Connecticut BHP
Supporting Health and Recovery

CT BHP Independent Practitioners (LCSW, LMFT, LPC, LADC)

Provider Frequently Asked Questions

Q: How do I determine if a member has HUSKY A, B, C or D coverage?
A: Providers can access the Automated Eligibility Verification System (AEVS) in the following way:

1. **Web Eligibility Verification** – Actively enrolled providers may verify client eligibility through the Connecticut Medical Assistance Program website at www.ctdssmap.com.
2. **Automated Voice Response System** – Actively enrolled providers may verify client eligibility using a touch tone phone and their assigned AVRS ID and PIN # through HP's Automated Voice Response System (AVRS) by calling 1–800–842-8440.

Q. Do I need to verify the client's eligibility?
A. Providers will only be reimbursed for covered services by the CT BHP that is provided to members who are HUSKY eligible at the time the services are provided. Because members' eligibility may change each month, providers are advised to verify eligibility each time services are provided.

Q. Can I be reimbursed for HUSKY C and D clients that are 21 years of age or older?
A. Yes. Effective 7/1/2014, Independent Practitioners (LCSW, LMFT, LPC, LADC) can be reimbursed by CT Medicaid for HUSKY C or D members aged 21 or older, and for cross-over claims for which Medicare has made payment.

Q: What if I check eligibility status of a member through AVES and the member has third party insurance, even though the member/family assures us that this is not or no longer the case?
A: Providers should fill out a TPL (Third Party Liability) form and send the completed form to Health Management Systems, Inc. (HMS). HMS is the Department's third party liability contractor. Providers may obtain TPL forms by:

1. Internet: Go to www.ctdssmap.com: Under "Information" → "Publications" → "Provider Manual" → "Chapter 5" → "Claim Submission Information" is where you may download and print the form.
2. Phone: 866-277-4271; HMS staff will either mail or fax you the form.
3. Email: You may submit a request to ctinsurance@hmsy.com and the form will be sent to the email address supplied.

Q: As a licensed Master's level provider, what age restrictions are there for members with HUSKY A and HUSKY B?
A: There are no age restrictions for these groups. For HUSKY A and HUSKY B, services provided by independent practitioners (LCSW, LMFT, LPC, LADC) are reimbursable for individuals of any age.

Q: Do services billed require modifiers?
A: Yes. Providers must continue to bill using modifiers identified in DSS Provider Bulletin PB 2005-79 on all claims for all client coverage groups.

Q: Do HUSKY Health members have financial responsibility for behavioral health services rendered?
A: HUSKY B members DO have to pay co-payments and may have out of pocket (deductible) expenses. For information about behavioral health co-pays, please call the Connecticut Behavioral Health Partnership at 877-552-8247.

Q. How do I know which services require authorization?
A. A complete listing of services that require authorization can be found on the CT BHP website at www.ctbhp.com. From the home page, go to "For Providers" → then "Covered Services" on the left-hand navigational menu. The Provider Covered Services page offers Authorization Schedules by provider type and specialty.

Q. What are the rates and fees under the Behavioral Health Partnership?
A. The fees for behavioral health clinicians are available on the DSS web site at www.ctdssmap.com. On the main navigation menu, select "Providers" then "Provider Fee Schedule Download". After accepting the end user agreement you can choose "Behavioral Health Clinician" from the list of fee schedules offered and then you can view the current rates. These recently established rates are effective for dates of service on or after January 1, 2012. Please note: The Departments and the Behavioral Health Oversight Council have melded the different rates previously paid for services to HUSKY A and HUSKY B members with those paid to HUSKY C and HUSKY D members to minimize the impact on providers and the state. Any claims for dates of service on or after January 1, 2012 that have already been paid at the previous rates will be reprocessed using these newly established rates. Providers do not need to initiate this reprocessing, the Department will automatically handle that.

January 1, 2013 UPDATE: The fee schedule has been revised to reflect required HIPAA compliance with changes in the CPT psychiatric procedure codes. Some longstanding procedure codes have been deleted and new codes implemented to replace them. The posted fee schedule includes currently effective fees and some fees that were in effect for dates of service through December 31, 2012. Please be sure to check the Effective Date and End Date column entries to insure that you are looking at the proper fees for the dates of service of interest. Fees for some established procedure codes are effective for dates of service on or after January 1, 2012 and other fees for recently introduced procedure codes are effective beginning January 1, 2013.