

Waiver Service Provider Refresher Workshop

Update & Review
Virtual Classroom/December 2025

Welcome to the Waiver Service Provider Refresher Workshop – December 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

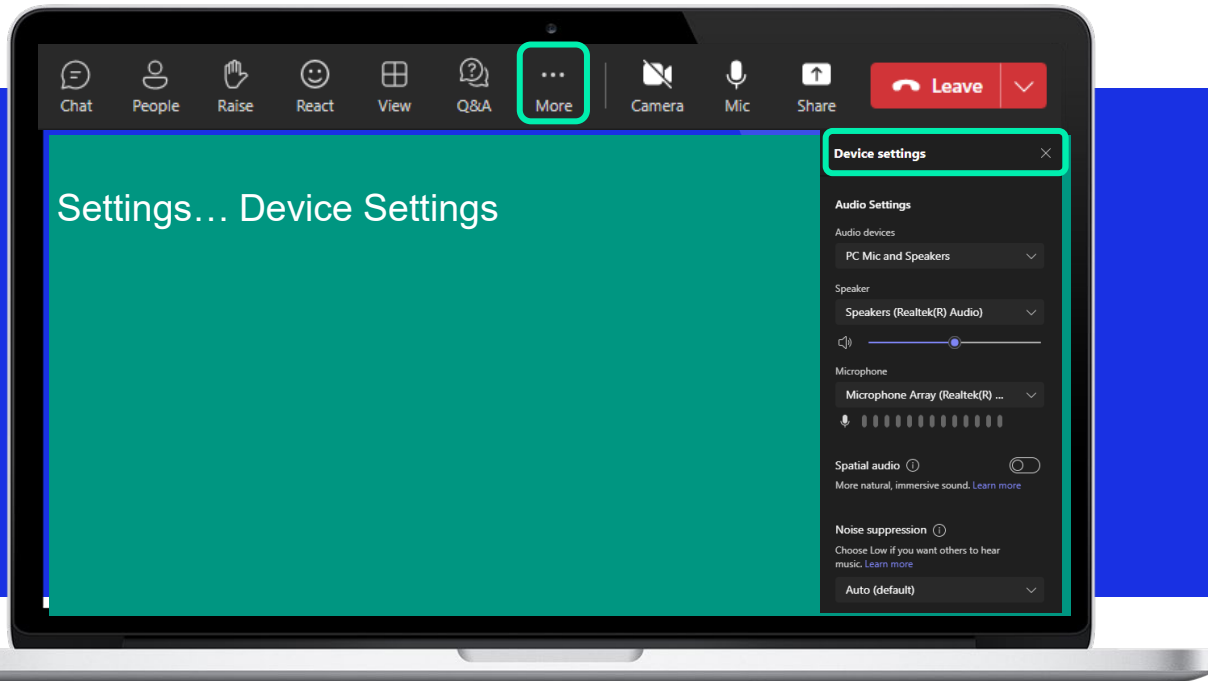
A Q&A session is included at the end of this event to answer your questions.



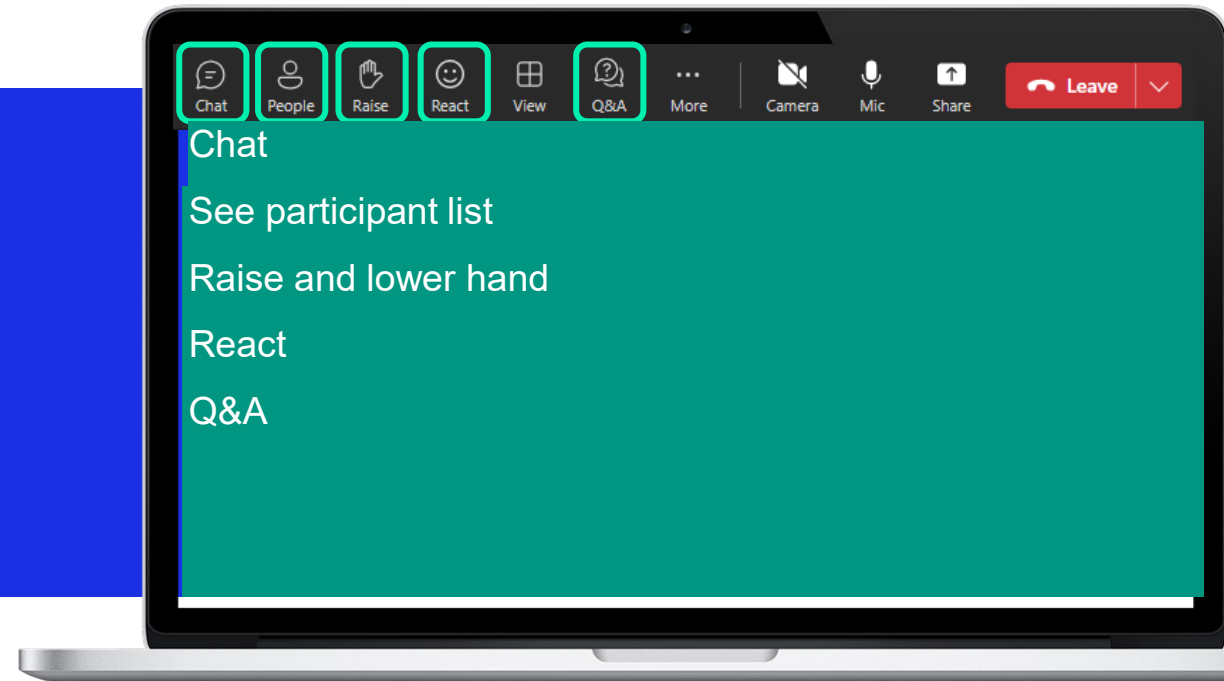
You can download the slides used in today's event from the email sent out after the event.

MS Teams Features and Functions

Manage audio and video settings



Engage with others

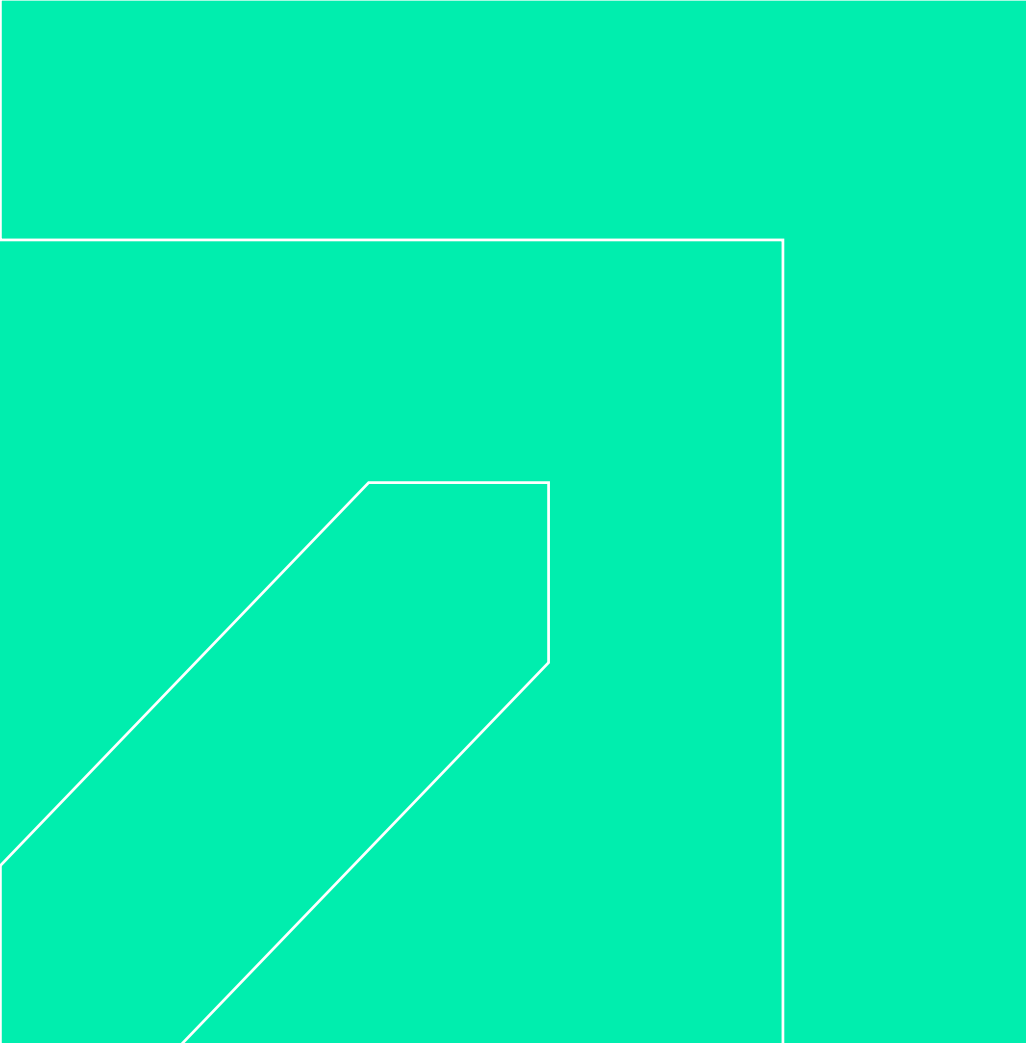


Agenda

- Program Updates 2024-2025
- Electronic Visit Verification (EVV) Updates 2024-2025
- Re-Enrollment – How to Maintain an Active Enrollment Status
- Maintaining your Secure Web Account
- Client Eligibility Verification
- Care Plan Review – Confirmation of Authorized Services
- Claim Submission
- Claim Denials and Resolution
- Monthly Claims Reprocessing
- Provider Tools and Resources
- Contacts
- Time for Questions

Program Updates – A Review of Waiver Program Changes

Waiver Service Provider Refresher Workshop
December 2025



Department of Social Services - New Fiscal Intermediary

- **GT Independence (GTI)**

- Department of Social Services (DSS) New Fiscal Intermediary effective March 23, 2024.
- Taken over the Responsibilities previously provided by Allied Community Resources
- Contractual Obligations include:
 - Credentialing and Re-Credentialing of the following Waiver Service Providers: (Ref: [PB 2024-84](#)).
 - Acquired Brain Injury (ABI)
 - Autism Waiver Solo Practitioners will continue to be credentialed/re-credentialed by Carelon (Ref: [PB 2024-58](#)).
 - Connecticut Home Care (CHC)
 - Personal Care Assistance (PCA)
 - Community First Choice (CFC) Support & Planning Coach (S & P)

Department of Social Services - New Fiscal Intermediary

- GTI's Contractual Responsibilities further include the Creation and Maintenance of an enrolled Waiver Service Provider Directory. The current directory format is still in process with the last format changes made as of 9/11/2025. Information provided is updated regularly but may not reflect recent changes.
- Providers are added to the directory once they have been credentialed by GTI and received their enrollment approval letter from Gainwell Technologies. An enrollment file is sent weekly on Wednesday to GTI to be added to the directory. **Note:** Presence on the Provider Directory and outreach to Access Agency does not guarantee a referral. The client or client's family representative determines the choice of service provider.
 - To access the Waiver Service Provider Directory, click on the following link: [HCBS Provider Directory](#)
 - Tabs at the bottom of the directory include:
 - Instructions Tab - How to use the Directory
 - Tab for each Waiver:
 - Acquired Brain Injury (ABI)
 - Autism
 - Community First Choice (CFC) Support & Planning Coach
 - Connecticut Home Care Program for Elders (CHCPE)
 - Personal Care Assistance (PCA)

Department of Social Services - Important Enrollment Requirement

Important Reminder Concerning Ownership Changes – Provider Bulletin (PB 2025-09)

- Due to Board Changes, Stock Exchange/Sale, Practice/Agency Sale, Changes in Leadership and all other Transactions that change the Ownership or change any Ownership of 5% or greater:
 - **Providers are Required** to notify the Department of Social Services (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 include in the Provider Manual (Chapter 2, Section 17b-262-526, section 9). Click [Provider Participation Policy](#)
 - Please refer to [PB 2025-09](#) for important enrollment requirements due to changes in ownership.

Department of Social Services – Reminder of Service Requirement

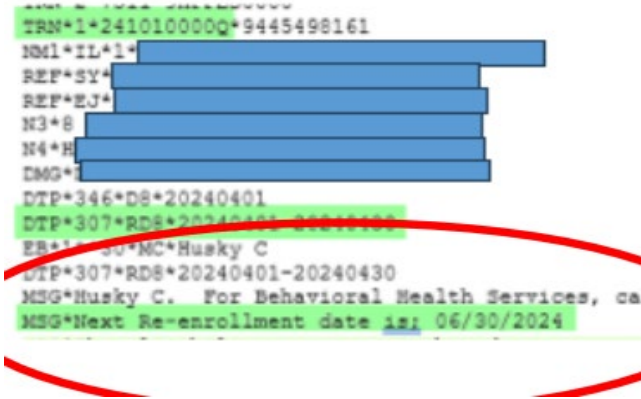
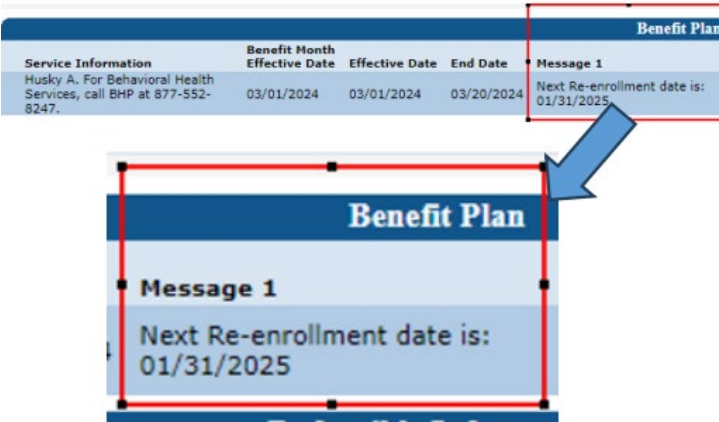
Effective **January 1, 2022**, changes in the Department of Consumer Protection regulations require **comprehensive background checks** for **Home and Community Based Waiver Providers** who are employees of **Homemaker and Companion Agencies**. (Ref: IM posted 11/12/2025)

- As a Medicaid Provider you must comply with this requirement.
- Providers should refer to https://www.cga.ct.gov/current/pub/chap_400o.htm for detailed information regarding comprehensive background checks for all employees.
- Please contact hope.mitchell-williams@ct.gov with any questions.

Update to Client Eligibility Verification Response

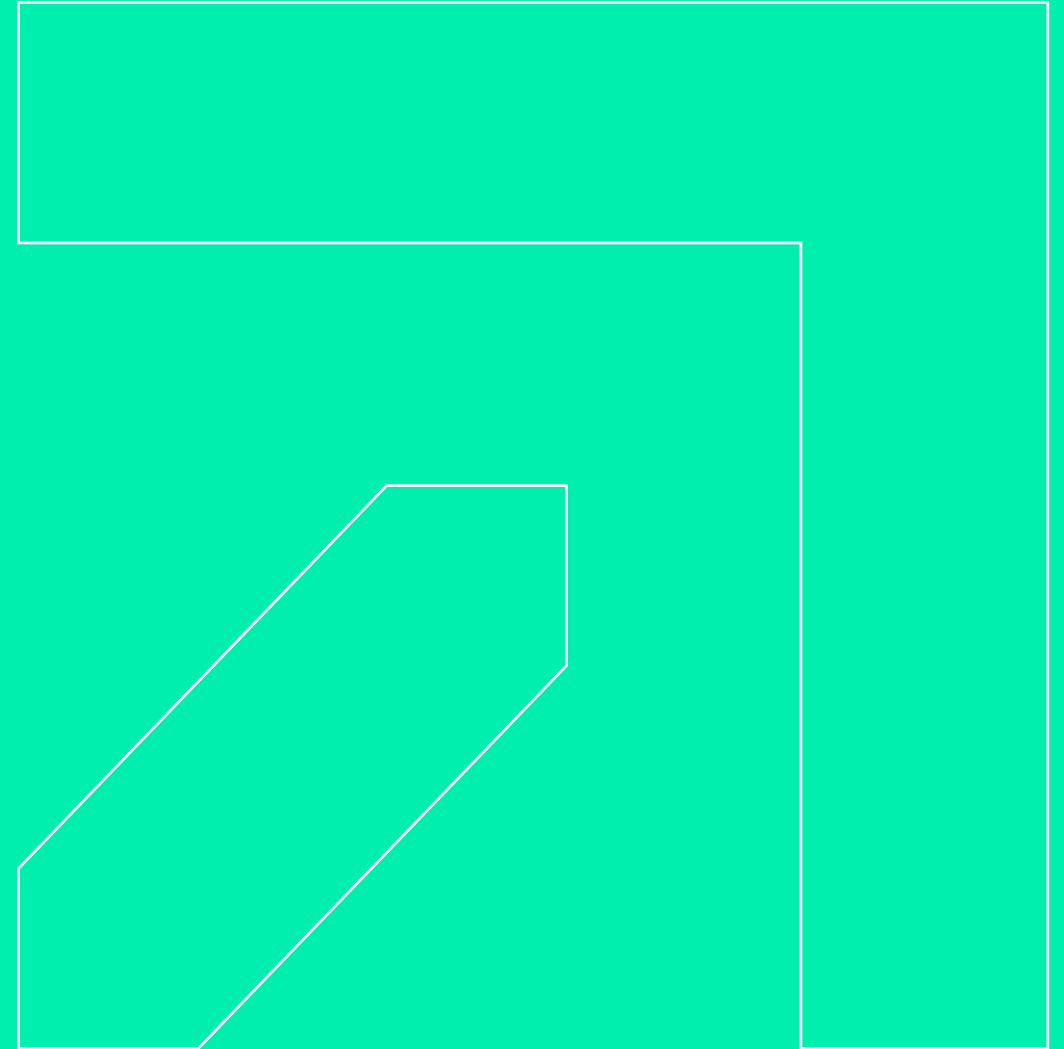
- Effective April 30, 2024, the Provider’s Secure Web Portal, Eligibility Verification Screen will return the following response in the Benefit’s Plan panel under Message 1:
- Providers are now able to proactively alert the HUSKY member of their upcoming renewal date to mitigate a disruption in service using either verification method.

- Effective April 30, 2024, the 5010 X12 271 Beneficiary Eligibility response will be updated with the new Re-enrollment date:
- Providers using this method of eligibility verification should contact their trading partner or clearing house to inform them of the updates to the X12N 271 Beneficiary Eligibility response to the 2110C MSG segment.



Electronic Visit Verification Updates

Waiver Service Provider Refresher Workshop
December 2025



Electronic Visit Verification (EVV) Initial Enrollment Reminders

- The Services credentialed and the Waiver(s) enrolled determine the EVV mandate.
- Providers should access the www.ctdssmap.com Website > Electronic Visit Verification > EVV Service Code listing to determine if EVV is mandated, optional or N/A for the Waiver Program services credentialed.
 - Once it has been determined that EVV is mandated for at least one service credentialed, providers must complete the online Learning Management System Training to secure their EVV welcome kit.
 - **Providers must notify Sandata of the AVRS ID for each Waiver Program enrolled where at least one procedure code is EVV mandated.** This allows the client and Prior Authorization data for each Waiver enrolled to flow to the provider's Sandata account for scheduling, visit confirmation and claim export.
- New Providers or those new to EVV are encouraged to access the many resources available under the Electronic Visit Verification menu heading on the www.ctdssmap.com Web site Home page such as:
 - At your fingertips tip sheets for who to contact, quick troubleshooting and how to resolutions.
 - Training Publications and Videos such as Hot Topic training for “Visit Maintenance” and “Getting Ready to Bill”.

Electronic Visit Verification (EVV) Reminders

- EVV Mandated services are required to have a confirmed visit
- As a reminder, whether billing through Sandata Agency Management or Alternate EVV, providers must **allow 48 hours** for the confirmed visits to be loaded into the Medicaid Management Information System (MMIS) prior to claim submission. For the claim to be considered for payment, a visit from the Sandata Agency Management system must exist in one of the following three confirmed statuses:
 - 02 – Confirmed – signals when a visit has been auto confirmed or manually verified and then confirmed. The visit is now ready and available to bill.
 - 03 – In Process – signifies that a visit for the service has already been confirmed and a claim exported for claims processing.
 - 04 – Closed – indicates that a visit has been confirmed, the claim has been exported for claims processing, and the claim has been paid or denied as appropriate. This status is set by the provider in the Santrax system.

Electronic Visit Verification (EVV) Reminder: How to Contact Sandata Customer Care

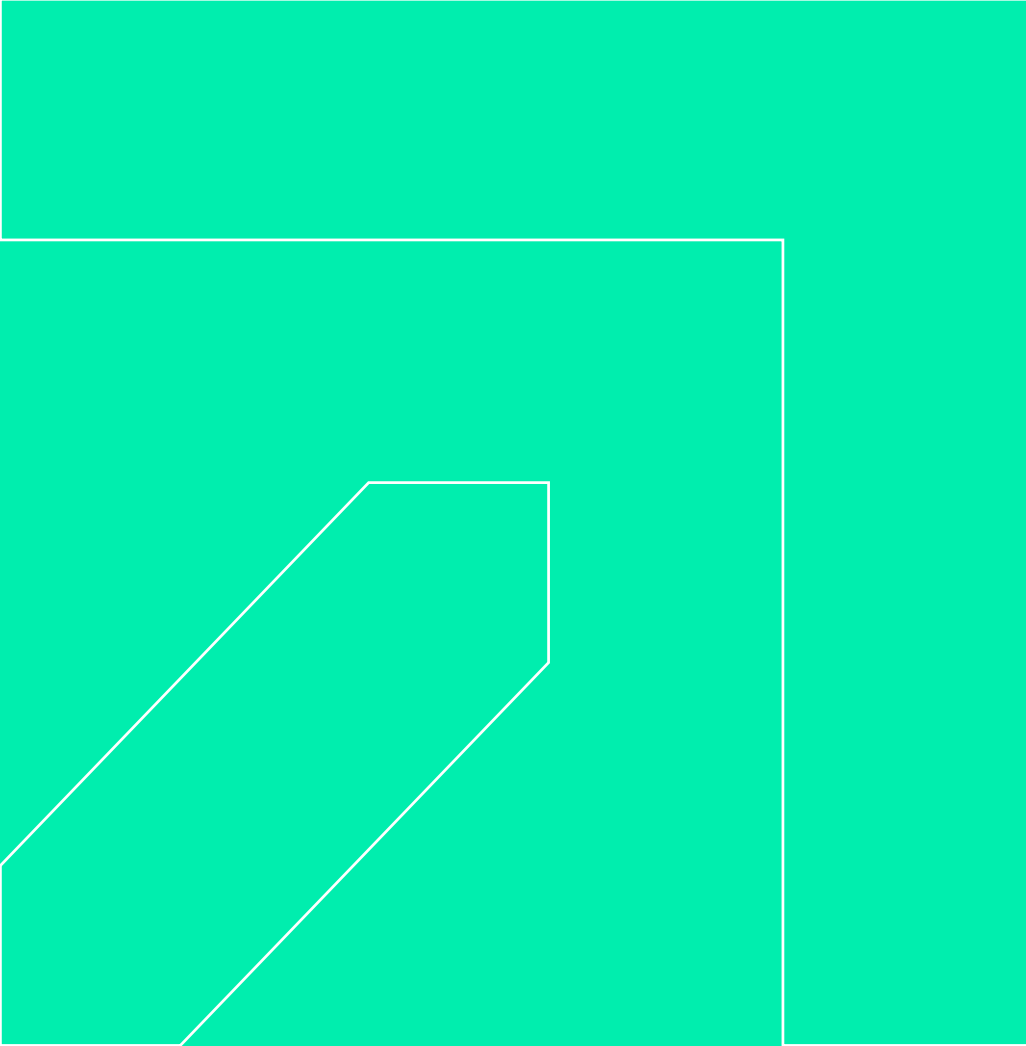
- All providers using EVV should use the following guidelines when contacting Sandata Customer Support if you have an issue and require assistance.
- Below are distinct guidelines for providers using the State's EVV system (i.e., Sandata Agency Management) or a third-party ("Alternate") EVV solution to capture visit data.
- **Providers using Sandata Agency Management**
 - Email Address: ctccustomer@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

Electronic Visit Verification (EVV) Reminder: How to Contact Sandata Customer Care

- **Providers using a third-party (“Alternate”) EVV solution**
 - 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 cannot open the ticket, then you, the provider, need to open the ticket. Please be sure to “cc” your vendor on the ticket.
 - Email Address: 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
 3. DOS or date range of services with which you are having issues
 4. Procedure Code that is being billed

Re-Enrollment – How to Maintain an Active Enrollment Status

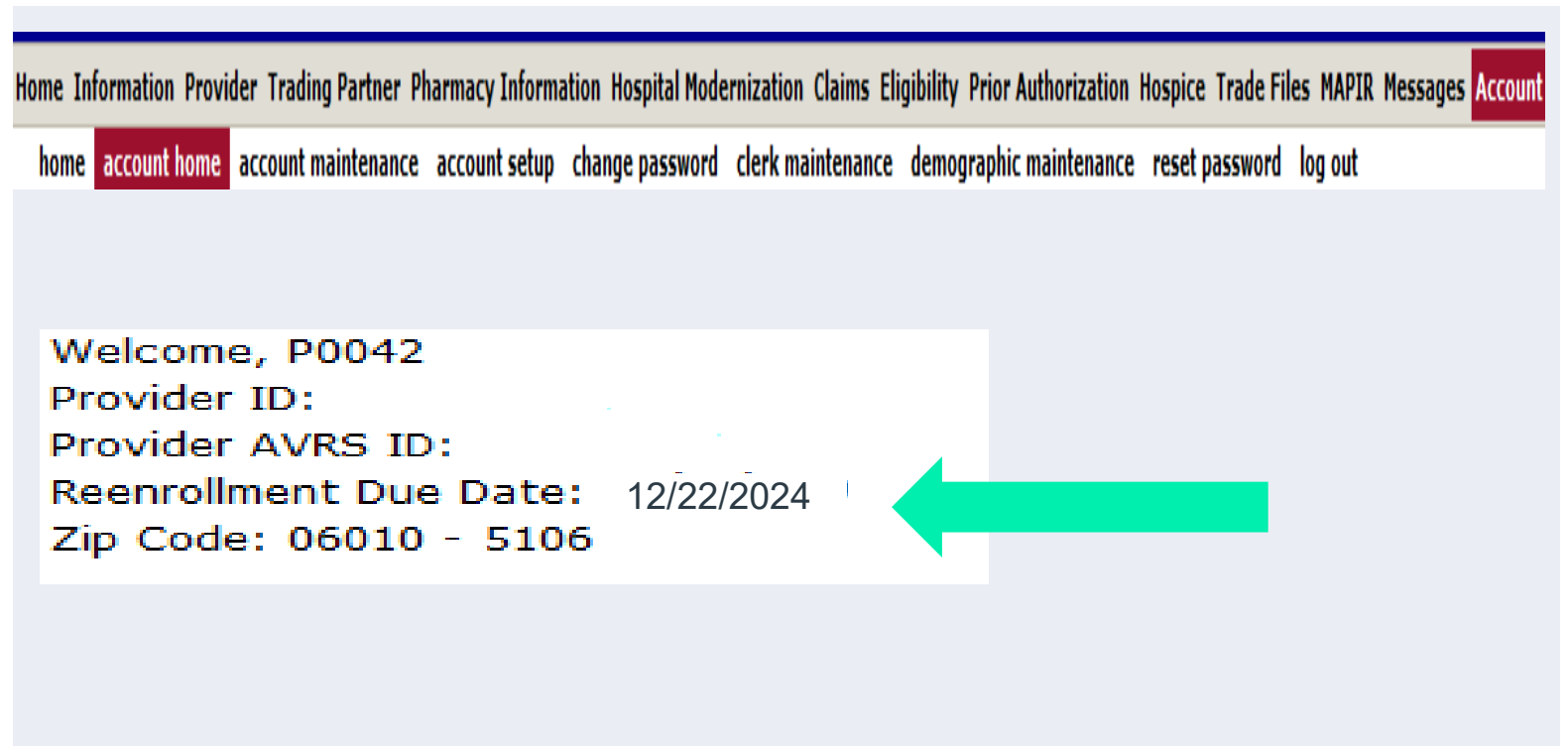
Waiver Service Provider Refresher Workshop
December 2025



Re-Enrollment

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

- Providers can view their re-enrollment due date on their Secure Account Home page.
- This feature allows agencies to better track their re-enrollment due dates prior to receiving their notice to re-enroll.



The screenshot displays the provider's account home page. At the top, there is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below this is a secondary navigation bar with links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The main content area shows a welcome message for provider P0042, followed by their Provider ID, Provider AVRS ID, Reenrollment Due Date (12/22/2024), and Zip Code (06010 - 5106). A large green arrow points to the Reenrollment Due Date.

The Provider Secure Account Home page indicates the Re-Enrollment Due Date. This date is available to the provider each time the provider accesses their Secure Web Account on the www.ctdssmap.com Home page.

Re-Enrollment (cont.)

Providers will receive a reminder letter when they are due for re-enrollment **6 months** prior to the end of their previous 2-year Waiver Service Provider contract. Providers enrolled in multiple Waiver Service contracts will receive a separate letter **6 months** prior to the re-enrollment due date of each contract enrolled.

- The reminder letter will include an **Application Tracking Number (ATN)**.
- To re-enroll, providers should:
 - Access the www.ctdssmap.com Web site
 - From the Home Page, click Provider > **Provider Re-enrollment**
 - Enter the **ATN** received in the re-enrollment reminder letter
 - Enter **NPI** or Non-medical provider identifier (**AVRS ID**)

Note: Re-enrollment notifications are sent via e-Delivery. The re-enrollment letter can be retrieved via the Trade Files menu on the secure web account of the Primary Account holder and clerks with role permission access to Trade Files.

Re-enrollment (cont.)

- **Prior to Enrolling/Re-Enrolling:**

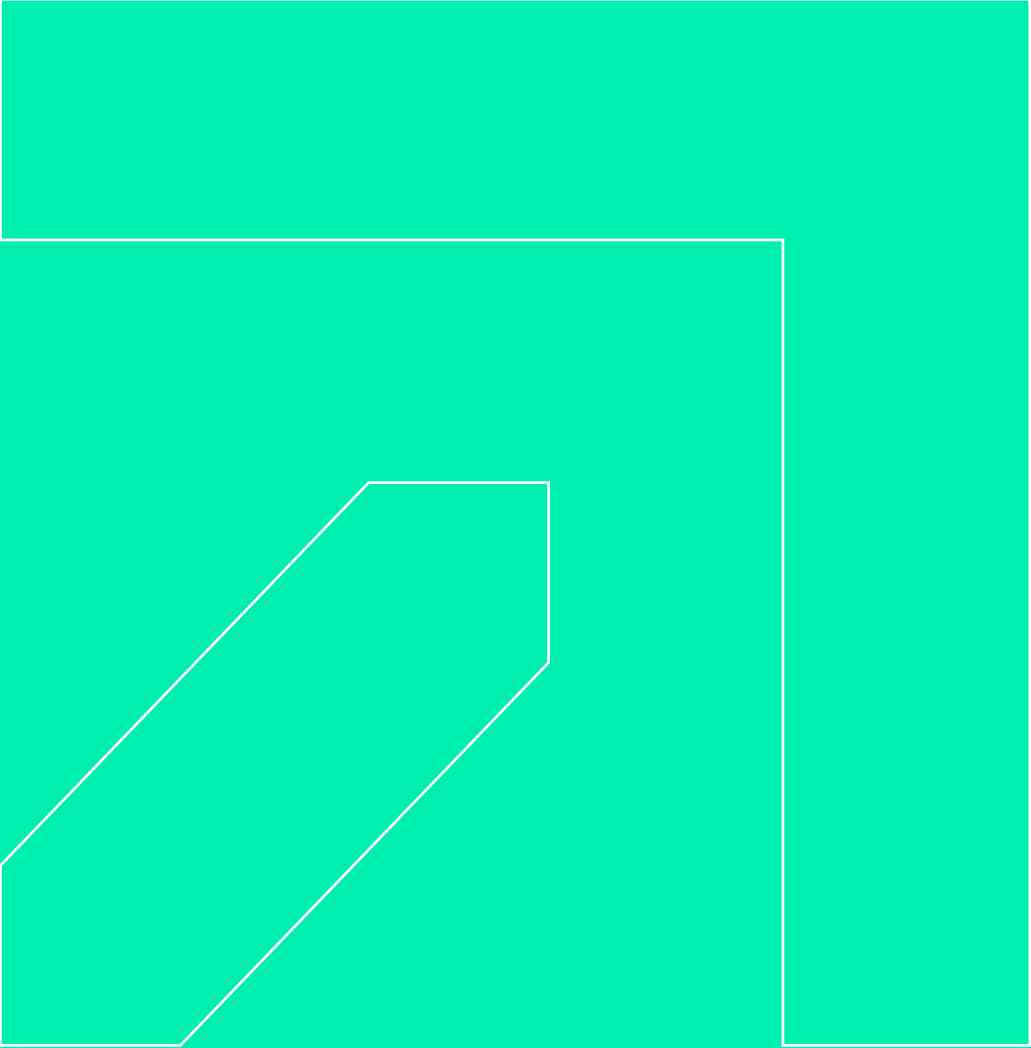
- Effect on or after **March 24, 2024**, **CT Home Care, PCA, ABI and Autism** Service providers must be credentialed/re-credentialed by GT Independence.
- **Solo Autism Waiver Service Providers** will continue to be credentialed and recredentialed by Carelon.
- **Mental Health Waiver** service providers will be credentialed by Advanced Behavioral Health (ABH)
- Providers should begin the credentialing process as soon as possible after receiving an e-message that an e-delivery letter is waiting for their pick-up as the credentialing approval letter is the follow-on document required to complete the application process with Gainwell Technologies.
- The credentialing entity will issue a separate letter to the provider for each waiver to be enrolled/re-enrolled confirming their credentials to continue to provide Waiver services.
- Providers must submit the credentialing letter as a follow-on document (FOD) to Gainwell Technologies, once they have submitted their enrollment or re-enrollment application.
 - The Application Tracking Number should be noted in the upper right-hand corner of the FOD to ensure the association of the FOD to the provider's re-enrollment application.

Re-enrollment (cont.)

- Providers should successfully **complete the re-enrollment application as quickly as possible** upon receipt of their credentialing/re-credentialing letter.
 - Providers with **re-enrollment applications** that are **not fully completed by** the provider's re-enrollment **due date** will receive a notice advising they have been **dis-enrolled** from the Connecticut Medical Assistance Program (CMAP). As a result:
 - Case Managers may not be able to enter new PAs for future services.
 - Providers will not be able to bill and be paid for services performed after their re-enrollment due date.
 - **DSS Quality Assurance may not expedite the process for late re-enrollments.**
- A Provider Enrollment contract will not be reinstated until the **application is finalized**.
 - Reinstatement of contracts without a finalized application violates Affordable Care Act (ACA) policies.

Secure Web Account Set-Up and Access

Waiver Service Provider Refresher Workshop
December 2025



Secure Web Account Set-up Upon Initial Enrollment

- **Providers who have successfully enrolled as a CHCPE or ABI, Autism, CHC, Mental Health or PCA Waiver Service Provider will receive:**
 - An approval letter with their new AVRS/Medicaid ID
 - An additional letter under separate mailing containing their Personal Identification Number (PIN)
- The AVRS ID and PIN allow the provider initial access to the Connecticut Medical Assistance Program Secure Web Portal to create a secure Web account for the “Primary Account Holder/Local Administrator”
- Providers should refer to Chapter 10 of the Provider Manual – “**Web Portal/Automated Voice Response System (AVRS)**” for secure account set-up and more information on secure Web Account Capabilities

Access to Secure Web Portal

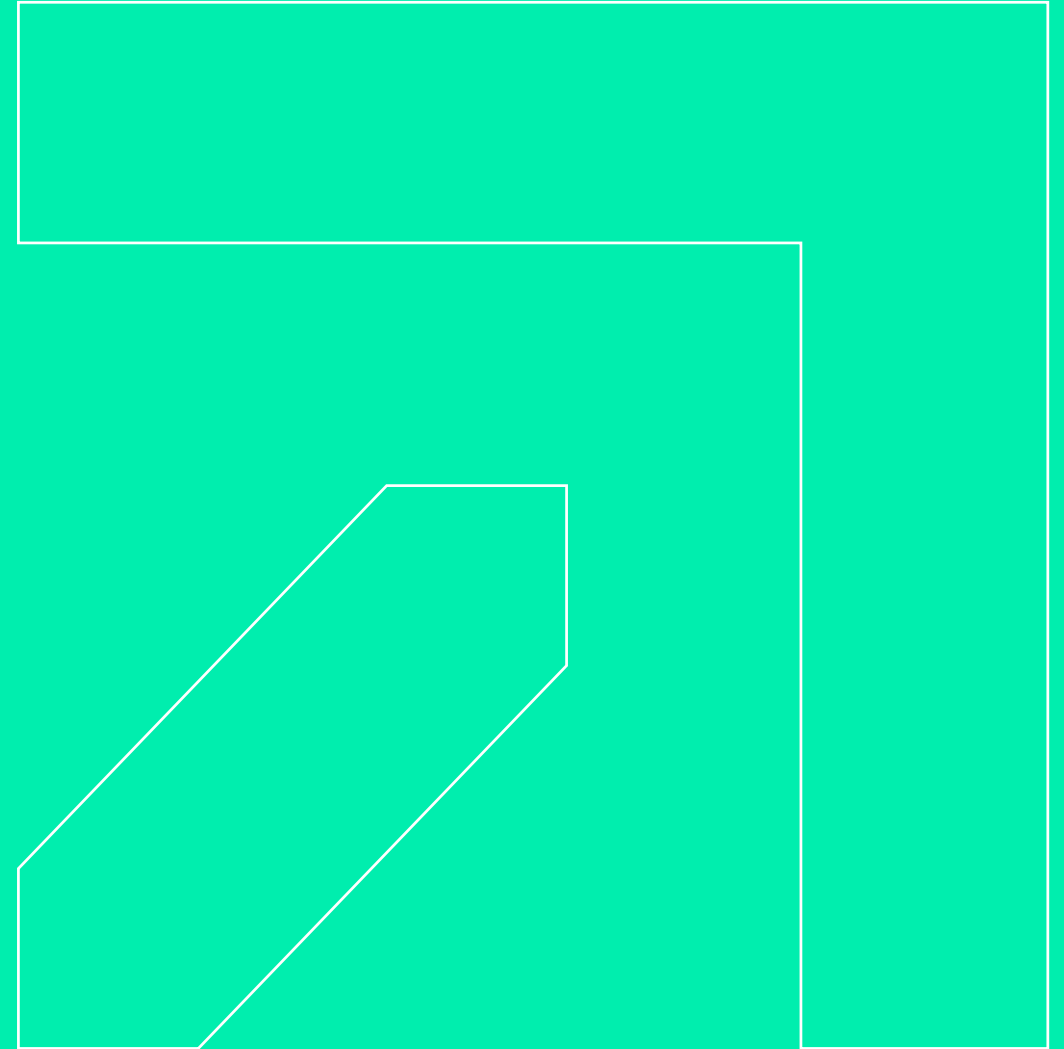
- **A Secure Web Account allows providers to:**
 - Verify their re-enrollment due dates
 - Change their passwords
 - Allows the Primary Account Holder to:
 - Make changes to their provider file to update demographic information such as:
 - Address/phone numbers/EFT and languages
 - Set up clerk accounts to allow multiple users access to areas of the secure web portal to perform job tasks or delete clerk accounts for those who no longer need access.
 - Switch Provider functionality
 - Allows switching from one provider secure web account to another for clerks that have been associated to multiple provider accounts, with the same User ID, easy access.

Access to Secure Web Portal (cont.)

- **Secure Web Account access allows providers to:**
 - Verify Client Eligibility
 - Review Service Authorizations (Prior Authorizations)
 - Create, submit, resubmit, adjust, void, and copy claims regardless of their original method of submission
 - EVV, 837 via vendor software or via secure web account
 - Web format is Professional HIPAA 5010 compliant
 - Query Claims
 - Download Trade Files such as:
 - Remittance Advices (claim activity report for the financial cycle)
 - 1099 Forms
 - e-Delivery Notifications of e-delivery Letters to be retrieved
 - Re-enrollment letters
 - **Determine the source and resolution of missing clients, Prior Authorizations and unpaid claims for EVV mandated and optional services scheduled and billed via the Santrax system. (You must be able to view them via your Secure Web account before you will be able to access them in Sandata.)**

Eligibility Determination and Resolution of Eligibility Issues

Waiver Service Provider Refresher Workshop
December 2025



Eligibility

Client Eligibility Verification for HUSKY, CHCPE or ABI, Autism, CHC or PCA Waiver Programs

- **Eligibility verification can be performed using any of the following methods:**
 - Internet Web site at www.ctdssmap.com.
 - Automated Voice Response System (AVRS).
 - Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction.
 - Provider Electronic Solutions (PES) software.
- **CMAP Guidelines for Client Eligibility Verification:**
 - Providers should verify client eligibility on the date of service, prior to rendering the service as eligibility can change at anytime.
- **It is recommended that providers at a minimum verify client eligibility:**
 - upon receipt of the initial service order
 - at the resumption of care
 - at a change in the plan of care
 - at regular intervals
 - Eligibility Redetermination (available via secure web account and 271 Health Care Eligibility/Benefit inquiry and Information Response Transaction)

Eligibility

Client Eligibility Verification for the Mental Health Waiver Program

- The Mental Health Waiver benefit plan will not be viewable to the provider when checking Mental Health Waiver client eligibility.
- To reduce claim denials due to client ineligibility:
 - DSS notifies ABH on-a-monthly basis of client ineligibility issues.
 - ABH will notify the servicing provider(s) of the client's ineligibility.
- Client ineligibility occurs most often due to client/representative issues in following through with the redetermination process.
 - DSS now notifies ABH when a client is up for redetermination.
 - ABH reaches out to resources who can assist the client/client representative with the redetermination process.

Eligibility (cont.)

Access to Client Eligibility Verification

Login to your secure Web account on the www.ctdssmap.com Web site to access the Eligibility tab.

- Further information regarding the methods of checking client eligibility under the CT Medical Assistance Program (CMAP) may be obtained via the “Publications” link to the Provider Manual:
 - Chapter 4 Eligibility
 - Chapter 6 Electronic Data Interchange (EDI)
 - Chapter 10 (Web Portal/AVRS)

Connecticut Department of Social Services
Making a Difference

Help
Wednesday, October 21, 2020

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

home site map about us

Information

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

Provider

- Provider Services
- Provider Search
- Provider Enrollment
- Promoting Interoperability Program
- OOS Instructions/Information
- Fingerprint Criminal Background Check Info
- Provider Training
- **Secure Site**

WELCOME
TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

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

Information Provider Trading Partner Pharmacy

Login

The Connecticut Department of Social Services Medical Assistance Program secure Web site is intended for providers, trading partners/billing agents, labelers/drug manufacturers and clerks designated by those entities.

If you have received your Personal Identification Number letter, click on the setup account button.

[setup account](#)

User ID*

Password*

[login](#)

If you have forgotten your password or need to reactivate your account, please click the reset password button.

[reset password](#)

Eligibility (cont.)

To verify a client's eligibility in the CMAP:

- Click on the Eligibility tab on the main menu
- Enter data for a valid eligibility search combination
 - When entering a full name as part of your search, the name entered must match the CMAP profile (name as stated on the Connect card)
- Dates of service entered cannot span months or exceed one year from the date of eligibility verification.
- Contact the Provider Assistance Center to verify eligibility for dates of service greater than one year from the current date of request.
- Click Search

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

Select a search combination and enter in the required fields

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID last name

SSN First Name, MI

Birth Date

From DOS* 11/15/2025
To DOS* 11/15/2025

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 (cont.)

Based on the client and service data entered, the eligibility response indicates the client is eligible.

Access to the benefit plan information indicates:

- the client has a CT Home Care (CHC) Community Based Case Managed Waiver on the date of service
- non-medical services by a CHC Waiver Service provider will be covered for 11/12/2025.

Retain the verification number in the event your claim is denied when submitted due to client ineligible on date of service.

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="CLIENT"/>	From DOS*	<input type="text" value="11/12/2025"/>
SSN	<input type="text"/>	First Name, MI	<input type="text" value="WAIVER"/>	To DOS*	<input type="text" value="11/12/2025"/>
Birth Date	<input type="text" value="08/09/1990"/>				
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"/>				

Eligibility Verification Response

Verification Number	<input type="text" value="15040039KM"/>
Response Text	<input type="text" value="Client is eligible. Refer to Benefit Plan for specific program coverage."/>

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
CT Home Care Community Based Case Managed Waiver	11/12/2025	11/12/2025	11/12/2025	
Husky C. For Behavioral Health Services, call BHP at 877-552-8247	11/12/2025	11/12/2025	11/12/2025	Next Re-Enrollment Date is 1/31/2026

The Waiver Benefit plan of the client must match the Waiver the provider is enrolled and will submit claims

Notify the client when they are nearing their re-enrollment date or are no longer enrolled. The client must have an active HUSKY benefit plan to be waiver eligible.

Eligibility cont.

Medicare Covered Services / QMB

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.

Eligibility (cont.)

Waiver Eligibility Points to Remember

- Clients may be eligible for only the CT Home Care Program for Elders (CHCPE) benefit plan.
 - Both Home Health and Non-Medical CHC Services are covered under this benefit plan
- Clients who are ABI, Autism, CHC, Mental Health or PCA “Waiver” eligible:
 - must also be HUSKY A, HUSKY C or HUSKY D eligible, depending on the Waiver
 - must also be HUSKY A, HUSKY C or HUSKY D eligible to be eligible for services under Community First Choice (CFC) .

Eligibility (cont.)

Important Resources to Resolve Eligibility Issues Upon Request for Service

- The Community Options Unit at DSS should be notified of an ABI, Autism, CHC or PCA eligibility issue **when a client begins service** so action can be taken to resolve the eligibility issue as soon as possible.
- Providers who identify an eligibility issue at the time of service 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 “CHC Client Eligibility Issue”, “ABI Client Eligibility Issue”, “PCA Client Eligibility Issue” or “Autism Client Eligibility Issue” in the subject line of the email.
- The Waiver.DSS@ct.gov mailbox helps to identify and refer the eligibility issue to the appropriate staff.
 - Eligibility issues often must be referred to the DSS Benefit Center.
 - Community Options does not direct the work-flow in these offices.

Eligibility (cont.)

Important Resources to Resolve Eligibility Issues Upon Claim Denial

- Providers who identify an eligibility issue upon claim denial should contact the client's care manager at the Access Agency (CHC or PCA), Case Management Agency (ABI), or DSS Autism Case Manager for assistance to confirm if all redetermination and financial verifications have been submitted to DSS for processing.
 - If the client's 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 "CHC Client Eligibility Issue", "ABI Client Eligibility Issue", "PCA Client Eligibility Issue" or "Autism Client Eligibility Issue" in the subject line of the email.
 - **Complete Medicaid redeterminations** not sent in on time, within 60 days of the redetermination date, may create lengthy periods of ineligibility. To avoid further claim denials, providers should check eligibility before resubmitting a claim.
 - Providers should not discontinue service. The case manager must be notified to discuss resolution of the client's ineligibility.
- The Waiver.DSS@ct.gov mailbox helps to identify and refer the eligibility issue to the appropriate staff.
- Eligibility issues often must be referred to the DSS Benefit Center.
 - Community Options does not direct the work-flow in these offices.

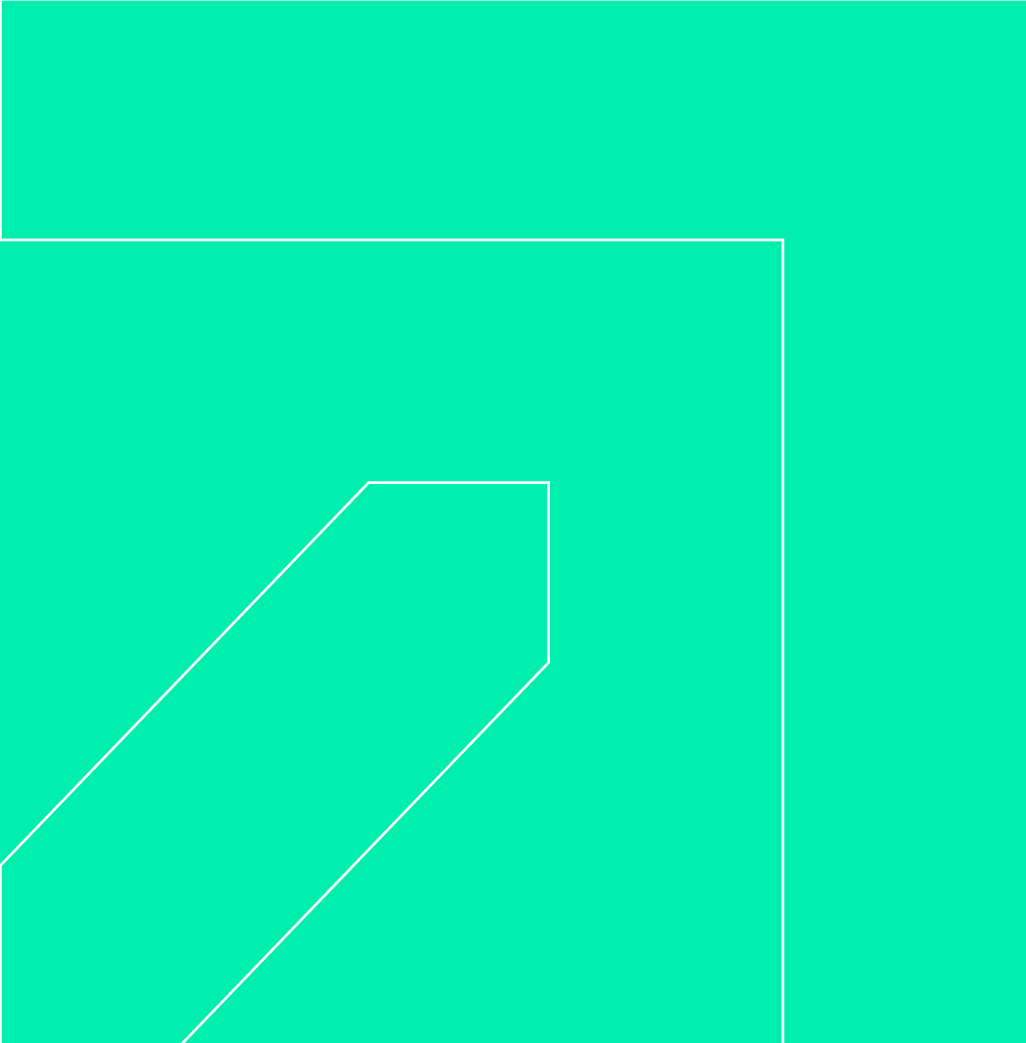
Eligibility (cont.)

Important Eligibility Reminders

- Client Eligibility must be verified prior to providing services to avoid claim denials because of ineligibility:
 - Make note of the **eligibility verification number** received. Dates of service corresponding to a favorable eligibility verification may be submitted for payment should services later be denied due to ineligibility.
 - The client must first appear **eligible in CMAP before** they will be **eligible in the EVV Santrax system**.
 - A client present in the EVV system does not automatically mean they will be eligible for the services provided.
 - **Eligibility can change at any time.**
 - **Prior Authorization does not guarantee that the client is eligible** for the services to be provided.
- If a client is ineligible and the service provided is an EVV mandated service:
 - A check-in/check-out can still occur.
 - Using the temporary client feature the visit can be scheduled and, when completed, confirmed in Santrax,
 - The visit **CANNOT** be exported or uploaded to Gainwell Technologies for claim adjudication until the client is benefit eligible and appears in Sandata.
 - Once the client is in Sandata, if a temporary client was set up, the two must be merged. See “At Your Fingertips” EVV TIP #21 on how to merge.
- **The Community Options Unit at DSS should be notified of an eligibility issue** when a client begins service so action can be taken to resolve the eligibility issue as soon as possible.

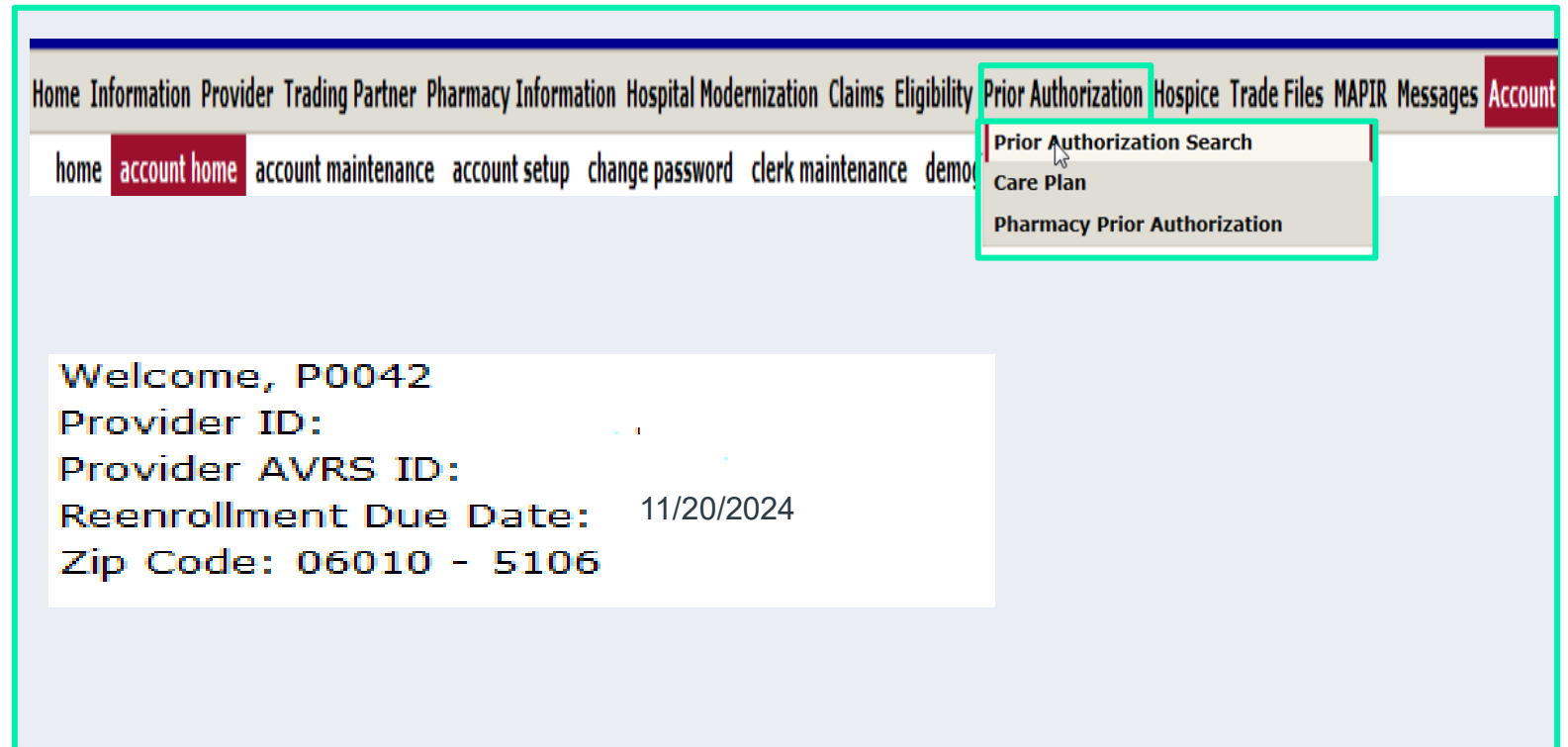
Prior Authorization (PA) - Viewing and Understanding the Care Plan

Waiver Service Provider Refresher Workshop
December 2025



Prior Authorization (PA)

- Primary Account holders and clerks assigned PA permission have access to PA via their secure Web account.
 - Available service authorizations can be accessed by selecting:
 - “Prior Authorization Search” from the PA menu



Secure Web Account Home Page with Prior Authorization Access

Prior Authorization (cont.)

Enter applicable search criteria

- Enter search criteria and click search for results.
 - PA number will provide the most definitive results.
 - Client ID will provide all PA records authorized since the provider has serviced the client.
 - Use other criteria such as:
 - requested/authorized effective and end dates
 - procedure code or code list to be authorized
- to reduce the number of PA records displayed from a client ID search.

The screenshot shows the 'Prior Authorization Search' interface. At the top, there is a navigation bar with links for 'home', 'prior authorization search', 'care plan', and 'pharmacy prior authorization'. Below this is a 'Quick Link' section with a link to 'Web Guide - Prior Authorization Search'. A text box explains: 'Search for a PA by PA #, if known, Client ID or Client ID with procedure code for the most defined search.' and 'Use the Web guide for further information regarding navigation and field definitions.' The main search area is titled 'Prior Authorization Search' and includes a 'Provider 008003693 MCD' header. The search criteria fields are: 'Client ID' (text input), 'Client Name' (text input), 'Search Pharmacy PAs only' (checkbox), 'Requested Eff Date' (text input), 'Requested End Date' (text input), 'Authorized Eff Date' (text input), 'Authorized End Date' (text input), 'Prior Authorization' (text input), 'PA Assignment' (dropdown), 'PA Assian - Sub' (dropdown), 'Procedure' (text input with 'Search' button), 'Revenue Code' (text input with '[Search]' button), 'Proc/Mod List' (text input), and 'Procedure Code List' (text input with '[Search]' button). A 'Records' dropdown is set to '20'. A 'search' button and a 'clear' button are at the bottom right. Annotations include a red box around the 'Web Guide' link, a red arrow pointing to it, a red box around the 'Client ID' field, a red box around the 'Procedure' field, a red box around the 'Records' dropdown, and a red box around the 'search' button. A red arrow points down to the 'search' button with the text 'Once search criteria has been entered click for results.' and another red arrow points to the 'Records' dropdown with the text 'Click to view if more than 20 records match search results.'

Prior Authorization Search Panel.

Prior Authorization (cont.)

- PA search results as noted below may be sorted for ease in viewing.
 - Each heading may be sorted in ascending or descending order.
 - Data may further be sorted by:
 - PA Number
 - Effective or end date of service
 - Procedure Code (Service) Authorized

Search Results																			
Prior Authorization	Line Item	Authorized Effective date	Authorized End date	Authorized Units	Authorized Dollars	Status	Determination Date	PA Assignment	PA Assign - Sub	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Revenue	IDC	Proc/Mod List	Procedure Code List	Frequency
2017275003	01	01012018	02282018	12	\$0.00	Approved		AUTISM		1223Z									1 Per Calendar Month
2017256001	01	01012018	01312018	10	\$0.00	Approved		AUTISM		1302Z									2 Per Calendar Week
2017256001	02	01012018	02282018	8	\$0.00	Approved	09/13/2017	AUTISM		1404Z									4 Per Calendar Month

Prior Authorization (cont.)

Additional Care Plan Information can be viewed by opening a PA from the PA Search Results Inquiry. Once a PA line detail is open, providers have access to units available and units used in addition to case manager notes, if applicable.

Base Information

Prior Authorization Number: 0719245098

Client ID: 000000000 PA Assignment: Mental Health Waiver

Last Name: Waiver First Name, MI: Betty

Billing Provider: [] MCD Date of Birth: 10/06/1986

Diagnosis: [] [Search] Insurance: None [v]

Estimated Date of Delivery: []

Patient Condition: Fair [v]

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	Revenue Code	Revenue Code List	Drug Name
01	10.000	\$0.00	10.000	\$0.00	Approved	H2023									
02	8.000	\$0.00	8.000	\$0.00	Approved	H0038									

Type changes below.

Line Item: 01

Service Type Code*: Procedure Code [v]

Procedure Code: H2023 [Search] Supported Employment, per 15 min

Mod 1: [] [Search]

Mod 2: [] [Search]

Mod 3: [] [Search]

Mod 4: [] [Search]

Revenue Code/List: [] [Search] [] [Search]

Proc/Mod List: []

Procedure Code List: []

Requested Eff./End Dates*: [] []

Requested Units/Dollars*: 10.000 \$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]

Drug Name: []

Status: Approved

Authorized Units/Dollars: 10 0.00

Authorized Eff./End Dates: 09/01/2019 09/30/2019

Used Units/Dollars: 0 0.00

Available Units/Dollars: 10 0.00

Frequency: 10 Per Calendar Month

Notes

*** No rows found ***

Prior Authorization (cont.)

- **Non-Medical Waiver Services may be authorized by:**
 - Procedure Code – The code authorized must be billed on the claim
 - Procedure Code with modifier(s) – The code and all modifiers authorized, for the service provided must be billed on the claim. Note: The service and service with modifier should be authorized on the same PA.
 - 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. **Please Note: When there is a code list, that contains the service you will be providing, the code list is usually authorized, even though the client may not be serviced for one or more of the procedure/modifier combinations on the list.**
 - Procedure Codes, Code Lists or Code/Modifier Lists are available on the applicable Waiver Procedure Code Crosswalk found on the www.ctdssmap.com Web site. From the Home Page click the Training link. Under the Materials heading, access the applicable Waiver Workshop link, (ABI, Autism, CHC, PCA, MH or Waiver, then the Waiver Crosswalk link).

Prior Authorization (cont.)

- **Non-Medical Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier or Proc/Mod lists:
 - Modifier **U2 - One Time Only Services** can be used to authorize:
 - Additional units needed on a day a **Waiver** service is provided
 - Another day of service in an existing care plan when a **Waiver** service is provided
 - An additional frequency to an existing service when **additional services are required outside of the existing frequency.**
 - For example: Client receives 1210Z, Companion Services, Agency, per 15 min (M-F x 4 units per day = 20 units per week). Client also receives 4 additional units per month on 1 Saturday per month = 4 units per month authorized as **1210Z U2.**

Prior Authorization (cont.)

- **Non-Medical Waiver Services** may be authorized with the use of the following modifiers when service is authorized by procedure code with modifier or Proc/Mod lists:
 - Modifier **TT** - Subsequent Client, can be used to authorize:
 - **Waiver** services for an additional client residing in the home, or group home sharing a common area, of a client already receiving the same service.
 - If the **TT** modifier is authorized, it must be associated to the procedure code on the care plan/PA.
 - The **TT** modifier reduces the subsequent client payment for service by **50%**.

Prior Authorization (cont.)

- Points to remember when viewing the client's Service Order/Prior Authorization on your secure Web Account:
 - The procedure code, modifiers, from and through dates of service, units and frequency should match the service authorization.
 - information in Santrax should match with your secure account, if claims to be adjusted are first voided via your secure Web account, rolled back in Sandata and resubmitted with changes.
 - **Note: Discrepancies should be reported to the Access/Case Management Agency, DSS Autism Case Manager or ABH.**

Prior Authorization (cont.)

- Codes Authorized on the care plan are not always the codes to be billed on the claim.
 - Refer to the [Waiver Service Provider Crosswalk](#) applicable to the client's waiver program for billing codes associated to the Procedure Code List or Procedure Code Modifier List authorized.
 - Codes associated to the list can be billed interchangeably, based on the service provided, up to the units authorized within the frequency, unless otherwise indicated by the care manager as documented on the service order.
 - If the procedure code on the service order is of a lesser reimbursement value than the service being provided from the code list, the provider must contact the care manager unless otherwise indicated in the external notes on the PA.
- Providers should also refer to the procedure code crosswalk for unit increments which should match back to the number of hours the service was authorized.

Prior Authorization (cont.)

Service Authorization Reference Document

- The Procedure Code Crosswalk provides a quick reference to the list of non-medical procedure codes, procedure code lists and procedure codes or procedure codes with modifier (proc/mod) lists that can be authorized under the ABI, Autism, CHC, PCA or MH Waiver.
- Providers should access the Procedure Code Crosswalks for the following information:
 - A list of procedure codes and procedure code/modifier combinations authorized under a procedure code/modifier list
 - Service descriptions
 - Unit increments
 - Billing Provider who can be authorized to bill the service
 - If service can be spanned when consecutive dates of service are performed
 - Care Plan limitations (Service Auto approved or PA required by DSS)
 - Frequency of service
 - Funding Source that covers the service
 - If a service is EVV Mandated, Optional, or N/A
 - For ABI Providers: ABI Waiver Benefit plan (1, 2, or both) the procedure code is covered
 - Effective/End Date of Service.



Prior Authorization (cont.)

The Procedure Code Crosswalks can be obtained on the www.ctdssmap.com Web site:

Access from the Provider Training Page:

- From the Web site Home Page > Click the “Provider Training” link > Under the Materials Heading > Click on the applicable Waiver Workshop link > Click the corresponding “Procedure Code Crosswalk” link. Providers may also scroll to Waiver Services to obtain a copy of one or more of the crosswalks.

Access from Chapter 8 of the Waiver Service Provider Manual:

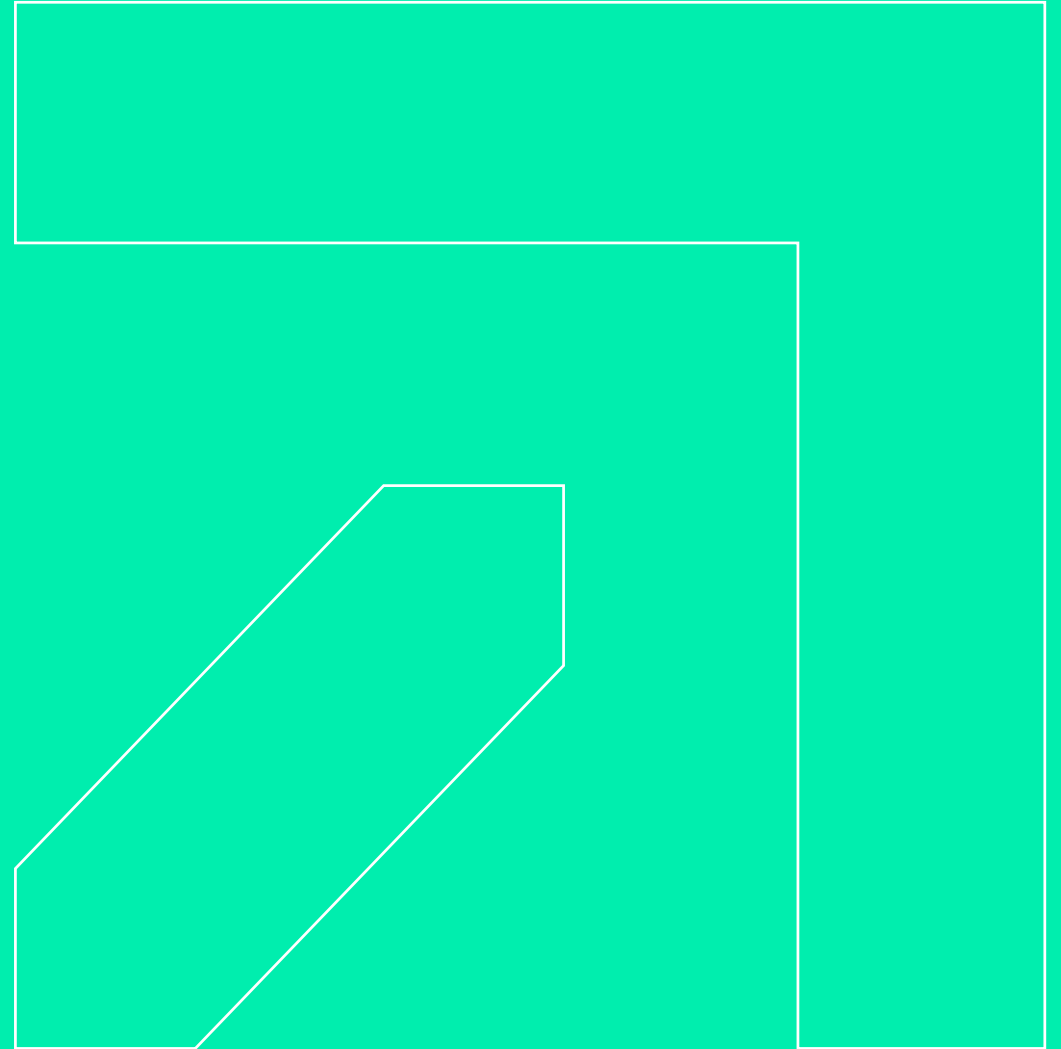
- From the Home page: Information > Publications > Provider Manuals > click on “View Chapter 8” > Choose “Autism”, “Connecticut Home Care”, “Acquired Brain Injury Services”, “Personal Care Assistance”, Mental Health Waiver > Claim Submission Instructions - field 24d.

Prior Authorization Points to Remember

- **Check the client's care plan (PA) to be sure the services you have been requested to provide have been authorized.**
 - Prior Authorization must first appear in the DSS portal (via provider's secure Web account on the www.ctdssmap.com Web site). **Providers should expect most service authorizations to be available via the DSS portal within 7 business days.** It may then take an additional 48 hours to view the service authorizations in Santrax.
 - Review the care plan carefully to ensure all services to be provided are on the initial care plan/PA.
 - Report discrepancies to the appropriate Access Agency, DSS Autism Case Manager or ABH immediately.
 - Review the care plan when you are notified of changes to be sure the services you are being requested to provide are on the care plan/PA.
 - Submit claims nearing timely filing that are pending PA to avoid timely filing denial. The claim will deny for PA, but you will be able to resubmit once the service/units have been updated on the PA file.

Claim Submission

Waiver Service Provider Refresher Workshop
December 2025



Methods of Claim Submission

• **Web Claim Submission**

- EVV Mandated, Optional or N/A EVV Claims may be submitted using this Method
- Provider must be enrolled in CMAP
- Requires a Secure Web Account
- Refer to Chapter 10 on the www.ctdssmap.com Web site for Secure Web account set-up
- Refer to Instructions for submitting Professional Claims via claims menu on the secure site.
- Refer to “Electronic Visit Verification (EVV) > Important Documentation > Important Messages > Claims Assistance.

• **ASC X12N 837 Professional Claim Format File**

- EVV Mandated, Optional or N/A EVV Claims may be submitted using this Method
- Provider must be enrolled in CMAP
- Requires a Trading Partner Agreement
- Refer to Chapter 6 EDI on the www.ctdssmap.com Web site.
- Refer to “Electronic Visit Verification (EVV) > Important Documentation > Important Messages > Claims Assistance.

• **Sandata EVV Santrax System**

- EVV Mandated or Optional service claims may be submitted via this method
- Provider must be enrolled in CMAP
- Provider must have completed required Training of the Santrax System via the Learning Management System
- Received Santrax Welcome Kit
- Refer to the Electronic Visit Verification Menu on the www.ctdssmap.com Web site for additional EVV information.

Claims Process – Cycle Schedule

- A Claim Cycle Schedule Bulletin is published semi-annually for the periods of January – June and July – December.
- Cycle Schedule bulletins are submitted via e-messaging to providers who have a valid email subscription on the www.ctdssmap.com Website.
- Here is the cycle schedule for January – June 2026.
- Claims are usually processed twice per month.
 - Periodically a claim cycle will be three weeks in duration. (see cycle dates noted with a b)
- Providers are strongly encouraged to review each semi-annual cycle bulletin to prepare in advance for these three-week cycles.
 - Providers are strongly encouraged to submit enough claims prior to the 3-week cycle to meet their organizations/agency’s operational need

2026 Month	Claim Cycle Date	Electronic Claims Received By	Web RA Availability	Check Mail Dates	\$35/EFT Dates
Jan	9-b	8	13	14	14
	23	22	27	28	28
Feb	6	5	10	11	11
	20	19	24	25	25
Mar	6	5	10	11	11
	20	19	24	25	25
Apr	10-b	9	14	15	15
	24	23	28	29	29
May	8	7	12	13	13
	22	21	27*	28*	28*
Jun	5	4	9	10	10
	19	18	23	24	24

b - Denotes 3 week cycle * Denotes a 1 day delay in availability

Claims Submission

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

20 25 118 123 456

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 our Web site 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 (**118** = the one hundred and eighteenth day of the year; April 28th)
- **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 Submission (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.**
 - If claim date of service > 366 days was there a **previously submitted claim that did not deny for timely filing?**
 - 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?
 - If EVV Mandated service(s), billed outside of Sandata, have the visits been confirmed?

Claim Submission – Web Account Access (cont.)

Home Information Provider Trading Partner ConnPACE Pharmacy Information Claims
home **account home** account maintenance account setup change password

Your Password will expire in 60 days on Jan. 30, 2026 [Change Password](#)

Welcome: John_Doe_Waiver
Provider ID: 1234567890 NPI
Reenrollment Due Date: [07/30/2027](#)
Zip Code: 06106 - 5501
Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Trade Files HAPIR Messages **Account**
maintenance reset password log out

Quick Link

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

Claims Eligibility Prior Authorization

Claim Inquiry

Professional

Institutional

Dental

Claim History for Specific Services

Global Messages

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

Secure Mailbox

*** No rows found ***

Claim Submission – Web Account Access (cont.)

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

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

Quick Links

- Internet Claims Submission FAQ
- Instructions for submitting Professional claims
- Claim Resolution Guide

Click on "FAQ" or "Instructions for Submitting Professional Claims" for help with submitting a claim.

Professional Claim

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

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident

NPI and AVRS ID auto populate based on secure web account login.

Claim Submission

- Claim inquiry allows the provider to query previously submitted claims based on criteria entered in the search panel below.
 - From and To Dates are limited to a three-month (93) date span.
 - Pending Claims are those submitted, but not yet processed, in a financial cycle.

Claim Search 1234567890 NPI

ICN	<input type="text"/>	Claim Type	<input type="text"/>
Client ID	<input type="text"/>	Status	<input type="text"/>
TCN	<input type="text"/>	FDate Paid	<input type="text"/>
FDOS	<input type="text"/>	TDate Paid	<input type="text"/>
TDOS	<input type="text"/>	Pending Claims	<input type="checkbox"/>
Prescription No (Pharmacy Only)	<input type="text"/>	Exclude Adjusted Claims	<input type="checkbox"/>
		Records	20 <input type="text"/>

The screenshot shows a web portal interface. At the top, there is a navigation menu with items: Home, Information, Provider, Trading Partner, ConnPACE, Pharmacy Information, Claims, Eligibility, Prior Authorization, & Messages, and Account. The 'Claims' menu is expanded, showing options: Claim Inquiry (highlighted with a red arrow), Professional, Institutional, Dental, and Claim History for Specific Services. Below the navigation, a message states: 'Your Password will expire in 60 days on...'. A welcome message follows: 'Welcome: John_Doe_Waiver', 'Provider ID: 1234567890 NPI', 'Reenrollment Due Date: March 3, 2023', and 'Zip Code: 06106 - 5501'. A note indicates: 'Your R.A.s, or 835 transactions, are being sent to: Your download page in the Trade Files menu option.' Below this is a 'Global Messages' table with columns: Category, Subject, Message, Sent Date, Effective Date, and End Date. The table contains one row: Notification, Web Claim Submission is Here!, Web claim submission is now..., 12/22/2009, 12/22/2009, 12/31/2299. Below the table is a 'Secure Mailbox' section with the text: '*** No rows found ***'.

Claim Submission

- **Web Claim Submission Options**

Paid claims allow you to:

- cancel** – Cancel any alterations you have made
- adjust** – Adjust the claim
- void** – Void the claim
- copy claim** – Copy the claim and use it as a template to create a new claim
- new claim** – Create a brand-new claim

Denied claims allow you to:

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

Suspended claims allow you to:

- new claim** – Create a brand-new claim

Claim Submission Reminders – Claims Submitted via Santrax

- **Claims Submitted via Santrax EVV System:**
 - All claims are validated in the EVV system prior to direct submission
 - Right Client
 - Authorized Services
 - Right Caregiver Type
 - Verified Visit Data
 - Only validated claims can be submitted for payment via the Santrax system
 - EVV Check in and Check out determines visit duration for a claim.

Claim Submission Reminders – Claims Submitted via Santrax cont.

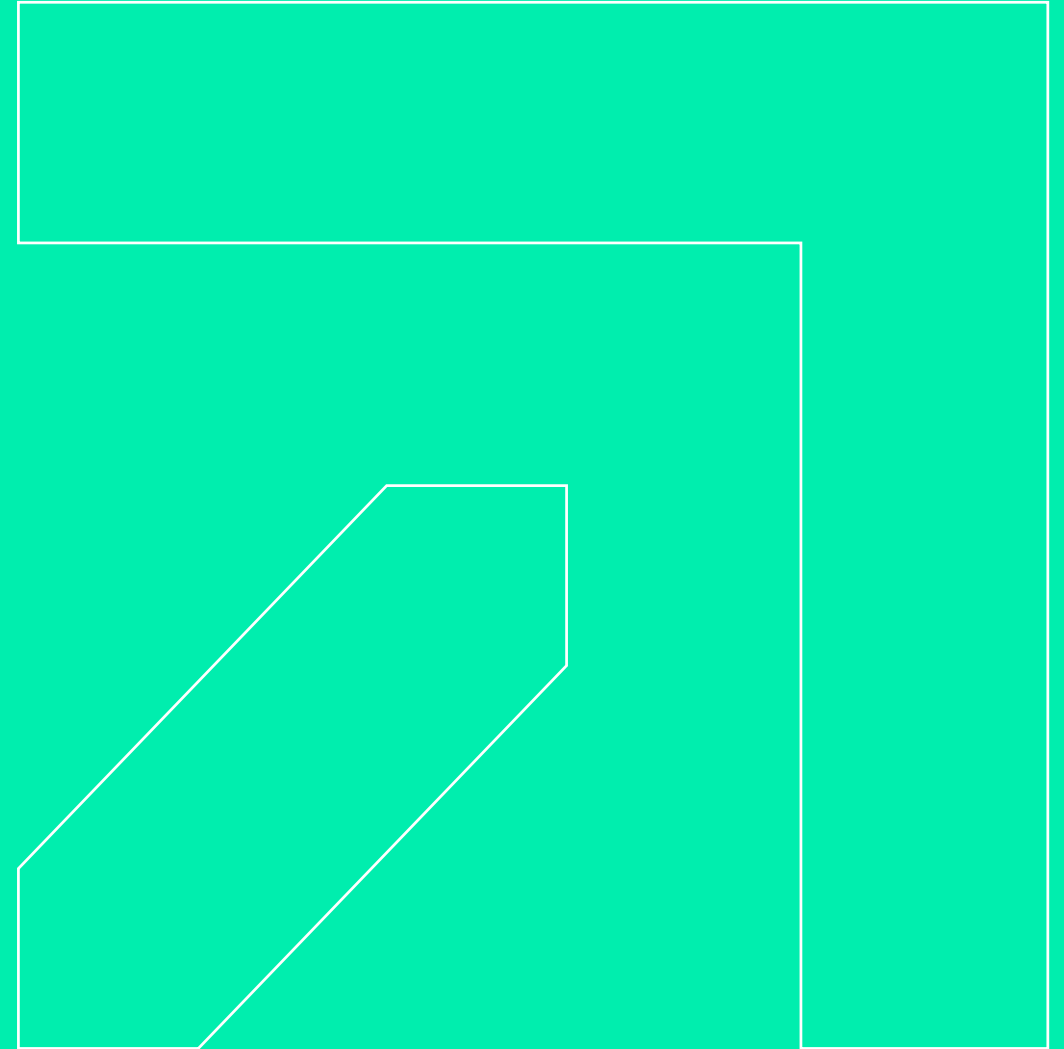
- Claims Submitted via the Santrax system that paid or partially paid and must be resubmitted or adjusted must be:
 - voided via the provider's Secure Web account on the www.ctdssmap.com Website.
 - rolled back in Sandata, altered and resubmitted.
 - This serves to add back units paid both in InterChange and in the Santrax system to maintain PA file synchronization
 - Altered claims to be resubmitted in Sandata will reflect an ok to bill status
- Altered visits may need to be reconfirmed 48 hours prior to resubmitting claims via the Santrax system.
- For new staff or those who may infrequently create and submit claims or need a refresher, please click [Creating Claims in the Santrax System](#)
- If further assistance is needed, please click the following: [Who to contact for Assistance](#) link.

Claim Submission Reminders – Electronic or Web Claim Submission

- Minimize claim submission time by:
 - Copying a prior paid claim, especially when billing for like services, minimizing changes needed for resubmission
 - Spanning dates of service on a single line detail when the same service is performed on consecutive dates reduces keystrokes and the number of details on a claim
- A visit must be confirmed at least twenty-four (24) hours prior to submission of the claim, when the method of claim submission is outside of the Sandata System.
 - Gainwell Technologies receives a daily report from Sandata which is used to validate units billed on claims submitted outside of Sandata.

Claim Denial and Resolution

Waiver Service Provider Refresher Workshop
December 2025



Claim Denials and Resolution

- **Denials Due to Timeliness of Claim Submission**

- **0512 Claim exceeds timely filing limit**

- The Department of Social Services timely filing limit for Waiver services is one year. This EOB code will appear on the claim if any of the following conditions exist:
 - The **date the claim was received** by Gainwell Technologies was **greater than 366 days from the claim date of service**
 - The **date the claim was received** by Gainwell Technologies was **greater than 366 days from the date the claim previously appeared on a Remittance Advice**
 - The claim **previously denied for timely filing.**

TPL Related Timely Filing Denials:

- The date the claim was received by Gainwell Technologies was greater than 366 days from the Other Insurance Explanation of Benefit or Medicare Explanation of Medicare Benefit date
- When there are multiple TPL Carriers and Medicare Carriers on the claim, if any one of the date checks do not meet these criteria, the EOB will set

Claim Denials and Resolution

- **Denials Due to Timeliness of Claim Submission**
 - **0512 Claim exceeds timely filing limit cont.**

Resolution:

- If the claim meets any of the noted criteria above, the claim exceeds the timely filing limit and cannot be paid.
- If the claim previously appeared on a Remittance Advice within the past 366 days, the claim must be resubmitted with the same provider ID, client ID, date of service, procedure/modifier and billed amount, otherwise, the claim will deny. If the previously processed claim denied for timely filing, the claim is not payable.

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, DSS Autism Case Manager or ABH 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 on care plan must be added by the Access Agency, DSS Autism Case Manager or ABH 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, DSS Autism Case Manager or ABH.
 - **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).
 - **Resolution 1:** Units of service must be added by Access Agency, DSS Autism Case Manager or ABH 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.)

- **Claim Denial Reason due to Provider Not Allowed to Submit Claims for Care Plan:**
 - **EOB Code 3017** – Provider not Allowed to Submit claims for Care Pan
 - **Cause:**
Provider Submitting Claim for Waiver Client or Service under a Provider Type or Specialty not allowed for the client's Care Plan.
 - **Resolution :** Provider must resubmit claim under the correct Waiver Service or correct Waiver Service Provider ID based on the client's Waiver benefit plan.

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, DSS Autism Case Manager or ABH 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

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

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 mandated claims submitted outside of the Santrax system cont'd:**

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

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.

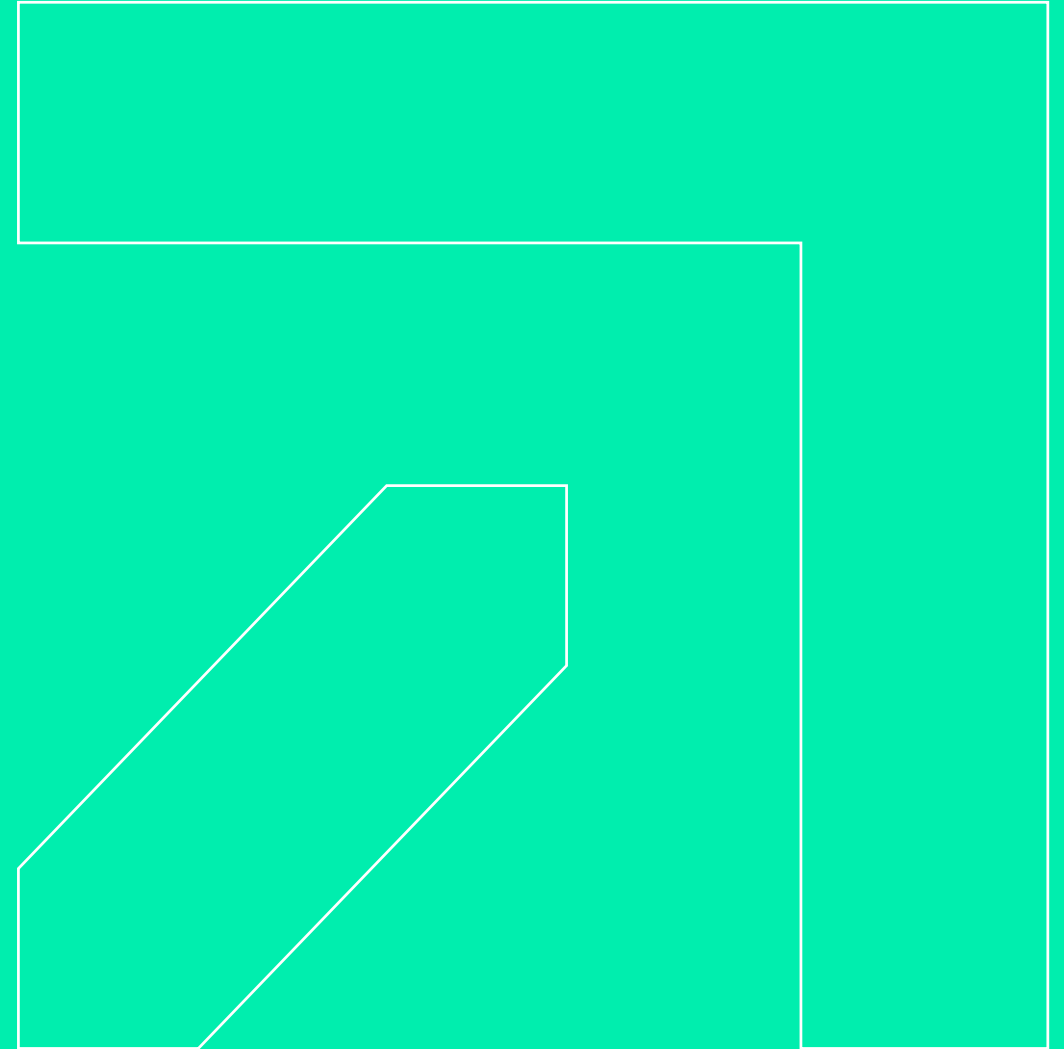
- **EOB Code 3329** - Details cannot exceed 31 days

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.

Monthly Claims Reprocessing- Remittance Advice Impact

Waiver Service Provider Refresher Workshop
December 2025



Monthly Claims Reprocessing

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

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 PA changes made by the Access Agency/DSS Autism Case Manager or ABH approximately two months prior. (Voided claim ICN region 52.)
- In the same cycle, Gainwell Technologies will reprocess, deny and/or pay claims posting to the correct PA/PA line detail (Reprocessed New Day claim ICN region 24.)

For example: **changes made to PAs in May 2024** by the Access Agency, DSS Autism Case Manager or ABH will result in claims being **voided** (region 52) and **reprocessed** (region 24) in **the first cycle of July 2024**.

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 Claim Reprocessing - Claim Recouped

REPORT: CRA-PHAD-R interChange MMIS Date: 10/15/201
 RA#: MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 33
 PROVIDER REMITTANCE ADVICE
 CMS 1500 CLAIM ADJUSTMENTS

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

PAYEE ID
 ISSUE DATE 10/15/201
 TAXONOMY
 P. AVRS ID

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.
		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	060314 061214	(116.16)	(58.08)	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)	(58.08)	(0.00)
1	52000000000000	060314 061214	116.16	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HEADER EOBS:		8236									

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 Claim Reprocessing - Claim Reprocessed

REPORT: CRA-PHPD-R
RA#:

interChange MMIS
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

Date: 10/15/2014
PAGE: 2

Home Care Agency
555 Any ST
Somewhere, CT00000-0000

PAYEE ID
ISSUE DATE 10/15/2014
TAXONOMY -----
P. AVRS ID

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.

CLIENT NAME: Sally Client		CLIENT NO.:									
	2400000000000	060214	061214	116.16	75.00	0.00	0.00	0.00	0.00	0.00	75.00
HEADER EOB 8238		SERVICE DATES RENDERING		BILLED		ALLOWED		DETAIL		EOBS	
PL SERV	PROC CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	AMOUNT	AMOUNT			
12	1542P		20	060214	061214	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, DSS Autism Case Manager or ABH immediately.

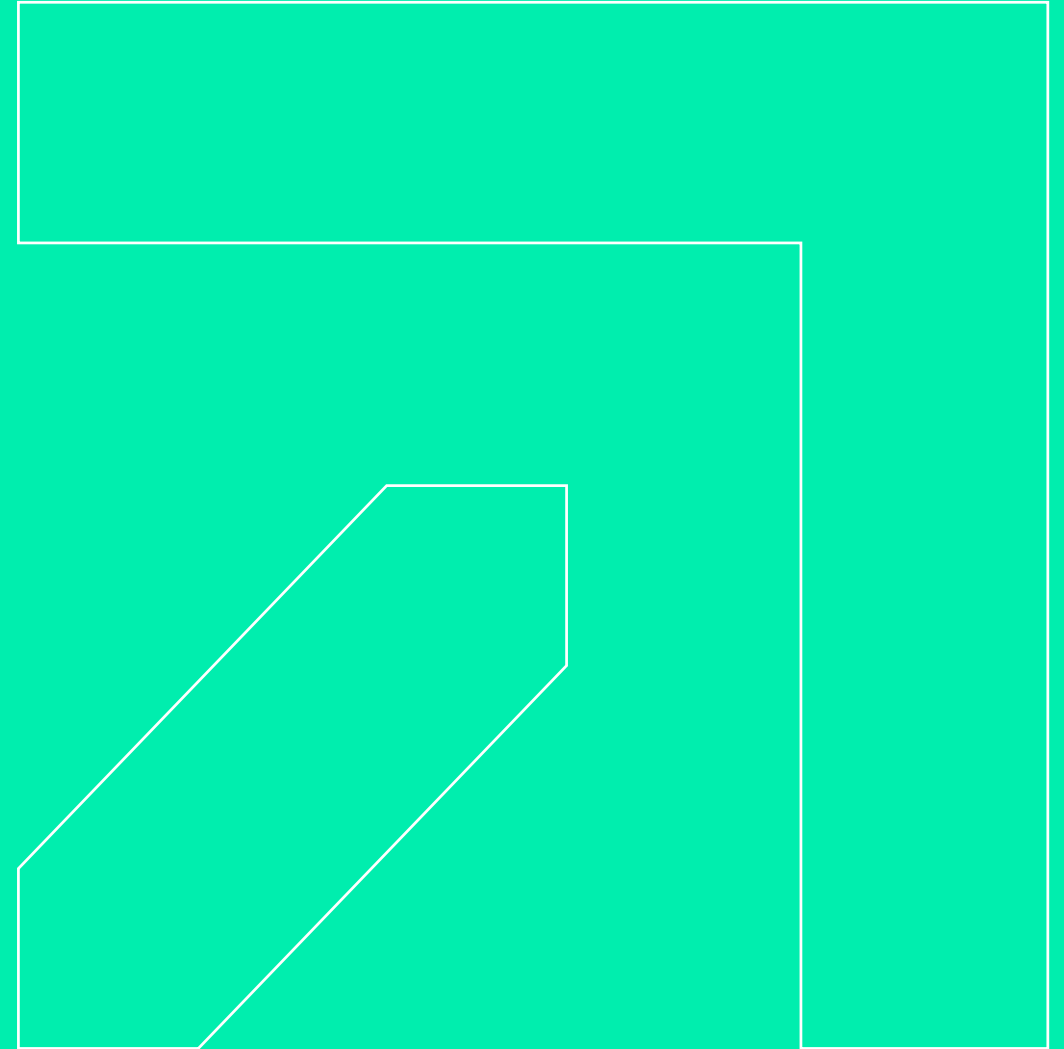
Monthly Claims Reprocessing (cont.)

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

- A PA may show negative units available, if the changes made by the Access/Case Management Agency, DSS Autism Case Manager or ABH 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 and available.
 - Until claims are recouped and reprocessed, the PA will show 12 units authorized – 16 used = (4) negative (available) units.

Information/Resources

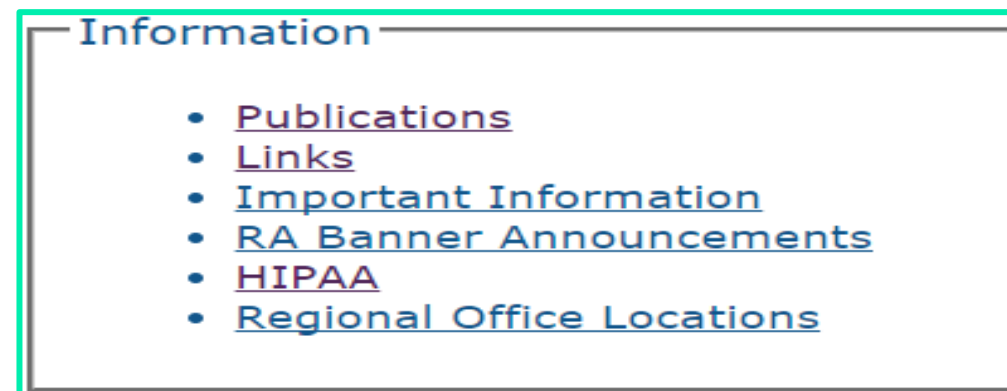
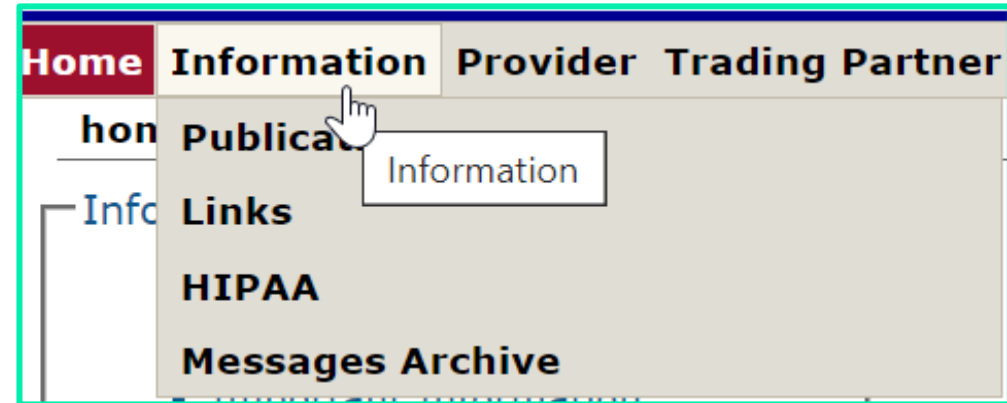
Waiver Service Provider Refresher Workshop
December 2025



Information/Resources (cont.)

- **Publications**

- Much 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 drop-down menu or the Information box on the left side of the home page

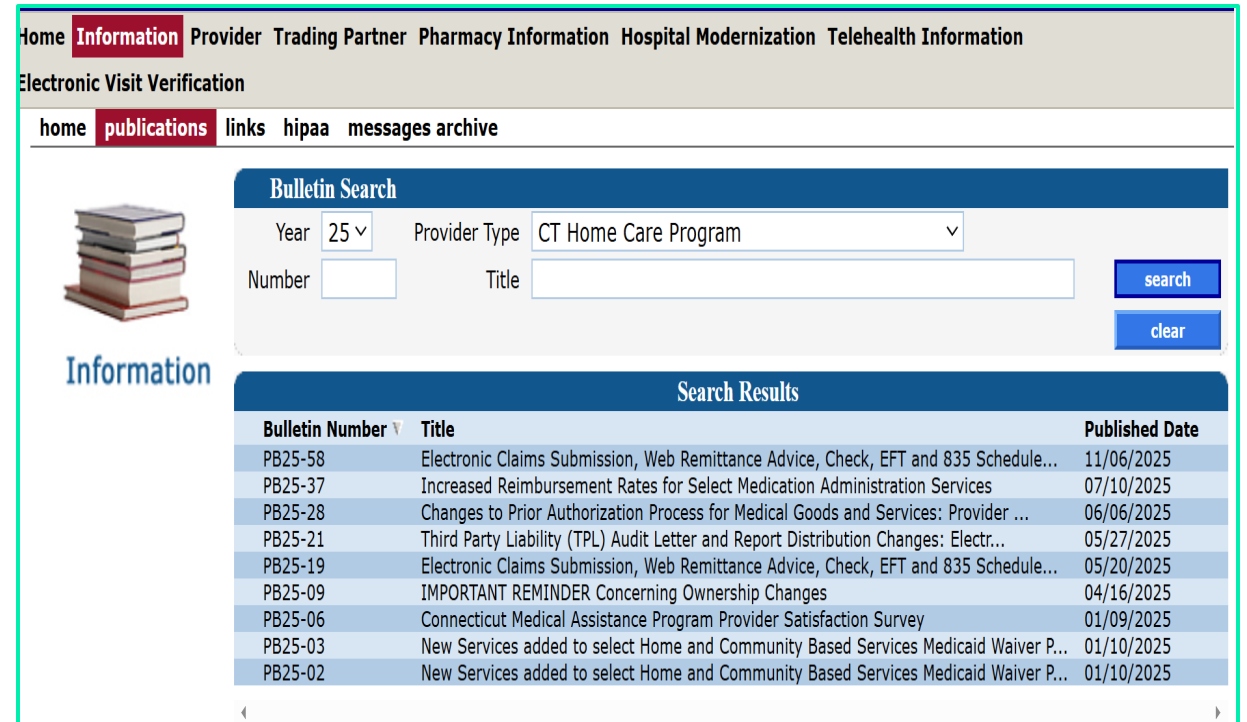


Information/Resources (cont.)

www.ctdssmap.com

Bulletins


- Publications posted to relevant provider types and specialties documenting 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.



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

Electronic Visit Verification

home **publications** links hipaa messages archive

 **Information**

Bulletin Search

Year Provider Type

Number Title

Search Results

Bulletin Number	Title	Published Date
PB25-58	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule...	11/06/2025
PB25-37	Increased Reimbursement Rates for Select Medication Administration Services	07/10/2025
PB25-28	Changes to Prior Authorization Process for Medical Goods and Services: Provider ...	06/06/2025
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.)

www.ctdssmap.com

- **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 \(Posted 11/17/25\)](#)

[Attention Home and Community Based Service \(HCBS\) and Home Health Providers: Important Update regarding Value Based Outcome Payments \(Posted 11/14/25\)](#)

[Attention Home and Community Based Waiver Providers, Homemaker and Companion Agencies: Reminder Background Check Requirement \(Posted 11/12/25\)](#)

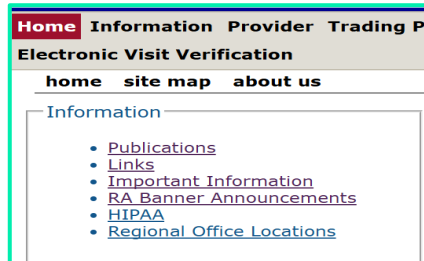
[Attention All Providers and Trading Partners: EXTENDED SYSTEM DOWNTIME NOTIFICATION \(Posted 11/12/25\)](#)

Information/Resources (cont.)

- www.ctdssmap.com

- **RA Banner Announcements**

- Available by clicking on the “RA Banner Announcements” link in the Information box on the left side of the home page, or by clicking on the Information menu heading on 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
05/23/2025-05/30/2025	Attention Select Providers	Attention Select Providers. PROCESSED THIS CYCLE: Home and Community Based Services (HCBS) providers who qualified to receive the value-based payment (VBP) will see these payments in their Remittance Advice dated May 28, 2025 with a reason code 8327 indicating HCBS Value Based Payment.
01/10/2025-01/17/2025	Attention Connecticut Home Care (CHC), Personal Care Assistant (PCA), Acquired Brain Injury (ABI), Autism and Mental Health (MH) Waiver Service Providers	Attention Connecticut Home Care (CHC), Personal Care Assistant (PCA), Acquired Brain Injury (ABI), Autism and Mental Health (MH) Waiver Service Providers. REMINDER OF OPTIONAL TRANSITION TO OPEN VENDOR ELECTRONIC VISIT VERIFICATION (EVV) MODEL: In 2016, Section 12006 of the 21st Century Cures Act established a requirement for all states to use an Electronic Visit Verification (EVV) system for Medicaid-funded Personal Care Services (PCS). Currently, the Department of Social Services (DSS) and Department of Mental Health and Addiction Services (DMHAS) utilize a State Mandated External Vendor model for the collection of PCS visit data. All PCS providers are required to submit visit data to the system designed by the State's external EVV vendor (i.e., Sandata Technologies). DSS and DMHAS will be transitioning from a State Mandated External Vendor model to an Open Vendor EVV model with an aggregator solution for PCS. The Open Vendor EVV model will allow providers the opportunity to use either the State's existing external EVV vendor system (i.e., Sandata Agency Management) or their own third-party ("Alternate EVV") system to capture visit data. Changes to accept all PCS visit data from either the State's existing EVV system or an Alternate EVV system were implemented on May 8, 2024. Additional information, including vendor specifications, presentations and recordings for all three Town Hall sessions Frequently Asked Questions (FAQ) Document and Alternate EVV Provider Registration Form can be found on the www.ctdssmap.com Web site Home Page under Important Messages by selecting the Electronic Visit Verification (EVV) Updates - as of May 31, 2024 link.

Information/Resources (cont.)

- **Archived 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.

- Archived Important Messages and Archived RA Banners can also be accessed by clicking the applicable link:

[Click here for Archived Messages](#)

[Click here for Archived RA Banner Announcements](#)

displayed at the end of the last cycle's Important Messages or RA Banner Announcements.

- 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 'Archived Search' interface. At the top, there is a dark blue header with the text 'Archived Search'. Below the header, there is a form with two main sections. The first section is labeled 'Type' and contains a dropdown menu with 'Important Messages' selected. The second section is labeled 'Keywords' and contains an empty text input field. To the right of the input field are two blue buttons: 'search' and 'clear'. Below the search form, there are three blue buttons stacked vertically, each with a white plus sign and the text '+ 2025 Important Messages Archived', '+ 2024 Important Messages Archived', and '+ 2023 Important Messages Archived' respectively.

The screenshot shows the 'Archived Search' interface. At the top, there is a dark blue header with the text 'Archived Search'. Below the header, there is a form with two main sections. The first section is labeled 'Type' and contains a dropdown menu with 'RA Banner Announcements' selected. The second section is labeled 'Keywords' and contains an empty text input field. To the right of the input field are two blue buttons: 'search' and 'clear'. Below the search form, there are three blue buttons stacked vertically, each with a white plus sign and the text '+ 2025 RA Banner Announcements Archived', '+ 2024 RA Banner Announcements Archived', and '+ 2023 RA Banner Announcements Archived' respectively.

Information/Resources (cont.)

- **Provider Manual**

- 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'd**
 - **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**

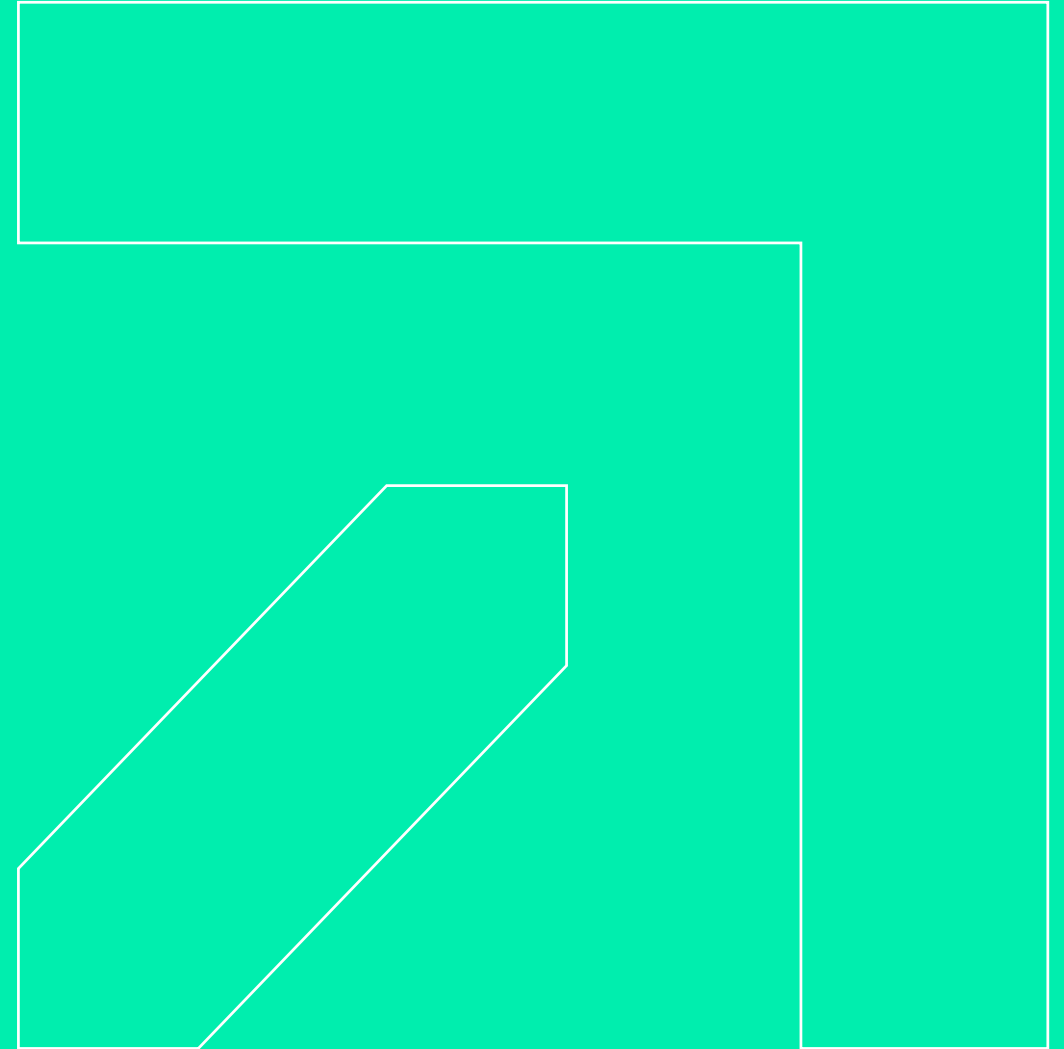
- Guides and FAQs to assist with billing/claims processing

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](#)

Other CMAP Resources

Waiver Service Provider Refresher Workshop
December 2025



Provider Fee Schedules



Home Information **Provider** Trading Partner Pharmacy Information

- Provider Enrollment
- Provider Re-enrollment
- Provider Enrollment Tracking
- Provider Matrix
- Provider Services
- Provider Search
- Drug Search
- Provider Fee Schedule Download**

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 fingerprint criminal background check info e-mail subscription secure site

Connecticut Provider Fee Schedule End User License Agreements

END USER LICENSE AGREEMENTS FOR CURRENT PROCEDURAL TERMINOLOGY (CPT) AND CURRENT DENTAL TERMINOLOGY (CDT) ARE DISPLAYED BELOW. TO ACCESS THE CONNECTICUT PROVIDER FEE SCHEDULES, REVIEW AND ACCEPT THE END USER LICENSE AGREEMENTS.

The license granted herein is expressly conditioned upon your acceptance of all terms and conditions contained in this agreement. If the foregoing terms and conditions are acceptable to you, please indicate your agreement by clicking below on the button labeled "I ACCEPT". If you do not agree to the terms and conditions, you may not access or use the software. Instead, you must click below on the button labeled "I DO NOT ACCEPT" and exit from this computer screen.

To access the CSV link for each Fee Schedule, hold down the CTRL key then click the CSV link.



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

Provider Fee Schedule Download

- Acquired Brain Injury Case Management [CSV](#)
- Acquired Brain Injury DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Fiduciary [CSV](#)
- Acquired Brain Injury II DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Service Provider [CSV](#)
- Acupuncture [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Autism Waiver Fiscal Intermediary [CSV](#)
- Autism Waiver Service Provider [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)
- Clinic - Dialysis [CSV](#)
- Clinic - Family Planning / Abortion [CSV](#)
- Clinic - Medical [CSV](#)
- Clinic - Rehabilitation [CSV](#)
- Community First Choice - Assessments [CSV](#)
- Community First Choice - Services [CSV](#)
- Connecticut Housing Engagement and Support Services [CSV](#)
- CT Home Care [CSV](#)
- DDS Specialized Services NF Fee Schedule [CSV](#)
- Dental Adult [CSV](#)
- Dental DOS Prior to 09/01/2016 [CSV](#)
- Dental Pediatric [CSV](#)
- Home Health [PDF](#)
- Hospice [CSV](#)
- Hospital DRG Organ Acquisition [PDF](#)
- Hospital Outpatient Flat Fee [CSV](#)
- Independent Audiology and Speech and Language Pathology [CSV](#)
- Independent Physical Therapy and Occupational Therapy [CSV](#)
- Independent Radiology [CSV](#)
- Lab [CSV](#)
- Local Health Department [CSV](#)
- MEDS - DME [CSV](#)
- MEDS-Hearing Aid/Prosthetic Eye [CSV](#)
- MEDS-Medical/Surgical Supplies [CSV](#)
- MEDS-MISC [CSV](#)
- MEDS-Parenteral-Enteral [CSV](#)
- MEDS-Prosthetic/Orthotic [CSV](#)
- Mental Health Waiver Assisted Living Provider [CSV](#)
- Mental Health Waiver DOS Prior to 02/01/2020 [CSV](#)
- Mental Health Waiver Service and Fiscal Intermediary Provider [CSV](#)
- Natureopath [PDF](#)
- Optician/Eyeglasses [CSV](#)
- Personal Care Assistant [CSV](#)

Provider Rates

- Provider Fee Schedule Rates – Set by DSS
- The Access Agencies cannot change the rates
- Allowed Rate (rate paid if service billed at equal to or greater than the fee schedule amount)
- Provider Usual & Customary Rate
 - Rate set by providers for all payors of service (Private Pay, Insurance, CMAP)
 - Can be equal to greater than or less than the DSS allowed amount
- Claims are processed and paid at the lessor of the DSS allowed rate or the billed rate on the claim
- If a Retro Active Rate Increase is approved by DSS
 - claims are systematically reprocessed and those claims that were billed at a Usual & Customary rate equal to or greater than the new allowed rate will be reprocessed and paid at the new allowed rate.
 - Providers who billed and were paid at the old allowed rate and want to be paid at the new allowed rate must adjust their own claims.
 - Providers submitting claims via Sandata must first update their rates in Sandata. Refer to [AYFT_33.pdf](#) for more information on entering and updating provide rates.

Provider Training – Current & Past Presentations

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

home site map about us

Information

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

Provider

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

Trading Partner

Information Provider Trading Partner Pharmacy

Workshop Invitations

Waiver Service Provider Workshop Invitation

Materials

- [ABI Service Provider Workshops](#) ←
- [Autism Waiver Service Provider Workshops](#) ←
- [Behavioral Health Clinicians Workshops](#)
- [Birth to Three Workshops](#)
- [CHC Workshops](#) ←
- [Connecticut Housing Engagement and Support Services \(CHESS\) - Enrollment Workshops](#)
- [Connecticut Housing Engagement and Support Services \(CHESS\) - Billing and Web Claims Workshops](#)
- [DDS Specialized Services Provider Workshops](#)
- [DDS Performing Provider Re-Enrollment Workshops](#)
- [Dental Workshops](#)
- [DMHAS Performing Provider Re-Enrollment Workshops](#)
- [Durable Medical Equipment Workshops](#)
- [Home Health Workshops](#)
- [Hospice Workshops](#)
- [Hospital Workshops](#)
- [Long Term Care Workshops](#)
- [Mental Health Waiver Provider Workshops](#) ←
- [New Provider Workshops](#)
- [PCA Service Provider Workshops](#) ←

Click applicable provider type link to access Workshop PowerPoint Presentations and Procedure Code Crosswalk

Information Communications– Email Subscriptions

Providers MUST register to receive information electronically for new provider publications and notifications through the email subscription function on the Connecticut Medical Assistance Program (CMAP) Web site at www.ctdssmap.com. For complete E-mail subscription information, please see provider bulletin PB 15-23 on the CMAP Web site.

Home Information Provider Trading Pa

Information

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

Provider

- [Provider Services](#)
- [Provider Search](#)
- [Provider Enrollment](#)
- [Promoting Interoperability Program](#)
- [OOS Instructions/Information](#)
- [Fingerprint Criminal Background Check Info](#)
- [Provider Training](#)
- [Secure Site](#)

Trading Partner

- [Trading Partner Enrollment](#)
- [Trading Partner Documents](#)
- [Provider Electronic Solutions Billing Instructions](#)

Pharmacy

- [Pharmacy Information](#)

Email Subscription

- [Register/Update Email Subscription](#)

Electronic Visit Verification

- [EVV Implementation Overview](#)

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.

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E-Mail

Confirm E-Mail

[Register](#)

Existing Subscribers

E-Mail

[Update](#)

Unsubscribe

E-Mail

[Unsubscribe](#)

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
 - Integrated Care for Kids (InCK)
 - Laboratory
 - Local Health Department
 - Mental Health Group Home
 - Mental Health Waiver
 - Naturopath
 - Optical Shop
 - Optician
 - Optometrist
 - Personal Care Services
 - Pharmacy
- **Topics**
 - EVV - Electronic Visit Verification
 - Hospital Modernization
 - Labeler/Drug Manufacturer
 - Trading Partner

Information/Resources – Electronic Visit Verification -EVV

Connecticut Department of Social Services
Making a Difference

Help
Site: B
Login
Tuesday, April 23, 2024 at 7:23:12 PM

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

home site map about us

Information

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

Provider

- [Provider Services](#)
- [Provider Search](#)
- [Provider Enrollment](#)
- [OOS Instructions/Information](#)
- [Fingerprint Criminal Background Check Info](#)
- [Provider Training](#)
- [Secure Site](#)

Trading Partner

Electronic Visit Verification

- New Provider Information**
- At Your Fingertips Tip Sheets
- General Program Information and FAQ's
- Important Documentation**
- Training Publications and Videos
- Archived Information

Information regarding the "Open Vendor EVV Model Implementation for Personal Care Service" can be found by clicking the Important Documentation link.

For Information on "Who to Contact for Assistance", click on New Provider Information or "Important Documentation"

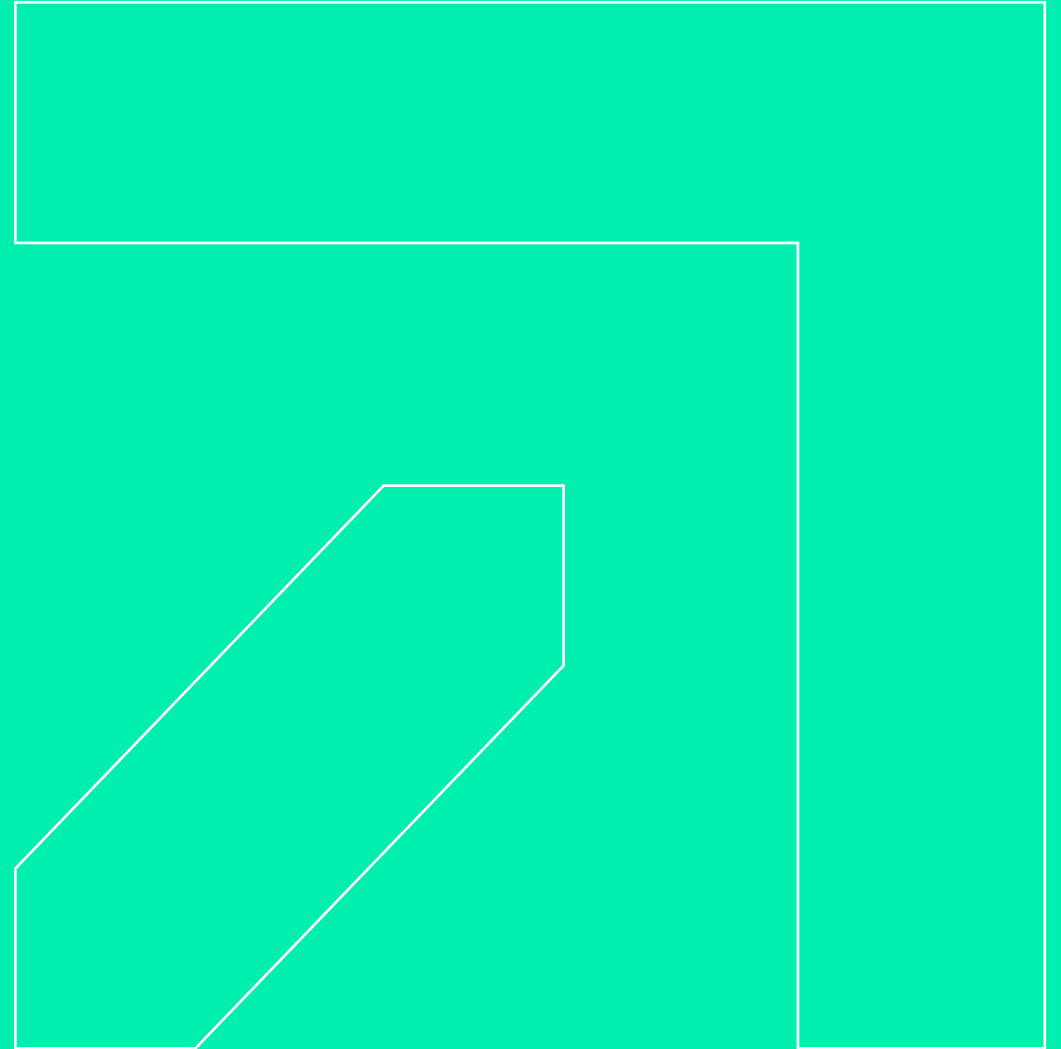
TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

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

Information Provider Trading Partner Pharmacy

Contacts

Waiver Service Provider Refresher Workshop
December 2025



Contacts

- **Gainwell Technologies Provider Assistance Center (PAC)**
 - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
 - ctdssmap-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 for future call reference.**
- **Gainwell Technologies Electronic Data Interchange (EDI) Help Desk**
 - 1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays
 - For issues with electronic claim files

Contacts (cont.)

- **Contact the EVV Email Mailbox at:**

- ctevv@gainwelltechnologies.com

If you are:

- missing a client from your Santrax system, and have verified via one of the eligibility verification methods noted in this presentation, 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 is present in Santrax.** If it has been more than 48 hours since the PA for the dates of service and procedure you are billing was verified as appearing on the www.ctdssmap.com portal, then contact the EVV email box for assistance.

Contacts (cont.)

- Access Agencies

- **Connecticut Community Care (CCC) - ServiceAuthIssues@ctcommunitycare.org**

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

Providers who want to be added to the CCC Provider Directory or make changes to their existing information in the directory should do so by accessing the link below to complete the online form.

Providers must also upload their supporting documentation from:

GT Independence (GTI) - most recent credentialing letter for each Waiver services are credentialed.

Gainwell Technologies - most recent enrollment or re-enrollment approval letter for each Waiver enrolled.

Once the agency is added to the CCC directory, they will receive an email with the confirmation.

<https://ctcommunitycare.org/providers/provider-enrollments-and-changes/>

Contacts (cont.)

- **Access Agencies continued**

- **Agency on Aging of South Central CT (AOASCC)**

- Email: providers@aoascc.org**

- Phone: 203-752-2958**

- Fax: 866-644-1929**

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 AASCC: 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.)

- **Access Agencies continued**

- **South Western 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 (Procedure code), the dates of service, the frequency of service and the number of units or hours per visit.

- **Western Connecticut Area on Aging (WCAA) - contact WCAA directly at (203) 465-1000**

Please have the following information available when contacting WCAA: client name, the client Medicaid ID number, the type of service (Procedure code), the dates of service, the frequency of service and the number of units or hours per visit.

Contact (cont.)

- **GT Independence (GTI)** - New Fiscal Intermediary for CT Community Based Services
 - GTI credentials Home and Community Based Service Agencies who wish to enroll or re-enroll as Acquired Brain Injury, Autism, CT Home Care or Personal Care Assistance Waiver Service Providers under the CT Medical Assistance Program.
 - Providers who wish to start the credentialing or re-credentialing process should send an email to: providercredentialing@gtindependence.com
 - Include the name of your Agency, your Provider AVRS ID, if re-credentialing. And your contact information should GTI need to reach out to you. Also include a brief summary of why you are contacting them.
 - For questions contact GTI at 1-877-659-4500.
 - To be added to the **Provider Directory** - Providers should complete the Provider Registry form given to providers by GTI as part of the credentialing process. Once enrolled or re-enrolled providers should return the form to GTI with a copy of their Enrollment or Re-enrollment Approval letter received from Gainwell Technologies.

Contacts (cont.)

- **Advanced Behavioral Health (ABH) - Mental Health Waiver (MHW) Fiscal Intermediary**
 - Telephone - 860-704-6201
 - Responsible for the credentialing of MHW Service Providers and Assisted Living Service Agencies
 - Prior Authorization
 - Assists Providers with Client Eligibility Issues – For Client Eligibility Issues:
- **Carelon**
 - Email: ctbhp@carelon.com
 - Toll Free – 877-552-8247
 - Carelon credentials Autism Individual Practitioners who wish to enroll as Autism Waiver Service providers.
- **DSS Community Options Unit**
 - **Community Option Unit at DSS-** For assistance in correcting a waiver client's eligibility file, please send an email to Waiver.DSS@ct.gov.

Questions



Survey

Thank you for attending the Connecticut Medical Assistance Program Waiver Service Provider 2025 Refresher Workshop!

All questions and comments regarding this training are welcome.

Please fill out the online workshop survey, as your feedback helps us to improve future workshops!

Thank you



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