



# Connecticut Medical Assistance Program Professional Refresher Workshop

Presented by  
The Department of Social Services & Gainwell Technologies

# 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

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 by using the following link:
  - [Ct Enrollment Criteria Matrix](#)
- Re-enrollment via the Enrollment/Re-enrollment Wizard on the CMAP Web site, [www.ctdssmap.com](http://www.ctdssmap.com), is required

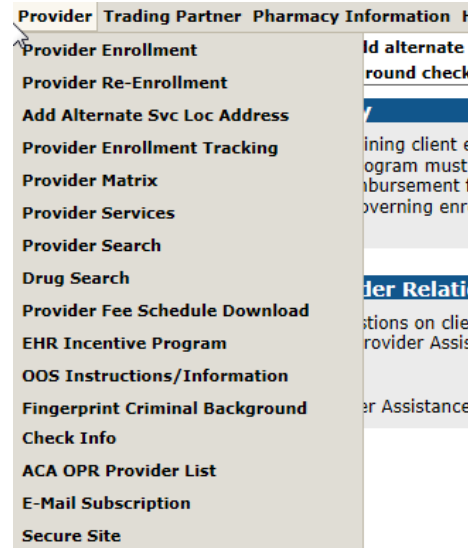
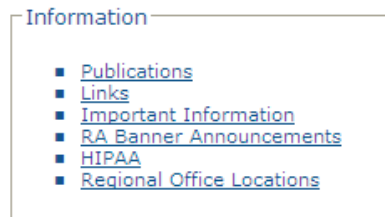
*Organization and individual providers with Secure Web portal access can view their re-enrollment due date on the Home page of their Secure Web portal once logged in!*

# Re-enrollment

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

- All 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 Gainwell Technologies 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



# 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 web portal interface. At the top is a navigation bar with links: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims, Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. The 'Account' link is highlighted in red. Below the navigation bar is a secondary menu with links: home, account home (highlighted in red), account maintenance, account setup, change password, clerk maintenance, demographic maintenance, reset password, and log out. Below the menu is a user profile section with the following text: 'Welcome, P0042', 'Provider ID: NPI', 'Provider AVRS ID:', 'Reenrollment Due Date: 10/18/2018', and 'Zip Code: 06010 - 5106'. A large blue arrow points from the right towards the 'Reenrollment Due Date' text.

# Re-enrollment

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



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

A screenshot of the 'Enrollment Tracking Search' form. It has a blue header with the text 'Enrollment Tracking Search'. Below the header, there are two input fields: 'ATN\*' with the value '305929' and 'Business OR Last Name\*' with the value 'SMITH'. To the right of the input fields are two buttons: 'search' and 'clear'.

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

Search Results	
Date	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

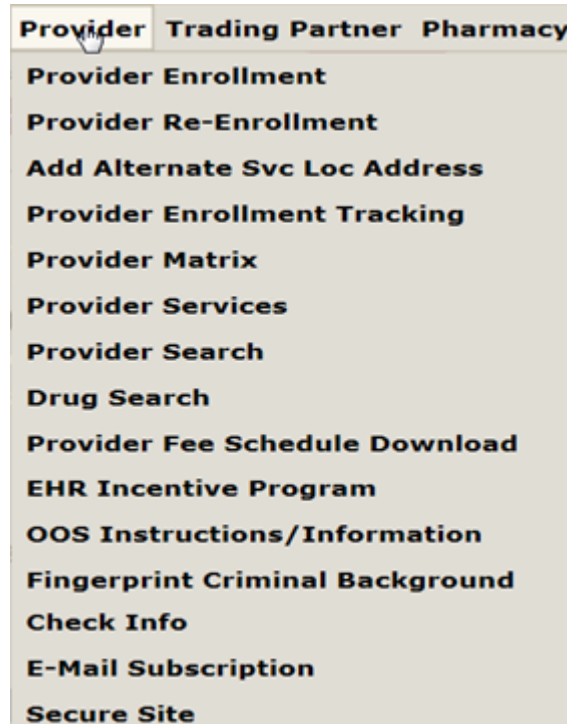
## Adding Alternate Service Location Addresses

- **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 Gainwell Technologies 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

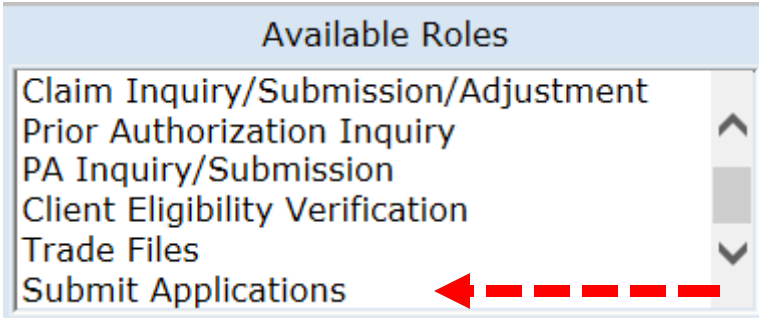
- To begin a new add alternate service location address application, navigate to the [www.ctdssmap.com](http://www.ctdssmap.com) Web site and log into your Secure Web portal account. Once logged in, select Provider > Add Alternate Svc Loc Address.



# 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

1. As of June 27, 2018, self-service functionality for master users (providers and trading partners) and their clerks has been enhanced.
2. 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.
3. The enhanced self-service functionality will allow users to:
4. Reset their password by responding to the updated questions and answers supplied through the one time set up process.
5. 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.
6. 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.
7. 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	<input type="text" value="Service Location"/>	City	<input type="text" value="MANCHESTER"/>
Provider Type	<input type="text" value="31 - Physician"/>	County	<input type="text" value="Hartford"/>
Provider Specialty	<input type="text" value="322 - Internal Medicine"/>	State/Zip	<input type="text" value="VT 02456-4556"/>
Phone	<input type="text"/>		

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



# Demographic Maintenance – Address Updates

Specify different mailing, payment, service location, home office, 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

Type changes below.

Name Type  Business Name  Personal Name

Name

Title

Usage

Country

Address 1\*

Address 2

City

State

Zip\*

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.

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

## Maintain Organization Members

• 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 Gainwell Technologies 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](http://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

search

clear

Organization Member ID ▲	ID Type	Organization Member Name	Effective Date	End Date	Reenrollment Due Date
	MCD		06/05/2000	01/31/2003	12/31/2299
	MCD		07/09/1999	09/24/2001	12/31/2299
	MCD		06/29/1999	06/01/2002	12/31/2299
	MCD		07/01/2001	02/11/2018	12/31/2299
	MCD		04/30/2000	09/24/2001	12/31/2299
	MCD		01/01/1999	09/24/2001	12/31/2299
	MCD		06/23/2000	08/31/2004	12/31/2299
	MCD		07/14/1999	09/24/2001	12/31/2299
	MCD		07/09/1999	09/24/2001	12/31/2299

# 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](http://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.

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"/>				

**\*\*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

## Gainwell Technologies accepts prior authorization requests for:

- 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](http://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](http://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](http://www.ctdssmap.com)

- Go to “Information” → “Publications” → “Authorization/Certification Forms” → “Prior Authorization Request Form”
  - The Gainwell Technologies 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](http://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](http://www.ctdssmap.com) secure Web portal to Submit Pharmacy PA requests.

The screenshot shows the top navigation bar of the Pharmacy Web PA portal. The navigation bar includes links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Claims Eligibility, Prior Authorization, Hospice, Trade Files, MAPIR, Messages, and Account. The Account link is highlighted in red. Below the navigation bar, there is a sub-menu for Prior Authorization with options for Search, Care Plan, Pharmacy Prior Authorization (highlighted with a mouse cursor), and Authorization. To the left of the sub-menu, there is a user information section with the following text: Welcome, P001358193; Provider ID: 1306896287 NPI; Provider AVRS ID: 001358193; Reenrollment Due Date: 01/02/2009; Zip Code: 06810 - 5629. Below this, there is a message: Your R.A.s, or 835 transactions, are being sent to: Your download page in the Trade Files menu option. To the right of the sub-menu, there is a Quick Link section with a list of links: Check E-messages, Claim Status Inquiry, Client Eligibility Verification, Prior Authorization Inquiry, Download Remittance Advices, ACA Ordering/Prescribing/Referring Provider List.

The screenshot shows the Base Information form for submitting a Pharmacy PA request. The form is titled "Base Information" and includes a note: "Required fields are indicated with an asterisk (\*)". The form fields are: Provider ID (with NPI dropdown), Client ID\* (with search button), PA Assignment\* (dropdown menu), Drug Requested\* (dropdown menu with options: BRAND MEDICALLY NECESSARY, EARLY REFILL, OPTIMAL DOSAGE, PREFERRED DRUG LIST), Last Name, First Name, MI, and Date of Birth. There are "Next" and "Exit" buttons at the bottom of the form. The bottom of the page features a footer with links for Home, CT.gov Home, Site Map, About Us, and Feedback.

# Professional Web Claim Submission

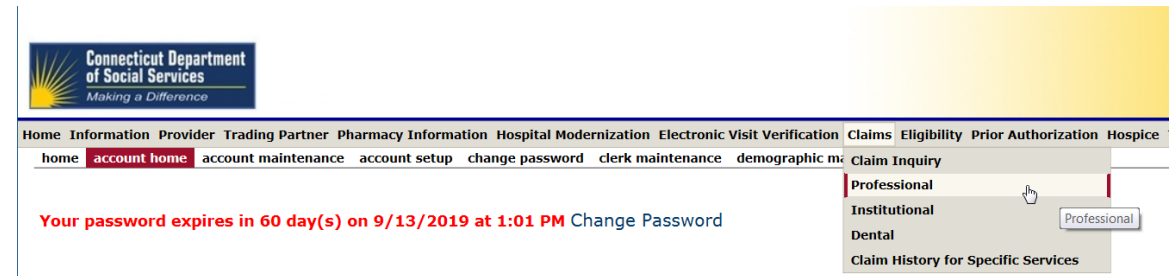
# Professional Web Claim Submission

Professional claims can be submitted through the secure Web site by signing into [www.ctdssmap.com](http://www.ctdssmap.com).

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

Claim types that can be submitted through the secure Web site [www.ctdssmap.com](http://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.



The screenshot shows the website header for the Connecticut Department of Social Services. The logo on the left reads "Connecticut Department of Social Services" with the tagline "Making a Difference". The navigation menu includes: Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, Electronic Visit Verification, Claims, Eligibility, Prior Authorization, Hospice, and Claim Inquiry. The "Claims" menu is open, showing options for Professional, Institutional, Dental, and Claim History for Specific Services. A red notification banner states: "Your password expires in 60 day(s) on 9/13/2019 at 1:01 PM Change Password".

# 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 3	<input type="text"/> [ Search ]	Other 4 <input type="text"/> [ Search ]
Other 6	<input type="text"/> [ Search ]	Other 7 <input type="text"/> [ Search ]
		Other 8 <input type="text"/> [ Search ]

- **The Internet Claims Submission FAQ** document contains relevant information that will guide you thru the process of submitting a claim via the web.
- **The Claim Resolution Guide** contains a list of common denial codes and resolution methods.

# 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	<input type="text" value="\$0.00"/>
First Name, MI	<input type="text"/>	Total Paid	<input type="text" value="\$0.00"/>
Date of Birth	<input type="text"/>	TPL Amount	<input type="text" value="\$0.00"/>
Patient Account #	<input type="text"/>	CoPay Amount	<input type="text" value="\$0.00"/>
Medical Record Number	<input type="text"/>	Medicare Crossover	<input type="text" value="No"/>
Referring Physician	<input type="text"/> [ Search ]	837 Version	<input type="text" value="5010"/>
SSN	<input type="text"/>		
Accident Related	<input type="text" value="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 ▲	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 ]
<input type="button" value="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	<input type="text" value="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*	<input type="text" value="1.00"/>	CoPay Amount	\$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"/>

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  Quantity  Unit of Measurement

- A Drug Search tool is available on the [www.ctdssmap.com](http://www.ctdssmap.com) Web site to assist providers to crosswalk the administered NDC to the corresponding HCPCS code. This tool also helps to validate whether the NDC is valid, rebateable and payable on the date of administration. To access the Drug Search tool from the Web site Home page, go to Provider, then Drug Search and enter at least one of the following: NDC, Drug Name, HCPCS code, or HCPCS Description in the appropriate field and click the search button.



Connecticut Department of Social Services  
Making a Difference

Home **Information** Provider Trading Partner Pharmacy

- 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

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**  
oos instructions/information fingerprint criminal background check info e-mail subscription secure site

**Drug Search**

NDC  Drug Name  Drug Sounds-Like

HCPCS  HCPCS Description  HCPCS Sounds-Like

DOS

Records

# Professional Web Claim Submission

- Determine the correct NDC Quantity and Unit of Measurement

- Example:

NDC 10599-0003-01

Unit of Measurement-refer to Dose Strength for reference

Quantity-Refer to Package Size for reference

**Additional NDCs (Detail Item 1)**  
 \*\*\* No rows found \*\*\*

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

National Drug Code  Quantity  Unit of Measurement

HCPSC Code for Mometasone furoate sinus implant, (sinuva), 10 micrograms J7402

- 1 HCPSC unit = 10 mcg
- NDC unit = 1350 mcg (dose strength equal to one package size)



Search Results											
NDC	Brand Name	Generic Name		Dose Strength	Dose Form	Package Size	HCPSC	End Date	HUSKY A, C, D, TB and Fam Plan Rebateable	HUSKY B Rebateable	OTC Indicator
10599000301	SINUVA	mometasone furoate NASAL 1350 MCG IMPLAN		1,350 mcg	IMPLANT	1	-	12/31/2299	Y	N	N
10599000301	SINUVA	mometasone furoate NASAL 1350 MCG IMPLAN		1,350 mcg	IMPLANT	1	J7402 - Mometasone sinus sinuva	12/31/2299	Y	N	N

# 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				Relationship				
Carrier Code	060	[ Search ]				Last Name			
Plan Name	BC/BS OF CONNECTICUT					First Name, MI			
Policy Number						Date of Birth			
Paid Amount*									
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 'Claim Status' field containing 'Not Submitted yet'. Below this are 'submit' and 'cancel' buttons, with the 'submit' button highlighted by a red box. A large red arrow points down to the second screenshot, which shows the same 'Claim Status Information' header, but the 'Claim Status' field now displays 'PAID'. Below this, a table lists various 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



- 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 Gainwell Technologies and are, therefore, **not** able to be adjusted via the [www.ctdssmap.com](http://www.ctdssmap.com) Web site

**\*\*\*Note: Provider claims that are submitted to Gainwell Technologies 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



copy claim

- 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

# Intermission



# 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](http://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					
<b>1</b> Column 1	<b>2</b> Column 2	<b>3</b> * = In existence prior to 1996	<b>4</b> Effective Date	<b>5</b> Deletion Date * = no data	<b>6</b> Modifier 0=not allowed 1=allowed 9=not applicable
1	2	prior to 1996	Date	*=no data	9
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 2<sup>nd</sup> 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)

- 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

<b>National Correct Coding Initiative Edits</b>
<a href="#">Medically Unlikely Edits</a>
<a href="#">Quarterly NCCI and MUE Version Update Changes</a>
<a href="#">NCCI Coding Edits</a>
<a href="#">Add-on Code Edits</a>
<a href="#">Transmittals</a>

# 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

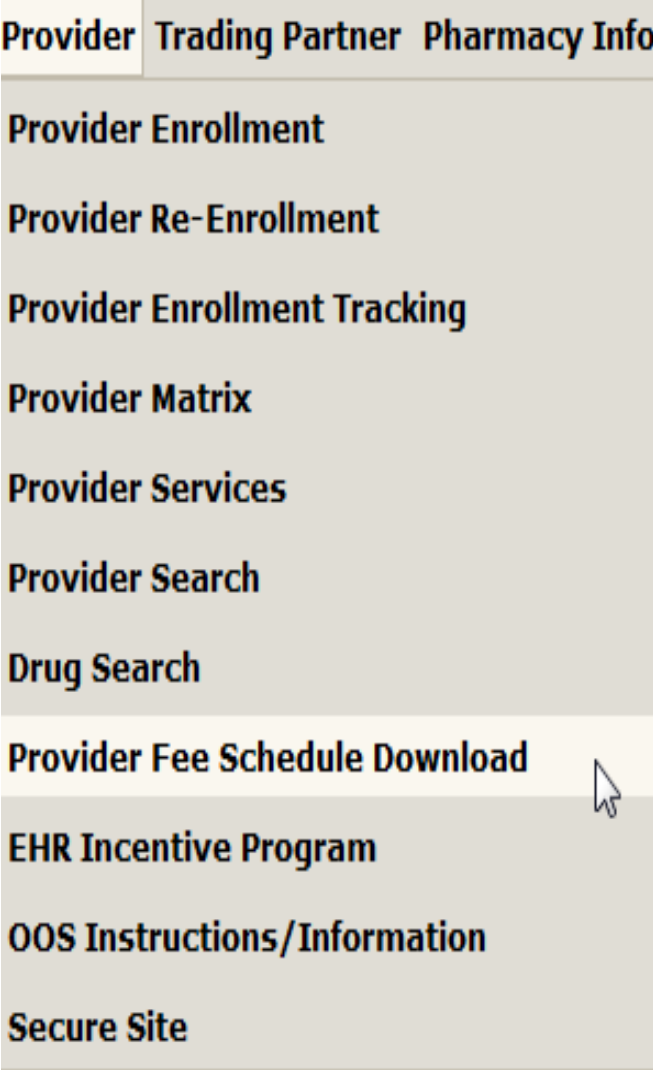
## Provider Fee Schedules

- 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](http://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 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:

Physician Surgical								
Rate type = PED; pediatric services; or OBS; obstetrical services; indicates a								
_____ unique rate for services for qualified clients and claim data. You may								
_____ disregard any other rate type.								
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

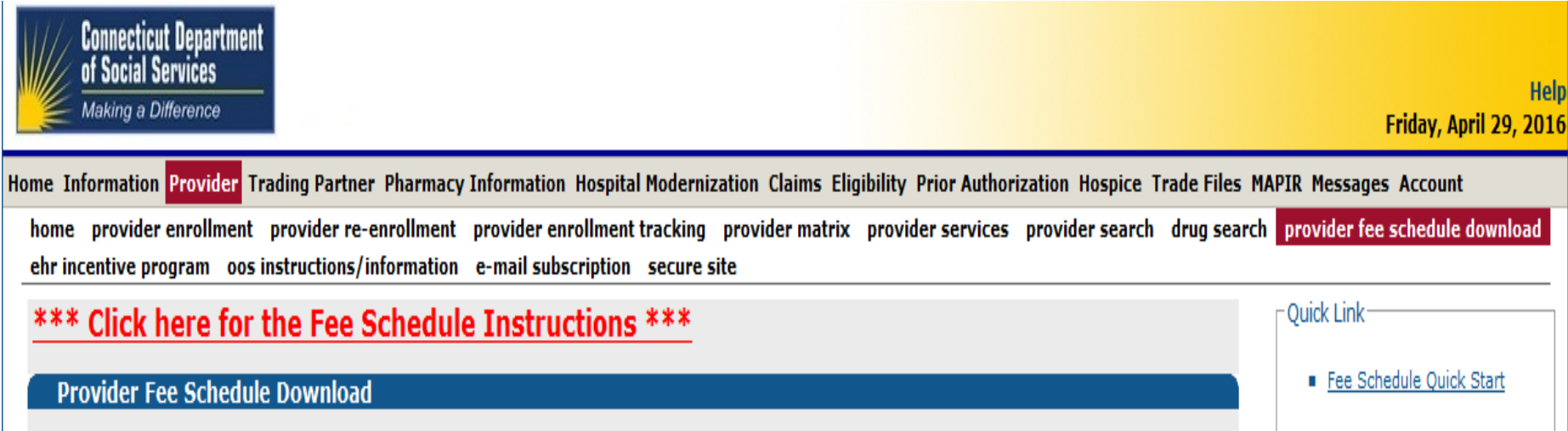
**To obtain PA for ICD-9-CM Diagnosis Codes 291-316 or for ICD-10-CM Diagnosis Codes\_\_\_\_ in the Fee Schedule Instructions Table 11 please contact CT BHP at\_\_\_\_ 1-877-552-8247**

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



**Connecticut Department of Social Services**  
*Making a Difference*

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](http://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](http://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](http://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



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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**

# 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



Help  
Friday, August 27, 2021

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## Provider

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## Trading Partner

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- [Provider Electronic Solutions Billing Instructions](#)

## Pharmacy

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## Email Subscription

- [Register/Update Email Subscription](#)

## Electronic Visit Verification

- [EVV Implementation Overview](#)

# 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

[Philips Respironics Medical Device Recall of CPAP, Bi-Level PAP, and Mechanical Ventilators \(Posted 8/13/21\)](#)

[Hospital Monthly Important Message \(Posted 8/11/21\)](#)

[Attention Providers: Revised Monthly Provider Manual Chapters \(Updated 8/2/21\)](#)

[Attention Medical Equipment, Devices, and Supplies \(MED\) Providers: Using the Web Portal Claim History Inquiry to Prevent Durable Medical Equipment \(DME\) Claim Denials \(Posted 7/27/21\)](#)

[COVID-19 Information and FAQs \(Updated 6/14/21\)](#)

[Attention All Providers: Reminder: Prior Authorization \(PA\) Requirements Reinstated: PB 2021-26: REVISED Reinstating PA Requirements that were Suspended During the PHE \(Posted 6/14/21\)](#)

[Attention All Providers: CMAP COVID-19 Telehealth \(audio-visual and telephone-only\) Policies \(Posted 5/18/21\)](#)

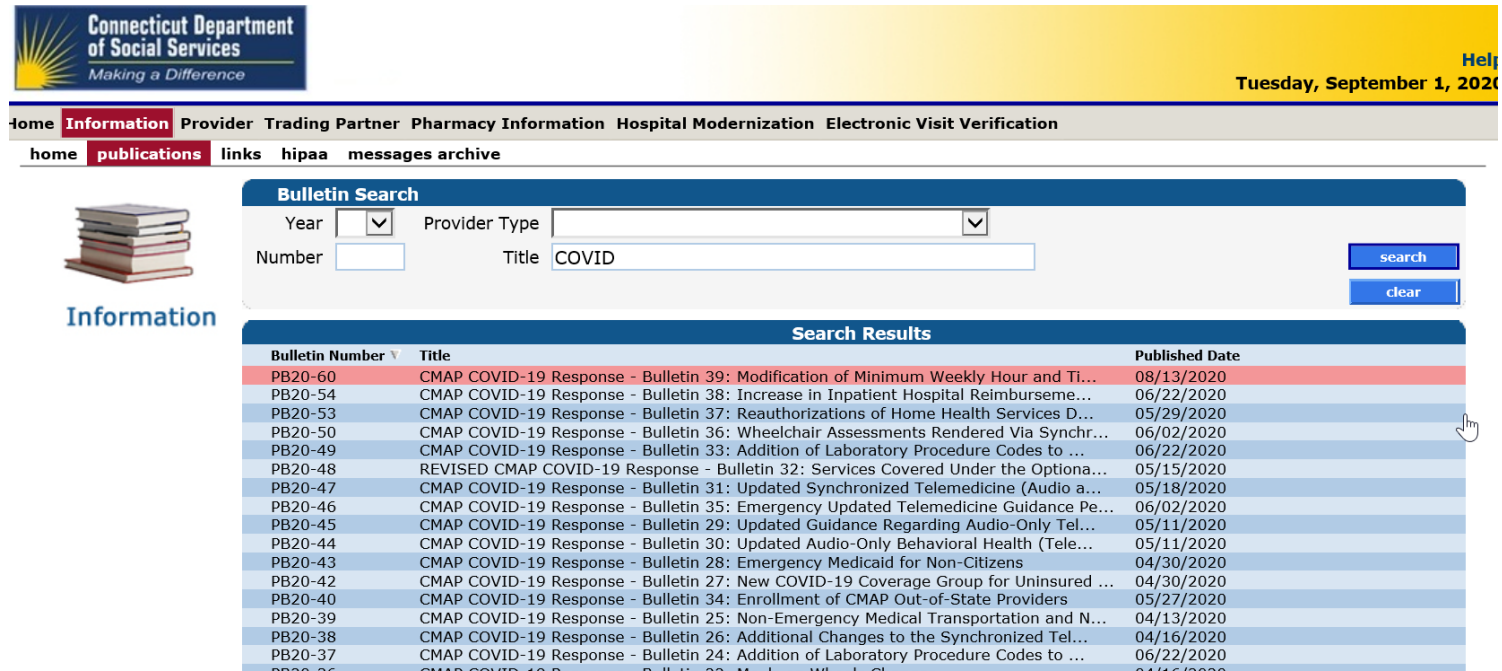
[Program Year 2020 - Objective 5 Pre-Payment Requirements \(Posted 11/16/20\)](#)

[HUSKY Health Primary Care Payment Program Extension Notification](#)

[Click here for Archived Messages](#)

# Telemedicine Services

- Bulletin Search : **Keyword COVID**



The screenshot shows the Connecticut Department of Social Services website. The header includes the department logo and the date Tuesday, September 1, 2020. A navigation menu contains links for Home, Information, Provider, Trading Partner, Pharmacy Information, Hospital Modernization, and Electronic Visit Verification. Below this, there are links for home, publications, links, hipaa, messages, and archive. The main content area features a 'Bulletin Search' form with fields for Year, Provider Type, Number, and Title (containing 'COVID'). Search and clear buttons are present. Below the search form is a 'Search Results' table with columns for Bulletin Number, Title, and Published Date. The first result is highlighted in red.

**Connecticut Department of Social Services**  
Making a Difference

Tuesday, September 1, 2020

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

home publications links hipaa messages archive

**Bulletin Search**

Year  Provider Type

Number  Title

**Search Results**

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

**eDelivery**

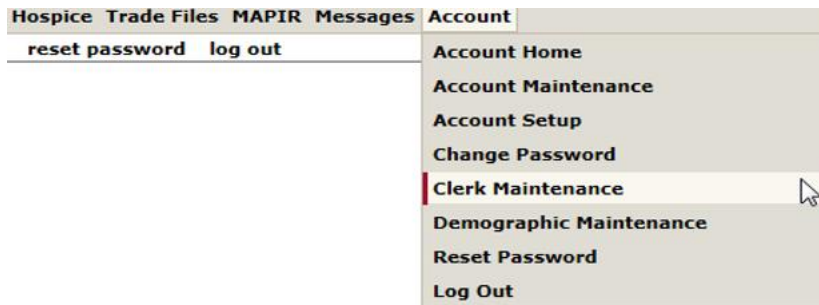
# eDelivery –Update

## 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

Clerk Roles (Internet Only)

Assigned Roles

Available Roles

- 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](http://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](mailto: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](http://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

- **Gainwell Technologies Provider Assistance Center (PAC)**
  - 1-800-842-8440 – Monday thru Friday, 8:00 AM – 5:00 PM (EST), excluding holidays
  - CTDSSMAP - [ProviderEmail@dxc.com](mailto:ProviderEmail@dxc.com)
- **Gainwell Technologies 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.
- **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
- **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](http://www.ct.gov/husky)
- [www.evicore.com/pages/providerlogin.aspx](http://www.evicore.com/pages/providerlogin.aspx)
- [www.CTDSSMAP.com](http://www.CTDSSMAP.com)

# Time for Questions

