Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2021-73**
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TO: All Providers

RE: Other Insurance/Medicare Claim Submission Instruction Reminders

The Connecticut Medical Assistance Program (CMAP) is the payer of last resort for all covered services. Therefore, if a client has applicable other insurance coverage or Medicare, the benefits of these policies must be fully exhausted prior to claim submission to the CMAP. Chapter 11 of the Provider Manual contains important instructions related to claim submission to CMAP after another insurance company, including Medicare, has either made a payment or denied a claim.

Chapter 11 can be accessed from the www.ctdssmap.com Web site by selecting Information > Publications, and then selecting the appropriate claim type from the drop down box.

Third party insurance carriers are identified by a three-digit carrier code. It is important to note that these carrier codes are specific to the Connecticut Medical Assistance Program (CMAP). If you are experiencing claim denials due to an invalid carrier code, it is important to ensure CMAP values are submitted. A valid carrier code must be indicated for each other payer submitted on a claim. To ensure a valid CMAP carrier code is submitted, providers should use the carrier code(s) returned on the client's eligibility verification response.

For further information on carrier codes, providers may refer to Chapter 5 of the Provider Manual, available on the www.ctdssmap.com Web site. Providers are reminded that this chapter also contains information on what to do in the instance of discrepancies with a client's other insurance information, including contact information for HMS.

Providers are strongly encouraged to submit a valid CMAP specific carrier code in the primary identifier field (qualifier = PI). However, providers may also submit a valid CMAP specific carrier code in the secondary identifier field (qualifier = 2U).

As a reminder, for all crossover claims submitted by a provider (i.e. those that do not systematically crossover from Medicare), Medicare must be identified by the 3-digit carrier code of MPA or MPB. It is not sufficient to submit only a claim filing indicator of MA or MB. The claims must also be submitted with the appropriate claim adjustment reason codes (CARC). In the future, crossover claims submitted by providers that do not contain a valid carrier code in the primary or secondary identifier field, including the carrier code of MPA or MPB when appropriate, will deny with EOB code 2515 – Claim other payer carrier code is not on file. Providers may also see EOB 2535 – No valid other payer ID submitted at the detail, when there is a payment but no carrier codes.

To assist providers with understanding other insurance/Medicare related claim denials, providers may refer to Chapter 12 of the Provider Manual, also available on the www.ctdssmap.com Web site. This chapter is revised as existing EOBs are modified and new EOBs are added.