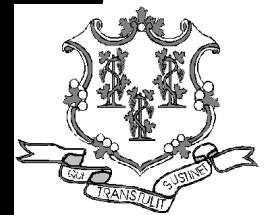


September 11, 2020

 Connecticut Department
of Social Services
Making a Difference

Connecticut Medical Assistance Program Professional Refresher Workshop

Presented by
The Department of Social Services & DXC Technology





Training Topics

- **Re-Enrollment**
- **Clerk Maintenance Updates**
- **Demographic Maintenance**
- **Eligibility Verification**
- **Prior Authorization/Pharmacy Web Prior Authorization**
- **Professional Web Claim Submission**
- **National Correct Coding Initiative (NCCI)**
- **Claim Resolution Guide**
- **DSS Audit Criteria**
- **Provider Fee Schedule**
- **Enhanced Rates**
- **Bulletins**
- **Telehealth Capabilities**
- **Wrap Up and Questions**

Re-enrollment

Re-enrollment

Re-enrollment Period:

- Most provider types are required to re-enroll every five years
- Providers will receive a letter when they are due for re-enrollment six (6) months prior to the end of their current contract
- If the provider has not successfully re-enrolled three (3) months prior to the end of their current contract, another letter will be sent
- Providers with re-enrollment applications that are not fully completed by the provider's re-enrollment due date will receive a notice advising they have been dis-enrolled from the Connecticut Medical Assistance Program (CMAP)
- The following are some of the providers that are required to re-enroll every two years:
 - Clinics (Except Enhanced Care) – DME/MEDS - Drug and Alcohol Abuse Centers
- The complete list of enrollment periods can be found in Chapter 3 of the Provider Manual
- Re-enrollment via the Enrollment/Re-enrollment Wizard on the CMAP Web site, www.ctdssmap.com, is required

Organization and individual 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!

Re-enrollment

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

- A majority of the required information is automatically populated based on the provider's previous contract information
- Online re-enrollment cannot be initialized until an *Application Tracking Number* (ATN) is received from the DXC Technology Provider Enrollment Unit

Select *Provider Enrollment* from either the *Provider* box on the left hand side of the home page or from the *Provider* drop-down menu; select *Provider Re-Enrollment* from the *Provider* drop-down menu

Information

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

Provider

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

Provider Trading Partner Pharmacy Information F

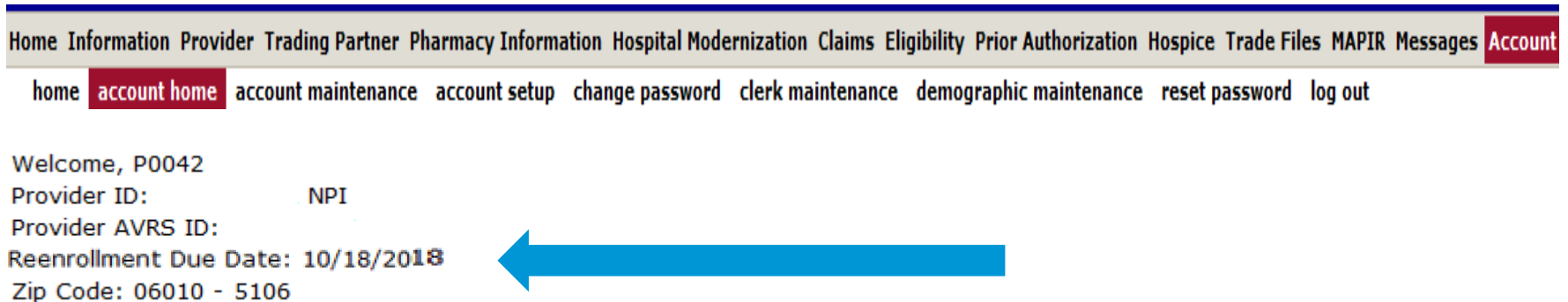
- Provider Enrollment
- Provider Re-Enrollment
- Add Alternate Svc Loc Address
- Provider Enrollment Tracking
- Provider Matrix
- Provider Services
- Provider Search
- Drug Search
- Provider Fee Schedule Download
- EHR Incentive Program
- OOS Instructions/Information
- Fingerprint Criminal Background
- Check Info
- ACA OPR Provider List
- E-Mail Subscription
- Secure Site

Re-enrollment

Re-enrollment Due Dates:

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

- Individual providers can view their re-enrollment due date on the Home page
- Organization providers can view their re-enrollment due date, as well as the re-enrollment due date of their members by accessing the “Maintain Organization Members” panel
- This enhancement allows individual providers and organizations to better track their re-enrollment due dates prior to receiving their notice to re-enroll



The screenshot shows a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. Below the navigation bar are links: home, account home, account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. The main content area displays: Welcome, P0042; Provider ID: NPI; Provider AVRS ID: ; Reenrollment Due Date: 10/18/2018; and Zip Code: 06010 - 5106. A large blue arrow points to the Reenrollment Due Date.

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

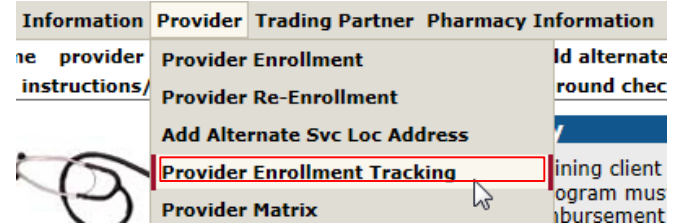
home account home account maintenance account setup change password clerk maintenance demographic maintenance reset password log out

Welcome, P0042
Provider ID: NPI
Provider AVRS ID:
Reenrollment Due Date: 10/18/2018
Zip Code: 06010 - 5106

Re-enrollment

To check the status of an enrollment / re-enrollment application, select *Provider Enrollment Tracking* from either the *Provider* submenu or the *Provider* drop-down menu

Provider Trading Partner Pharmacy Information Hospital Modernization Claims Eligibility Prior Au
r enrollment provider re-enrollment add alternate svc loc address provider enrollment tracking pr
s/information fingerprint criminal background check info aca ordering/prescribing/referring provide



Enter your *ATN* and *Business OR Last Name* and click *search*

Enrollment Tracking Search

ATN*

Business OR Last Name*

- In this example DSS is reviewing the application that was submitted by Jonathan Q. Smith on June 25, 2019.

Search Results

Date Received	Status
06/25/2019	DSS Conducting Initial Review

Re-enrollment

Performing Providers:

- Billing groups need to associate their **performing providers** to the group since performing providers are now enrolled / re-enrolled independent of the groups they belong to.
- The performer would re-enroll according to their re-enrollment due date which may be different from the group.
- The re-enrollment letter will only be sent to one address if the performing provider belongs to more than one group.
- Organizations/Groups can view the re-enrollment due dates of their members by accessing the “Maintain Organization Members” from the “Demographic Maintenance panel”.
- This enhancement will allow organizations/groups to better track their re-enrollment due dates prior to receiving their notice to re-enroll.

Provider Re-enrollment Adding Alternate Service Location Addresses

Provider Bulletin 2018-19: Web Portal Enhancement – Alternate Service Location Addresses

On **April 11, 2018**, DSS implemented a new functionality for the online Enrollment/Re-enrollment Wizard which allows billing providers to submit an application for the purpose of adding alternate service location(s).

This enhancement eliminates the need for providers to contact DXC Technology to first obtain an ATN.

A new alternate service location address application must be submitted when a provider is expanding the number of practice locations.

More than one new practice location may be submitted in one application.

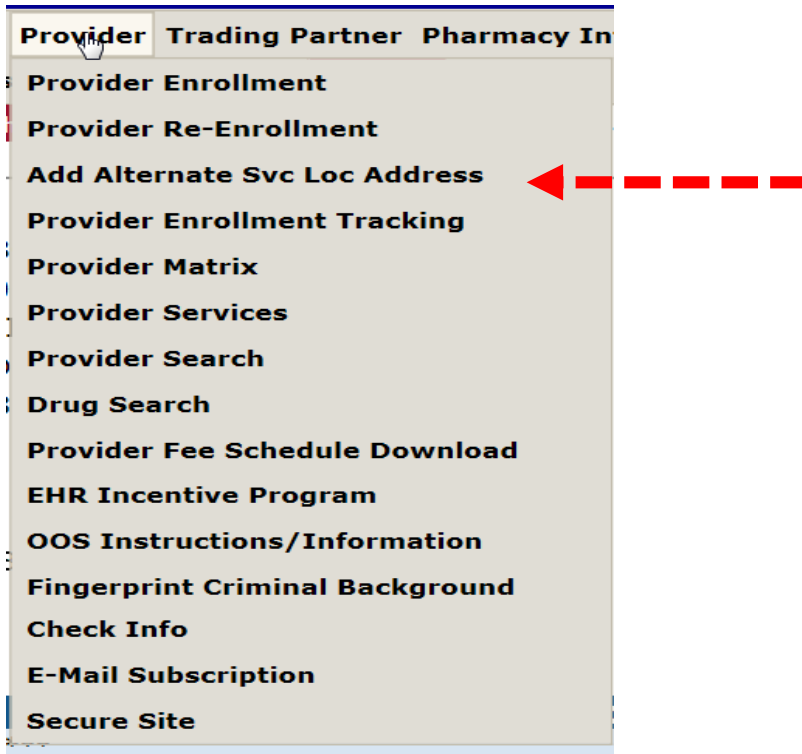
Caution: Do not use this application to:

- Change an existing address(es) of a practice;
- Add a practice location to an Automated Voice Response System (AVRS) ID that already exists under another billing AVRS ID registered to that provider.

Provider Re-enrollment

Adding Alternate Service Location Addresses

To begin a new add alternate service location address application, navigate to the www.ctdssmap.com Web site and log into your Secure Web portal account. Once logged in, select Provider > Add Alternate Svc Loc Address.



Provider Re-enrollment

Adding Alternate Service Location Addresses

Who can submit an Add Alternative Service Location Address application?

In addition to the provider (i.e. the master user) being able to submit this new application, a new clerk role, Submit Applications, has been created to allow providers/master users to designate clerks to submit the add alternate service location address application.

A master user is required to add the Submit Applications role to the clerk(s) that will be responsible for updating their organization's service locations. To assign the Submit Applications role, a master user will sign into their Secure Web portal account, select Clerk Maintenance, enter the clerk ID to which the role will be assigned, and assign the role of Submit Applications.



For more information, please refer to Provider Bulletin 2018-19 [“Web Portal Enhancement – Alternate Service Location Addresses”](#).

Clerk & Demographic Maintenance

Clerk Maintenance

Enhanced Secure Web Site Features

As of June 27, 2018, self-service functionality for master users (providers and trading partners) and their clerks has been enhanced.

Users logging into their secure Web portal are presented with a one time only increased site security panels to enter two (2) updated security questions and answers and an updated email address.

The enhanced self-service functionality will allow users to:

- Reset their password by responding to the updated questions and answers supplied through the one time set up process.
- Unlock their account in instances where their account has been locked due to entering an incorrect password more than six (6) times, by responding to their updated security questions and answers supplied through the one time process.
- Reactivate their account in the instance where they have not accessed their account within the last ninety (90) days by responding to the updated security questions and answers supplied through the one time process.

For more information, please see [Provider Bulletin 2018-34 “Enhanced Secure Web Site Features for Password Resets, Locked Accounts, and Disabled Accounts”](#).

Demographic Maintenance

DSS requires providers to update their demographic information via their secure Web account. Demographic information includes provider addresses, Electronic Funds Transfer (EFT) and member of organization maintenance. The main account administrator must log on to their account and click on the “Demographic Maintenance” tab. See Chapter 10 of the Provider Manual for more information.

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization 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

Provider Information

Provider ID	<input type="text"/>	Address	<input type="text"/>
AVRS ID	<input type="text"/>		<input type="text"/>
Usage	Service Location	City	MANCHESTER
Provider Type	31 - Physician	County	Hartford
Provider Specialty	322 - Internal Medicine	State/Zip	VT 02456-4556
Phone	<input type="text"/>		

[Location Name Address](#) > [EFT Account](#) > [Service Language](#)

Demographic Maintenance – Address Updates

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

Location Name Address
✕

Usage	Name	Address 1	City	State	Zip	Zip + 4	Phone	Ext	Handicap Access
Mail to	DOE, JOHN	15 MAIN STREET	WILLIMANTI	CT	06614	4008	(203)555-5555	5555	Y
Pay to	DOE, JOHN	250 OAK AVENUE	WILLIMANTI	CT	06614	0001	(203)555-5555	5555	Y
Service Location	DOE, JOHN	15 MAIN STREET	WILLIMANTI	CT	06614	4008	(203)555-5555	5555	Y
Enrollment	DOE, JOHN	123 STEELE STR	WILLIMANTI	CT	06614	0001	(203)555-5555	5555	Y

Name Type Business Name Personal Name

Name

Title

Usage

Country

Address 1*

Address 2

City

State

Zip*

Type **Apply Changes To:**

Svc Loc

Pay To

Mail To

Enrollment

Phone*

Fax

Handicap Accessible?

EMail

Demographic Maintenance – EFT Updates

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

- Click “*add*”; enter the appropriate information; and click “*save*”

Location Name Address > **EFT Account** > Service Language > Maintain Organization Members

EFT Account

Click here to open Provider EFT Enrollment instructions.

Financial Institution Name	Financial Institution Routing Number	Provider's Account Number with Financial Institution	Type of Account at Financial Institution	Last Change Date	EFT Status
BANK OF AMERICA, N.A.	011900571		Checking		Active

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

Required fields are indicated with an asterisk (*)

Account Number Linkage to Provider Identifier*

Provider Name*

Provider Tax Identification Number (TIN)

OR

National Provider Identifier (NPI)

Provider Identifiers*

Provider Federal Tax Identification Number (TIN)
OR Employer Identification Number (EIN)

****This action will place the provider in a *pre-notification* status****

Demographic Maintenance – Maintain Organization Members

The *Maintain Organization Members* panel allows you to:

- Search current or historical members using the search button
- Add new members by entering their *Organization Member ID* (NPI) as well as *Effective Date*
- Separate members by selecting their *line* and entering an *End Date*

All Current Historical Organization Member ID

Member Business/Last Name Member First Name

Organization Member ID ▲	ID Type	Organization Member Name	Effective Date	End Date
1414141414	NPI	BOYLE, DR. DAWN	06/01/2012	12/31/2299
2011120906	NPI	GEORGETTE, GOVOLA	06/01/2012	12/31/2299

Total Count: 2 Current Count: 2 Historical Count: 0

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

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

Organization Member ID [Search] Effective Date

Organization Member Name End Date

Demographic Maintenance – Maintain Organization Members

Re-Enrollment due dates are visible on the maintain organization panel.

Maintain Organization Members
X

- This Maintain Organization Members panel allows providers to view, add or separate members of their organization. Members must first enroll in the Connecticut Medical Assistance Program in order to join your organization. Members will receive a letter from HP when any additions or separations are made to their association to your organization. Note: 12/31/2299 represents an open ended association with the organization.

- Warning - PCMH and Glide Path Providers ONLY**
 If you are a PCMH or Glide Path provider and you are adding a member to your group via the Web, and your intent is for that provider to be PCP under your PCMH/Glide Path practice, you must first use this Web portal to associate the member to your group and then use CHN's Change Request Form in order to add that practitioner as a PCP. Conversely, if you are dis-associating a member from your group and that member is no longer a PCP under your PCMH/Glide Path practice, you must first use this Web portal to dis-associate the member from your group and then use CHN's Change Request Form in order to remove that provider as a PCP under the PCMH/Glide Path practice. CHN's Change Request Form is located at www.huskyhealthct.org, by selecting the Providers tab, clicking on the Person-Centered Medical Home link, and locating the PCMH and Glide Path Change Request Form.

- Scroll down to add or separate a member.

Refer to section 10.15 within Chapter 10 of the Provider Manual to view instructions for maintaining your organization members. [Click here to view Chapter 10.](#)

Refer to section 3.1 within Chapter 3 of the Provider Manual to view which provider types and specialties may join your organization. [Click here to view Chapter 3.](#)

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

Organization Member ID	ID Type	Organization Member Name	Effective Date	End Date	Reenrollment Due Date
[REDACTED]	NPI	[REDACTED]	07/01/2013	12/31/2299	12/31/2018
[REDACTED]	NPI	[REDACTED]	09/14/2007	12/31/2299	02/28/2018
[REDACTED]	NPI	[REDACTED]	04/17/2014	12/31/2299	04/03/2018
[REDACTED]	NPI	[REDACTED]	07/01/2013	12/31/2299	08/06/2018
[REDACTED]	NPI	[REDACTED]	05/29/2002	12/31/2299	10/18/2018
[REDACTED]	NPI	[REDACTED]	06/24/2014	12/31/2299	08/19/2018
[REDACTED]	NPI	[REDACTED]	07/26/2013	12/31/2299	08/13/2018
[REDACTED]	NPI	[REDACTED]	06/26/2014	12/31/2299	10/19/2016

Total Count: 10
Current Count: 8
Historical Count: 2

Eligibility Verification



Eligibility Verification

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

Eligibility verification can be performed in the following ways:

- Internet Web site at www.ctdssmap.com
- Automated Voice Response System (AVRS)
- Point of Sale (POS) Device
- Vendor software utilizing the ASC X12N 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transaction
- Via e-Prescribing using SureScripts and the ASC X12N 270/271 transaction

Eligibility Verification

To verify a CMAP client's eligibility through the secure site – click on the *Eligibility* tab on the main menu.

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

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

Valid Search Combinations

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

Eligibility Response Quick Reference Guide

Eligibility Verification Request

Client ID	<input type="text"/>	last name	<input type="text" value="DOE"/>	From DOS*	<input type="text" value="06/23/2016"/>
SSN	<input type="text" value="666-55-4444"/>	First Name, MI	<input type="text" value="JOHN"/> <input type="text"/>	To DOS*	<input type="text" value="06/23/2016"/>
Birth Date	<input type="text"/>				
Service Type Code 1	<input type="text" value="30 - Health Benefit Plan Coverage"/>	Service Type Code 2	<input type="text"/>		
Service Type Code 3	<input type="text"/>	Service Type Code 4	<input type="text"/>		
Service Type Code 5	<input type="text"/>				

search

clear

****When entering a full name as part of your search, a middle initial is required if present in their CMAP profile****

Prior Authorization Information

Prior Authorization Information

DXC Technology accepts prior authorization requests for:

- Home Care Program for Elders- completed by Access Agencies through the Care Plan Portal
- Home Health- Money Follows the Person
- Pharmacy

CHNCT accepts prior authorization requests for:

- Outpatient Hospital Rehabilitation Therapy
- Inpatient Medical
- Surgical Care
- Home Care Services
- Vision Care Services
- Physical Therapy, Occupational Therapy, and Speech Therapy
- Medical Equipment, Devices, and Supplies (MEDS)
- Laboratory Procedures (including genetic testing)
- Outpatient Surgery
- Non-Behavioral Health Clinics
- Palivizumab (Synagis®) Request

Beacon Health Options accepts prior authorization requests for:

- Behavioral Health Services

Prior Authorization Information

Prior authorization forms are located online:

www.ct.gov/husky Click “*For Providers*” → “*Provider Bulletins, Updates and Forms*” → “*Outpatient Authorization Request Form*”

- Authorization requests may be submitted to CHNCT via either:
 - *Clear Coverage* online portal
www.ct.gov/husky click on “*For Providers*”, then “*Clear Coverage*”
 - Phone: 1-800-440-5071 (Monday through Friday, 8 a.m. to 7 p.m.)
 - Fax: 203-265-3994

www.ctdssmap.com

- Go to “*Information*” → “*Publications*” → “*Authorization/Certification Forms*” → “*Prior Authorization Request Form*”
- The DXC Technology fax number for PA submission depends upon the type of authorization being requested; refer to the form for the correct fax number

www.ctbhp.com (Beacon Health Options)

- Go to “*Providers*” > Log in -> enter Prior Authorization Request
- Phone: 1-877-55-CTBHP

Pharmacy Web Prior Authorization

Pharmacy Web Prior Authorization

Enrolled prescribing providers can utilize the Pharmacy Web PA feature on the www.ctdssmap.com secure Web portal to Submit Pharmacy PA requests.

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

home **account home** account maintenance account setup change password clerk maintenance demo **Prior Authorization** password log out

Search
Care Plan
Pharmacy Prior Authorization

Welcome, P001358193
Provider ID: 1306896287 NPI
Provider AVRS ID: 001358193
Reenrollment Due Date: 01/02/2009
Zip Code: 06810 - 5629

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

Base Information

Required fields are indicated with an asterisk (*)

Provider ID NPI

Client ID* [Search]

PA Assignment*

Drug Requested* [Search]

Last Name

First Name, MI

Date of Birth

BRAND MEDICALLY NECESSARY
EARLY REFILL
OPTIMAL DOSAGE
PREFERRED DRUG LIST

Next Exit

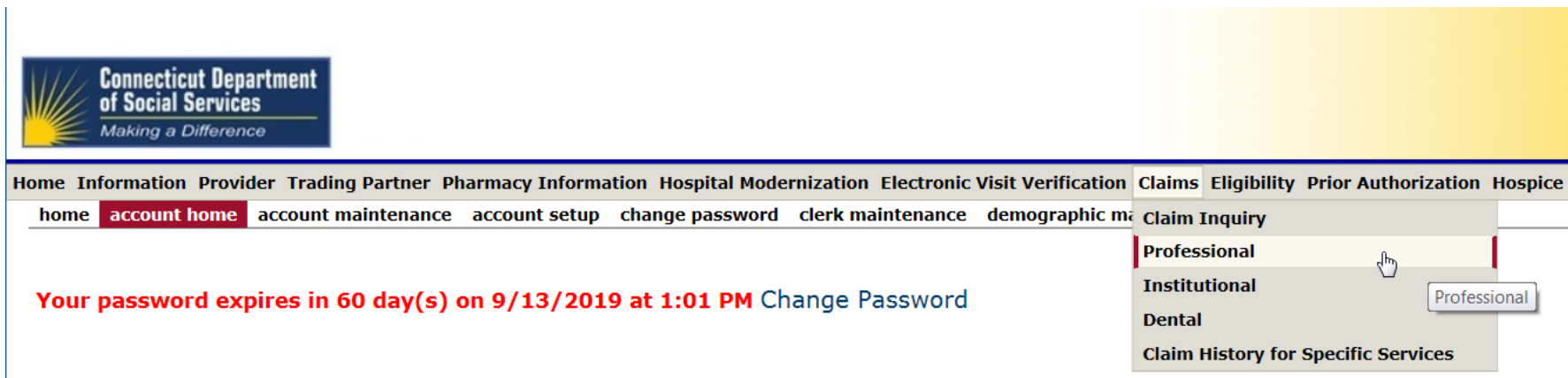
Home CT.gov Home Site Map About Us Feedback

Professional Web Claim Submission

Professional Web Claim Submission

Professional claims can be submitted through the secure Web site by signing into www.ctdssmap.com.

- Once on the secure site, select Professional from the claims drop-down menu.




The screenshot displays the website interface for the Connecticut Department of Social Services. At the top left is the logo with the text "Connecticut Department of Social Services" and "Making a Difference". A navigation bar contains links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, and Hospice. Below this is a secondary navigation bar with links: home, account home (highlighted in red), account maintenance, account setup, change password, clerk maintenance, and demographic ma. A red notification message states: "Your password expires in 60 day(s) on 9/13/2019 at 1:01 PM Change Password". On the right, a "Claims" drop-down menu is open, showing options: Claim Inquiry, Professional (highlighted with a mouse cursor), Institutional, Dental, and Claim History for Specific Services. A small "Professional" label is visible next to the selected option.

Claim types that can be submitted through the secure Web site www.ctdssmap.com:

- Primary and Secondary/Third Party Liability (TPL) claims.
- Re-submission and adjustments for non-crossover claims, if they are within timely filing.
- Recoup/Void a claim at any time regardless of timely filing.

Professional Web Claim Submission



Connecticut Department of Social Services
Making a Difference

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization **Claims** Eligibility Prior Authorization Hospice

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

Quick Links

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

Professional Claim

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

Accident Related Causes

Auto Accident Another Party Responsible Employment Related Other Accident

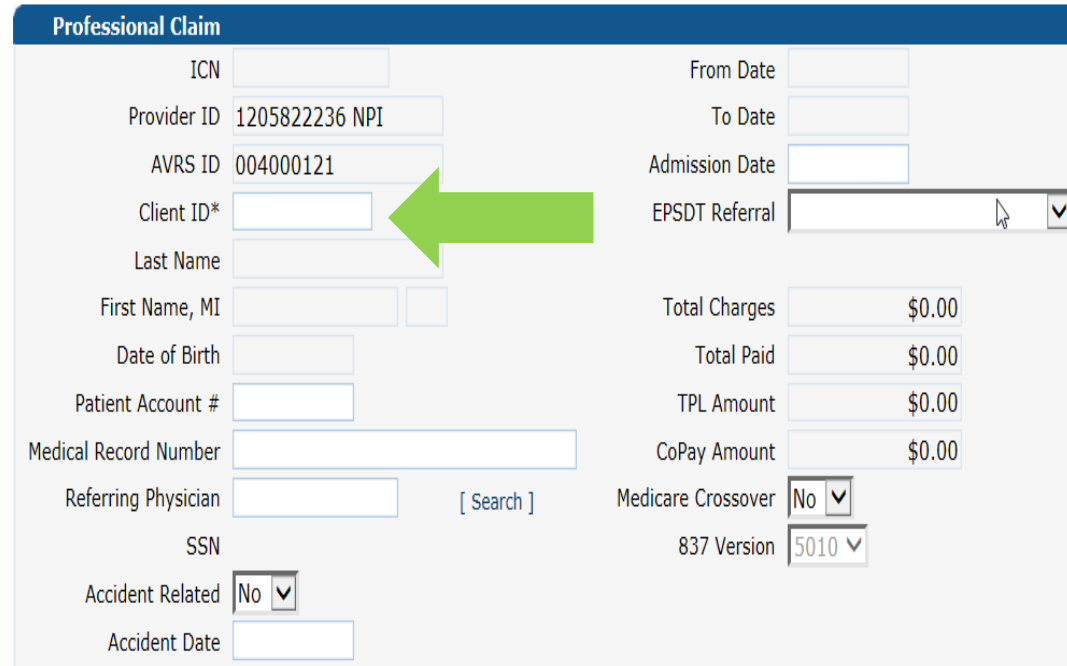
Diagnosis

Diag-Sequence	Diagnosis	Description
Code Set	<input type="text"/> ICD 10	
Principal	<input type="text"/> [Search]	Other 1 <input type="text"/> [Search] Other 2 <input type="text"/> [Search]
Other 3	<input type="text"/> [Search]	Other 4 <input type="text"/> [Search] Other 5 <input type="text"/> [Search]
Other 6	<input type="text"/> [Search]	Other 7 <input type="text"/> [Search] Other 8 <input type="text"/> [Search]

Professional Web Claim Submission

Perform the following steps to easily submit a new claim:

- Select Professional claim type from the Claims drop down box
- A blank claim will appear
- At a minimum, enter data into all required fields (identified by an asterisk after the field name)



Professional Claim

ICN	<input type="text"/>	From Date	<input type="text"/>
Provider ID	1205822236 NPI	To Date	<input type="text"/>
AVRS ID	004000121	Admission Date	<input type="text"/>
Client ID*	<input type="text"/>	EPSDT Referral	<input type="text"/>
Last Name	<input type="text"/>	Total Charges	\$0.00
First Name, MI	<input type="text"/>	Total Paid	\$0.00
Date of Birth	<input type="text"/>	TPL Amount	\$0.00
Patient Account #	<input type="text"/>	CoPay Amount	\$0.00
Medical Record Number	<input type="text"/>	Medicare Crossover	No
Referring Physician	<input type="text"/> [Search]	837 Version	5010
SSN	<input type="text"/>		
Accident Related	No		
Accident Date	<input type="text"/>		

Professional Web Claim Submission

- Enter up to 12 Diagnosis codes on a professional claim, click the add more button to enter more than 9.

Diagnosis		
Diag-Sequence ▲	Diagnosis	Description
Code Set	ICD 10 ▼	
Principal	<input type="text"/>	[Search]
Other 1	<input type="text"/>	[Search]
Other 2	<input type="text"/>	[Search]
Other 3	<input type="text"/>	[Search]
Other 4	<input type="text"/>	[Search]
Other 5	<input type="text"/>	[Search]
Other 6	<input type="text"/>	[Search]
Other 7	<input type="text"/>	[Search]
Other 8	<input type="text"/>	[Search]

[add more](#)

Professional Web Claim Submission

New Claim

Perform the following steps to submit a new claim:

- At a minimum, enter data into all required fields (identified by an asterisk after the field name)

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1			1.00	\$0.00		\$0.00

Type data below for new record.

Item	1	Status	
From DOS*		Emergency Indicator	No
To DOS*		Pregnancy	Not pregnancy Related
Procedure*	[Search]	EPSDT Referral	None
Modifiers	[Search] [Search]	Family Planning	No
Units*	1.00	Allowed Amount	\$0.00
Facility Type Code*	[Search]	CoPay Amount	\$0.00
Charges*	\$0.00	Medicare Paid Date	
Rendering Physician	[Search]	Medicare Calc Allowed Amt	\$0.00
SSN		Medicare Paid Amount	\$0.00
Referring Provider	[Search]	Medicare Deductible Amount	\$0.00
Ordering Provider	[Search]	Medicare Coinsurance Amount	\$0.00
		Diagnosis Code Pointer	
		National Drug Code	
		NDC Quantity	0
		NDC Unit of Measurement	

Professional Web Claim Submission

Detail							
Item	From DOS	To DOS	Procedure	Units	Charges	Status	Allowed Amount
A	1			1.00	\$0.00		\$0.00

Type data below for new record.

Item	1	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	No
To DOS*	<input type="text"/>	Pregnancy	Not pregnancy Related
Procedure*	<input type="text"/> [Search]	EPSDT Referral	None
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	No
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	\$0.00
Units*	1.00	CoPay Amount	\$0.00
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	\$0.00	Medicare Calc Allowed Amt	\$0.00
Rendering Physician	<input type="text"/> [Search]	Medicare Paid Amount	\$0.00
SSN	<input type="text"/>	Medicare Deductible Amount	\$0.00
Referring Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	\$0.00
Ordering Provider	<input type="text"/> [Search]	Diagnosis Code Pointer	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
		National Drug Code	<input type="text"/>
		NDC Quantity	<input type="text"/> 0
		NDC Unit of Measurement	<input type="text"/>

delete add

Rendering Physician
Referring Provider
Ordering Provider

These fields may be required depending on the service provided and the billing provider type

Professional Web Claim Submission

Perform the following steps to easily submit a new claim:

- To enter additional Detail lines click the “add” button within the panel

Detail							
Item	From DOS	To DOS	Procedure	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"/>	Status	<input type="text"/>
From DOS*	<input type="text"/>	Emergency Indicator	<input type="text" value="No"/>
To DOS*	<input type="text"/>	Pregnancy	<input type="text" value="Not pregnancy Related"/>
Procedure*	<input type="text"/> [Search]	EPSDT Referral	<input type="text" value="None"/>
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]	Family Planning	<input type="text" value="No"/>
	<input type="text"/> [Search] <input type="text"/> [Search]	Allowed Amount	<input type="text" value="\$0.00"/>
Units*	<input type="text" value="1.00"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Facility Type Code*	<input type="text"/> [Search]	Medicare Paid Date	<input type="text"/>
Charges*	<input type="text" value="\$0.00"/>	Medicare Calc Allowed Amt	<input type="text" value="\$0.00"/>
Rendering Physician	<input type="text"/> [Search]	Medicare Paid Amount	<input type="text" value="\$0.00"/>
SSN	<input type="text"/>	Medicare Deductible Amount	<input type="text" value="\$0.00"/>
Referring Provider	<input type="text"/> [Search]	Medicare Coinsurance Amount	<input type="text" value="\$0.00"/>
Ordering Provider	<input type="text"/> [Search]	Diagnosis Code Pointer	<input type="text"/>
		National Drug Code	<input type="text"/>
		NDC Quantity	<input type="text" value="0"/>
		NDC Unit of Measurement	<input type="text"/>

Professional Web Claim Submission

Perform the following steps to easily submit a new claim:

- To enter additional National Drug Codes (NDCs) click the “add” button within the panel

Additional NDCs (Detail Item 1)

*** No rows found ***

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

National Drug Code	<input type="text"/>	Quantity	<input type="text"/>	Unit of Measurement	<input type="text" value="v"/>
<input type="button" value="delete"/>	<input type="button" value="add"/>				

Professional Web Claim Submission

Medicaid is the Payer of last resort. The three digit Carrier Code of the Other Insurance (OI) is required to be submitted on the claim when OI is primary.

The three digit code can be found on the client eligibility verification screen under TPL (Third Party Liability) Information

		TPL
Carrier Code ▲	Carrier Name	
060	BC/BS OF CONNECTICUT	
K50	PRIME THERAPEUTIC	

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

It can also be found on the claim submission screen under the TPL panel in the “**Client Carriers**” field.

Professional Web Claim Submission

TPL

Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
A 060	BC/BS OF CONNECTICUT	UPX8289514	\$0.00						

Type data below for new record.

Client Carriers: 060 - BC/BS OF CONNECTICUT [v]

Carrier Code: 060 [Search] Relationship: [v]

Plan Name: BC/BS OF CONNECTICUT Last Name: []

Policy Number: [] First Name, MI: [] []

Paid Amount*: [] Date of Birth: []

Paid Date*: []

Adjustment Reason Code: [Search] [Search] [Search]

Adjustment Amount: [\$0.00] [\$0.00] [\$0.00]

[delete](#) [add](#)

Professional Web Claim Submission

Perform the following steps to easily submit a new claim:

- Click the submit button at the bottom of the claim page
- The claim will process immediately and return a status of Paid, Denied or Suspended

The image shows a two-step process for claim submission. The top screenshot shows a 'Claim Status Information' header with a dropdown menu displaying 'Claim Status Not Submitted yet'. Below this, there are two buttons: 'submit' (highlighted with a red box) and 'cancel'. A large red arrow points down to the second screenshot, which shows the same 'Claim Status Information' header, but the dropdown menu now displays 'PAID'. Below the dropdown, a table lists the claim details.

Claim Status Information	
Claim Status	PAID
Claim ICN	2219084250003
Paid Date	03/25/2019
Paid Amount	\$265.60
Patient Liability	\$0.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

Professional Web Claim Submission Void



void

Perform the following steps to void or completely recoup a paid claim:

- Select Claim Inquiry
- Enter the paid claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the Search button
- Once the claim is retrieved, click the **void** button at the bottom of the claim page
- The void will process immediately and return a message that the claim has been successfully adjusted / voided with a new ICN

Professional Web Claim Submission Adjustment

Perform the following steps to adjust a paid claim:

- Select Claim Inquiry
- Enter the paid claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the search button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the **adjust** button at the bottom of the claim page
- The adjustment will process immediately and return a status of Paid, Denied, or Suspended

Claim Status Information	
Claim Status	Adjusted / Voided
Claim ICN	2019085250003
Paid Date	03/28/2019
Paid Amount	\$85.60
Patient Liability	\$0.00
Charter Oak Coinsurance	\$0.00
Charter Oak Deductible	\$0.00

Professional Web Claim Submission

Web claim adjustment limitations

Timely Filing

- Claims that are over the Timely Filing guidelines cannot be adjusted, unless the adjustment is submitted to pay the same or less than the original claim. Otherwise, claim adjustments outside of the timely filing limit will be fully recouped.

Medicare Crossovers

- Crossover claims cannot be adjusted. They must be voided, copied and then submitted as new claims.

Special Handled Claims

- Claims with an ICN that begins with either “12” or “13” indicate that they have been special handled by DXC Technology and are, therefore, **not** able to be adjusted via the www.ctdssmap.com Web site

*****Note: Provider claims that are submitted to DXC Technology for special handling, such as timely filing overrides are excluded from the Elimination of Paper Claims mandate.*****

Professional Web Claim Submission Copy

Paid claims may be copied and submitted as a new claim

- This feature is helpful for reoccurring services



Perform the following steps to easily copy a paid claim for submission as a new claim:

- Select Claim Inquiry
- Enter the paid claim ICN (**found on your RA or via Claim Inquiry**) in the ICN field
- Click the search button
- Once the claim is retrieved, click the copy button at the bottom of the claim page
- Make the necessary changes to the claim
- Click the submit button at the bottom of the claim page

The new claim will process immediately and return a status of Paid, Denied or Suspended

Professional Web Claim Submission Resubmit



re-submit

Resubmission - Perform the following steps to easily resubmit a denied claim:

- Select Claim Inquiry
- Enter the denied claim ICN (found on your RA or via Claim Inquiry) in the ICN field
- Click the search button
- Once the claim is retrieved, make any necessary changes to the claim
- Click the re-submit button at the bottom of the claim page

The new claim will process immediately and return a status of Paid, Denied or Suspended

Professional Web Claim Inquiry

What can I do with these claims?

Paid claims allow you to:

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

Denied claims allow you to:

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

Suspended claims allow you to:

- new claim** Create a brand new claim

National Correct Coding Initiative (NCCI)

National Correct Coding Initiative (NCCI)

- To comply with federal legislation, the Department of Social Services (DSS) has adopted the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) standard payment edits designed to promote correct coding and control improper billing that could lead to inappropriate payments.
- **DSS has implemented the following NCCI edits:**
 - Medically Unlikely Edits (MUE) or units-of-service edits have been defined for each Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code which identifies the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g. claims for excision of more than one gallbladder).

National Correct Coding Initiative (NCCI)

- DSS will mirror Medicare's adoption of MUE edits and services exceeding the medically unlikely units will deny and post Explanation of Benefits (EOB) code 0770 "MUE Units Exceeded."
- Quarterly MUE updates are not published on the www.ctdssmap.com Web Site and providers are asked to refer to the CMS MUE tables by clicking on the link below to obtain published quarterly additions, deletions, and revisions:

<https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>

National Correct Coding Initiative (NCCI)

- Procedure code to procedure code (PTP) edits define pairs of HCPCS/CPT codes that should not be reported together on the same date of service for a variety of reasons and prevent reimbursement for both procedures.
- Medicaid NCCI procedure-to-procedure edits have a single column 1/column 2 correct coding edit (CCE) file.

A	B	C	D	E	F
Column1/Column 2 Edits					
1	2	3	4	5	6
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date	Modifier 0=not allowed 1=allowed 9=not applicable
1	2	prior to 1996	Date	*=no data	
99215	G0101		19980401	19980401	9

National Correct Coding Initiative (NCCI)

- Three Explanation of Benefits (EOB) codes inform providers if the procedure submitted on the claim fails the procedure code to procedure code edits.
- For some code pairs, modifiers may be used to bypass CCE which will allow column 1 and column 2 codes to be paid when performed on the same day for the same client.

Coding decisions for edits are based on conventions defined in the American Medical Association's (AMA's) "CPT Manual," national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Prior to the implementation of MUEs, the proposed edits are released for review and comment to the AMA, national medical/surgical societies, and other national health care organizations, including non-physician professional societies, hospital organizations, laboratory organizations, and durable medical equipment organizations. Similarly, proposed NCCI edits are released to various national health care organizations for review and comment prior to implementation.

National Correct Coding Initiative (NCCI)

EOB codes:

- 5924 – “Claim Denied, CCI Greater and Lesser Procedure are Not Covered on Same Date of Service”.
 - This edit will set if both the greater and the lesser procedure codes are submitted on the same claim.
- 5925 – “CCI Column 1 Code or Mutually Exclusive Code Was Billed on the Same Date as Previous Column 2 Code”.
 - This edit will set if the lesser procedure code has been paid and a claim with the greater procedure code is submitted for the same client for the same date of service.
 - The greater procedure will pay, but the lesser procedure will be recouped in the 2nd cycle of every month.

National Correct Coding Initiative (NCCI)

- 5926 – “CCI Column 2 Code Was Billed on the Same Date as Previous Column 1 or Mutually Exclusive Code”.
 - This edit will set if the greater code has been paid and a claim is submitted with the lesser code for the same client for the same date of service.

National Correct Coding Initiative (NCCI)

- **The list of modifiers allowed by Medicaid is identical to the list of modifiers allowed by Medicare.**
 - The Chapter 8 Physician Provider Manual has a detailed list of modifiers that can be used. This information can be accessed from our Web site www.ctdssmap.com. From the Home page, click on “Information”, then “Publications”, scroll down the page to Provider Manuals section, select “Physician” from the drop down menu for Chapter 8 and click “View Chapter 8”.
 - Provider Bulletins addressing NCCI can be accessed from our Web site www.ctdssmap.com. From the Home page, click on “Information”, then “Publications”, and then enter the appropriate year and bulletin number under Bulletin Search.

National Correct Coding Initiative (NCCI)

- Visit the CMS Web site

<http://www.cms.gov/NationalCorrectCodInitED/> for:

- Instructions on how to use NCCI
- How to locate the NCCI Tables Manual
- How to look up procedure code to procedure code edits
- Use of bypass modifiers

National Correct Coding Initiative Edits
Medically Unlikely Edits
Quarterly NCCI and MUE Version Update Changes
NCCI Coding Edits
Add-on Code Edits
Transmittals

Claim Resolution Guide

Claim Resolution Guide

Provider Manual Chapter 12 – Claim Resolution Guide

- This guide lists commonly posted Explanation of Benefit (EOB) codes and provides a brief explanation of the reason why claims were either suspended or denied.
- This guide provides a detailed description of the cause of each EOB and more importantly, the necessary correction to the claim, if appropriate, in order to resolve the error condition.
- This guide also provides tips by identifying where providers can go to find additional information to assist with correcting their claims.

Example of an EOB:

EOB								
View								
<input checked="" type="radio"/> All <input type="radio"/> Current <input type="radio"/> Historical								
Detail Number	EOB Code	EOB Description	Financial Payer	Benefit Plan	Status	Adjustment Amount	Adjustment Units	Origin
0	1912	BILLING PROVIDER'S TAXONOMY IS MISSING			Current	\$130.00	0.000	System Generated
1	9996	REFER TO HEADER EOB			Current	\$130.00	0.000	System Generated

Provider Audits



Provider Audits

In accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, audit protocols have been published on the Department of Social Services' Web site. An introduction to audit protocols and an overview of the audit process can be found at: <http://www.ct.gov/dss/auditprotocols>. Additional resources can be found in Bulletin PB17-29.

Links to audit protocols organized by provider type are located on the lower section of this Web page.

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

[Dental audit protocols](#)

[Homecare audit protocols](#)

[Home health audit protocols](#)

[Medical equipment audit protocols](#)

[Outpatient hospital audit protocols](#)

[Pharmacy audit protocols](#)

[Physicians audit protocols](#)

Provider Audits

The Office of Quality Assurance

[Overview](#)

[Related Resources](#)

Provided by:

[Department of Social Services](#)

Related Resources

These audit protocols are being published on the Department of Social Services' (the "Department") Internet website in accordance with subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes. The purpose of the protocols is to assist the medical provider community in developing programs to improve compliance with Medicaid requirements under state and federal law. Audit protocols are intended solely as guidance in this effort. As provided in subdivision (11) of subsection (d) of section 17b-99 of the Connecticut General Statutes, these audit protocols "may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation," and do not constitute rulemaking by the Department. Nothing in the audit protocols alters any statutory or regulatory requirements. **In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.**

A Medicaid provider's legal obligations are governed by applicable federal and state law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law.

Audit protocols are applied to a specific provider or category of service in the course of an audit and involve the Department's application of articulated Medicaid agency policy and the exercise of agency discretion. The Department, consistent with state and federal law, may pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program.

The Department will amend its audit protocols as necessary. Reasons for amending protocols include, but are not limited to, responding to court or administrative decisions, directives from the Centers for Medicare and Medicaid Services or statutory or regulatory changes.

Provider Fee Schedules

Provider Fee Schedules

All professional services will be reimbursed based on the physician fee schedule.

The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Web site, www.ctdssmap.com. From the Home page, go to “Provider”, then to “Provider Fee Schedule Download”, you must read and accept the End User License Agreement prior to downloading the fee schedule and click “I Accept” and then go to the appropriate “Physician” fee schedule. To access the CSV file, press the control key while clicking the CSV link, then select “Open”.

Services rendered by an APRN or physician assistant (PA) will be reimbursed at 90% of the established physician fee; or 90% of the obstetrical or pediatric fee when all of the applicable criteria are met.

Provider Fee Schedules

CMAP *fee schedules* are available for download from the Web site.

- Select *Provider Fee Schedule Download* from the *Provider* drop-down menu
- You must read and accept the *End User License Agreement* prior to downloading the fee schedule; click *I Accept*

Provider	Trading Partner	Pharmacy Info
Provider Enrollment		
Provider Re-Enrollment		
Provider Enrollment Tracking		
Provider Matrix		
Provider Services		
Provider Search		
Drug Search		
Provider Fee Schedule Download		
EHR Incentive Program		
OOS Instructions/Information		
Secure Site		

Provider Fee Schedules

- Provider Fee Schedules are listed by provider type and specialty.
- Click the corresponding link to download the appropriate fee schedule. If it is a CSV link, you will be required to hold down the “ctrl” key.

***** 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](#)
- Behavioral Health Clinician [CSV](#)
- Chiropractor [CSV](#)
- Clinic - Ambulatory Surgical Center [CSV](#)
- Clinic - Chemical Maintenance [CSV](#)
- Clinic - Clinic and Outpatient Hospital Behavioral Health [CSV](#)
- Clinic - Dialysis [CSV](#)
- Clinic - Family Planning / Abortion [CSV](#)
- Clinic - Medical [CSV](#)
- Clinic - Rehabilitation [CSV](#)
- Community First Choice - Assessments [CSV](#)
- Community First Choice - Services [CSV](#)
- CT Home Care [CSV](#)
- Dental Adult [CSV](#)
- Dental DOS Prior to 09/01/2016 [CSV](#)
- Dental Pediatric [CSV](#)
- Home Health [PDF](#)
- Hospice [CSV](#)
- Hospital DRG Organ Acquisition [PDF](#)
- Hospital Outpatient [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](#)

Provider Fee Schedules

Example of the Physician Surgical fee schedule:

Procedure Code	Proc description	Mod1	Rate Type	Max Fee	Effective Date	End Date	PA	Surgery
37192	Redo endovas vena cava filtr		FTS	228.37	10/1/2014	12/31/2299		
37192	Redo endovas vena cava filtr		SUR	1134.5	1/1/2012	12/31/2299		
37193	Rem endovas vena cava filter		FTS	228.15	10/1/2014	12/31/2299		
37193	Rem endovas vena cava filter		SUR	1082.36	1/1/2012	12/31/2299		
37195	Thrombolytic therapy stroke		SUR	195.86	1/1/2008	12/31/2299		#
37197	Remove intrvas foreign body		FTS	186.68	10/1/2014	12/31/2299		
37197	Remove intrvas foreign body		SUR	788.05	1/1/2013	12/31/2299		

Rate Types

SUR – Surgical Rate

FTS – Facility Surgical Rate (For POS 19, 21-25, 31 or 32)

Provider Fee Schedules

Example of the Physician Office and Outpatient Services fee schedule:

Procedure	Proc description	Mod1	Mod1 des	Rate Type	Max Fee	Effective Date	End Date	PA
93010	Electrocardiogram report			DEF	5.12	1/1/2008	12/31/2299	
95810	Polysom 6/> yrs 4/> param	26		DEF	103.59	9/7/2015	12/31/2299	
95810	Polysom 6/> yrs 4/> param	26		DEF	265.53	8/18/2010	9/6/2015	
99283	Emergency dept visit			MPH	36.78	1/1/2012	12/31/2299	
99291	Critical care first hour			DEF	159.51	1/1/2008	12/31/2299	
99291	Critical care first hour			FTD	127.59	1/1/2015	12/31/2299	

Rate Types

DEF – Default Rate

MPH – Melded Physician Rate

FTD – Facility Default Rate (For POS 19, 21-25, 31 or 32)

Fee Schedules (Footer Section)

The footer is a great source of additional information:

MP in Max Fee column designates Manually Priced

Psychiatry Specialty Physician/Groups or Advance Practice Nurse/Groups (Type/____ Specialty 09/106; 09/339; 31/339; 31/639; 70/106; 70/339; 72/339; 72/639) for____ coverage groups BHP A; BHP B; CHOAK; and FFS the following codes always require____ PA: 90791; 90792; 90832; 90834; 90837; 90846; 90847; 90849; 90853; 90865;____ 90876; 90870; 90875; 90880; 90887; 96101; 96118; 99201-99215; 99241- 99245;____ 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99318; 99324;____ 99325; 99326; 99327; 99328; 99334; 99335; 99336; 99337; 99339; 99340; and____ M0064. To obtain PA contact CT BHP at 1-877-552-8247

To obtain PA for ICD-9-CM Diagnosis Codes 291-316 or for ICD-10-CM Diagnosis Codes____ in the Fee Schedule Instructions Table 11 please contact CT BHP at____ 1-877-552-8247

PA required for ALL rehabilitation services beyond initial evaluation - HUSKY B and____ Charter Oak (97010-97039; 97110-97150; 97530-97537; 97542-97546;____ and 92507-92508)____ 87800; 88302; 88304; 88305; 88307; 90649; 90650; 90651; 96372; 99070; 99144; 99145;____ 99201-99205; 99211-99215; 99384-99386; 99394-99396; A4261; A4264;____ A4266; J0696; J1050; J7297; J7298; J7300; J7301; J7302 (for dates of service____ through 12/31/2015); J7303; J7304; J7306; and J7307____ S4993; S5000; S5001 only codes covered for Family Planning Service Only clients

HUSKY B does not cover the following codes: 90880; 90901; 90911; 93784____ 93786; 93788; 93790; 97810-97814; 99450; 99455; 99456; A4264

Provider Fee Schedules

The Fee Schedule Instructions link can be found above the Provider Fee Schedules



Help

Friday, April 29, 2016

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

home provider enrollment provider re-enrollment provider enrollment tracking provider matrix provider services provider search drug search **provider fee schedule download**
ehr incentive program oos instructions/information e-mail subscription secure site

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

Provider Fee Schedule Download

Quick Link

■ [Fee Schedule Quick Start](#)

Enhanced Rates

HUSKY Health Primary Care Increased Payments Policy

As mandated under Section 1202 of the Affordable Care Act (ACA), Medicaid increased its payments to equal the 2013 and 2014 Medicare fee for certain primary care codes when billed by an eligible primary care provider, who has submitted a valid attestation to the Department of Social Services. In order to continue increased primary care payments for dates of service beyond December 31, 2014, the Connecticut General Assembly appropriated funding within the Medicaid budget. Effective January 1, 2015 the primary rate increase payments are being made under the **HUSKY Health Primary Care Increased Payment Policy** and are contingent on funding appropriated annually by the General Assembly.

Providers must be enrolled with CMAP and self attest to one or more of the following specialties:

- Pediatric medicine
- Family Medicine
- Internal Medicine
- Subspecialists within one or more of the specialties listed above

Please refer to PB 14-75, PB 15-44, and PB 17-44 for additional information as well as an IM published on the ctdssmap.com Web site.

Person-Centered Medical Home (PCMH)

The Department of Social Services introduced an initiative in 2012 for practices and clinics that demonstrates an innovative model of care focusing on the person rather than the medical condition.

Program Participation - To be eligible to apply and qualify for PCMH status, a practice must be enrolled in the CMAP under one of the following designations, Independent physician group, or solo practice; Hospital outpatient clinic

Program Payment – Physician practices and Hospital outpatient clinics are eligible for higher level reimbursement for primary care services and performance-based payments.

Please visit www.HUSKYHealthct.org for additional information.

Provider Bulletins



Provider Bulletins

Provider Bulletins

- Access the Publications page by selecting Publications from either the Information box on the left hand side of the home page (www.ctdssmap.com) or from the Information drop-down menu.
- Bulletin Search allows you to search for specific bulletins (by year, number, or title) as well as for all bulletins relevant to your provider type.
 - When searching by provider title, you can search by any word as long as that word is in the title of the bulletin.

Provider Bulletins

Provider Bulletins – Searching by Year and Type



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

home **publications** links hipaa messages archive



Information

Bulletin Search

Year Provider Type

Number Title

search

clear

Search Results

Bulletin Number	Title	Published Date
PB19-50	Claim Rejection E-Mailboxes for Providers and Who to Contact	07/11/2019
PB19-49	Correction to the Guidance for Billing Evaluation and Assessment Services for Ho...	07/11/2019
PB19-48	Adult Family Living Residency Requirements	06/27/2019
PB19-47	Updated Prior Authorization Requirement for Frenulectomies for Children	06/26/2019
PB19-46	Methadone Maintenance Reimbursement Rates	07/02/2019
PB19-45	Elimination of Paper Trading Partner Agreements Notification	06/24/2019
PB19-44	Revision of Rates for Certain Clinical Diagnostic Laboratory Testing Codes	06/20/2019
PB19-43	Meals on Wheels Rate Increase	06/18/2019
PB19-42	Update for the Adult Dental Fee Schedule Composite Restorations on Molar Teeth	07/04/2019
PB19-41	Update to the Dental Fee Schedule Cone Beam Computed Tomography Imaging	06/17/2019
PB19-40	New Coverage Guidelines: Peristeen Anal Irrigation System	06/25/2019
PB19-39	Updated Guidance for Billing Medical Services Performed in Federally Qualified H...	06/06/2019
PB19-38	Update for Billing Coding for the Access for Baby Care to Dental Examination and...	06/13/2019
PB19-37	Clarifying the Guidance for Electronic Consultations Performed by Federally Qual...	05/30/2019
PB19-36	July 2019 Update to MEDS Fee Schedule	06/07/2019

Telehealth Capabilities



Telemedicine Services

Effective for dates of service March 13, 2020 and forward, the Department of Social Services (DSS) will implement medical and behavioral health services of specified synchronized telemedicine, which is defined as an audio and video telecommunication system with real-time communication between the patient and practitioner.

Telemedicine services are covered under the Connecticut Medical Assistance Program (CMAP) only when they:

- Are medically necessary, in accordance with the statutory definition of medical necessity in section 17b-259b of the Connecticut General Statutes.
- Are rendered via a HIPAA-compliant, real time audio and video communication system (but note that certain popular video chatting software programs are not HIPAA-compliant).
- Comply with all CMAP requirements that would otherwise apply to the same service performed face-to-face (in-person), including, but not limited to, enrollment, scope of practice, licensure, documentation, and other applicable requirements.



Telemedicine Services

BILLING AND DOCUMENTATION GUIDELINES

Reimbursement/payment rates for telemedicine services are the same as for equivalent in-person services and based on the CMAP Professional Fee Schedule.

Documentation must be maintained by both the originating site provider and the distant site provider to substantiate the services provided. Originating site documentation must indicate the member received or has been referred for telehealth services.

- Originating site - the physical location of the CMAP member when the member receives telemedicine services.
- Distant site - the physical location of the CMAP practitioner/provider who is performing the telemedicine service.

If a telehealth service cannot be provided or completed for any reason, such as due to technical difficulty, the provider shall not submit a claim.



Telemedicine Services

BILLING AND DOCUMENTATION GUIDELINES

The following categories of medical services described below are eligible for payment when rendered via telemedicine and should be billed by the individual physician or physician group.

- Established Patient Evaluation and Management (E/M) Services 99211-99215.

The following modifier(s) must be billed on services that were rendered via telemedicine.

- Modifier “GT” is used when the member’s originating site is located in a healthcare facility or office.
- Modifier “95” is used when the member is located in the home.

For additional information on telemedicine services refer to provider bulletin 2020 – 09 “New Coverage of Specified Telemedicine Services Under the Connecticut Medical Assistance Program (CMAP).”

Telephonic (Audio-Only) Services

In response to concerns over the spread of COVID-19, effective March 18, 2020 until otherwise notified by DSS in writing, select services for established patients rendered via the telephone or other audio only modalities will be covered by CMAP.

Description	Billable CPT/HCPC Code	Rate
Physician telephone patient service, 11-20 minutes of medical discussion	99442	\$42.93
Physician telephone patient service, 21-30 minutes of medical discussion	99443	\$64.99

A member does not need the diagnosis or symptoms of COVID-19 to access these services via the telephone. To the extent applicable, providers must comply with applicable state laws regarding telehealth and scope of practice.



Telephonic (Audio-Only) Services

Providers must adhere to the following guidelines when billing telephonic services only.

Providers must obtain verbal informed consent from the member before providing services via the telephone and document such consent in the medical record. The provider must ensure each member is aware they can opt-out or refuse services at any time.

- If the member is a minor child, a parent or legal guardian must provide verbal informed consent before providing services via the telephone.
- Providers must develop and implement procedures to verify provider and patient identity.
- Providers must document completely for the service billed, including a notation that the service was rendered via the telephone and follow current documentation requirements for the type of service being billed.
- If a service cannot be provided or completed for any reason, such as due to technical difficulty, providers shall not submit a claim.

Telemedicine Services Resources For Telehealth

COVID-19 FAQs Important Message



Help
9/1/2020

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Trading Partner

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WELCOME TO THE CONNECTICUT MEDICAL ASSISTANCE PROGRAM

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



Information



Provider



Trading Partner



Pharmacy

Important Messages

[COVID-19 Information and FAQs \(Updated 9/1/20\)](#)


[Attention Providers: Provider Bulletin 2020-63 Clarification \(Posted 8/27/20\)](#)



Telemedicine Services

Resources For Telehealth

Bulletin Search : **Keyword COVID**



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Tuesday, September 1, 2020

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Bulletin Search

Year Provider Type

Number Title

Search Results

Bulletin Number	Title	Published Date
PB20-60	CMAPI COVID-19 Response - Bulletin 39: Modification of Minimum Weekly Hour and Ti...	08/13/2020
PB20-54	CMAPI COVID-19 Response - Bulletin 38: Increase in Inpatient Hospital Reimburse...	06/22/2020
PB20-53	CMAPI COVID-19 Response - Bulletin 37: Reauthorizations of Home Health Services D...	05/29/2020
PB20-50	CMAPI COVID-19 Response - Bulletin 36: Wheelchair Assessments Rendered Via Synchr...	06/02/2020
PB20-49	CMAPI COVID-19 Response - Bulletin 33: Addition of Laboratory Procedure Codes to ...	06/22/2020
PB20-48	REVISED CMAPI COVID-19 Response - Bulletin 32: Services Covered Under the Optiona...	05/15/2020
PB20-47	CMAPI COVID-19 Response - Bulletin 31: Updated Synchronized Telemedicine (Audio a...	05/18/2020
PB20-46	CMAPI COVID-19 Response - Bulletin 35: Emergency Updated Telemedicine Guidance Pe...	06/02/2020
PB20-45	CMAPI COVID-19 Response - Bulletin 29: Updated Guidance Regarding Audio-Only Tel...	05/11/2020
PB20-44	CMAPI COVID-19 Response - Bulletin 30: Updated Audio-Only Behavioral Health (Tele...	05/11/2020
PB20-43	CMAPI COVID-19 Response - Bulletin 28: Emergency Medicaid for Non-Citizens	04/30/2020
PB20-42	CMAPI COVID-19 Response - Bulletin 27: New COVID-19 Coverage Group for Uninsured ...	04/30/2020
PB20-40	CMAPI COVID-19 Response - Bulletin 34: Enrollment of CMAPI Out-of-State Providers	05/27/2020
PB20-39	CMAPI COVID-19 Response - Bulletin 25: Non-Emergency Medical Transportation and N...	04/13/2020
PB20-38	CMAPI COVID-19 Response - Bulletin 26: Additional Changes to the Synchronized Tel...	04/16/2020
PB20-37	CMAPI COVID-19 Response - Bulletin 24: Addition of Laboratory Procedure Codes to ...	06/22/2020

eDelivery

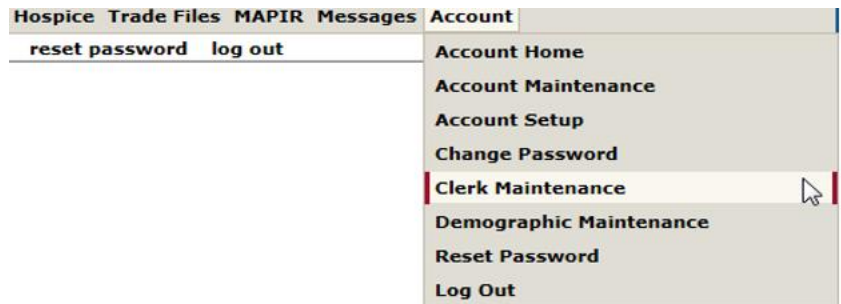
eDelivery –Update

Clerk Maintenance

A clerk can access e-delivered letters if assigned that permission by their primary account holder. This can be done through two roles:

- the existing role of Trade Files (has been re-named Trade Files Includes E-Delivery) – allows access to download all files
- a new role of Trade Files E-Delivery Only – allow access to eDelivery 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



eDelivery –Update

The following screen print displays the two roles that can be assigned to a clerk that include eDelivery: (Clerks can be assigned either role, but not both)

- Trade files includes E-Delivery
- Trade files E-Delivery Only

Connecticut Department of Social Services
Making a Difference

Help
Thursday, February 28, 2019

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

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

Clerk Maintenance

User ID	Contact First Name	Contact Last Name
CLERK01	Dawn	Test
CLERK02	Dawn	Test
CLERK05	Dawn	Test
CLERK06	Dawn	Test
CLERK08	Dawn	Test
CLERK31	Test	Clerk

Type data below for new record.

remove clerk add clerk

User ID*
Contact First Name*
Contact Last Name*
Phone Number*
Password*
Confirm Password*
AVR ID
AVR Pin
Confirm AVR Pin

unback reset password

Assigned Roles Available Roles

Clerk Roles (Internet Only)

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

submit cancel

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eDelivery –Update

- A user can download their letters by selecting Trade Files then Download from the menu items.
- Select E-Delivery from the Transaction Type field.
- A user can also sort their letters by title, date available and date downloaded.

Connecticut Department of Social Services
Making a Difference

Thursday, February 28, 20

Home Information Provider Trading Partner Pharmacy Information Hospital Modernization **Trade Files** MAPIR Messages Account

home **download** upload claim level detail

File Download Search

Transaction Type | E-Delivery

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.

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
000322230_PRV-9137-R_1179846_379798_20190220.pdf	OOS License Verification Request Letter	02/20/2019	02/21/2019

eDelivery –Update

Notification

- **Email notification will be sent to the email address associated with the primary account holder and clerk’s Secure Web portal account.**
- **Email sent daily for letters posted the day prior.**
- **Only one email generated, even if multiple letters posted the previous day.**

➤ If a clerk is associated to multiple master users, the email will indicate the master user(s) to which the posted letters apply.

- **Sample Email text:**

From: ctdssmap@dx.com

Subject: CMAP E-Delivery Alert – Letter(s) Available

- **Reminder: It is important all users keep their data updated, including their contact email information, as well as maintaining clerk data.**

Resources

Resources

- **Connecticut Medical Assistance Program Web site**
- www.ctdssmap.com
- **Information > Publications > Claims processing information**
 - Internet Claims Submission FAQ
- **Information > Publications > Provider Manuals**
 - Chapter 8 Provider Specific Claim Submission Instructions
 - Chapter 10 Web Portal/AVRS
 - Chapter 11 Other Insurance and Medicare Billing Guides
 - Chapter 12 Claim Resolution Guide

Contacts

Contacts

DXC Technology Provider Assistance Center (PAC)

1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays

CTDSSMAP - ProviderEmail@dxc.com

DXC Technology Pharmacy Prior Authorization Assistance Center (PPAAC)

1-866-409-8386 – In the office Monday thru Friday, 7:00 AM – 9:00 PM (EST), and Saturday, 9:00 AM – 4:00 PM (EST), on-call service available outside of office hours.

DXC Technology Electronic Data Interchange (EDI) Help Desk

1-800-688-0503 – Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays

CHNCT Provider Relations (prior authorizations)

1-800-440-5071 – Monday through Friday, 9 a.m. to 7 p.m. (EST)

Beacon Health Options

1-877-552-8247– Monday through Friday, 9 a.m. to 7 p.m. (EST)

www.ct.gov/husky

www.evicore.com/pages/providerlogin.aspx

www.CTDSSMAP.com

Time for Questions

