

Welcome to the Hospital Refresher Workshop Presentation – December 2025

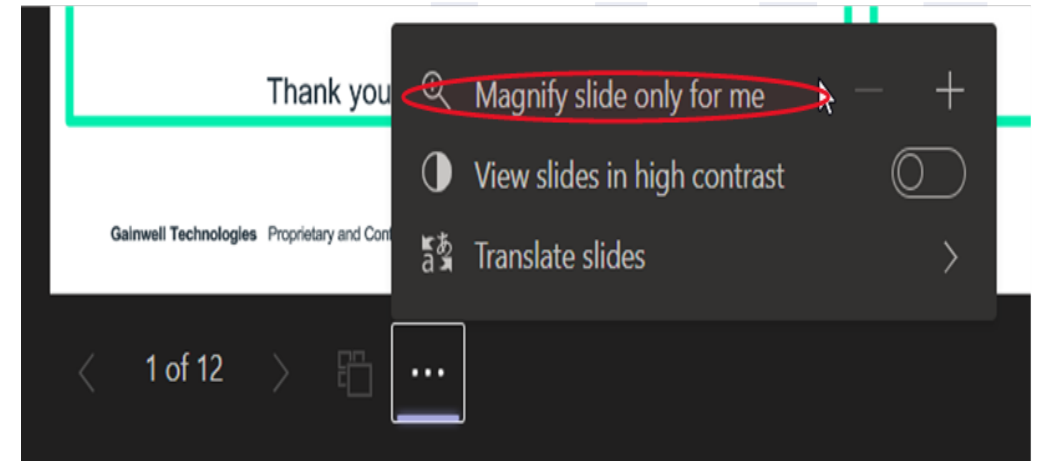
Once you have joined the Microsoft Teams meeting, please follow these communication rules:

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

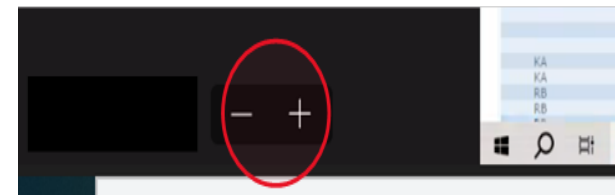
Thank you for your participation!

Troubleshooting Tips:

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



Or it may appear with this option next to the speaker's name, allowing you to Zoom In or Out:



Connecticut Medical Assistance Program Hospital Refresher Workshop

Presented by The Department of Social Services & Gainwell Technologies

December 2025



Agenda

Connecticut Medical Assistance Program (CMAP) Web Site
Telemedicine Services
Hospital Modernization
Clerk Maintenance
E-Delivery Overview
Re-Enrollment Web Portal Overview
Web Claims Overview
Prior Authorization
CMAP Addendum B
Provider Fee Schedule
All Patient Refined Diagnostic Related Group (APR DRG)
Discharge Delay Days/Value Based Payments
Regulations and Policies
Frequent Claim Denials
Frequently Asked Questions
Resources

CMAP Web Site



Important Messages

- Important Messages are available on the www.ctdssmap.com Web page on the welcome page located in the “Information” section

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

- 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

Site Details


- Site: D
- Updated: 4/26/2022
- Release: CTM-1557

WELCOME 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

Important Messages

- [Attention Behavioral Health Clinicians: Mental Health Access Improvement Act \(Posted 12/5/23\)](#)
- [Attention Home Health Agencies, Occupational Therapist Groups, and Individual Occupational Therapists: Opportunity for Home Health Agencies \(HHAs\) to take part in new services: COPE and CAPABLE \(Posted 11/30/23\)](#)
- [Attention All Providers: CMAP Telehealth Services \(Posted 11/27/23\)](#)
- [Attention Acquired Brain Injury, Connecticut Home Care Program, and Personal Care Services/Assistant \(PCA\) Providers: Prior Authorization Issue \(Posted 11/22/23\)](#)
- [Hospital Monthly Important Message \(Posted 11/20/23\)](#)
- [ATTENTION Obstetrics & Gynecology and Family Practice Physicians and APRNs, Women's Health APRNs and Certified Nurse Midwives: Register for the HUSKY Maternity Bundle Provider Forum \(Posted 11/6/23\)](#)
- [Attention Home Health Providers: Sandata Agency Management System Update to Medication Administration Visits less than Eight \(8\) Minutes \(Posted 11/1/23\)](#)
- [Attention Hospitals: CMAP Addendum B Updated and New DRG Codes Added to Calculator \(October 1, 2023\) \(Posted 10/31/23\)](#)
- [Attention All Providers: COVID-19 Vaccine Procedure Code Updates \(Posted 10/25/23\)](#)
- [Revised CT Medical Assistance Program \(CMAP\) Telehealth Table - Addition of procedure code S0199 - Effective October 16, 2023 \(Posted 10/11/23\)](#)
- [Attention Home Health Providers: Electronic Visit Verification \(EVV\) Updates - 1\) Sandata Agency Management Auto-Confirm Issue 2\) COMING SOON: Sandata Agency Management Group Visit Feature and Visits Less than Eight \(8\) Minutes Update 3\) New Sandata Customer Support Web Forms 4\) Additional Resources \(Posted 10/6/23\)](#)

Important Messages

Home Information Provider Trading Partner Pharmacy Information Hospital Modern

home publications links hipaa **messages archive**

Archived Search

Type **Important Messages**

Keywords

Information

+ 2013 PI (Formerly EHR) Important Messages Archived

Telehealth Important Messages Search Results
No matching Telehealth Important Messages were found.

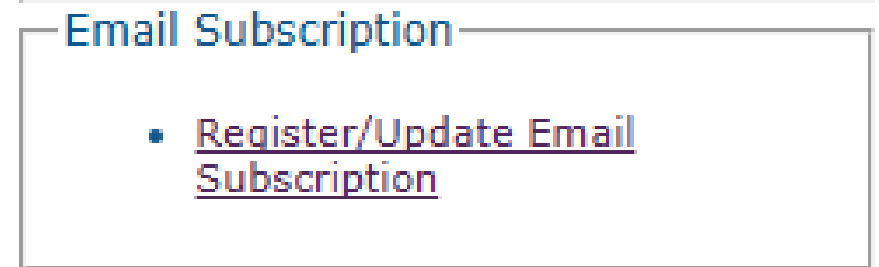
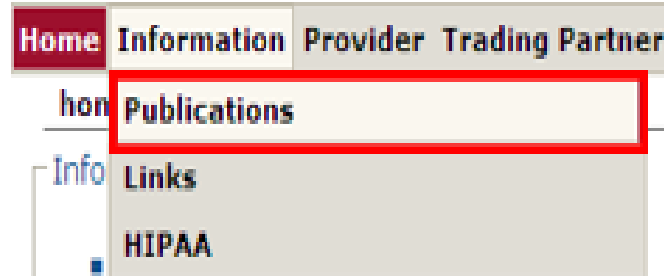
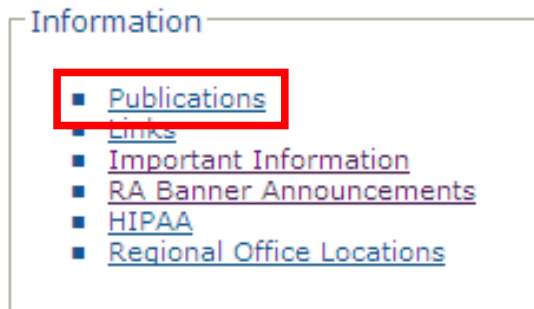
- 2025 Important Messages Archived

Message Effective Date	Title
12/02/2025-12/02/2025	Emergency Down Time Notification (Posted 12/2/25)
10/10/2025-11/16/2025	Hospital Monthly Important Message (Posted 10/10/25)
10/09/2025-12/01/2025	Attention Certified Dietitian Nutritionists, Physicians, Physician Assistants, Certified Nurse Midwives, Advanced Practice Registered Nurses, Federally Qualified Health Centers, Outpatient Hospitals, and Rehabilitation Clinics: Updates to Table 26 for Medical Nutrition Therapy (MNT) Services (Posted 10/9/25)

- Important Messages provide information on any changes or updates for providers.
- The most recent Important Messages are available on the www.ctdssmap.com Web site from the “Important Information” link from the home page or in the Publications page.
- Providers can also access the Important Messages Archives page by selecting “Information” > “Messages Archive” drop-down menu. This will direct you to all Important Messages that have been published.
 - For Hospital related Important Messages, typing the word “Hospital” into the keywords for search will narrow down the search.

Provider Bulletins

- Provider bulletins are available to specific provider types documenting changes and/or updates to CMAP.
- Provider bulletins are available on the www.ctdssmap.com Web site from the Publications page.
- Providers can access the Publications page by selecting Publications from either the Information box on the left-hand side of the Home page or from the Information drop-down menu.



- Providers can choose to subscribe to receive emails on updates on on-line publications such as provider bulletins, workshop invitations, newsletters, and important messages.


Provider Bulletins

- Provider 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 by selecting “Hospital”. The online database of bulletins goes back to the year 2000.

Example: Looking for all Hospital related bulletins with “MNT” in the title.

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

[home](#) [publications](#) [links](#) [hipaa](#) [messages](#) [archive](#)



Information

Bulletin Search

Year
Number

Provider Type
Title

Search Results

Bulletin Number	Title	Published Date
PB25-41	Update to Table 26: List of Diagnosis Codes for Medical Nutrition Therapy (MNT) ...	08/21/2025
PB25-18	New Coverage of Medical Nutrition Therapy (MNT)	06/11/2025

Telemedicine Services



Telemedicine Services

- [PB23-38](#) REVISED Guidance for Service Rendered via Telehealth published May 11, 2023.
- [PB24-78](#) Updates to Telehealth – January 2025 Updates
- Accessing Telehealth Policies and Covered Services Comprehensive information on telehealth can be found on the www.ctdssmap.com Web page by selecting “Telehealth Information.” This page will provide details such as the CMAP Telehealth Table, FAQs, Provider Bulletins, IMs, and all other telehealth communications. Please refer to this page periodically for updates.

Connecticut Department of Social Services
Making a Difference

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

Telehealth Overview

In accordance with sections 17b-245e and 17b-245g of the Connecticut General Statutes, the Department of Social Services (DSS) provides reimbursement for select services when performed via telehealth under the Connecticut Medical Assistance Program (CMAP). Telehealth services include synchronized audio-visual (telemedicine) two-way communication services and, where specified by DSS, audio-only two-way synchronized communication services delivered via telephone. In developing the CMAP Telehealth policy, DSS consulted with practicing clinicians to determine clinically appropriate policy, limitations and criteria. DSS' telehealth policy was developed to support the HUSKY Health member's ability to access clinically appropriate, clinical effective services while maintaining the highest quality of care. The health, safety, and experience of the HUSKY Health member are central drivers of CMAP's policy. Notwithstanding federal or state statutes, the Department reserves the right to update and/or amend the telehealth policy going forward based on relevant research on this topic and/or based on feedback the Departments solicits from HUSKY members and providers.

This web page has been developed for providers to refer to for the latest telehealth updates including, Important Messages (IMs), Frequently Asked Questions (FAQs), and the CMAP Telehealth table, which provides a complete list of procedure codes approved to be rendered via telehealth. Providers are encouraged to monitor this Web page for updates. DSS will publish IMs to notify providers if updates are made to the Telehealth Table. Providers must also refer to PB 2023-38: Revised Guidance for Services Rendered via Telehealth for additional telehealth guidance. All provider bulletins, fee schedules and FAQs can be found on the CMAP Web site, www.ctdssmap.com. Providers should carefully review CMAP's Telehealth Table for the full list of approved procedure codes and, when applicable, the Revenue Center Codes (RCCs), that are eligible via telehealth. Only the codes listed on the table are allowed to be provided via telehealth. Therefore, if a code is NOT listed on table, the code is NOT eligible for payment when rendered via telehealth. Providers must refer to the Effective Date/End Date and Policy Guidelines columns detailing any specific policy criteria and/or limitations for each procedure code. Please see the bottom of Telehealth Table for proper use of modifiers for telehealth services. Providers should refer to this table periodically to ensure use of the most recent version. Providers must continue to refer to their applicable reimbursement methodology and/or fee schedule to ensure that the service identified as being eligible to be rendered as a telehealth service is payable for their specific provider type and for the reimbursement rate.

[CMAP Telehealth Table](#)

[Telehealth FAQ](#)

Important Messages - Telehealth

[Revised CT Medical Assistance Program \(CMAP\) Telehealth Table - Addition of procedure code S0199 - Effective October 16, 2023 \(Posted 10/11/23\)](#)

Quick Login

User ID*

Password*

Login

[Logging in for the first time?](#)

[Forgot your password?](#)

Helpful Information & Publications

- [Provider Bulletins and Policy Transmittals](#)
- [Provider Training](#)
- [Provider Manuals](#)
- [CT Provider Fee Schedule](#)

Contact Us

- toll free at 1-800-842-8440
- 1-877-413-4241 (fax)

Email Subscription

- [Register/Update Email Subscription](#)

Hospital Modernization Page



Hospital Modernization Page

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

[Inpatient Payment Methodology](#) [Outpatient Payment Methodology](#)

DRG IMPLEMENTATION

The All Patient Refined-Diagnostic Related Group (APR DRG) inpatient payment methodology was implemented for claims with a date of admission on and after January 1, 2015. DRG pricing now applies to acute care hospital inpatient claims with the exception of chronic disease hospitals, psychiatric hospitals and free-standing birth centers.

Providers should reference all materials surrounding this inpatient payment methodology including Frequently Asked Questions (FAQs), Bulletins, and Important Messages. Providers should also continue to visit this Web page for detailed information and continuous updates regarding APR DRG and the upcoming changes to the outpatient payment methodology.

Please continue to email questions or concerns in reference to the modernization of the Hospital reimbursement system to <mailto:ctxixhospipay@gainwelltechnologies.com>

Quick Login

User ID*

Password*

[Login](#)

[Logging in for the first time?](#)
[Forgot your password?](#)

DRG Calculator

- [DRG Calculator](#)

DSS Links

- [DSS Reimbursement Home Page](#)
- [Decision Log](#)

Comprehensive information on Connecticut Inpatient and Outpatient Payment Methodologies can be found on the “Hospital Modernization” page on the Web site www.ctdssmap.com. Please refer to this page often, as this will be updated throughout the year.

- Important Messages – Connecticut Hospital Modernization:
 - Hospital Monthly Important Messages
 - Current CMAP Addendum B
 - Prior Authorization Grid for Outpatient Hospitals
 - Provider Type and Specialty to Revenue Center Code Crosswalk

Hospital Modernization Page

- DRG Calculator
 - DRG Calculator (For the most current version of the DRG Calculator)
 - DRG Calculator Historical Versions
- DSS Links
 - DSS Reimbursement Home Page
 - Decision Log
- Hospital Outpatient Payment Methodology – Ambulatory Payment Classification (APC)
 - Outpatient Hospital Modernization FAQ
 - Hospital Based Practitioners – Outpatient Services
 - CMAP Addendum B
 - CMAP Addendum B Changes and Historical Versions
- Helpful Information & Publications
 - Provider Bulletins and Policy Transmittals
 - Provider Training
 - Refresher Workshop Materials
 - FAQs
 - Provider Manuals
 - HUSKY Health Benefit Grid (CHNCT Web site)
 - CT BHP Authorization Schedule (Carelon Behavioral Health)
 - CT Provider Fee Schedule

DRG Calculator

- [DRG Calculator](#)

DSS Links

- [DSS Reimbursement Home Page](#)
- [Decision Log](#)

Helpful Information & Publications

- [Provider Bulletins and Policy Transmittals](#)
- [Provider Training](#)
- [FAQs](#)
- [Provider Manuals](#)
- [HUSKY Health Benefit Grid](#)
- [CT BHP Authorization Schedule](#)
- [CT Provider Fee Schedule](#)

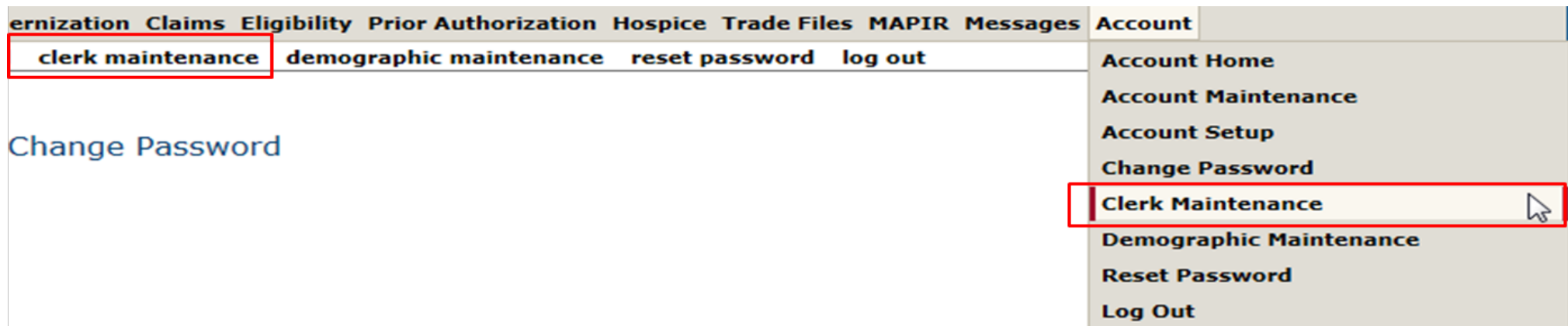
Clerk Maintenance



Clerk Maintenance Provider Manual Chapter 10

Clerk Maintenance is Important as part of the feature of being a clerk allows access to the Secure Web Portal.

- A clerk can access E-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:
 - “Trade Files Includes E-Delivery” – allows access to download all files
 - “Trade Files E-Delivery Only” – allow access to E-Delivery letters only
- Access the Clerk Maintenance section of the Secure Site by selecting clerk maintenance from either the Account submenu or the Account drop-down menu
 - For more information, please see [Provider Manual Chapter 10](#) “Web Portal and Automated Voice Response System (AVRS)”.



Clerk Maintenance Provider Manual Chapter 10

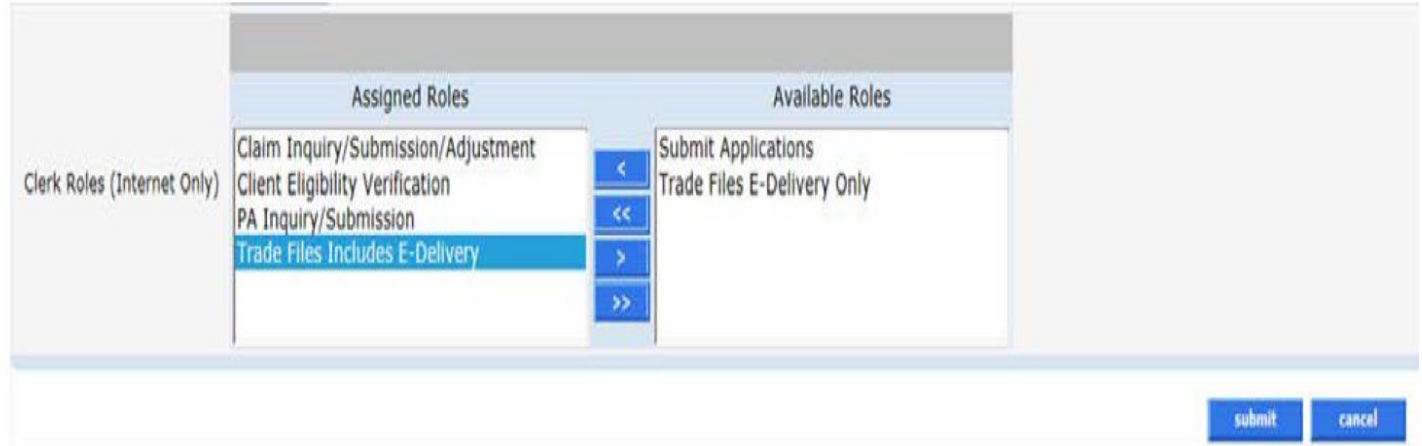
- To create a new clerk account
- Click 'add clerk'
- Fill in the required fields, click 'submit'

The clerk roles that can be assigned are:

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



The screenshot shows the 'Clerk Maintenance' web application. At the top, there is a header with 'User ID', 'Contact First Name', and 'Contact Last Name'. Below this, there is a table with one row containing 'A CLERK'. To the left of the table, there are buttons for 'remove clerk' and 'add clerk'. The 'add clerk' button is circled in red. Below the table, there is a form with the following fields: 'User ID' (value: CLERK32), 'Contact First Name*' (value: Test), 'Contact Last Name*' (value: Clerk), 'Phone Number*' (value: (111)222-3333), 'Password*' (masked with dots), 'Confirm Password*' (masked with dots), 'AVR ID', 'AVR Pin', and 'Confirm AVR Pin'. There are 'submit' and 'reset password' buttons on the right side of the form.



The screenshot shows the 'Clerk Roles (Internet Only)' assignment interface. It features two columns: 'Assigned Roles' and 'Available Roles'. The 'Assigned Roles' column contains the following roles: 'Claim Inquiry/Submission/Adjustment', 'Client Eligibility Verification', 'PA Inquiry/Submission', and 'Trade Files Includes E-Delivery'. The 'Available Roles' column contains: 'Submit Applications' and 'Trade Files E-Delivery Only'. Between the columns are four navigation buttons: '<', '<<', '>', and '>>'. At the bottom right, there are 'submit' and 'cancel' buttons.

E-Delivery Overview



E-Delivery

Overview

- The Department of Social Services (DSS) has implemented the electronic delivery of provider's letters. This is replacing the mailing of many paper letters that you currently receive from the Connecticut Medical Assistance Program (CMAP) through the United States Postal Service (USPS).
- DSS posts letters to the provider's Secure Web portal account.
- The letter(s) will be systematically posted to that user's Secure Web portal account for retrieval (E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available).
- An email notification will be sent notifying the user that a letter(s) has been posted.
- Primary Account holders have been automatically set up for E-Delivery.
- A clerk can access e-delivered letters if assigned that permission by their primary account holder.
- Please refer to [PB19-15](#) 'Implementation of Electronic Delivery of Letters - Replacement to the Mailing of Connecticut Medical Assistance Program Letters' to sign up for your E-Delivery account for further information.

New to E-Delivery – Third Party Liability (TPL) Audit Letters and Reports (June 1, 2025) Provider Bulletin [25-21](#)

- As of June 1, 2025, Third Party Liability (TPL) Audit Letters and Reports will be electronically delivered to providers who have established Secure Web portal accounts. Any providers who have not yet established their Secure Web portal accounts, or for which a unique Secure Web portal account cannot be determined, will continue to receive these letters via USPS.
 - Providers will receive an email notifying them when a new letter(s) has been posted to their Secure Web portal account. This email notification will be sent to the email address associated to that Secure Web portal account.
- Please refer to [PB 25-21](#) 'Third Party Liability (TPL) Audit Letter and Report Distribution Changes: Electronic Delivery via the Web Portal' for details on accessing the TPL Audit Letters and Reports via the Secure Web portal.
- **Failure to respond to the audit results in recoupment of the claims listed on the audit report.**

New to E-Delivery – Third Party Liability (TPL) Audit Letters and Reports: Provider Bulletin 25-21

Connecticut Department of Social Services
Making a Difference

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

Messages Behavioral Health Attestation Account

home **download** upload claim level detail

File Download Search Transaction Type **E-Delivery**

File Download Search Transaction Type **TPL Crossover Audit Rpt** **search** **clear**

REMINDER: DOWNLOAD WEB FILE RETENTION
Web file retention periods vary based on the type of file being downloaded.

- Remittance Advices (RA) in PDF format, the ASC X12N 835 Health Care Claim Payment/Advice, Functional Acknowledgements (999), Interchange Acknowledgement (TA1), Eligibility Response (271), Claim Status Response (277), Prior Authorization Response (278), Benefit Enrollment (834), Premium Payment (820), and any other proprietary format files (excluding Drug Rebate files) available for download will be retained on the www.ctdssmap.com web site for a period of five (5) months, at which time they will be removed and will no longer be available.
- Historical Drug Rebate files will be available to authorized users for a period of twelve (12) months, at which time they will be removed and will no longer be available.
- E-Delivery letter retention will be approximately six (6) to twelve (12) months, at which time they will be removed and will no longer be available.
- 1099 file retention will be approximately three (3) years, at which time they will be removed and will no longer be available.

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

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

Files are listed in order of the date they become available.

Current Files Available for Download			
File Name	Title	Date Available	Date Downloaded
004025250_TPL-0600-M_1344145_411127_20250421.pdf		04/21/2025	

New to E-Delivery – Third Party Liability (TPL) Audit Letters and Reports: Provider Bulletin [25-21](#)

- To access TPL Audit Letters and Reports:
 - Providers will receive an email when a new letter(s) has been posted.
 - To access the letter(s), providers will need to log into the Secure Web Portal.
 - Once you log in, in the top right section there is the “Trade Files” tab > “Download” tab > select Transaction Type “E-Delivery” > “Search” > the File name for TPL Audit Letters and Reports will always have “TPL” in the file name
 - The Audit Letters and Reports will be split into TPL Audit Report or TPL Crossover Audit Rpt

Current Files Available for Download			
File Name	Title	Date Available	Date Downloaded
004025250_TPL-0600-M_1344145_411127_20250421.pdf		04/21/2025	

Current Files Available for Download				
File Name	Original File Name	Transaction Type	Date Available	Date Downloaded
2435198_0_9041261A_TPLAUDITXBATCH_0_004236148.txt	TPLX_004236148.txt	TPL Crossover Audit Rpt	03/28/2025	

- To access E-Delivery Letters and Reports, information on accessing the Secure Web Portal, and Secure Web Portal access, please refer to Provider Bulletin [19-15](#).

New to E-Delivery – Third Party Liability (TPL) Audit Letters and Reports: Provider Bulletin 25-21

- TPL Audit Letter Sample:

Gainwell Technologies
P.O. Box 2991
Hartford, CT 06104

DD/MM/YYYY
Provider ID: 999999999

Provider Name
Address 1
Address 2
City, State, Zip

Dear Connecticut Medical Assistance Program Provider:

You have been randomly selected to participate in a Department of Social Services (DSS) third party liability audit. As described in your provider manual, you are not required to provide a copy of other insurance payment, denial documents or Medicare denials when submitting a claim. However, you are required to maintain a copy of these and provide them upon request.

Gainwell Technologies
P.O. Box 2991
Hartford, CT 06104

DD/MM/YYYY
Provider ID: 999999999

Provider Name
Address 1
Address 2
City, State, Zip

Dear Connecticut Medical Assistance Program Provider:

You have been randomly selected to participate in a Department of Social Services (DSS) third party liability audit. As described in your provider manual, you are not required to provide a copy of other insurance payment, denial documents or Medicare denials when submitting a claim. However, you are required to maintain a copy of these and provide them upon request.

If you have access to a secure Web portal account, you now have access to functionality to download a copy of the report that identifies claims recently submitted where it is indicated that other insurance made a payment, other insurance denied the claim, or Medicare denied the claim. Otherwise, attached is a copy of that report. To respond to this audit, please send copies of the other insurance Explanation of Benefits (EOB) or Explanation of Medicare Benefits (EOMB) that correspond to each claim on the report. Attach these EOBs/EOMBs to a copy of the report listing all the claims. Mail this information to:

Gainwell Technologies
P.O. Box 2981
Hartford, CT 06104

This information must reach Gainwell Technologies within thirty (30) days of the postmark date of this notification. Providers must respond to this audit request. If the information is not received, or if the EOB/EOMB does not support the claim as submitted, the claim(s) will be recouped. The recouped claims will appear on a future Connecticut Medical Assistance Program Remittance Advice (RA) and will have EOB 8202 'Claim has been recouped due to a TPL failure' posted to the claim.

If you have a claim recouped for this reason, you may resubmit the claim electronically or via the secure web portal. However, please be advised that the claim may be selected for a future audit. At that time, you will be required to resubmit the appropriate EOB or EOMB.

If Medicare makes a payment on the claim, the claim should cross to Medicaid automatically for processing. For post-payment audit purposes, providers should retain the Medicare EOMB showing the payment. If you have any questions about the audit process, please call the Provider Assistance Center at 1-800-842-8440.

Sincerely,
Gainwell Technologies Claims Operations Audit Unit

New to E-Delivery – Third Party Liability (TPL) Audit Letters and Reports: Provider Bulletin 25-21

- TPL Crossover Claims Audit Letter Sample:

Gainwell Technologies
P.O. Box 2991
Hartford, CT 06104

Provider Name
Address 1
Address 2
City, State, Zip

Dear Connecticut Medical Assistance Program Provider:

You have been randomly selected to participate in a Department of Social Services (DSS) audit on Medicare crossover co-insurance and deductible claim payments that were recently submitted electronically. To facilitate ease of claim submission, electronic claims do not require attachments for crossover claims billed for coinsurance or deductible payments. However, you are required to maintain a copy of these and provide them upon request.

MM/DD/YYYY
Provider ID: 999999999

Gainwell Technologies
P.O. Box 2991
Hartford, CT 06104

Provider Name
Address 1
Address 2
City, State, Zip

Dear Connecticut Medical Assistance Program Provider:

You have been randomly selected to participate in a Department of Social Services (DSS) audit on Medicare crossover co-insurance and deductible claim payments that were recently submitted electronically. To facilitate ease of claim submission, electronic claims do not require attachments for crossover claims billed for coinsurance or deductible payments. However, you are required to maintain a copy of these and provide them upon request.

If you have access to a secure Web portal account, you now have access to functionality to download a copy of the report that identifies a sample of the claims that you submitted electronically to receive co-insurance or deductible payments. Otherwise, attached is a copy of that report. To respond to this audit, please send copies of the Explanation of Medicare Benefits (EOMB) that correspond to each claim on the report. Attach these EOMBs to a copy of the report listing all the claims. Mail this information to:

Gainwell Technologies
P.O. Box 2981
Hartford, CT 06104

This information must reach Gainwell Technologies within thirty (30) days of the postmark date of this notification. Providers must respond to this audit request. If the information is not received, or if the EOB/EOMB does not support the claim as submitted, the claim(s) will be recouped. The recouped claims will appear on a future Connecticut Medical Assistance Program Remittance Advice (RA) and will have EOB 8202 'Claim has been recouped due to a TPL failure' posted to the claim.

If you have a claim recouped for this reason, you may resubmit the claim electronically or via the secure web portal. However, please be advised that the claim may be selected for a future audit. At that time, you will be required to resubmit the appropriate EOB or EOMB.

If Medicare makes a payment on the claim, the claim should cross to Medicaid automatically for processing. For post-payment audit purposes, providers should retain the Medicare EOMB showing the payment.

If you have any questions about the audit process, please call the Provider Assistance Center at 1-800-842-8440.

Sincerely,
Gainwell Technologies Claims Operations Audit Unit

MM/DD/YYYY
Provider ID: 999999999

Re-enrollment Web Portal Overview

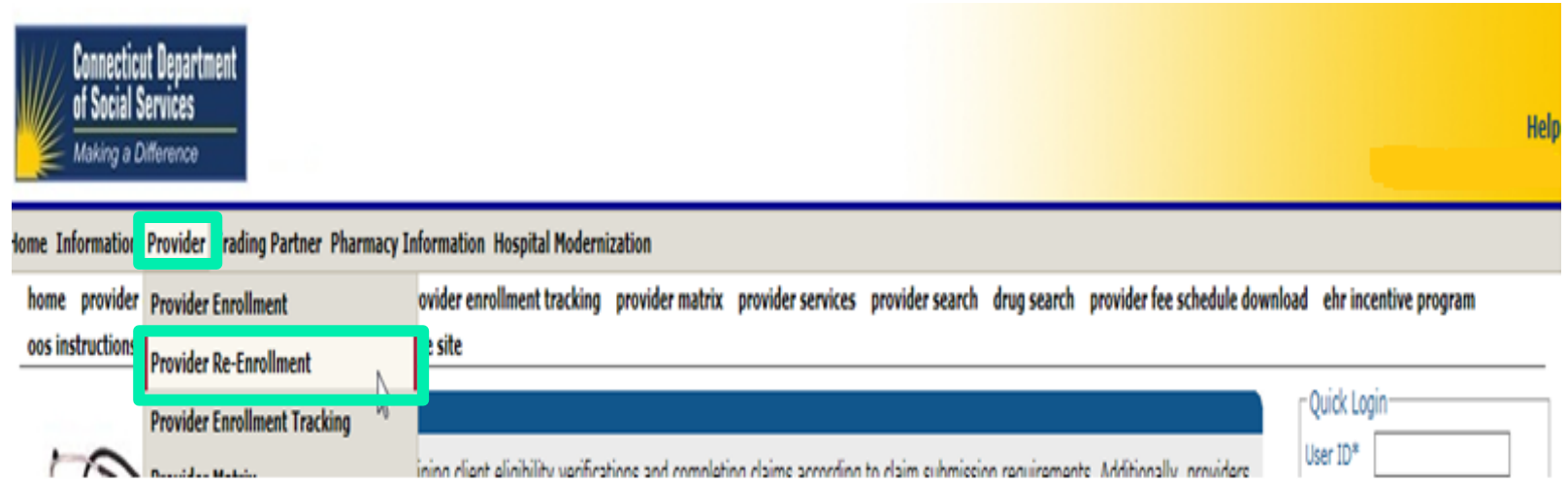
www.ctdssmap.com



Re-enrollments

The Department of Social Services requires providers to re-enroll online. Hospitals enroll every 2 years.

- A majority of the required information is automatically populated based on the information currently stored in the CMAP for the provider.
- Online re-enrollment cannot be initialized until an Application Tracking Number (ATN) is received from the Gainwell Technologies Provider Enrollment Unit. Letters are sent 6 months prior to the due date.
- It can take time for an enrollment to be completed. If it is not completed by the due date, claims will not be paid.



Providers with Secure Web portal access can view their re-enrollment due date on the Home page of their Secure Web portal once logged in! This enhancement allows providers to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Re-Enrollment


Home Information Provider Trading Partner Pharmacy Information Hospital Modernization Electronic Visit Verification Claims Eligibility Prior Authorization Hospice Trade Files MAPIR Messages

Account

home account home account maintenance account setup change password clerk maintenance demographic maintenance reset password log out

Your password expires in 60 day(s) on 00/00/0000 at 00:00 [Change Password](#)

Welcome, [Provider Account User ID](#)
Provider ID [Enrollment NPI or AVRS](#)

Reenrollment Due Date: **08/12/2024** 
Zip Code: 06226 - 3606

Your R.A.s, or 835 transactions, are being sent to:
Your download page in the Trade Files menu option.

Quick Link

- Check E-messages
- Claim Status Inquiry
- Client Eligibility Verification
- Prior Authorization Inquiry
- Download Remittance Advices
- ACA Ordering/Prescribing/Referring Provider List

Email Subscription

- Register/Update Email Subscription

Please Note: Failure to submit a timely Medicaid provider re-enrollment application will result in provider disenrollment from the Medicaid program. Each re-enrollment application must be finalized by DSS before the re-enrollment process is completed. If disenrolled the provider will not receive Medicaid reimbursement for dates of service beyond the re-enrollment due date, will be unable to request new Prior Authorizations (PAs), and will not be able to add client information to the Sandata System (Autism, ABI, CHC, CFC, Mental Health, PCA Waiver Services and Home Health Services).

Re-enrollments on average take 4 to 8 weeks so please start your re-enrollment early enough to make sure it is completed by the due date.

Re-enrollments

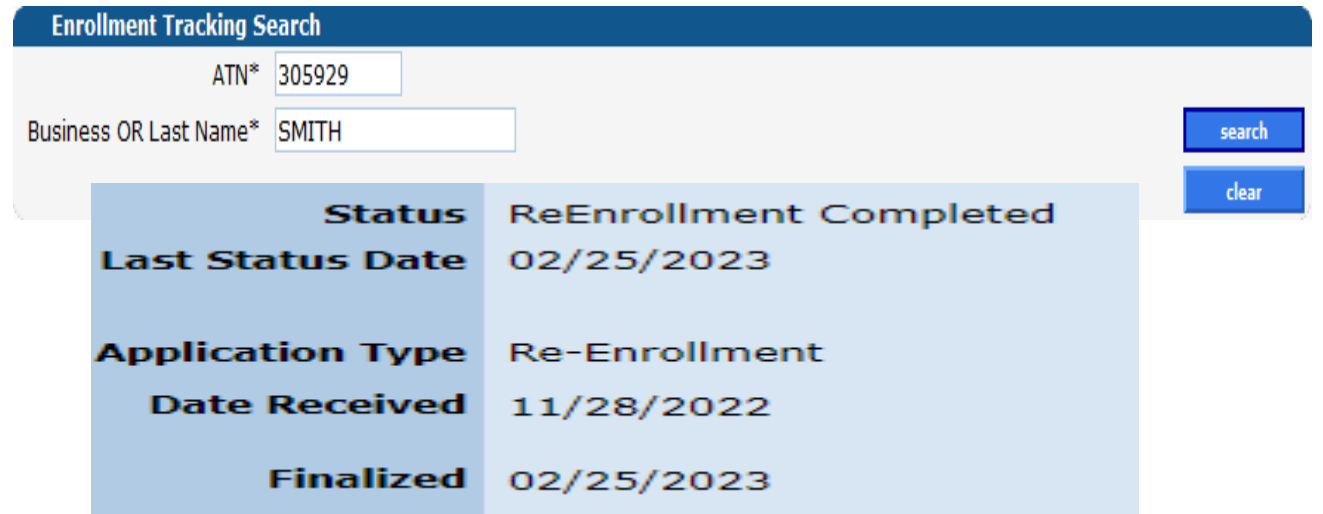
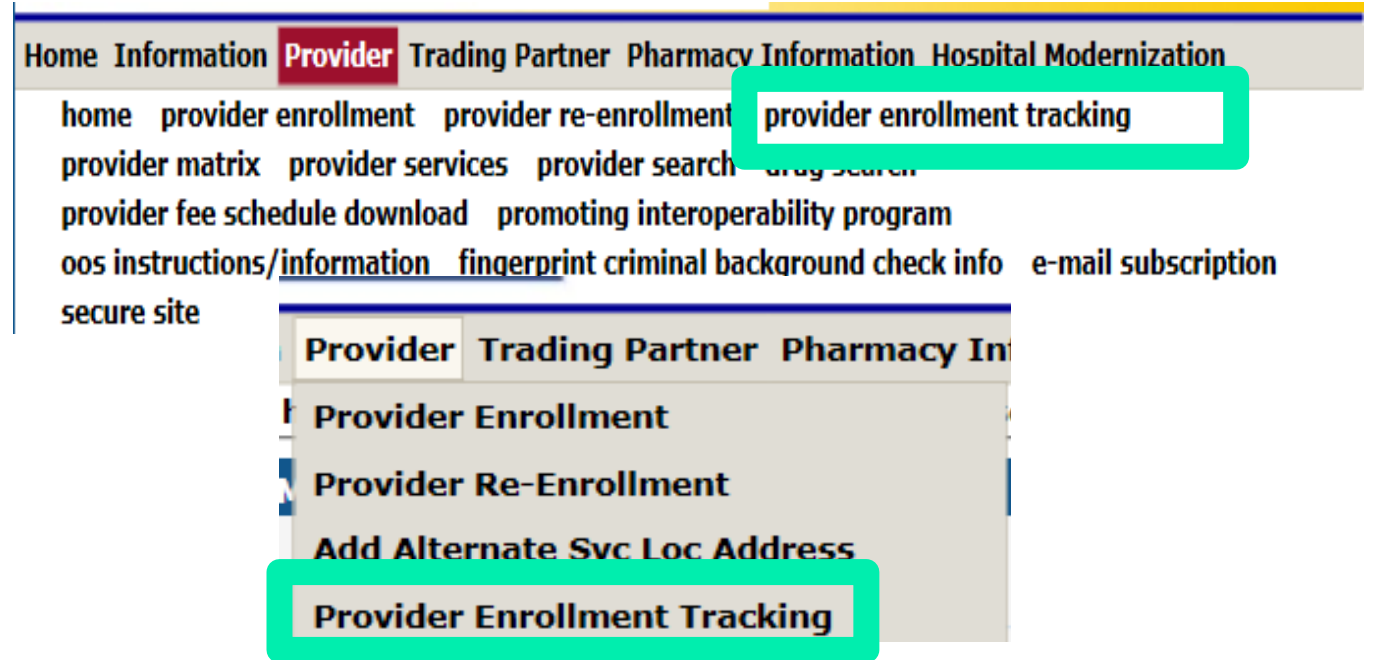
- It is imperative that providers successfully complete the re-enrollment application as quickly as possible upon receipt of their notice.
- **Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from CMAP.**
- Providers who are dis-enrolled will not be able to do the following until re-enrollment is completed:
 - Receive Prior Authorization
 - Bill or receive payment for services rendered
- Reinstatement of contracts w/out a finalized application violates ACA policies
- Re-enrollment due dates are published monthly in the Hospital Important Message:

The following hospitals have re-enrollment due dates coming up in the next 6 months:

- Johnson Memorial Hospital, Inc - Outpatient 1/15/2026
- Johnson Memorial Hospital, Inc - Inpatient 1/15/2026
- Gaylord Hospital, Inc - Outpatient 4/22/2026

Re-enrollments

- To check the status of a re-enrollment application from www.ctdssmap.com, select Provider Enrollment Tracking from either the Provider submenu or the Provider drop-down menu
- Enter your ATN and Business or Last Name and click search
- In this example DSS has reviewed and approved the application effective 02/25/2023.



Web Claims Overview



Web Claim Submission

- **Revenue Code – Hospitals can use the Provider Type and Specialty to Revenue Center Code (RCC) Crosswalk on the Hospital Modernization page on the www.ctdssmap.com Web site to view the appropriate payable RCCs as limited by their scope of practice and Department policy.**
 - If the hospitals bill with an inappropriate RCC that detail will deny with EOB code 4151 “Billing Provider Not Authorized to Bill for Submitted Service for Client”.
- Please refer to the Provider Type and Specialty to Revenue Center Code Crosswalk to determine which RCCs can be used for billing.
- Provider Manual Chapter 8 contains information on CPT/HCPCS to RCC restrictions that needs to be used for billing.
- **HCPCS – Refer to CMAP Addendum B on the hospital modernization page for a list of HCPCS/CPT.**
- **Modifiers – A list of the modifiers that could impact your payment on your claims has been added to the Hospital Provider Manual chapter 8 “Provider Specific Claims Submission Instructions” found on the www.ctdssmap.com Web site. It is not a full list of modifiers that can be used on your claim, you should refer to the CMS Web site www.cms.gov for an entire list of modifiers.**

Web Claim Submission

To submit an institutional claim using the ctdssmap.com secure site, click on “Claims” on the main menu and then from the drop-down menu select “Institutional.” Once you do that you will need to select your claim type to start your claim.

The screenshot displays the Connecticut Department of Social Services web portal. At the top left is the logo with the text "Connecticut Department of Social Services" and "Making a Difference". The main navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, and Prior Authorization. The "Claims" link is active, and a dropdown menu is open, showing options for Claim Inquiry, Professional, Institutional (highlighted with a red box), and Dental. Below the navigation bar, a user is logged in as PTOM123. A second navigation bar shows links for home, claim inquiry, professional, institutional (highlighted with a red box), dental, and claim histor. Below this is a "Quick Links" section with three links: Internet Claims Submission FAQ, Instructions for submitting Institutional claims, and Claim Resolution Guide. The "Institutional Claim" section is active, showing a form with fields for Claim Type*, ICN, Provider ID, AVRS ID, and Type Of Bill*. A dropdown menu for Claim Type* is open, listing options: A - Institutional Xover Claims, C - Outpatient Xover Claims, H - Home Health Claims, I - Inpatient Claims, L - Long Term Care Claims, and O - Outpatient Claims.

Institutional Claim	
Claim Type*	A - Institutional Xover Claims
ICN	C - Outpatient Xover Claims
Provider ID	H - Home Health Claims
AVRS ID	I - Inpatient Claims
Type Of Bill*	L - Long Term Care Claims
	O - Outpatient Claims

Web Claim Submission

- Diagnosis and Detail Panels on an inpatient claim.

Diagnosis	Cause of Injury	Reason For Visit	Condition	Surgical Procedure	Occurrence/Span
*** No rows found ***					
Code Set <input type="text" value="ICD 10"/> [v]					
Principal	<input type="text"/>	[Search]	Admitting	<input type="text"/>	[Search]
Other 1	<input type="text"/>	[Search]	Other 2	<input type="text"/>	[Search]
Other 2	<input type="text"/>	[Search]	Other 3	<input type="text"/>	[Search]
Other 3	<input type="text"/>	[Search]	Other 4	<input type="text"/>	[Search]
Other 4	<input type="text"/>	[Search]	Other 5	<input type="text"/>	[Search]
Other 5	<input type="text"/>	[Search]	Other 6	<input type="text"/>	[Search]
Other 6	<input type="text"/>	[Search]	Other 7	<input type="text"/>	[Search]
Other 7	<input type="text"/>	[Search]			
<input type="button" value="add more"/>					

Detail									
Item	From DOS	To DOS	Revenue Code	HCPCS/Rates	Units	Charges	Status	Allowed Amount	
A	1				1.00	\$0.00		\$0.00	
Type data below for new record.									
Item	<input type="text" value="1"/>		Revenue Code*	<input type="text"/>	[Search]				
From DOS*	<input type="text"/>		HCPCS/Rates	<input type="text"/>	[Search]				
To DOS*	<input type="text"/>		Modifiers	<input type="text"/>	[Search]	<input type="text"/>	[Search]	<input type="text"/>	[Search]
Units*	<input type="text" value="1.00"/>		Units Of Measurement	<input type="text"/>	[v]				
Charges*	<input type="text" value="\$0.00"/>		Status	<input type="text"/>	[v]				
			Allowed Amount	<input type="text" value="\$0.00"/>					
			CoPay Amount	<input type="text" value="\$0.00"/>					
			TPL Amount	<input type="text" value="\$0.00"/>					
			Referring Provider	<input type="text"/>			[Search]		
<input type="button" value="delete"/> <input type="button" value="add"/>									

Web Claim Submission

- Once all information is entered on your claim, hit submit to submit your claim to Gainwell Technologies. A response from Gainwell Technologies is immediate and will provide APC or DRG Information depending on your claim type.

Claim Status Information

Claim Status

Claim Status Information

Claim Status	PAID
Claim ICN	221-██████████
Paid Date	05/09/2016
Paid Amount	\$2,250.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

EOB Information		
Detail Number	Code	Description
0	0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX
1	8620	APC PACKAGED SERVICE
2	8621	APC PRICING APPLIED

APC Information									
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount	
1	N		17.1.0	0	0%	\$0.00	\$0.00	\$0.00	
2	J2	08011	17.1.0	1	100%	\$2,701.86	\$0.00	\$2,701.86	

Web Claim Submission

- Explanation of Benefits (EOB) information – Explains how the claim or service pays, denies or suspends.
- Chapter 12 of the Provider Manual may be referenced EOB codes

Claim Status Information	
Claim Status	PAID
Claim ICN	2216 [REDACTED]
Paid Date	05/09/2016
Paid Amount	\$2,250.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

EOB Information		
Detail Number	Code	Description
0	0618	BILLING PROVIDER ADDRESS CANNOT CONTAIN PO BOX
1	8620	APC PACKAGED SERVICE
2	8621	APC PRICING APPLIED

APC Information									
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount	
1	N		17.1.0	0	0%	\$0.00	\$0.00	\$0.00	
2	J2	08011	17.1.0	1	100%	\$2,701.86	\$0.00	\$2,701.86	

cancel
adjust
void
copy claim
new claim

Web Claim Inquiry

What can I do with these claims?

Paid claims allow you to:

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
cancel	Cancel any alterations you have made

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
------------------	--------------------------

Web Claim Adjustments

After you submit a claim if you need to adjust a paid claim, you can perform the following steps to adjust your claim:

- Select Claim Inquiry
- Perform search to find your claim and click the search button.
- Once the claim is retrieved, make any necessary changes to the claim.
- Click the adjust button at the bottom of the claim page.



The following are web claim adjustments that can be submitted through the secure Web site www.ctdssmap.com.

- Claims that are not past timely filing.
- Claims past timely filing that will pay the same or less than the original claim without the services being modified.
- Claims that do not have an ICN# that begins with a 12 or 13.

Claims Processing/Submission Information: Timely Filing Limit

It is the provider's responsibility to ensure that all claims for services provided to clients are submitted within 365 days from the actual date of service.

Situations that allow the timely filing limit (1 year) to be bypassed:

- Client eligibility has been added or updated where the claim date of service is within the effective dates of the update and the claim submission date is within range of the update
- Medicare and/or Other Insurance Payment:
 - TPL or Medicare paid amount is greater than \$0.00 and the paid date is within 366 days of the claim submission date
 - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny

Claims Processing/Submission Information Conditions that Waive the Timely Filing Limit

Situations that allow the timely filing limit to be bypassed

- Prior claim history:
 - When a claim in history with the same Client, Provider, Billed Amount, detail From and Through dates of service, and Revenue Center Code or Procedure Code where the claim submission date is within 365-day range of the previous claim's Remittance Advice date and the previous claim did not deny for timely filing



Prior Authorization



Prior Authorization

Prior Authorization Requirements

- HUSKY Health Program benefits and authorization requirements for non-behavioral health services can be found on the HUSKY Health Web site at www.ct.gov/husky, under “For Providers” under “Medical Management” then select “Benefit Grids”.
- For Behavioral Health, Hospitals should refer to the Connecticut Behavioral Health Partnership Web site at www.CTBHP.com > For Providers > Log in or Register to enter Authorization Requests

Prior Authorization Reminder for Advanced Imaging Services

- Hospitals must confirm that a valid, approved authorization is on file for the appropriate Healthcare Common Procedure Coding System (HCPCS) “C” code instead of the Current Procedural Terminology (CPT) code. For a list of corresponding codes, the providers can refer to provider bulletin [PB17-27](#) “Reminder About Use of “C” Codes for Certain Advanced Imaging Services.”
- If the authorization on file does not have a “C” code, the outpatient claim will deny, and the hospital would need to contact Community Health Network of CT (CHNCT) at [1-800-440-5071](tel:1-800-440-5071) to correct the PA.

Prior Authorization

Prior Authorizations are requested through the appropriate Administrative Service Organizations (ASOs):

- Community Health Network of Connecticut (CHNCT) at [1-800-440-5071](tel:1-800-440-5071)
- Carelon Behavioral Health CT Behavioral Health Partnership (CTBHP) at [1-877-552-8247](tel:1-877-552-8247) or www.ctbhp.com

Prior authorizations are required for all nonmaternity, non-emergent admissions.

Emergency Admits: Providers must notify CHNCT (for admissions that are medical in nature) or CTBHP (for admissions that relate to behavioral health) within 2 business days. Notifications greater than 2 days from the admission date are subject to denial of services.

Maternity Admits: Effective 11/1/2022, notification of deliveries occurring at in-state and border hospitals is NOT needed. Please note, there is an Important Message for [Inpatient Delivery Stays and Prior Authorization \(PA\) Reminder](#) which covers the criterion for primary diagnosis codes that bypass the Prior Authorization requirement for delivery stays.

ICU Admissions: All requests for admissions to ICU must go to CHNCT.

For admissions where the admitting diagnosis is alcohol withdrawal delirium (ICD 10 codes F10.121, F10.221, F10.231, F10.921), prior authorization requests must be submitted to the CT Behavioral Health Partnership (CTBHP) except when the member is admitted to an intensive care unit (ICU). In these instances, prior authorization requests must be submitted to CHNCT.

Decisions regarding approval or denial of elective inpatient admissions must be rendered within 5 business days.

Prior Authorization

Overlapping Inpatient Authorization

- If the hospital received 2 inpatient behavioral health prior authorization for one inpatient stay and the hospital is billing the entire stay under one inpatient claim, this could cause the incorrect amount of days to be paid on the claim.
- If the inpatient claim pays incorrectly the hospital should void the inpatient claims and contact Carelon Behavioral Health (CTBHP) to request an update to the PA to match the inpatient claim. Carelon Behavioral Health will update the PA once the units are decremented from the PA.

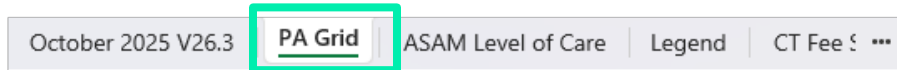
Inpatient Admit Change from Medical to Psychiatric

- When a HUSKY client is admitted and the primary reason for the admission is medical in nature, and then the client is subsequently transferred to a psychiatric unit, the hospital should administratively discharge (Patient Status 65) the client from medical and re-admit the client to behavioral health.
 - If the hospital does not submit with the correct patient status, the initial inpatient claim might not identify as a medical admission and deny for prior authorization due to two separate prior authorizations and two inpatient claims being billed that will overlap due to discharge date and admit date being the same.

Prior Authorization

- The Outpatient Hospital PA grid can be accessed 2 ways from the Hospital Modernization Page:

- The PA Grid is available and part of the Excel Version of the CMAP Addendum B



- The PA Grid is available www.ctdssmap.com Web site by selecting the “Hospital Modernization” Web page. It is located under “Important Messages – Connecticut Hospital Modernization”.

Important Messages - Connecticut Hospital Modernization

[Hospital Monthly Important Message \(Posted 11/17/25\)](#)

[CMAP Addendum B \(excel\)](#)

[Attention All Inpatient Hospital Providers: 3M Grouper and DRG Calculator for ICD-10-CM Updates \(Posted 10/29/25\)](#)

[Attention Outpatient Hospitals: CMAP ADDENDUM B Updated \(October 29, 2025\) \(Posted 10/28/25\)](#)

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

[Prior Authorization Grid for Outpatient Hospitals](#)

[Provider Type and Specialty to Revenue Center Code Crosswalk](#)

RCC Code or procedure	Prior Authorization Conditions	Notes
Rehabilitation - PT, OT, SLP		
424, 434, 444	More than one evaluation per calendar year per provider.	
421, 423, 431, 433, 441, 443	Greater than two visits per calendar week per provider.	
421, 431, 441	Greater than nine visits per calendar year for certain diagnosis per provider, per service	<p style="text-align: center;">722.xx-724.xx</p> <p>M43.21-M43.28, M43.36, M46.41-M46.48, M48.01-M48.08, M50.01-M53.1, M53.2x8, M53.2X9, M53.3-M54.9, M62.830, M96.1, M99.20-M99.79, 783.X, R62.0-R63.6</p> <p>All mental disorders including diagnoses relating to mental retardation and specific delays in development. For a list of equivalent ICD-10 CM Diagnosis codes, please visit The DSS Fee Schedule Instructions located at www.ctdssmap.com → Provider → Provider Fee Schedule Download → Provider Fee Schedule Instructions (table 15).</p>

CMAP Addendum B



CMAP Addendum B

- CT Medicaid’s Outpatient Prospective Payment System (OPPS) processing is based on the CMAP version of Addendum B which is derived from Medicare’s Addendum B. The differences between the CMAP version of Addendum B and the Medicare version of Addendum B primarily involve detail service coverage and pricing methodology.

Please refer to CMAP’s Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment

The CMAP Addendum B in an Excel format can be found on the “Hospital Modernization” page on the Web site www.ctdssmap.com under Important Messages – Connecticut Hospital Modernization.

The screenshot shows the top navigation bar of the CMAP website with the following tabs: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization (highlighted in red), Telehealth Information, and Electronic Visit Verification.

Below the navigation bar, there are two links: [Inpatient Payment Methodology](#) and [Outpatient Payment Methodology](#).

The **DRG IMPLEMENTATION** section contains the following text:

The All Patient Refined-Diagnostic Related Group (APR DRG) inpatient payment methodology was implemented for claims with a date of admission on and after January 1, 2015. DRG pricing now applies to acute care hospital inpatient claims with the exception of chronic disease hospitals, psychiatric hospitals and free-standing birth centers.

Providers should reference all materials surrounding this inpatient payment methodology including Frequently Asked Questions (FAQs), Bulletins, and Important Messages. Providers should also continue to visit this Web page for detailed information and continuous updates regarding APR DRG and the upcoming changes to the outpatient payment methodology.

Please continue to email questions or concerns in reference to the modernization of the Hospital reimbursement system to <mailto:ctxixhosppay@gainwelltechnologies.com>

On the right side of the page, there is a **Quick Login** form with the following fields:

- User ID*
- Password*
-
- [Logging in for the first time?](#)
- [Forgot your password?](#)

Below the login form is a **DRG Calculator** section with a link to [DRG Calculator](#).

At the bottom right is a **DSS Links** section with the following links:

- [DSS Reimbursement Home Page](#)
- [Decision Log](#)

CMAP Addendum B :

CMAP Addendum B October 1, 2025

CMAP Addendum B - OPSS Payment Type by Procedure Code

Effective October 1, 2025

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
0001F	Heart failure composite	E1				No		
0001U	Rbc dna hea 35 ag 11 bld grp	A				No		
0002M	Liver dis 10 assays w/ash	Q4				No		
0002U	Onc clrc 3 ur metab alg plp	Q4				No		
0003M	Liver dis 10 assays w/nash	Q4				No		
0003U	Onc ovar 5 prtn ser alg scor	Q4				No		
0004M	Scoliosis dna alys	A				No		
0005F	Osteoarthritis composite	E1				No		
0005U	Onco prst8 3 gene ur alg	Q4				No		
0006M	Onc hep gene risk classifier	A				No		
0007M	Onc gastro 51 gene nomogram	A				No		
0007U	Rx test prsmv ur w/def conf	Q4				No		
0008U	Hpylori detcj abx rstnc dna	A				No		
0009U	Onc brst ca erbb2 amp/nonamp	Q4				No		
00100	Anesth salivary gland	N				APC		
00102	Anesth repair of cleft lip	N				APC		
00103	Anesth blepharoplasty	N				APC		
00104	Anesth electroshock	N				APC		
0010U	Nfct ds strn typ whl gen seq	Q4				No		
0011M	Onc prst8 ca mrna 12 gen alg	A				No		
0011U	Rx mntr lc-ms/ms oral fluid	Q4				No		
00120	Anesth ear surgery	N				APC		
00124	Anesth ear exam	N				APC		
00126	Anesth tympanotomy	N				APC		
0012F	Cap bacterial assess	E1				No		
0012M	Onc mrna 5 gen rsk urthl ca	A				No		
0013M	Onc mrna 5 gen recr urthl ca	A				No		
00140	Anesth procedures on eye	N				APC		
00142	Anesth lens surgery	N				APC		
00144	Anesth corneal transplant	N				APC		
00145	Anesth vitreoretinal surg	N				APC		
00147	Anesth iridectomy	N				APC		
00148	Anesth eye exam	N				APC		

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate
0001F	Heart failure composite	E1			
0001U	Rbc dna hea 35 ag 11 bld grp	A			
0002M	Liver dis 10 assays w/ash	Q4			
0002U	Onc clrc 3 ur metab alg plp	Q4			
0003M	Liver dis 10 assays w/nash	Q4			
0003U	Onc ovar 5 prtn ser alg scor	Q4			
0004M	Scoliosis dna alys	A			
0005F	Osteoarthritis composite	E1			
0005U	Onco prst8 3 gene ur alg	Q4			
0006M	Onc hep gene risk classifier	A			
0007M	Onc gastro 51 gene nomogram	A			
0007U	Rx test prsmv ur w/def conf	Q4			
0008U	Hpylori detcj abx rstnc dna	A			
0009U	Onc brst ca erbb2 amp/nonam	Q4			
00100	Anesth salivary gland	N			
00102	Anesth repair of cleft lip	N			
00103	Anesth blepharoplasty	N			
00104	Anesth electroshock	N			
0010U	Nfct ds strn typ whl gen seq	Q4			
0011M	Onc prst8 ca mrna 12 gen alg	A			
0011U	Rx mntr lc-ms/ms oral fluid	Q4			
00120	Anesth ear surgery	N			
00124	Anesth ear exam	N			
00126	Anesth tympanotomy	N			
0012F	Cap bacterial assess	E1			
0012M	Onc mrna 5 gen rsk urthl ca	A			
0013M	Onc mrna 5 gen recr urthl ca	A			
00140	Anesth procedures on eye	N			
00142	Anesth lens surgery	N			
00144	Anesth corneal transplant	N			
00145	Anesth vitreoretinal surg	N			
00147	Anesth iridectomy	N			
00148	Anesth eye exam	N			
0014F	Comp preop assess cat surg	E1			
0015F	Melan follow-up complete	E1			
0015M	Adml cortcl tum bchm asy 25	Q4			
00160	Anesth nose/sinus surgery	N			
00162	Anesth nose/sinus suraerv	N			

October 2025 V26.3

CMAP Addendum B

CMAP Addendum B - Legend Tab

Field Label	Field Description	Valid Values
Procedure Code	Five digit CPT or HCPCS code.	See CPT or HCPCS manual.
Short Descriptor	Short description for the procedure code field.	See CPT or HCPCS manual.
Status Indicator	The status indicator assigned by CMS. If the Payment Type value is APC, the status indicator will process according to CMS/Medicare guidelines.	See Medicare Addendum D1.
APC[†]	The APC group assigned by CMS for that procedure code.	See Medicare Addendum B for APC group and Medicare Addendum A for APC descriptions.
Relative Weight[†]	The relative weight assigned by CMS for the APC group assigned.	See Medicare Addendum A or Addendum B.
Payment Rate[†]	For procedure codes with a payment type of APC-PR and PR this field is the rate that the procedure code will be reimbursed. For procedure codes with payment type of SURG, this field indicates MP for manual priced or the rate the procedure code will be reimbursed.	
Payment Type	Identifies the payment method used by DSS to determine if and how the procedure code will be reimbursed.	<p>APC — Reimbursed using APC methodology.</p> <p>APC-FS — APC (Packaged) except when billed without a APC payable service, then reimbursed based on the Lab fee schedule.</p> <p>APC-PR — APC reimbursed based on payment rate.</p> <p>FS — Reimbursed based on the CT fee schedule listed in the CT Fee Schedule field.</p> <p>FS-CMAP — Reimbursed based on the CT fee schedule listed in CT Fee Schedule field. These codes are not on Medicare's version of Addendum B.</p> <p>MP — Manually priced.</p> <p>No — Not covered by CT Medicaid (payment denied).</p> <p>NP — Service only reimbursed when non-patient and will pay off LAB fee schedule.</p> <p>PR — Reimbursed based on amount in Payment Rate field.</p> <p>RCC — Reimbursed based on revenue center code pricing.</p> <p>SURG — Surgical procedures manually priced.</p>

CMAP Addendum B

CMAP Addendum B - Legend Tab Cont.

CT Fee Schedule	Identifies which fee schedule will be utilized for a given procedure code. Field is blank if service will not be paid using a fee schedule.	See CT Fee Schedule Legend.
Change	This field is only present on the Changes tab and indicates whether it is a changed or a new record. Discontinued codes have been removed.	New - The procedure code was added by CMS. G K - The procedure code has a status indicator G or K or K1 rate change. X - A change has been made to the procedure code or status indicator. Blank - No change

CMAP Addendum B - CT Fee Schedule Legend Tab

Fee Schedule Label	Fee Schedule Description
Clinic/OP - BH if RCC = 900	Clinic and Outpatient-Behavioral Health fee schedule except for 90867-90869 which pay the rate posted on the Addendum B, only if it is billed with a Behavioral Health RCC 900. All other instances are not covered.
Clinic/OP - BH if RCC = 905	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 905. All other instances are not covered.
Clinic/OP - BH if RCC = 906	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 906. All other instances are not covered.
Clinic/OP - BH if RCC = 907	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 907. All other instances are not covered.
Clinic/OP - BH if RCC = 913	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 913. All other instances are not covered.
Clinic/OP - BH if RCC = 914	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 914. All other instances are not covered.
Clinic/OP - BH if RCC = 915	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 915. All other instances are not covered.
Clinic/OP - BH if RCC = 916	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 916. All other instances are not covered.
Clinic/OP - BH if RCC = 918	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 918. All other instances are not covered.
Clinic/OP - BH if RCC = 919	Clinic and Outpatient-Behavioral Health fee schedule, only if it is billed with a Behavioral Health RCC 919. All other instances are not covered.
Dietitian/Nutritionist	Dietitian/Nutritionist
FP/OFOUT	For 340B providers use the Clinic-Family Planning fee schedule. For all others providers use the Physician Office and Outpatient fee schedule.
LAB	Lab fee schedule.
MEDS - DME	MEDS-DME fee schedule.
MEDS - Hearing Aid	MEDS-Hearing Aid/Prosthetic Eye fee schedule.
MEDS - Prosthetic/Orthotic	MEDS - Prosthetic/Orthotic

CMAP Addendum B

CMAP Addendum B - CT Fee Schedule Legend Tab Cont.

Fee Schedule Label	Fee Schedule Description
FP/OFOUT	For 340B providers use the Clinic-Family Planning fee schedule. For all others providers use the Physician Office and Outpatient fee schedule.
LAB	Lab fee schedule.
MEDS - DME	MEDS-DME fee schedule.
MEDS - Hearing Aid	MEDS-Hearing Aid/Prosthetic Eye fee schedule.
MEDS - Prosthetic/Orthotic	MEDS - Prosthetic/Orthotic
NDCLOW	The National Average Drug Acquisition Cost (NADAC) established by the Centers for Medicare and Medicaid Services; when no NADAC is available for the specific drug then it is based on the lower amount between, The Affordable Care Act Federal Upper Limit (FUL); or Wholesale Acquisition Cost (WAC) plus zero (0) percent.
OFOUT	Physician Office and Outpatient fee schedule.
PHRAD	Physician Radiology fee schedule.
RCC 401	The procedure code must be billed with RCC 401 and will be reimbursed based on the rate on file for RCC 401 on the hospital outpatient flat fee schedule.
RCC 403	The procedure code must be billed with RCC 403 and will be reimbursed based on the rate on file for RCC 403 on the hospital outpatient flat fee schedule.
RCC 771	The procedure code must be billed with RCC 771 and will be reimbursed based on the rate on file for RCC 771 on the hospital outpatient flat fee schedule.
RCC 901	The procedure code must be billed with RCC 901 and will be reimbursed based on the rate on file for RCC 901 on the hospital outpatient flat fee schedule.
RCC 953	The procedure code must be billed with RCC 953 and will be reimbursed based on the rate on file for RCC 953 on the hospital outpatient flat fee schedule.
Therapy RCC	The procedure code must be billed with one of the appropriate therapy RCCs and will be reimbursed based on the rate on file for the RCC on the hospital outpatient flat fee schedule. (421,423,424,431,433,434,441,443,444)

CMAP Addendum B

Payment Type - APC

- If the payment type is APC Payment, it will be reimbursed using APC methodology.
- Example: Procedure code 99283 “Emergency dept visit”, payment type indicator “APC”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
99283	Emergency dept visit	J2	05023	2.7643	\$223.34	APC		

- APC Payment = (Provider Wage Adjusted Conversion Factor * units) * APC Relative Weight.
 - If the hospital’s wage adjusted conversion factor was \$85.00, the APC allowance would be $(\$85.00 \times 1) \times 2.7643 = \234.96 .

CMAP Addendum B

Payment Type - APC – FS

- Example: Procedure code 36415 “Routine Venipuncture”, payment type “APC-FS” and status indicator “Q4”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
36415	Routine venipuncture	Q4				APC-FS		
80047	Metabolic panel ionized ca	Q4				APC-FS		

- If the APC grouper returns the service as APC payable, this case will be reimbursed based on payment type “APC-FS” using the CT lab fee schedule.
- If the APC grouper returns a status indicator “N” the detail will be packaged and zero pay (no separate reimbursement).

CMAP Addendum B

Payment Type - NP – These services are only reimbursed when non-patient and will pay off LAB fee schedule.

- Example: Procedure code 80050 “General health panel” payment type “NP”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
80050	General health panel	E1				NP		
83992	Assay for phencyclidine	E1				NP		
85060	Blood smear interpretation	B				NP		
86910	Blood typing paternity test	E1				NP		
86911	Blood typing antigen system	E1				NP		

CMAP Addendum B

Status indicator is “Q1, Q2, Q3 or Q4” on CT Addendum B, but the APC grouper could return detail line with an “N” status.

- Q1 – STVX-Packaged Codes
- Q2 – T-Packaged Codes
- Q4 – Conditionally Packaged Laboratory Tests
 - If there is another procedure code on the outpatient claim that is APC payable, the APC grouper usually would return a status indicator of “N” and the detail will be packaged. The detail will zero pay.
 - Services are only reimbursed when a non-patient and will pay off LAB fee schedule.
- Q3 – Codes that could be paid through a composite APC
 - The procedure with SI “Q3” could pay with a different APC code from CMAP Addendum B.
- More information on Status Indicators can be found on www.cms.gov/status-indicators

CMAP Addendum B

- Procedure codes with status indicator “Q3”
- When payable separately from the APC payable procedure code on an outpatient claim will normally pay at the APC code list on the CMAP addendum B. If those procedures are billed with other procedures with status indicator “Q3” it could be paid through a composite APC code 08004-08008 which is not listed on CMAP Addendum B. **The APC payment would be based on the composite APC weight, not the APC listed on the CMAP Addendum B.**
- Example: Procedure code 70551 “MRI brain stem w/o dye”, payment indicator “APC” and status indicator “Q3”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
70551	Mri brain stem w/o dye	Q3	05523	2.8844	\$233.04	APC		

➤ APC grouper returns SI “S” and it will pay based on APC 05523 and relative weight 2.8844

APC Information								
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
1	S	05523	18.0.0	1	100%	\$238.29	\$0.00	\$238.29

CMAP Addendum B

- Example: Procedure code 70551 “MRI brain stem w/o dye”, billed with procedure code 72146 and both procedures on CMAP Addendum B state payment type “APC” and status indicator “Q3”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
70551	Mri brain stem w/o dye	Q3	05523	2.8844	\$233.04	APC		
72146	Mri chest spine w/o dye	Q3	05523	2.8844	\$233.04	APC		

- The claim goes through the APC grouper and 70551 status indicator is returned as SI “S” with composite APC 08007 and 72146 status indicator is “N” packaged.
- APC payment would be based on the composite APC code.
- Explanation of Benefit (EOB) code 0013 “Composite APC Applied” will set on that detail.

APC Information									
Detail Number	Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount	
1	S	08007	18.0.0	1	100%	\$581.98	\$0.00	\$581.98	
2	N		18.0.0	0	0%	\$0.00	\$0.00	\$0.00	

CMAP Addendum B

Comprehensive APC codes are listed on CMAP Addendum B.

Status Indicator “J1” could pay the APC code on the CMAP addendum B, but if it is billed with other services it can be paid through a comprehensive APC code which might be listed on CMAP Addendum B for another code.

- Example: Procedure code 28300 “Incision of heel bone”, payment indicator “APC” and status indicator “J1”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
28300	Incision of heel bone	J1	05114	74.0404	\$5,981.95	APC		

➤ J1 – Hospital Part B Services Paid through a Comprehensive APC.

➤ When billed by itself the APC grouper returns SI “J1” and it will pay based on APC 05114 and relative weight 74.0404.

CMAP Addendum B

- Example: Procedure code 28300 “Incision of heel bone”, payment indicator “APC” and status indicator “J1” is billed with procedure code 28238 “Revision of foot tendon”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
28238	Revision of foot tendon	J1	05114	74.0404	\$5,981.95	APC		
28300	Incision of heel bone	J1	05114	74.0404	\$5,981.95	APC		

- The claim goes through the APC grouper and 28300 status indicator is “J1” with comprehensive APC 05114 and 28238 status indicator is “N” packaged.
- APC payment would be based on the comprehensive APC code.

CMAP Addendum B

- Example: Procedure code 99284 “Emergency dept visit”, payment indicator “APC” and status indicator “J2” is billed with procedure code G0378 “Hospital observation per hr”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
99284	Emergency dept visit	J2	05024	4.3542	\$361.79	APC		
G0378	Hospital observation per hr	N				APC		

- The claim goes through the APC grouper and 99284 status indicator is “J2” with comprehensive APC 08011 and G0378 status indicator is “N” packaged.
- APC payment would be based on the comprehensive APC code 08011.
- Explanation of Benefit (EOB) code 0014 “Comprehensive APC Applied” will set on that detail.

Status Indicator	APC	Version	Discounting Factor	Discounting Percentage	Base Payment	Outlier Payment	Total Allowed Amount
J2	08011	20.0.0	1	100%	\$2,660.94	\$0.00	\$2,660.94
N		20.0.0	0	0%	\$0.00	\$0.00	\$0.00

CMAP Addendum B

Payment Type APC-PR – Line item paid based on CMS payment rate.

- Example: Procedure code C9158 “Inj, uzedy, 1mg”, payment type “APC-PR” and J1610 “Glucagon hydrochloride/1 mg.”

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
C9158	Inj, uzedy, 1 mg	G	09266		\$25.38	APC-PR		New
J1610	Glucagon hydrochloride/1 mg	K	09042		\$187.50	APC-PR		G K

- Status Indicator G “Drug Biological Pass Through” and K “Non-Pass Through Drugs and Biologicals”
 - If the procedure code payment type is APC-PR with a status indicator of G or K, it will be reimbursed based on the payment rate on CMAP Addendum B x the number of units up to the detail billed charges. We will pay lesser of billed charges versus the payment rate x units.

CMAP Addendum B

Payment Type – FS – Line item paid based on CT policy (CT fee schedule payment).

- Example: Procedure code 77062 “Breast tomosynthesis bi”, payment type “FS”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
77061	Breast tomosynthesis uni	E1				FS	PHRAD	
77062	Breast tomosynthesis bi	E1				FS	PHRAD	
77063	Breast tomosynthesis bi	A				FS	PHRAD	

- This procedure code would pay based on the Physician Radiology fee schedule.

Payment Type - No – Line item denied based on CT policy.

- Example: Procedure code 61796 “Srs cranial lesion simple”, payment type “No”.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
61796	Srs cranial lesion simple	B				No		
61797	Srs cran les simple addl	B				No		

CMAP Addendum B

Status Indicator N – Packaged

- Line-item details that return an “N” status indicator will be packaged, because the reimbursement for these items and/or services are included in the APC payment for another detail on the same date.
- The cost of the packaged services are allocated to the APC but are not paid separately. Some examples of packaged items are:
 - ancillary services;
 - implantable medical devices;
 - most clinical diagnostic laboratory tests; and
 - recovery room use.

Procedure Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	Payment Type	CT FEE SCHED	Change
A4206	1 cc sterile syringe&needle	N				APC		

CMAP Addendum B

Status Indicator and APC Relative Weights

- The relative weights used on the CMAP Addendum B are received from the Centers for Medicare & Medicaid Services (CMS) under Addendum A and Addendum B updates on the CMS Web site.
 - The hospital can use the following link to get to the site:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>
- Updates are made quarterly to the Hospital Modernization tab on the Medicaid Web site www.ctdssmap.com.

Provider Fee Schedule



Provider Fee Schedule

To view the hospital's fee schedule, from the Web site www.ctdssmap.com go to "Provider", then to "Provider Fee Schedule Download", then scroll down and click on "I Accept", then depending on the services you performed based on CMAP Addendum B and click on the CSV link.

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

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search **provider fee schedule download**
promoting interoperability program oos instructions/information fingerprint criminal background check info e-mail subscription secure site

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

Provider Fee Schedule Download

- Acquired Brain Injury Case Management [CSV](#)
- Acquired Brain Injury DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Fiduciary [CSV](#)
- Acquired Brain Injury II DOS Prior to 09/01/2016 [CSV](#)
- Acquired Brain Injury Service Provider [CSV](#)
- Ambulatory Detoxification [CSV](#)
- Autism Spectrum Disorder [CSV](#)
- Autism Waiver Fiscal Intermediary [CSV](#)
- Autism Waiver Service Provider [CSV](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)

Quick Link

- [Fee Schedule Quick Start](#)

Email Subscription

- [Register/Update Email Subscription](#)

Provider Fee Schedule

- 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](#)
- 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 [CSV](#)
- Natureopath [PDF](#)
- Optician/Eyeglasses [CSV](#)
- Personal Care Assistant [CSV](#)
- Physician Anesthesia [CSV](#)
- Physician Office and Outpt Services [CSV](#)
- Physician Radiology [CSV](#)
- Physician Surgical [CSV](#)
- Psychologist [CSV](#)
- Special Services [CSV](#)
- Special Services-Birth to Three Yrs [CSV](#)
- Target Case Management Non-Contracted [CSV](#)
- Transportation - Air Ambulance [CSV](#)
- Transportation - Basic/Advanced [CSV](#)
- Transportation - Critical Helicopter [CSV](#)
- Transportation - Non-emergency Medical [CSV](#)
- Transportation - Travel Agent [CSV](#)

[Click here for the Historical Behavioral Health Fee Schedules](#)

[Hospital - Click here for the current CMAP Addendum B](#)

[Hospital - Click here for the Historical CMAP Addendum B](#)

Provider Fee Schedule

Clinic and Outpatient Hospital Behavioral Health								
Please contact CT BHP at 1-877-552-8247 for all Prior Authorizations								
T1015 may be billed only by FQHC and has a provider specific rate								
Providers must have a Day Treatment or Day and Evening Treatment license from DPH in order to provide and bill Day Treatment or Day/Evening Treatment (H2013). Providers must be certified by CMS as a CMHC in order to provide and bill for PHP (H0035). Providers must have an Extended Day Treatment (EDT) license from DCF in order to provide and bill for EDT (H2012). Providers must have an EMPS certification from DCF to provide and bill for EMPS (S9484 or S9485); and have certification for specific home based services from DCF in order to provide and bill for home based services (H2019 or T1017).								
Procedure	Proc description	Mod1	Mod1 desc	Rate Type	Max Fee	Effective Date	End Date	PA
90785	Psytx complex interactive			ECC	14.95	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive			MMH	11.26	7/1/2015	12/31/2299	Y
90785	Psytx complex interactive			OEC	14.95	7/1/2016	12/31/2299	Y
90785	Psytx complex interactive			OMH	11.26	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation			ECC	140.1	7/1/2015	12/31/2299	Y
90791	Psych diagnostic evaluation			MMH	133.1	7/1/2015	12/31/2299	Y
90791	Psych diagnostic evaluation			OEC	140.1	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation			OMH	133.1	7/1/2016	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	Autism Services	ECC	612	1/1/2019	12/31/2299	Y
90791	Psych diagnostic evaluation	U5	Autism Services	MMH	612	1/1/2019	12/31/2299	Y
90792	Psych diag eval w/med srvc			ECC	150.87	7/1/2015	12/31/2299	Y
90792	Psych diag eval w/med srvc			MMH	143.33	7/1/2015	12/31/2299	Y
90792	Psych diag eval w/med srvc			OEC	150.87	7/1/2016	12/31/2299	Y
90792	Psych diag eval w/med srvc			OMH	143.33	7/1/2016	12/31/2299	Y

Rate Types

- OEC and OMH rate types are only payable for Outpatient Hospital Providers.

Provider Fee Schedule

Hospital Outpatient Flat Fee Schedule					
RCC Code	RCC description	Rate Type	Amount	Effective Date	End Date
401	DIAGNOSTIC MAMMAGRAPHY	DEF	148.61	7/1/2016	12/31/2299
401	DIAGNOSTIC MAMMAGRAPHY	RCC	151.88	1/1/2020	12/31/2299
403	SCREENING MAMMAGRAPHY	DEF	117.91	7/1/2016	12/31/2299
403	SCREENING MAMMAGRAPHY	RCC	120.5	1/1/2020	12/31/2299
421	PHYS THERP/VISIT	DEF	83.98	7/1/2016	12/31/2299
421	PHYS THERP/VISIT	RCC	85.83	1/1/2020	12/31/2299
431	OCCUP THERP/VISIT	DEF	97.24	7/1/2016	12/31/2299
431	OCCUP THERP/VISIT	RCC	99.38	1/1/2020	12/31/2299
441	SPEECH PATH/VISIT	DEF	106.08	7/1/2016	12/31/2299
441	SPEECH PATH/VISIT	RCC	108.41	1/1/2020	12/31/2299
771	VACCINE ADMINISTRATION	DEF	2	7/1/2016	12/31/2299
771	VACCINE ADMINISTRATION	RCC	2.04	1/1/2020	12/31/2299

RCC 769 is a hospital specific rate for hospitals approved to provide services for _____ CARES (Child and Adolescent Rapid Emergency Stabilization)					

Rate type DEF is for non-governmental licensed short-term general hospitals located in the _____ state					

Rate type RCC is for all hospitals other than DEF (governmental licensed short-term _____ general; children's; chronic disease; psychiatric; out-of-state and border _____ hospitals)					

Rate Types:

- DEF – Nongovernmental licensed short-term general hospitals.
- RCC – All other hospitals other than DEF.

Provider Fee Schedule

Reimbursement Rate Increases for Select Behavioral Health Services for Children

PB24-39

- The Connecticut Department of Social Services (DSS) was allocated seven million dollars towards increasing the reimbursement rates of select behavioral health services for children covered under HUSKY Health.
- As of August 13, 2024, DSS increased the reimbursement rates of select behavioral health services (including family therapy services) for HUSKY Health members ages 20 years old and under for dates of service July 1, 2024 and forward.
- Claims processed prior to August 13, 2024 where the detailed billed amount is greater than the new allowed amount were retroactively adjusted. Outpatient Hospital Behavioral Health were included.
- [Important Message](#) posted 8/20/2024

OEC	Outpt ECC rate	ECK	Outpt ECC rate kid
OMH	Outpt Mental Hlth	OMK	Outpt MentHlth kid

90785	90791	90792	90832	90833
90834	90836	90837	90838	90846
90847	90849	90853	90870	90875
90876	90880	90887	96105	96110
96112	96113	96116	96121	96125
96130	96131	96132	96133	96136
96136-TF	96137	96137-TF	96156	96158
96159	96164	96165	96167	96168
96170	96171	97153	97158	99202
99203	99204	99205	99211	99212
99213	99214	99215	99242	99243
99244	99245	99406	99407	99412
99442	99443	G8431	G8510	H0012
H0014	H0015	H0031	H0032	H0032-TS
H0035	H0046	H2012	H2013	H2014
H2019	S9480	S9484	S9484-HM	S9484-HT
S9485	S9485-HT	T1016	T1017	

Outlier Payments

In addition to services being paid via the APC methodology outpatient claim might be eligible for an outlier payment.

Outlier adjustments ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers.

- **Similar to Medicare, in order for an outpatient claim to qualify for an outlier payment, two thresholds must both be met:**
 - Multiple Threshold – The multiple threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount based on a defined multiplier.
 - Fixed-Dollar – The fixed-dollar threshold is met when the cost of furnishing an APC service or procedure exceeds the APC payment amount plus a fixed amount.
- Outlier calculations and methodology can be found on www.portal.ct.gov
 - https://portal.ct.gov/dss/health-and-home-care/medicaid-hospital-reimbursement/medicaid-hospital-reimbursement/fees?language=en_US

Intermission



All Patient Refined- Diagnostic Related Group (APR DRG)



APR DRG

Inpatient Hospital claims are processed based on the Diagnostic Related Group (DRG) returned from the All Patient Refined-Diagnostic Related Group (APR DRG) grouper.

- 3M Health/Solventum Information Systems has made a tool available to the hospitals to determine the APR DRG based on input of several data elements on the inpatient claim to determine the DRG code that will be used to price the claim.
 - The tool is available on the Web site <https://patientclassificationmethodologies.solventum.com/login>.

APR DRG



Patient Classification Methodologies Portal

We never
stop solving
for you

ACCESS AGREEMENT

PLEASE READ THE FOLLOWING TERMS AND CONDITIONS CAREFULLY BEFORE CONTINUING.

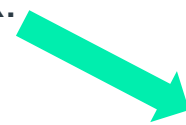
THE PURPOSE OF THIS ACCESS AGREEMENT ("Agreement") IS TO GIVE INTERESTED PARTIES THE OPPORTUNITY TO REVIEW AND EVALUATE Solventum™ AM-PPCs (Solventum™ Ambulatory Potentially Preventable Complications Classification System), Solventum™ APR DRGs (Solventum™ All-Patient Refined Diagnosis Related Groups Classification System), Solventum™ CRGs (Solventum™ Clinical Risk Groups Classification System), Solventum™ EAPGs (Solventum™ Enhanced Ambulatory Patient Groups Classification System), Solventum™ IR-DRGs (Solventum™ International Refined Diagnosis Related Groups Classification System), Solventum™ PFEs (Solventum™ Patient Focused Episodes Classification System), Solventum™ PFPs (Solventum™ Population Focused Preventables Classification System), Solventum™ PPCs (Solventum™ Potentially Preventable Complications Classification System), and/or Solventum™ PPRs (Solventum™ Potentially Preventable Readmissions Classification System).

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- 1. Materials.** As used herein, the term "Materials" shall mean the Solventum™ APR DRG software and the Definitions Manuals for the Solventum™ APR DRG, Solventum™ CRG, Solventum™ PFE, Solventum™ PFP, Solventum™ PPC, and Solventum™ PPR classification systems, including their respective content (the logic, formulas, algorithms, and software code for selecting a particular code for defining or assigning a particular patient classification or subset of patient classifications or selecting a particular code or subset of codes contained or reflected in such Materials). Title to the Materials, and the ownership of all copyright, trademark, patent, trade secret, or any other right of a similar kind or nature arising under the laws of any country in the world (collectively, "Intellectual Property Rights") thereto, are the property of Solventum and/or its suppliers.
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Every user needs to
create an account by
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APR DRG

- Home Page
- Click on APR DRG
- Then click on Assignment Report In Drop down under APR DRG

APR DRG Overview

APR DRG Definitions Manual

APR DRG Methodology

APR DRG Assignment Report

is Related Groups (APR DRGs) Classification System


The Solventum™ All Patient Refined (APR) DRGs have become the standard for classifying hospital inpatients in non-Medicare populations. As of August 2020, 27 state Medicaid programs use Solventum APR DRGs to pay for hospital inpatient care. Over 2,400 hospitals have licensed Solventum APR DRGs to verify payment and analyze their internal operations.

The Solventum APR DRG Assignment Report provides an in-depth explanation of how each of the 18 steps in the APR DRG Severity of Illness and Risk of Mortality assignment logic is applied to a patient. It can assist in understanding the methodology and can be used as a teaching tool to help ensure for accurate APR DRG assignment. The report can dynamically visualize the information contained in the Solventum APR DRG Definitions Manual.

[Learn more about Solventum APR DRGs...](#)

APR DRG

- Demographics Tab

 solventum Patient Classification Methodologies Portal
[United States](#) | [Health Information Systems](#) | [Drive value-based care and outcomes](#) | [Patient classification methodologies](#)

HOME APR DRG

APR DRG Assignment Report

Groupers Version: APR DRG Grouper v42.0 (10/01/24) ICD-10

Demographics Diagnoses Procedures

Grouping Type: Discharge DRG Admission/Discharge DRG

Case ID:

Sex: Male

Birth Weight:

Birth Weight Option: 1 - Entered only

Discharge Status: 1 - Home - Self-care (Routine)

Days on Mech. Vent.:

Admission Age: Years Days

Discharge Age:

Generate Report

Clear Form

APR DRG

APR DRG Assignment Report

The screenshot shows the 'APR DRG Assignment Report' form. The 'Grouper Version' dropdown is highlighted in red, showing a list of options: 'APR DRG Grouper v43.0 (10/01/25) ICD-10', 'APR DRG Grouper v43.0 (10/01/25) ICD-10', 'APR DRG Grouper v42.0 (10/01/24) ICD-10', 'APR DRG Grouper v41.0 (10/01/23) ICD-10', 'APR DRG Grouper v40.0 (10/01/22) ICD-10', and 'APR DRG Grouper v39.1 (04/01/22) ICD-10'. The 'Grouping Type' section has 'Discharge DRG' selected with a radio button. The 'Sex' dropdown is highlighted in red and set to 'Male'. The 'Birth Weight' dropdown is highlighted in red and set to 'Weight in grams'. The 'Birth Weight Option' dropdown is set to '1 - Entered only'. The 'Discharge Status' dropdown is highlighted in red and set to '1 - Home - Self-care (Routine)'. The 'Admission Age' dropdown is highlighted in red and set to 'Age in years', with the 'Years' radio button selected. The 'Discharge Age' dropdown is set to 'Age in days'. Other fields include 'Case ID', 'Days on Mech. Vent.', and 'Discharge Age'.

Demographics Tab

- Grouper Version –
 - Select from drop down for the Appropriate Grouper version for the dates of service of the claim

Grouping Type –

- Select: Admission/Discharge DRG (Excludes non-POA Complication of Care codes).

Sex – Select Male, Female, or Unknown.

Discharge Status – Select the patient status on the claim from the drop-down selection.

Admission Age – Enter the age of the client at the time of admission in days or years.

APR DRG

Demographics Diagnoses Procedures

Grouping Type: Discharge DRG Admission/Discharge DRG

Admission Date: Discharge Date:

Birth Weight: Birth Weight Option:

Discharge Status:

Admission Age: Years Days

- 1 - Entered only
- 2 - Coded only
- 3 - Entered or coded
- 4 - Entered or coded, cross-checked
- 5 - Coded only with default (2500 grams)
- 6 - Entered or coded with default (2500 grams)
- 7 - Entered or coded with default (2500 grams), cross-c...

Demographics Tab

Grouping Type –

If selecting “Admission Date and Discharge Date” – Enter the date of admission and discharge date of the inpatient stay

- Select: Admission/Discharge DRG (Excludes non-POA Complication of Care codes).

Birth Weight (Grams)* – Enter weight of newborn in grams.

Birth Weight Option* – Select 7 “Entered or coded w/default, X-chk”.

*Birth Weight Option and Birth Weight (Grams) only needs to be filled in if you are trying to determine the DRG code on a newborn claims.



APR DRG

- “Diagnoses” Tab
- Enter the diagnosis on the claim beginning with the Principal Diagnosis (PDX).
- Enter the corresponding Present on Admission (POA) indicator for each diagnosis.

#	Diagnosis Code	Description	Present on Admission
PDX	<input type="text"/>		Y - Yes <input type="button" value="v"/>
1	<input type="text"/>		Y - Yes <input type="button" value="v"/>

APR DRG

- Procedures Tab
- Enter the ICD-10 Surgical Code and Procedure Date.

#	Procedure Code	Description	Procedure Date
1	<input type="text"/>		Select date 
2	<input type="text"/>		Select date 

APR DRG

- Once all information is entered hit the Generate Report Button to get the report on your request which will include the APR DRG and Severity of Illness (SOI) code for the inpatient stay. In this example the inpatient claim will process based on DRG code 1372.

Generate Report

Clear Form

SolventumTM Health Information Systems

SolventumTM APR DRG Assignment Report

APR DRG Version 42.0

Codes FY 2025 ICD-10

Patient ID :	<i>Not entered</i>	Sex :	Female
Age in Years :	41	Status :	1 - Home - Self-care (Routine)
Days Mech Vent (DMV) :		DMV Source :	6 - No DMV
DMV Days After Admission :			

Grouper Results for Discharge APR DRG

MDC : 4 - DISEASES AND DISORDERS OF THE RESPIRATORY SYSTEM

All Patient Refined DRG : 137 - MAJOR RESPIRATORY INFECTIONS AND INFLAMMATIONS

Severity of Illness : 2 - Moderate Patient Severity of Illness

Risk of Mortality : 2 - Moderate Patient Risk of Mortality

Medical/Surgical DRG : Medical

Return Code : 0 - DRG assigned

APR DRG

- DRG Calculator

Once the 3M tool sets a DRG code 1372, the hospitals can use the interactive DRG calculator to see what the DRG payment amount is on their inpatient claim.

- The interactive DRG calculator is available on the hospital modernization page on the www.ctdssmap.com Web page.
- If the 3M tool returns with DRG code 956 “Ungroupable”, it means the DRG could not be determined based on the information on the inpatient claim.
 - The inpatient claim will deny with EOB code 0691 “DRG – Ungroupable”.

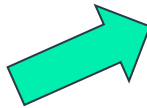
If the hospital is questioning the DRG code or payment on their inpatient claim they can e-mail their questions to the Hospital Modernization APR or DRG questions e-mail address ctxixhosppay@gainwelltechnologies.com with a screen shot of the results from the 3M tool or DRG calculator.

Please note, the information from your screenshot must match the information submitted on the claim.

APR DRG

- DRG Calculator

Connecticut Medical Assistance Program APR DRG Pricing Calculator		
Effective for Discharges 1/1/2024 and Forward		
Information	Data	Comments or Formula
INFORMATION FROM THE CLAIM		
Submitted charges	\$37,500.00	UB-04 Field Locator 47.
Non-covered charges	\$0.00	UB-04 Field Locator 48. For the purposes of calculating the outlier add-on payment, the non-covered charges must include a reduction for HCAC related charges.
Length of stay	6	Used for transfer pricing and non-covered days adjustments.
Client eligible days	6	Used for non-covered days adjustment.
Was patient transferred with discharge status = 02 or 05?	No	Used for transfer pricing adjustment.
Organ acquisition costs	\$0.00	UB-04 Field Locator 47 for RCC 81X used for calculating outlier add-on.
Practitioner costs	\$0.00	UB-04 Field Locator 47 for RCC 96X, 97X and 98X used for calculating outlier add-on.
Observation over 72 hours	\$0.00	UB-04 Field Location 47 for RCC 762 use for calculating outlier add-on.
Third Party Liability	\$0.00	UB-04 Field Locator 54 for payments by third parties.
Provider AVRS ID	008055460	Select AVRS ID. Out of state and border status hospitals should select AVRS ID 008055460.
Provider name	OUT OF STATE/BORDER STATUS HOSPITAL	Look up from Provider table.
APR DRG INFORMATION		
APR DRG	7221	From 3M-PC software version 41.
APR DRG description	FEVER AND INFLAMMATORY CONDITIONS	Look up from DRG table.
APR DRG weight	0.3814	Look up from DRG table.
Average length of stay for this APR DRG	1.95	Look up from DRG table.
HOSPITAL INFORMATION		



APR DRG

DRG Calculator

- Each field is defined under the Calculator Instructions
- Green fields are required to be entered by the user.
 - Submitted Charges – UB-04 field locator 47.
 - Non-covered Charges – UB-04 field locator 48. This would include charges for non-covered days.
- Length of Stay – This is used in pricing transfer stays or partial eligibility.
 - The length of stay equals discharge date minus admit date, unless the discharge date equals the admit date, in which case length of stay is 1.
 - ❖ Inpatient stay admitted on October 24, 2023 and discharged on October 30, 2023 the hospital would enter 6.

APR DRG

DRG Calculator

- If the stay is for a transfer claim, the length of stay will equal discharge date minus admit date plus one day.
 - ❖ Inpatient stay admitted on October 24, 2023, and transferred on October 30, 2023, the hospital would enter 7.
- Client Eligible Days – Used for non-covered days adjustments. Enter the number of days the client is eligible during the stay. In most cases this will equal the full length of stay including transfer claims.
- Was patient transferred with discharge status = 02 or 05? - Enter Yes or No from the drop-down box.
- Organ Acquisition Costs – If billing RCC 810-812, enter billed amount.
- Practitioners Costs – If the hospital bills 96X, 97X, 98X on the institutional claims instead of CMS-1500 the service will be denied on the claim and the hospital needs to enter the billed amount in this field.

APR DRG

DRG Calculator

- Observation over 72 hours – RCC 762 enter amount billed for charges over 72 hours.
- Third Party Liability (TPL) – Enter TPL payment.
- Provider AVRS ID – Select AVRS ID based on drop down list.
 - Provider Name – Auto-populated
 - Hospital Base Rate – Auto-populated
 - Hospital cost-to-charge ratio – Auto-populated

Once you entered all the information, the DRG pricing calculator will estimate the APR DRG allowed amount (E45) and payment amount (E48).

APR DRG

DRG Calculator

Example – Inpatient stay admitted on October 24, 2023, and discharged on October 30, 2023, with a discharge status 01 for a female client 34 years old. Total charges \$37,500, APR DRG 2542, APR DRG weight 0.6275, Average Length of Stay (ALOS) of 2.78, and DRG Outlier Threshold of \$30,595.85. The Hospital base rate is \$12,361.61 and Hospital cost-to-charge ratio is 0.28166.

- APR DRG weight, ALOS and DRG Outlier Threshold amounts are found under the DRG Table CT on the DRG Pricing Calculator.
- DRG Table CT - The "DRG Table CT" is the final tab under the DRG calculator that contains a list of the APR DRG codes and parameters used in pricing individual hospital inpatient stays. APR DRG codes, descriptions, national relative weights, and Average Lengths of Stay (ALOS) are determined by 3M Health Information Systems. The DRG Outlier Thresholds were developed specifically for CT through a rate setting process.

APR DRG

- DRG Calculator – Payment Amount

29	APR DRG BASE PAYMENT		
30	Pre-transfer APR DRG base payment	\$5,674.12	E24*E21
31	TRANSFER PAYMENT ADJUSTMENT		
32	Is a transfer adjustment potentially applicable?	No	E11
33	Transfer base payment	N/A	IF(E32="Yes", (E30/E22)*(E9+1), else "N/A")
34	Is transfer base payment < pre-transfer base payment?	N/A	IF(E32="Yes", IF(E33<E30, "Yes", else "No"), else "N/A")
35	Full Stay APR DRG base payment	\$5,674.12	IF(E34="Yes", E33, else E30)
36	OUTLIER ADD-ON DETERMINATION		
37	Hospital specific estimated cost of the stay	\$11,919.38	(E7-E8-E12-E13-E14) * E24
38	Does this claim require an outlier payment?	No	IF E27 > E37 "No", Else "Yes"
39	Cost outlier payment	\$0.00	IF E38 = "Yes" (E37 - E27) * E28, Else 0
40	NON-COVERED PAYMENT ADJUSTMENT		
41	Are covered days less than length of stay	No	IF E10 < E9 "Yes", Else "No"
42	Non-covered day reduction factor	1.000000	IF E41 = "Yes", (E10/E9) Else 1.0
43	Non-covered adjusted APR DRG base payment	\$5,674.12	IF E41 = "Yes", IF(E32="Yes", (E30/E22)*(E10+1), ((E10/E9)*E30)) else E35
44	Non-covered adjusted outlier payment	\$0.00	E39 * E42
45	CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT		
46	APR DRG allowed amount	\$5,674.12	IF(E43>E30, E30+E44, E43+E44)
47	Does the charge cap apply?	No	IF E46 > E7 "Yes", Else "No"
48	Third Party Liability	\$0.00	E15
49	Payment amount	\$5,674.12	IF E46="Yes", then (E7-E47), Else (E45-E47) This will not include payment made for organ acquisition which is paid outside of the DRG payment methodology
CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.			

Payment Amount is \$5,674.12. (The hospital claim payment will not exceed the total billed amount of the claim)

- EOB code 8600 “Reimbursed via DRG Pricing” will post to claims that pay at DRG pricing.

Discharge Delay Days/Value Based Payments



Discharge Delay Days/Value Based Payments (VBP)

[PB24-69](#) **Pediatric Inpatient Psychiatric Services: Interim Voluntary Value-Based Payment Opportunity for Increasing Needed Capacity and Interim Rate Add-On for Acuity and Revised Discharge Delay Policy** – Published 12/27/2024

1. Interim Voluntary VBP for Increasing Needed Capacity

Effective for dates of service from December 1, 2021, through December 31, 2026, the following categories of Connecticut hospitals may be eligible for a VBP that includes a rate add-on to the per diem rate based on their ability to: 1) Increase actual bed capacity and utilization for pediatric inpatient psychiatric services (individuals under the age of 18), and 2) Comply with the requirements detailed below that are designed to improve the quality of care over the long term.

2. Interim Rate Add-On for Acuity

Effective for dates of service from December 1, 2021 through December 31, 2026, the following hospitals that provide pediatric inpatient psychiatric services for individuals under the age of 18 and bill using the per diem rate for such services and psychiatric hospitals may be eligible for an interim acuity-based rate add-on to the applicable per diem rate if authorized by the behavioral health ASO in accordance with the standards set forth.

3. Revised Discharge Delay Policy

Effective for dates of service from December 1, 2021 until December 31, 2026 unless otherwise notified, the Medically Necessary Discharge Delay policy for pediatric inpatient psychiatric services is revised as detailed in the bulletin and this revised policy supersedes any provisions in provider bulletin 2012-32 to the extent that any of those provisions are inconsistent with this revised policy. This policy remains applicable only to CMAP members under age 19.

4. Proposed Future Value-Based Payment Model

Effective for dates of service on and after January 1, 2025, all short-term general hospitals, short-term children's general hospitals, private psychiatric hospitals, and chronic disease hospitals in Connecticut and applicable qualifying border hospitals that provide pediatric inpatient psychiatric services may voluntarily choose to participate in an updated value-based payment (VBP) program, which is currently under development and will include various performance measures and other metrics to be determined.

Discharge Delay Days/Value Based Payments

Hospital Eligibility:

- licensed short-term general hospital with a pediatric inpatient psychiatric unit
- licensed short-term children's general hospital with a pediatric inpatient psychiatric unit
- private psychiatric hospital
- chronic disease hospital with a pediatric inpatient psychiatric unit or a dedicated unit for providing specialized behavioral health services to children, including autism spectrum disorder services

This rate add-on is also potentially available to border hospitals in accordance with the same conditions as in-state hospitals and that also meet all of the following parameters:

- licensed short-term general hospital with a pediatric inpatient psychiatric unit or a private psychiatric hospital
- located no more than 10 miles from the Connecticut border and
- has no fewer than 50 episodes of pediatric inpatient psychiatric services paid by Connecticut Medicaid each calendar year beginning in 2019 and continuing on an ongoing basis.

Discharge Delay Days/Value Based Payments

Requirements for Interim Voluntary VBP for Increasing Needed Capacity:

This rate add-on is available only if, on an ongoing basis, the hospital successfully maintains and demonstrates full compliance with all of the following requirements, as determined by DSS or its behavioral health administrative services organization (ASO):

- Request Process
- Certification of Beds
- Minimum Increase in Beds
- Licensing and Certificate of Need (CON) Compliance
- Bed Tracking
- Post-Discharge Follow-Up
- Comprehensive Services
- Quality and Care Transitions'
- Suicide Prevention
- Additional Data Reporting

Discharge Delay Days/Value Based Payments

Interim Voluntary VBP for Increasing Needed Capacity

Billing Instructions for Rate Add-on Amount for Acute Care and Children's Hospitals:

- If approved by DSS for Acute Care and Children's Hospitals and authorized by Carelon for rate add-on amount in accordance with the standards set forth above, the hospital will need to bill those authorized days with RCC code 160 to receive rate add-on amount. Private Psychiatric Hospitals should continue to use their current approved RCC codes when billing.

Discharge Delay Days/Value Based Payments

Interim Rate Add-On for Acuity

If authorized by the behavioral health ASO, the hospital will add Revenue Center Code (RCC) 169 to the claim of the child and the acuity-based rate add-on will increase the per diem rate by 10% for the specific patient bed days for which the add-on was authorized, which is calculated on the hospital's per diem rate for the date of service, which, if applicable to the hospital, would include the rate add-on for increasing needed capacity set forth above. The acuity-based rate add-on is not applicable to the medically necessary discharge delay bed days (regardless of whether or not such bed days fall into the revised discharge delay policy set forth below). This is not a diagnosis-based rate add-on; however, the following conditions and/or behaviors are provided as examples of conditions that may warrant a rate add-on if the child's condition meets the standard for acuity detailed above:

- Severe problem sexual behavior, such that the child may endanger the welfare of another child on the unit;
- Severe aggression, such that the child may pose a risk to self, the staff or the other children;
- Severe risk of self-harm, including recent history of lethal suicide attempts;
- Eating disorder, such that advanced medical and behavioral health services are required; or
- Physical and/or intellectual disability and/or autism spectrum disorder such that the disability inhibits or negatively impacts participation in therapeutic services.

Discharge Delay Days/Value Based Payments

Interim Rate Add-On for Acuity

Billing Instructions for Acuity-Based Rate Add-On for all hospitals:

If authorized by Carelon for an acuity-based rate add-on in accordance with the standards set forth above, the prior authorization will be authorized for the approved days with revenue code/list 2069. The hospital will need to bill those authorized days with RCC code 169 to receive the acuity-based rate add-on.

If the hospital received two (2) authorizations for an inpatient stay, one for acute behavioral health (BH) days not subject to the rate add-on and one authorizing the acuity-based rate add-on, the hospital will need to bill their inpatient claims with one detail with the acute BH room & board RCC for the days authorized only for acute BH days and a second detail with RCC 169 for the days also authorized at the acuity-based add-on rate.

Failure to bill RCC 169 correctly could cause claims to process at an incorrect rate or deny.

Discharge Delay Days/Value Based Payments

Revised Discharge Delay Policy

Due to the current demand for acute pediatric inpatient psychiatric services in conjunction with a decreased capacity for community-based behavioral health services, the hospital will be paid the full applicable per diem rate (not the discharge delay rate) when all of the following have been confirmed by the behavioral health ASO on a case-by-case basis as part of the authorization process for each applicable prior authorization or concurrent review request:

- the hospital has made and continues to make every attempt to secure the appropriate discharge plan that best meets the individual's needs;
- the ASO confirms that the discharge plan is appropriate, but that plan cannot be implemented for the applicable dates of service due to lack of availability of community-based services that are appropriate for the individual's discharge plan; and
- that active treatment is occurring in the hospital that is based on the individual's needs and meets medical necessity. This authorization process will enable the hospital to bill for all bed days meeting the above requirements using the same revenue center code used to bill the standard psychiatric per diem rate.

Reference for Pediatric Discharge Delays and the use of RCC 224: [PB12-32](#) Hospital Inpatient Services

Discharge Delay Days/Value Based Payments

Proposed Future Value-Based Payment Model

Hospitals that provide pediatric inpatient psychiatric services that were not able to increase bed capacity under the above-referenced initial phase may still be eligible to seek to participate in the VBP program, in accordance with all applicable requirements, which are also under development.

Hospitals that do not elect to participate in the VBP are not eligible for the VBP rate methodology.

The Department will implement value-based payment with data collection to start later in the year pending implementation in 2025.

Regulations / Policies



Regulations / Policies

Provider Manuals

The Provider Manual is available to assist providers in understanding how to receive prompt reimbursement through complete and accurate claim submission. The provider manual contains detailed instructions regarding CMAP 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.

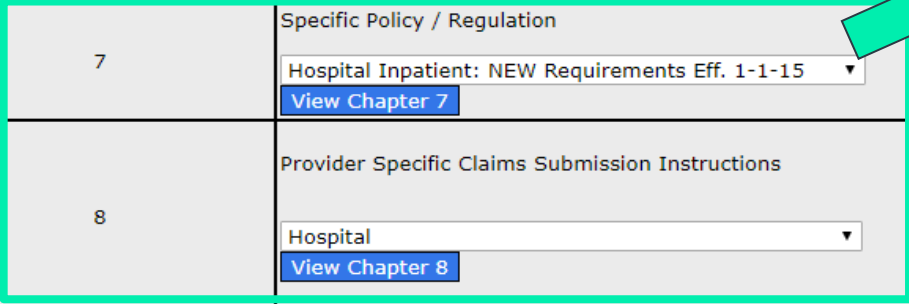
The provider manual is available on the www.ctdssmap.com Web site from the Publications page.

Regulations / Policies

Provider Manuals	
Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information
	Additional Chapter 5 Information <ul style="list-style-type: none"> • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation
	<input type="text" value="Hospital Inpatient: NEW Requirements Eff. 1-1-15"/> View Chapter 7
8	Provider Specific Claims Submission Instructions
	<input type="text" value="Hospital"/> View Chapter 8
9	Prior Authorization
10	Web Portal/AVRS
11	Other Insurance and Medicare Billing Guides
	<input type="text" value="Select a claim type"/> View Chapter 11
12	Claim Resolution Guide

Select a provider type ▼

- Hospice
- Hospital Inpatient: Effective 1-1-15
- Hospital Outpatient: Effective 7-1-16
- Independent Clinical Lab
- Independent Radiology



Regulations / Policies

Provider Manuals

Chapter 1 – Introduction

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

Chapter 2 – Provider Participation Regulations

- Details the CMAP regulations for provider participation

Chapter 3 – Provider Enrollment

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

Chapter 4 – Client Eligibility

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

Chapter 5 – Claim Submission Information

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

Chapter 6 – EDI Options

- Provides information on electronic claim submission and electronic RAs

Regulations / Policies

Provider Manuals

Chapter 7 – Regulations/Program Policy

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

Chapter 8 – Billing Instructions

- Provides information on provider specific billing requirements and instructions

Chapter 9 – Prior Authorization

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

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

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

Chapter 11 – Other Insurance/Medicare Billing Guides

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




Chapter 12 – Claim Resolution Guide

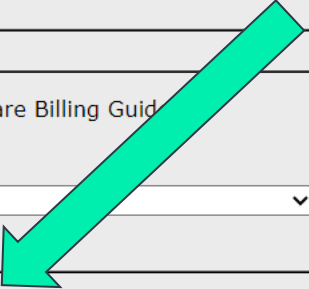
- Provides descriptions of common EOBs and, if applicable, information to resolve the errors

Frequent Claim Denials



Chapter 12 Claim Resolution Guide

Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information Additional Chapter 5 Information <ul style="list-style-type: none">• Carrier Listing Sorted by Name• Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy / Regulation <input type="text" value="Select a provider type"/>  View Chapter 7
8	Provider Specific Claims Submission Instructions <input type="text" value="Select a provider type"/>  View Chapter 8
9	Prior Authorization
10	Web Portal / AVRS
11	Other Insurance and Medicare Billing Guide <input type="text" value="Select a claim type"/>  View Chapter 11
12	Claim Resolution Guide



Chapter 12 Claim Resolution Guide

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- 12.2 Explanation of Benefit Codes 3
 - 0013 Composite APC Applied 4
 - 0014 Comprehensive APC Applied 4
 - 0047 Confirmed Visit Units are Exceeded 5
 - 0204 Prescribing provider not authorized to prescribe 6
 - 0206 Submitted prescriber's ID is invalid 6
 - 0207 Prescribing provider not enrolled 7
 - 0209 Prescriber ID of group; Resubmit individual's NPI 7
 - 0224 Detail diagnosis code pointer invalid on paper claim 8
 - 0226 Referring Provider Name/Number is missing 8
 - 0303 APC - Inappropriate specification of bilateral procedure 9
 - 0304 APC - Service considered an inpatient procedure 9
 - 0305 APC - Medical visit on same day as type T or S procedure w/o modifier 25 - significant separate E&M service 10
 - 0306 APC - Medical visit on same day as type T or S procedure 10
 - 0307 APC - Invalid age 11
 - 0308 APC - Invalid gender 11
 - 0309 APC - Only incidental services reported 12
 - 0311 APC - Implanted device without implantation procedure or administered substance without associated procedure 12

Frequent Claim Denial

EOB code 0305 “APC - Medical visit on same day as type T or S procedure w/o modifier 25 - significant separate E&M service”

Cause

- A clinic or emergency department visit (status indicator V-clinic or emergency department visit paid under OPSS) has been billed without modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the same date of service as a significant procedure (status indicator S or T Significant Procedure payable under OPSS).

Resolution

- Correct the claim by adding modifier 25. Re-submit the claim. If there is already a modifier 27 on that detail, add the modifier 25 in the 2nd position.

EOB code 0316 “APC - Only incidental services reported”

Cause

- The outpatient claim was submitted with only incidental services being billed.

Resolution

- Please verify the procedures submitted on the claim. If an outpatient claim was submitted without an APC payable service and just packaged services will be denied.

Frequent Claim Denial

EOB Code 0690 Principal diagnosis invalid as discharge

Cause

- The Inpatient claim contains an invalid principal diagnosis code. The International Classification of Diseases, Clinical Modification identifies diagnosis codes that require a more specific diagnosis code be submitted on the claim.
An ICD-10 example of this is E11 (Diabetes Mellitus).

Resolution

- Change the principal diagnosis code on the claim to a more specific ICD-10 diagnosis code and resubmit the claim.

Cause

When an incorrect primary delivery diagnosis code is used.

Resolution

Review the Important Message link below for list of approved codes for inpatient delivery stays and prior authorizations. Posted in 2021

[Inpatient Delivery Stays and Prior Authorization \(PA\) Reminder](#)

Frequent Claim Denial

EOB code 0337 “APC Total amount allowed on APC claim is zero.”

Cause

- An outpatient claim was billed with an APC payable procedure code that was denied with a different EOB code causing there to be no APC payable allowed amount on the claim.

Resolution

- Review the other EOB code setting on the APC payable procedure code and, once you resolve that EOB, it should resolve EOB 0337 at the same time.

Frequently Asked Questions:

- EOB 0861 NDC IS MISSING, INVALID or NON-REBATEABLE

NDC Requirements for Claims Processing

- Claims that do not comply with the mandate will be denied. Claims will be denied if the NDC is missing, invalid, terminated, not rebateable, DESI, institutional, repackage, inner package, or the NDC qualifier is missing or invalid. A list of DESI drugs is maintained at www.ctdssmap.com by selecting Pharmacy Information, then Pharmacy Program Publications, and locating the DESI List.

Participating labelers

- Connecticut Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical manufacturer of that drug is a participating labeler with the Centers for Medicare and Medicaid Services (CMS). A ‘participating labeler’ is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A labeler is identified by the first 5 digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first 5 digits of the NDC) to the list of participating labelers which is maintained on the Connecticut Medical Assistance Program Web site at www.ctdssmap.com. Providers may access this list by clicking on the “Pharmacy Information” page, then on the client’s benefit plan under the “Drug Manufacturer Rebate Lists” posted in the “Pharmacy Program Publications” panel. Providers can determine whether an NDC is rebateable or not by utilizing the “Drug Search” functionality under “Provider” from the www.ctdssmap.com Web site.

Frequently Asked Questions:

- EOB 0861 NDC IS MISSING, INVALID or NON-REBATEABLE (continued)
 - Providers can search by selecting “Drug Search” from the Provider drop down > Enter the NDC or the Drug Name

Drug Search

NDC	<input type="text"/>	Drug Name	<input type="text" value="VIZAMYL"/>	Drug Sounds-Like	<input type="checkbox"/>
HCPCS	<input type="text"/>	HCPCS Description	<input type="text"/>	HCPCS Sounds-Like	<input type="checkbox"/>
DOS	<input type="text" value="11/14/2025"/>				

Records 20

Search Results

NDC	Brand Name	Generic Name	Dose Strength	Dose Form	Package Size	HCPCS	End Date	HUSKY A, C, D, TB and Fam Plan Rebateable	HUSKY B Rebateable	OTC Indicator
17156006730	VIZAMYL	flutemetamol F-18 INTRAVEN 5 MCI VIAL	5 mCi (185 MBq)	VIAL	1	-	12/31/2299	N	N	N

Provider	Trading Partner	Pharmacy I
Provider Enrollment		
Provider Re-Enrollment		
Provider Enrollment Tracking		
Provider Matrix		
Provider Services		
Provider Search		
Drug Search		
Provider Fee Schedule Download		
OOS Instructions/Information		
Fingerprint Criminal Background		
Check Info		
E-mail Subscription		
Secure Site		

- Note the “Husky A, C, D, TB, and Fam Plan Rebateable” column.
- If a Husky B client, note the “Husky B Rebateable” column.
- In this example, Vizamyl is a currently not in rebate and not payable.
- Information on NDCs on claims processing can be found: www.ctdssmap.com > Publications > [Provider Manual Chapter 8](#)

Frequently Asked Questions:

- The DRG on the claim does not show what our coding department is stating it should be.
 - Resolution: Verify the claim and submitted Diagnosis Codes and Procedure Diagnosis Codes. The DRG is assigned by 3M Grouper Software. Run an independent 3M report on the claim to verify the DRG assignment of the claim submitted. Verify that the correct version of 3M report is used as the versions differ depending on dates of service of the claim.
- The claim is denying for Medicare information incomplete on a Crossover claim.
 - Resolution: Verify the claim and submitted Medicare information. The Medicare payment information must be populated fully on the claim. Verify that the Medicare paid amount, Medicare Paid Date, Deductible Amount, Coinsurance Amount, and Patient Responsibility Amount fields are populated appropriately for the claim.

Frequently Asked Questions:

Can you verify an appeal?

- There are many requests on the status of an appeal without any relevant information. Verify what the appeal was for: Was this an appeal with HMS due to an Audit? Is this an appeal for a payment on a claim? Is this a Prior Authorization appeal?
- **For HMS Audits and appeals**, HMS audit related questions must be directed to HMS. Please refer to the letter/contact from HMS to proceed with any questions on HMS audits or appeals process.
- **For appeals on a claim**, please make sure to run an appropriate 3M or APC report. Often there is an appeal for a DRG on a claim, but the 3M report provided as reference from the provider has information that differs from the claim such as missing or additional diagnosis codes. Please also make sure to use the correct version of 3M when running the report as there are different versions depending on the dates of service.
- **For questions on denied Prior Authorizations**, please contact either:
 - CHN information: <https://www.huskyhealthct.org/providers/prior-authorization.html> or 1-800-440-5071
 - Carelon Behavioral Health (Appeals information is under [Section VI](#)) with your appeals information: <https://providers.ctbhp.com/providers/manual/>

Frequently Asked Questions:

Resources for quick FAQs:

Hospital Inpatient Payment Methodology - Diagnosis Related Group (DRG)

Inpatient hospital reimbursement for general acute care hospitals and children's hospitals is now using APR DRG system where hospital payments will be established prospectively for inpatient stays

Gainwell Technologies integrated 3M's APR DRG "grouper" software into the Medicaid Management Information Systems (MMIS). Each inpatient claim is assigned an APR DRG by utilizing claim data submitted such as diagnoses, procedures, member age, and gender.

DRGs will aid in DSS goals to move towards a system that encourages access to care, rewards efficiency, improves transparency, and improves equity by paying similarly across hospitals for similar care. Payment by DRGs also simplifies the payment process, encourages administrative efficiency, and bases payment on patient acuity and hospital resources rather than length of stay.

See the following for more detailed information:

[APR DRG FAQs](#)

[Interim Billing](#)

[3-Day Rule: Outpatient Services Prior to Inpatient Admission](#)

[Claims Paid Per Diem Rates](#)

[Health Care Acquired Condition \(HCAC\) / Present on Admission \(POA\)](#)

[Hospital Based Practitioners - Inpatient Services](#)

Hospital Outpatient Payment Methodology - Ambulatory Payment Classification (APC)

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for July 1, 2016.

[Outpatient Hospital Modernization FAQ](#)

[Hospital Based Practitioners - Outpatient Services](#)

CMAP Addendum B

CT Medicaid's OPPS processing will be based on the CMAP version of Addendum B which is derived from Medicare's Addendum B. The differences between the CMAP version of Addendum B and the Medicare version of Addendum B primarily involve detail service coverage and pricing methodology. Please refer to CMAP's draft Addendum B to determine which services will be paid based on fixed fee, fee schedule or APC assignment. Also, background information for CMAP Addendum B can be found on the Connecticut Department of Social Services Reimbursement Modernization web site at: <http://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Hospital-Reimbursement/Medicaid-Hospital-Reimbursement>

Frequently Asked Questions:

Hospital Email Inbox:

CTXIXHOSPYPAY@GAINWELLTECHNOLOGIES.COM

- The hospital inbox is setup to help answer questions concerning APC and DRG questions.
- For general claims denials, please reference Provider Manual Chapter 12 Claim Resolution Guide:
 - <https://www.ctdssmap.com/CTPortal/Information/Publications>
 - The Claim Resolution Guide can be used to reference Error EOBs for resolutions on many claim denials.
 - If the Claim Resolution Guide does not answer your question for a general claim denial, please contact Provider Assistance Center at [1-800-842-8440](tel:1-800-842-8440)
 - If you have a 3rd Party Vendor that helps with claims processing, please make sure they have access to Provider Manual Chapter 12 as many questions that come from 3rd Party Vendors can be resolved through the Claim Resolution Guide.
- When emailing the Hospital Inbox, please make sure to include:
 - ICN of the claim in question.
 - The exact nature of your inquiry (Please be as specific as you can in your question).

Resources



Resources

Claims, Enrollment, and Eligibility Questions should be directed to:

- Gainwell Technologies Provider Assistance Center (PAC) 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
If hospitals are experiencing extended call wait times, hospitals may email the provider assistance call center with their question at ctdssmap-provideremail@gainwelltechnologies.com. Please be sure to include your name and phone number with your inquiry
- Hospital Modernization e-mail address (**APC or DRG specific questions only**)
ctxixhosppay@gainwelltechnologies.com
- 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

Prior Authorizations:

- Community Health Network of Connecticut (CHNCT) at 1-800-440-5071
- Carelon Behavioral Health CT Behavioral Health Partnership (CTBHP) at 1-877-552-8247 or www.ctbhp.com

Third Party Insurance issues:

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

Review



Review

- Web portal access
 - ✓ Make sure you have access to the Web Portal and have appropriate clerk access. If you need access, contact the master user for clerk maintenance.
- Check Re-enrollment date for your organization and take note of when it will be due. It can take 4-8 weeks so please put it on the calendar.
- Check available resources to keep handy as a lot of our resources are PDF/Excel spreadsheets that can be stored for future reference.
 - ✓ Provider Manuals Chapters 5, 7, 8, 12 are most relevant to claims related issues; Chapter 12 is your best resource for EOB resolutions.
 - ✓ Make sure to clear your cache to view the most current versions of all information available on our web portal as older file versions may load.
- Note contacts for HMS (TPL Audits), CHN (PA), Carelon (PA) and Provider Assistance (General Questions). Full list under “Resources” slide.
- Save email: ctxixhosppay@gainwelltechnologies.com for APC/DRG questions.
- Save a copy of this presentation for future reference.

Wrap Up and Questions

Thank you so much for attending today's workshop!
Please fill out survey provided in MSTeam's chat.



Upcoming Workshops:

December 16, 2025 Tuesday: Long Term Care Refresher Workshop

December 18, 2025 Thursday: Hospital Refresher Workshop

December 18, 2025 Thursday: New Provider Workshop

We offer a variety of Workshops for all Providers.

Please make sure to keep yourself posted on any future workshops!

All Workshop Training Information can be found:

https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/Provider_Training.pdf

Thank you so much for attending today's workshop!

Please fill out survey provided in MSTeam's chat.

