s are available to download as well

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims Eligibility
 Prior Authorization Hospice Trade Files MAPIR Messages Account
 home download upload claim level detail

File Download Search

Transaction Type

- REMINDER: DOI**
 Web file retention

 - Remittance Interchange Enrollment be retained available.
 - Historical will not be available.
 - E-Delivery available.
 - 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.
- REMINDER: DOI**
 Web file retention

 - the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit (279), and any other proprietary format files (excluding Drug Rebate files) available for download will remain on this web site for a period of five (5) months, at which time they will be removed and will no longer be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
 - approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.

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

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

Remittance Advice cont.

Banner Page contains

- Important messages from DSS or Gainwell Technologies

Claims Information (Paid, Denied, and Adjustments)

- Sorted by claim type and status; reports up to 20 EOB codes per claim

TPL Information

- The primary insurance that is on file for clients whose services appear on the RA

Financial Transactions Processed

- Payouts, Refunds, Account Receivables

RA Summary

- Month-to-day and year-to-day summaries of financial activities, account receivables

EOB Code Descriptions

- Descriptions of the EOB codes that posted to claims on the RA

Claims in Process

- Lists claims that were in suspense when the financial cycle was run

Remittance Advice cont.

Banner Page

REPORT: CRA-BANN-R
RA#: 7766400

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

Date: 08/24/2021
PAGE: 1

123 Home Care
This Rd
EAST HARTFORD, CT 06118-4001

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI 1234567890
08/24/2021
251E00000X
123456789

Attention All Providers.

HOLIDAY CLOSURE: Please be advised, the Department of Social Services (DSS) and Gainwell Technologies will be closed on Monday, September 6, 2021 in observance of the Labor Day holiday. Both the DSS and Gainwell Technologies offices will re-open on Tuesday, September 7, 2021.

Claim Information (Paid, Long Term Care):

REPORT: CRA-LTPD-R
RA#: 6800455

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
LONG TERM CARE FACILITY CLAIMS PAID

Date: 08/24/2021
PAGE: 9

642 DANBURY ROAD
RIDGE HEALTH CARE
RIDGEFIELD, CT 06877-2719

RIDGE HEALTH CARE

PAYEE ID
ISSUE DATE
TAXONOMY
P. AVRS ID

NPI 09/26/2017
314000000X

FP --ICN-- ATTEND PROV.
--PATIENT NUMBER--

| SERVICE DATES FROM | THRU | DAYS | BILLED AMOUNT | ALLOWED AMOUNT | DEDUCT AMOUNT | CO-INS AMOUNT | TPL AMOUNT | PATIENT LIABILITY | PAID AMOUNT |
|--------------------|----------|------|---------------|----------------|---------------|---------------|------------|-------------------|-------------|
| 07032021 | 07262021 | 23 | 6,178.95 | 6,178.95 | 0.00 | 0.00 | 0.00 | 0.00 | 6,178.95 |

CLIENT NAME:
M 2217262150238 NPI
051130000FIKR
REV CD HCPCS/RATE SRV DATE
100 07032021

CLIENT NO. :
UNITS BILLED AMT ALLOWED AMT
23.00 6,178.95 6,178.95

Remittance Advice cont.

Claim Information (Paid, Long Terms Care):

| | | | | | | | | | | |
|---------------------------|-------------------|--|------------|------------------|----------------|---------------|---------------|------------|-------------------|-------------|
| REPORT: CRA-LTPD-R | | interChange MMIS | | Date: 08/24/2021 | | | | | | |
| RA#: 6800455 | | MEDICAID MANAGEMENT INFORMATION SYSTEM | | PAGE: 9 | | | | | | |
| | | PROVIDER REMITTANCE ADVICE | | | | | | | | |
| | | LONG TERM CARE FACILITY CLAIMS | PAID | | | | | | | |
| | RIDGE HEALTH CARE | | | | | | | | | |
| 642 DANBURY ROAD | | | | PAYEE ID | | | | | | |
| RIDGE HEALTH CARE | | | | ISSUE DATE | | | | | | |
| RIDGEFIELD, CT 06877-2719 | | | | TAXONOMY | | | | | | |
| | | | | P. AVRS ID | | | | | | |
| | | | | NPI | | | | | | |
| | | | | 09/26/2017 | | | | | | |
| | | | | 314000000X | | | | | | |
| FP --ICN-- | ATTEND PROV. | SERVICE DATES | DAYS | BILLED AMOUNT | ALLOWED AMOUNT | DEDUCT AMOUNT | CO-INS AMOUNT | TPL AMOUNT | PATIENT LIABILITY | PAID AMOUNT |
| --PATIENT NUMBER-- | | FROM THRU | | | | | | | | |
| CLIENT NAME: | | CLIENT NO.: | | | | | | | | |
| M 2217262150238 | NPI | 07032021 07262021 | 23 | 6,178.95 | 6,178.95 | 0.00 | 0.00 | 0.00 | 0.00 | 6,178.95 |
| 051130000FIKR | | | | | | | | | | |
| REV CD HCPCS/RATE | SRV DATE | UNITS | BILLED AMT | ALLOWED AMT | DETAIL | EOBS | | | | |
| 100 | 07032021 | 23.00 | 6,178.95 | 6,178.95 | | | | | | |

EOB Code Description:

| | | | | |
|------------------------------|--|--|--|------------------|
| REPORT: CRA-EOBM-R | | interChange MMIS | | Date: 08/24/2021 |
| RA#: 7766400 | | MEDICAID MANAGEMENT INFORMATION SYSTEM | | PAGE: 41 |
| | | PROVIDER REMITTANCE ADVICE | | |
| | | EOB CODE DESCRIPTIONS | | |
| 123 Home Care | | | | PAYEE ID |
| This Rd | | | | ISSUE DATE |
| EAST HARTFORD, CT 06118-4001 | | | | TAXONOMY |
| | | | | P. AVRS ID |
| | | | | NPI |
| | | | | 08/24/2021 |
| | | | | 251E00000X |
| EOB CODE | EOB CODE DESCRIPTION | | | |
| 0047 | CONFIRMED VISIT UNITS ARE EXCEEDED | | | |
| 1042 | RESIDENT NOT ALLOWED AS ATTENDING PROVIDER | | | |
| 2504 | BILL PRIVATE CARRIER FIRST OR INVALID ADJUSTMENT REASON CODE BILLED. | | | |
| 2522 | BILL MEDICARE FIRST OR PROVIDE APPROPRIATE ADJUSTMENT REASON CODE AND DATE OF ABN OR NOMNC | | | |
| 3003 | Prior authorization is required for payment of this service. | | | |
| 3016 | SERVICE NOT COVERED UNDER CARE PLAN | | | |
| 3327 | CONFIRMED VISIT NOT FOUND | | | |
| 4021 | The procedure billed is not a covered service under the client's benefit plan. | | | |
| 4227 | The RCC billed is not a covered service under the client's benefit plan. | | | |
| 4980 | The procedure billed is restricted under the client's benefit plan. | | | |
| 6230 | PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK | | | |
| 6237 | PLAN OF CARE EXCEEDED OR PA REQUIRED > 5 NURSE VISITS PER WEEK | | | |
| 6420 | PLAN OF CARE EXCEEDED OR PA REQUIRED > 2 NURSE VISITS PER WEEK | | | |
| 9918 | PRICING ADJUSTMENT - MAX FEE PRICING APPLIED | | | |
| 9977 | PRICING ADJUSTMENT - PROVIDER RCC CUSTOMARY CHARGE PRICING APPLIED | | | |

Remittance Advice cont.

Financial Transaction:

| TRANSACTION NUMBER | CCN | PAYOUT AMOUNT | REASON CODE | APPLICANT/CLIENT NO. | APPLICANT/CLIENT NAME | LIAB DATE | | | |
|---|------------------------------|---------------------|-----------------|----------------------|-----------------------|-------------|----------------------|-----------------------|--------------------|
| -----NON-CLAIM SPECIFIC PAYOUTS----- | | | | | | | | | |
| NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDER | | | | | | | | | |
| -----REFUNDS/CASH RECEIPTS FROM PROVIDER----- | | | | | | | | | |
| CCN | REFUNDS/CASH RECEIPTS AMOUNT | REASON CODE | | | | | | | |
| NO REFUNDS FROM PROVIDER | | | | | | | | | |
| -----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 |
| 5921230012713 | 08/20/2021 | 155.88 | 155.88 | 155.88 | 0.00 | 8400 | 001141231 | WILLIAM NARGI | |
| -----1099 ADJUSTMENTS----- | | | | | | | | | |
| TRANSACTION NUMBER | SETUP DATE | ADJUSTMENT AMOUNT | REASON CODE | | | | | | |
| NO 1099 ADJUSTMENTS | | | | | | | | | |

Financial Transaction Reason Codes:

| FINANCIAL TRANSACTIONS REASON CODES | |
|-------------------------------------|----------------------------|
| RSN CODE | REASON CODE DESCRIPTION |
| 8400 | result of claim adjustment |

Remittance Advice - 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 |

Information/Resources



Information/Resources – Important Messages

www.ctdssmap.com Web site contains a wealth of information for providers:

Important Messages:

- Available on the Home page and 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.



Information

Important Messages

[Hospital Monthly Important Message \(Posted 8/18/25\)](#)

[Attention Acquired Brain Injury \(ABI\), Autism, Connecticut Home Care \(CHC\), Mental Health \(MH\), and Personal Care Assistant \(PCA\) Waiver Service Providers and Home Health Providers: Electronic Visit Verification \(EVV\) Reminder: How to Contact Sandata Customer Care \(Posted 8/6/25\)](#)

[Attention Outpatient Hospitals: CMAP Addendum B Updated \(July 1, 2025\) \(Posted 7/31/25\)](#)

[Attention BH Clinics and ECCs - Children's Mental Health Urgent Crisis Centers: ACTION REQUIRED - Children's Mental Health Urgent Crisis Centers Certification Letter Upload Instructions and Billing Reminder \(Posted 7/31/25\)](#)

[Attention Home Health Agencies and Access Agencies providing In-Home Services and Supports to Medicaid Members: Important Reminder for Recipients of the In-Home Safety Enhancements Awards \(Posted 7/22/25\)](#)

[Attention Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse-Midwives, Medical Clinics and Federally Qualified Health Centers: REMINDER: Connecticut Medical Assistance Program \(CMAP\) Coverage of Behavioral Health Screenings in Primary Care \(Posted 7/21/25\)](#)

[Attention Home Health Agencies: 10% Rate Add-On Extended for COPE, Confident Caregiver, and CAPABLE Services through September 30, 2025 \(Posted 6/26/25\)](#)

[Attention Ophthalmologists, Optometrists, Opticians, Outpatient Hospitals, and Hearing Aid Providers: Children's Health Insurance Program/HUSKY B Services - Elimination of Allowances for Eyeglasses and Hearing Aids - DSS Payment in Full \(Posted 6/25/25\)](#)

[Attention Federally Qualified Health Center \(FQHC\) Providers: FQHC Certification Letter Upload Instructions and Billing Reminder \(Posted 5/30/25\)](#)

[Attention Physicians, Physician Assistants, APRNs, Certified Nurse Midwives and Doulas: Frequently Asked Questions \(FAQ\): Connecticut Maternity Bundle Billing and Claims \(Posted 5/29/25\)](#)

[Attention ICF/IID Providers: Supplemental Public Notice \(Posted 5/20/25\)](#)

Information/Resources cont.

RA Banner Announcements

- Available by selecting Information > Messages Archive or clicking on RA Banner Announcements in the Information box on the left side of the home page.
- Messages originally published for providers on the first page of their remittance advice. Some banner announcements are provider specific and therefore are only sent to the relevant provider types/specialties.
- Often published in reference to reprocessed claims; explaining the reasons behind the reprocessing as well as the claim types affected.

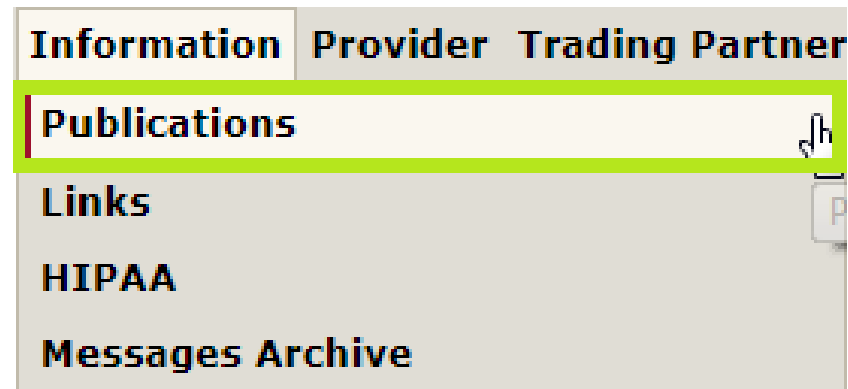
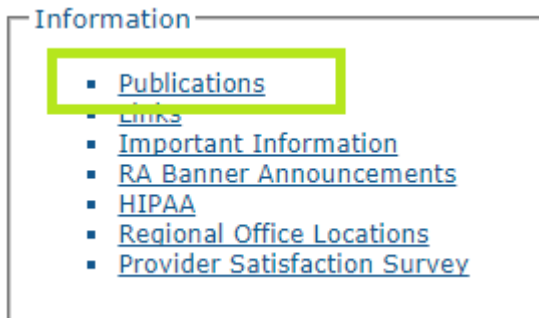
| RA Banner Announcements | | |
|-------------------------|----------------------------|---|
| Banner Effective Date | Providers | Banner Page Announcement |
| 08/22/2025-08/29/2025 | Attention Select Providers | Attention Select Providers. PCMH REPROCESS: Providers enrolled in the Person-Centered Medical Home Initiative (PCMH) were enrolled with retroactive effective dates or were approved for changes in PCMH level or site address with retroactive effective dates. Claims which processed prior to the completion of the provider's PCMH enrollment or level/site address change were not paid with the PCMH differential payment rate and have now been reprocessed to include that amount. For any providers with retroactive site terminations, claims which processed with the PCMH differential payment rate have now been reprocessed without that amount. The impacted claims have been identified and reprocessed and will appear on your August 27, 2025 Remittance Advice (RA) with an Internal Control Number (ICN) beginning with region code 55. |
| 08/22/2025-08/29/2025 | Attention All Providers | 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 updated, click on the "Maintain Address" button to type in the new address and then save your changes. You can also add or remove performing providers to your group practice as applicable by clicking on "Maintain Organization Members". For detailed instructions, please refer to Section 10.18 "Provider Demographic Maintenance" in Chapter 10 of the Provider Manual. The chapter is available from the Web site www.ctdssmap.com by clicking on "Publications" under Information, scrolling down to Provider Manuals and then clicking on "Web Portal/AVRS". Providers may contact the Provider Assistance Center at 1-800-842-8440 between the hours of 8:00 AM to 5:00 PM Monday through Friday if further assistance is needed in updating the information from their secure Web portal account. *There are special instructions for PCMH providers and licensed facilities such as hospitals, pharmacies, and clinic providers for updating their service location or alternate service location addresses. Please refer to the warning messages on the Web pages, as well as Chapter 10 for additional information. |

Information/Resources cont.

Publications

A majority of the information available on the www.ctdssmap.com Web site is located on the Publications page.

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



Information/Resources cont.

Provider Bulletins

Publications posted to relevant provider types / specialties documents changes or updates to the CT Medical Assistance Program.

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. The online database of bulletins goes back to the year 2000.

| Search Results | | |
|-------------------|---|----------------|
| Bulletin Number ▼ | Title | Published Date |
| PB25-37 | Increased Reimbursement Rates for Select Medication Administration Services | 07/10/2025 |
| PB25-34 | Policy Updates and Changes to Clinical Review Criteria | 07/10/2025 |
| PB25-28 | Changes to Prior Authorization Process for Medical Goods and Services: Provider ... | 06/06/2025 |
| PB25-25 | Prior Authorization of Medical Home Health Services | 06/03/2025 |
| PB25-21 | Third Party Liability (TPL) Audit Letter and Report Distribution Changes: Electr... | 05/27/2025 |
| PB25-19 | Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule... | 05/20/2025 |
| PB25-09 | IMPORTANT REMINDER Concerning Ownership Changes | 04/16/2025 |
| PB25-06 | Connecticut Medical Assistance Program Provider Satisfaction Survey | 01/09/2025 |
| PB25-03 | New Services added to select Home and Community Based Services Medicaid Waiver P... | 01/10/2025 |
| PB25-02 | New Services added to select Home and Community Based Services Medicaid Waiver P... | 01/10/2025 |

Information/Resources cont.

Archive Important Messages and Banner Announcements

Important Messages and RA Banner Announcements are available on the Home page of the www.ctdssmap.com Web site. Only the most current messages will be posted in the main areas on the Web for a limited time; thereafter, providers will be able to retrieve previously published Important Messages and Banner Announcements from messages archive. To access the messages archive page, select messages archive from the Information drop-down menu on the home page.

RA Banner Announcements and Important Messages dated January 1, 2014, and forward are saved on the Web site and are available for review.



The screenshot shows the 'messages archive' page on the CTDSSMAP website. The navigation bar includes 'Home', 'Information', 'Provider', 'Trading Partner', 'Pharmacy Information', 'Hospital Modernization', 'Telehealth Information', and 'Electronic Visit Verification'. The 'Information' menu is expanded, showing 'home', 'publications', 'links', 'hipaa', and 'messages archive'. Below the navigation is an 'Archived Search' section with a dropdown menu set to 'Important Messages' and a 'Keywords' input field. To the left of the search box is an icon of a stack of books and the word 'Information'. Below the search box is a table titled '- 2023 Important Messages Archived' with two columns: 'Message Effective Date' and 'Title'. The table contains six rows of archived messages.

| Message Effective Date | Title |
|------------------------|--|
| 04/21/2023-05/15/2023 | Attention Home Health Providers: 1) Incorrect Prior Authorization (PA) Effective Date Displaying in the Sandata Agency Management (SAM) System 2) Potential Duplicate Home Health Procedure Codes on Master Rates (Posted 4/21/23) |
| 04/11/2023-04/14/2023 | Attention All Providers: Automated Voice Response System Downtime Notification (Posted 4/11/23) |
| 04/10/2023-05/07/2023 | Hospital Monthly Important Message (Posted 4/10/23) |
| 03/30/2023-04/03/2023 | Attention Home Health Providers: Upcoming SAM Training Dates and Previous Town Hall Recordings (Posted 3/30/23) |
| 03/29/2023-04/30/2023 | Attention Home Health Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments (VBP) (Posted 3/29/23) |
| 03/29/2023-04/30/2023 | Attention Home and Community Based Service Providers: URGENT: ACTION REQUIRED to receive 2% rate increase through value-based payments (VBP) (Posted 3/29/23) |

Information/Resources cont.

Register for E-mail Subscriptions:

- Providers **MUST** register to receive information electronically for new provider publications and notifications through the email subscription function on the CMAP Web site at www.ctdssmap.com.

Communications are no longer mailed to providers and must be downloaded from the DSS Web site.

For complete E-mail subscription information, please see [PB15-23](#) on the CMAP Web site

E-Mail Subscriptions

Do you want to get the latest information from the Connecticut Medical Assistance Program (CMAP)? Registration is a very quick and simple process! You can register now to receive on-line publications such as provider bulletins, workshop invitations, newsletters, and important messages via email by entering your email address below under "New Subscriber". Once you have entered your email address and confirmed that address, you will be asked to select the type of information you wish to receive (reference list of provider types, trading partner, and topics on the right side of the screen). Once registered, you will receive a confirmation email.

There is no limit on the number of e-mail subscriptions per office! Each provider, member of your office staff, enrollment support staff, etc. can subscribe to receive information via email.

It is important to note that, as of June 30, 2015, the Department of Social Services will no longer send provider bulletins and workshop invitations via the postal service. To ensure that you receive the latest information from CMAP, you must either subscribe to receive this information or review the information posted to www.ctdssmap.com daily to obtain newly published information.

Once you have subscribed, you can modify the type of information you receive at any time by entering your email in the Existing Subscribers box below. You may also unsubscribe at any point in time by entering your email in the Unsubscribe box below.

Click [here](#) to receive detailed instructions on how to newly subscribe, modify an existing subscription, or unsubscribe.

New Subscriber

E-Mail

Confirm E-Mail

Register

Available Subscriptions

- **Provider**
- ALL Provider Types
- Acquired Brain Injury
- Acupuncturist
- Advance Practice Nurse
- Autism Spectrum Disorder/Behavior Analysts
- Autism Waiver
- BHH/TCM/Waiver Provider
- Behavioral Health Clinician
- Birth to Three
- CHC Access Agency
- CHC Assisted Living
- CHC PCA Fiduciary
- CHC Service Providers
- CT Housing Engagement and Support Services
- Certified Nurse Midwife
- Chiropractor
- Clinic
- Community First Choice
- Community Services
- DDS Employment and Day Supports
- DDS Specialized Services
- DME/Medical Supply Dealer
- Dental
- Drug and Alcohol Abuse Center
- Extended Care Facility/Long Term Care
- FQHC - Behavioral Health
- FQHC - Dental
- FQHC - Medical & Tribal Svs Medical
- Home Health Agency
- Hospice Agency
- Hospital
- Laboratory
- Local Health Department
- Mental Health Group Home
- Mental Health Waiver

Information/Resources cont.

Access via the www.ctdssmap.com Web site Home page > Information > Resources > Provider Manuals

- The **Provider Manual** is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission,
- It is the primary source of information for submitting CMAP claims, prior authorizations, and other related transactions.
- This manual contains detailed instructions regarding the Program and should be your first source of information pertaining to policy and procedural questions.

The Provider Manual is divided into twelve (12) chapters:

- Click on the chapter title to open the document (*disable* pop-up blockers)
- Chapters 7 and 8 are provider specific – select your provider type from the drop-down menu and click **View Chapter** to access the chapter
- Chapter 11 is claim-type specific

Information/Resources cont.

Provider Manual

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 reference 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 and billing requirements

Chapter 6 – EDI Options

Provides information on electronic claim submission and electronic RAs

Information/Resources cont.

Provider Manual cont.

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

Information/Resources cont.

Provider Newsletters

- Quarterly publications to providers on a wide range of topics

Provider Newsletters

- [September 2025 interChange Newsletter](#)
- [June 2025 interChange Newsletter](#)
- [March 2025 interChange Newsletter](#)
- [December 2024 interChange Newsletter](#)
- [Provider Newsletter Archives](#)

Claims Processing Information

- Guides and FAQs to assist with billing/claims processing

Claims Processing Information

- [Eligibility Response Quick Reference Guide](#)
- [Internet Claims Submission FAQ](#)
- [Hospice Procedure Code Exception List](#)
- [ICD-10 Diagnosis Codes Not Allowed as Primary Diagnosis](#)
- [ICN Region Code List](#)
- [CT Medical Assistance Program EOB Crosswalk - Pharmacy and Non-Pharmacy](#)
- [Medically Unlikely Edit \(MUE\) Updates](#)
- [OPR Enrollment FAQ](#)

Information/Resources cont.

How to access and register for Sandata Learn Training Portal

1. Go to the CMAP Portal, www.ctdssmap.com Web site.
2. Top Header - Hover on Electronic Visit Verification.
3. Click on New Provider Information.
4. Click on Learning Management System Enrollment Instructions.
5. Click on Learning Management System Enrollment Instructions **again**.

Sandata
Learn

You need to log in or sign up before continuing.

Email address
Add email Address

Password

Sign In

Forgot my password
Sign Up
Click here for Support

Contacts



Contacts

Gainwell Technologies Provider Assistance Center (PAC)

- 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
- www.ctdssmap.com
- provideremail@gainwelltechnologies.com

This should be your first call resource to answer all **enrollment, eligibility, and billing** related questions. Should your issue require a higher level of research, it will be escalated to your provider representative. Please be sure to ask the PAC representative for your call tracking number (CTN) for future call reference.

Gainwell Technologies Pharmacy Prior Authorization Assistance Center (PPAAC)

- 1-866-409-8386 – Available 24/7

Gainwell Technologies Electronic Data Interchange (EDI) Help Desk

- 1-800-688-0503 – Monday through Friday, 8:00 AM – 5:00 PM (EST), excluding holidays

HMS (a Gainwell Technologies Company): Third Party Liability Issues and Audits

- 1-866-252-0671
- CTinsurance@gainwelltechnologies.com

Contacts cont.

EVV Email Mailbox

➤ ctevv@gainwelltechnologies.com

If you are:

- Missing a client from your Santrax system and have verified that the client is eligible on their waiver benefit plan and has a valid PA;
 - or if a prior authorization (PA) is present on the www.ctdssmap.com portal but is not present in the Santrax system. **NOTE: it can take up to 48 hours before a PA that is present on the www.ctdssmap.com portal to be present in Santrax.**
 - then contact the EVV email box for assistance.
- If you are experiencing issues with the Santrax system or its functionality, please contact Sandata Customer Care for assistance by phone 1-855-399-8050 Mon – Fri 8:00 AM – 6:00 PM or you can email Sandata at ctcustomer@sandata.com.
- If you are unsure who to contact for assistance, please send an e-mail to ctevv@gainwelltechnologies.com.
 - You are also encouraged to send an e-mail to the ctevv@gainwelltechnologies.com mailbox if you feel you need additional support resolving your issue. Please be sure to include your Sandata ticket number if applicable.

Contacts cont.

Providers using Sandata Agency Management

➤ 1-855-399-8050 or ctcustomer@sandata.com

When sending an email, please include the following:

1. Agency name and Sandata account number in the subject line
2. Client Medicaid ID# and client name
3. Prior Authorization (PA) number if you have it
4. Date of Service (DOS) with which you are having issues
5. Procedure code that is on the PA
6. Reason(s) you require assistance

Contacts cont.

Providers using Alternate EVV

If you require assistance, it is highly recommended that your Alternate EVV vendor send an email to open a ticket, as Sandata typically needs technical information directly from your vendor to investigate the issue(s). However, if your Alternate EVV vendor is not able to open the ticket, then you, the provider, need to open the ticket. Please be sure to “cc” your vendor on the ticket.

➤ ctaltevv@sandata.com

When sending an email, please include the following:

1. Agency name and Sandata account number in the subject line
2. Client Medicaid ID# if specific to one client and client name
3. DOS or date range of services with which you are having issues
4. Procedure Code / service code description if applicable
5. Reason(s) you require assistance such as visits are not flowing into the Sandata Aggregator from a provider’s EVV system or unexpected claim denials for “confirmed visit not found”
6. Include the JavaScript Object Notation (JSON) file provided by your Alt EVV vendor and Universally Unique ID (UUID) if available

Important: Do not email client-identifying data unless you encrypt your email. If you are unable to encrypt your email, please provide a claim Internal Control Number (ICN) or PA number for the client that can be used to research your issue.

Contacts cont.

Connecticut Community Care (CCCI) - ServiceAuthIssues@ctcommunitycare.org

- Providers must include the following information when submitting service authorization issues to CCCI: provider name, client name, client Medicaid ID number, CCCI number, EOB code on rejecting claim at Gainwell Technologies, from and to dates of service, the type of service (SNV, Med Admin, etc.), the frequency of service (Spanned dates, monthly or weekly), the number of units needed, CCCI service order number, if available and any comments the provider wishes to communicate to CCCI.

Southwestern Connecticut Area on Aging (SWCAA) - SWCAABillings@swcaa.org

- Please have the following information available when contacting SWCAA: Client name, the client Medicaid ID number, the type of service (SNV, Med Admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Agency on Aging of South-Central CT (AOASCC) - chcbilling@aoascc.org

- Companies without secure e-mail, please fax service order inquiries to (203) 528-0455. All other provider information may be faxed to (203)752-3064. Due to the high volume of inquiries AOASCC requests your primary source of communication to them be by e-mail or fax.
- Service Order inquiries must include, on an Excel spreadsheet, the applicable following information when contacting AOASCC: client name, EMS#, type of service (procedure code), dates of service (from/to), frequency of service and the number of units or hours per visit.

Contacts cont.

Western Connecticut Area Agency on Aging (WCAAA) - billing@wcaaa.org

- Billing inquiries should be sent through secure email or faxed to 203-465-1030
- Please include the following information when contacting WCAAA: client name, the client Medicaid ID number, the type of service (SNV, Med admin, etc.), the dates of service, the frequency of service and the number of units or hours per visit.

Community Option Unit at DSS - Waiver.DSS@ct.gov

- Client eligibility issues related to Medicaid waiver clients should be directed via an encrypted/secure e-mail to the Department of Social Services at this e-mail address.

Alternate Care Unit - ACUFinancial.DSS@ct.gov

- For eligibility issues regarding State-funded clients with a CT Home Care Community Based Case Managed State Funded Benefit plan, (CBCMS), CT Home Care Community Based Program for Disabled Adults (CBCMD) and CT Home Care Self Directed State Funded (SDIRS) benefit plan.

Autism Waiver - contact Mike Olsen at Michael.Olsen@ct.gov

Contacts cont.

Administrative Service Organizations (ASOs)

CHNCT (Medical ASO and Prior Authorizations)

- 1-800-440-5071 – Monday through Friday, 9:00 AM to 7:00 PM (EST)
- www.huskyhealthct.org

Carelon Behavioral Health (Behavioral Health ASO and Prior Authorizations)

- 1-877-552-8247
- www.ctbhp.com

Questions?



Thank you



gainwell