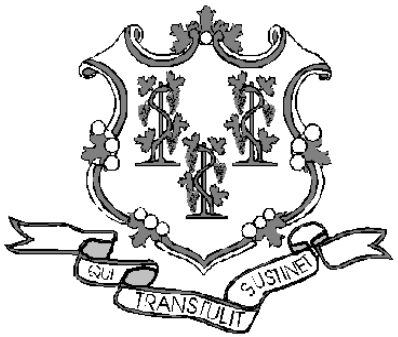
Connecticut Department of Social Services

Caring for Connecticut



Hospital Refresher Workshop

Presented by

The Department of Social Services

& HP

Training Topics

- **Client Eligibility Reference Guide**
- **Automated Test Panel Fees**
- **Present on Admission Indicator**
- **Birth Weight**
- **Other Insurance Billing Instructions**
- **Medicare Billing Instructions**
- **Timely Filing Updates**
- **Most Frequent Claim Denials**
- **SAGA Updates**
- **Web Claim Submission**
- **Questions**

Client Eligibility Reference Guide

• To access the Client Eligibility Reference Guide, the following steps apply:

1. Go to the Public Web site at www.ctdssmap.com, navigate to the Information page and select Publications on the drop down.

2. Scroll down the Information page to the Claims Processing Information Panel.

3. Select the Eligibility Response Quick Reference Guide.

Client Eligibility Reference Guide

- Client Eligibility Responses:
  - Client Population
  - Program Benefits
  - Prior Authorization Request
  - Claims

Automated Test Panel Fees

- To access Automated Test Panel (ATP) fees, the following steps apply:

1. Go to the Public Web site at www.ctdssmap.com, navigate to the Provider tab, select Provider fee schedule on the drop down.

2. Under Provider Fee Schedule Download – Select Lab.

3. To download, click on the PDF file.

  – On the last page of the fee schedule PDF file it lists the lab codes included in ATP fees. If you bill multiple lab panels on that list we will allow the ATP contracted fee based on the number of panels billed.

Present on Admission (POA) Indicator

The Deficit Reduction Act of 2005 (DRA) mandates the identification of hospital-acquired conditions (HAC) on inpatient admissions.

- All inpatient claims with an admission date of 4/1/2010 or later must contain a Present on Admission (POA) Indicator.

POA Indicator	POA Indicator Description
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A.

Present on Admission (POA) Indicator

The POA indicator should be entered in the field identified below for each diagnosis code entered on the claim.

- UB-04 paper claim submissions
  - POA indicator must be entered in fields 67 and 67A – 67Q in the shaded area.
- HP Provider Electronic Solutions
  - Header 2 will be updated to include a POA indicator field next to the diagnosis codes.
- Web Claim Submission through the Provider secure Web site at www.ctdssmap.com
  - POA indicator must be entered in the field next to the diagnosis codes.
- 837I Health Care Format
  - POA indicator must be entered in Loop 2300, Segment K3.

Present on Admission (POA) Indicator

Erroneous Surgeries

Hospitals are also instructed to report erroneous surgeries to the Department. The inpatient hospital claims, should be submitted as a Type of Bill (TOB) 110, a no-pay claim, with one of the following ICD-9-CM diagnosis code:

- E876.5 - Performance of wrong operation (procedure) on correct patient (existing code).
- E876.6 - Performance of operation (procedure) on patient not scheduled for surgery.
- E876.7 – Performance of correct operation (procedure) on wrong side/body part.

The diagnosis code listed above should be reported in the diagnosis position 2-9, **not** in the External Cause of Injury (E-code) field.

Birth Weight

All inpatient claims with an admission date of 4/1/2010 or later and an admission type 4 (newborn), must include the newborn's weight in grams.

- The birth weight should be entered in the field identified below:
  - UB-04 paper claim submissions
    - Value code 54 and the newborn's birth weight must be entered in fields 39 – 41.
  - HP Provider Electronic Solutions
    - Value code 54 and the newborn's birth weight must be entered in Header 4.
  - Web Claim Submission through the Provider secure Web site at www.ctdssmap.com
    - Birth weight field
  - 837I Health Care Format
    - Birth weight must be entered in Loop 2300, Segment HI.

Other Insurance/Medicare Billing Instructions

Institutional Other Insurance / Medicare Billing Guide

- Providers can access this guide from the Connecticut Medical Assistance Program Web site www.ctdssmap.com Information page, under Publications, then Claims Processing Information.

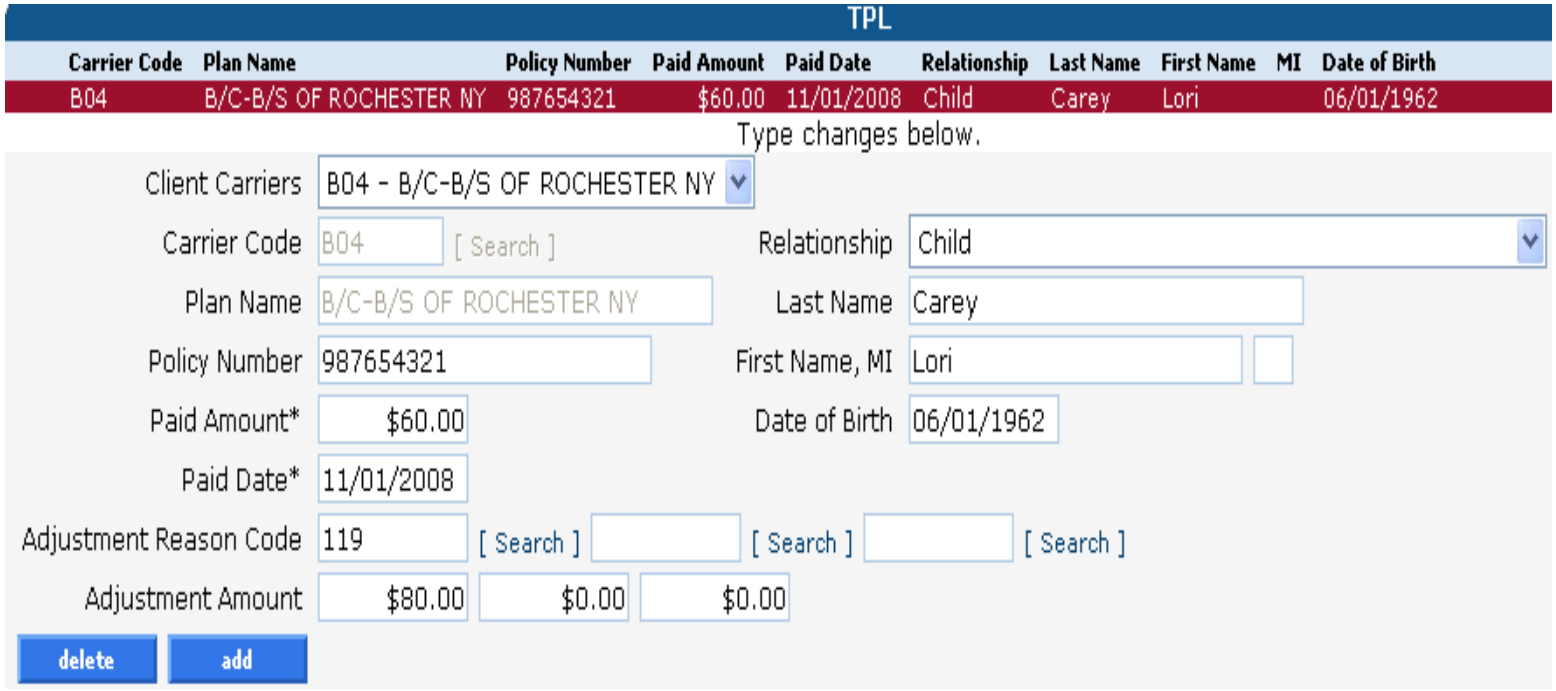
  - This guide will assist providers with submitting claims when the client has primary coverage through commercial insurance or Medicare, and secondary coverage through Connecticut Medicaid.

  - The guide contains field by field instructions illustrating the correct format for completing the other insurance and/or Medicare information.

Other Insurance Billing Instructions

Other insurance (OI) payment – Web claim submission

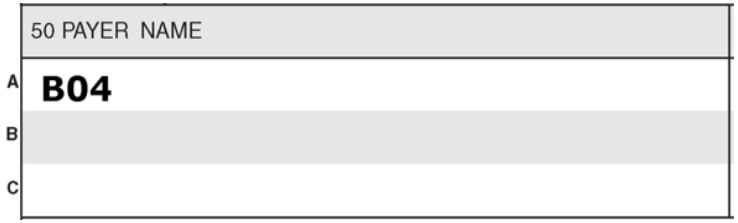
- The following example illustrates a single OI payment of 60.00 from carrier code B04 with an OI paid date of 11/1/2008.

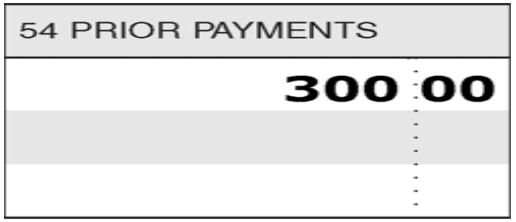


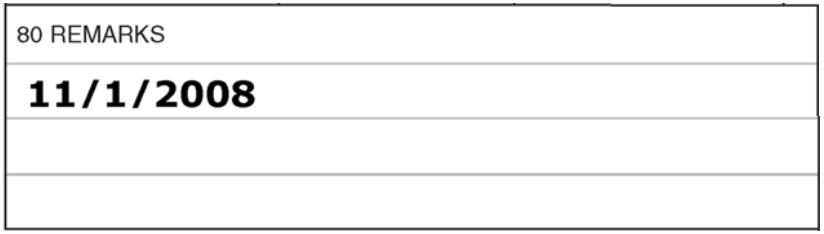
Other Insurance Billing Instructions

Other insurance (OI) payment – UB-04 claim submission

- The following example illustrates a single OI payment of 300.00 from carrier code B04 with an OI paid date of 11/1/2008.
- The OI EOB should not be attached to the paper claim.



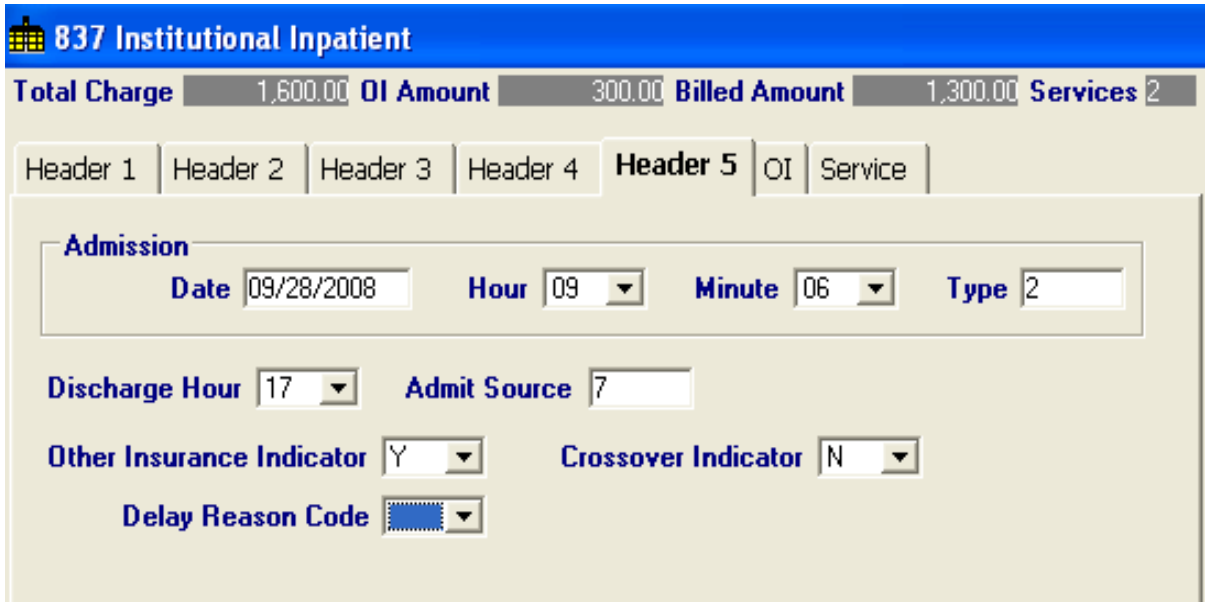




Other Insurance Billing Instructions cont.

Other insurance payment – Provider Electronic Solutions claim submission

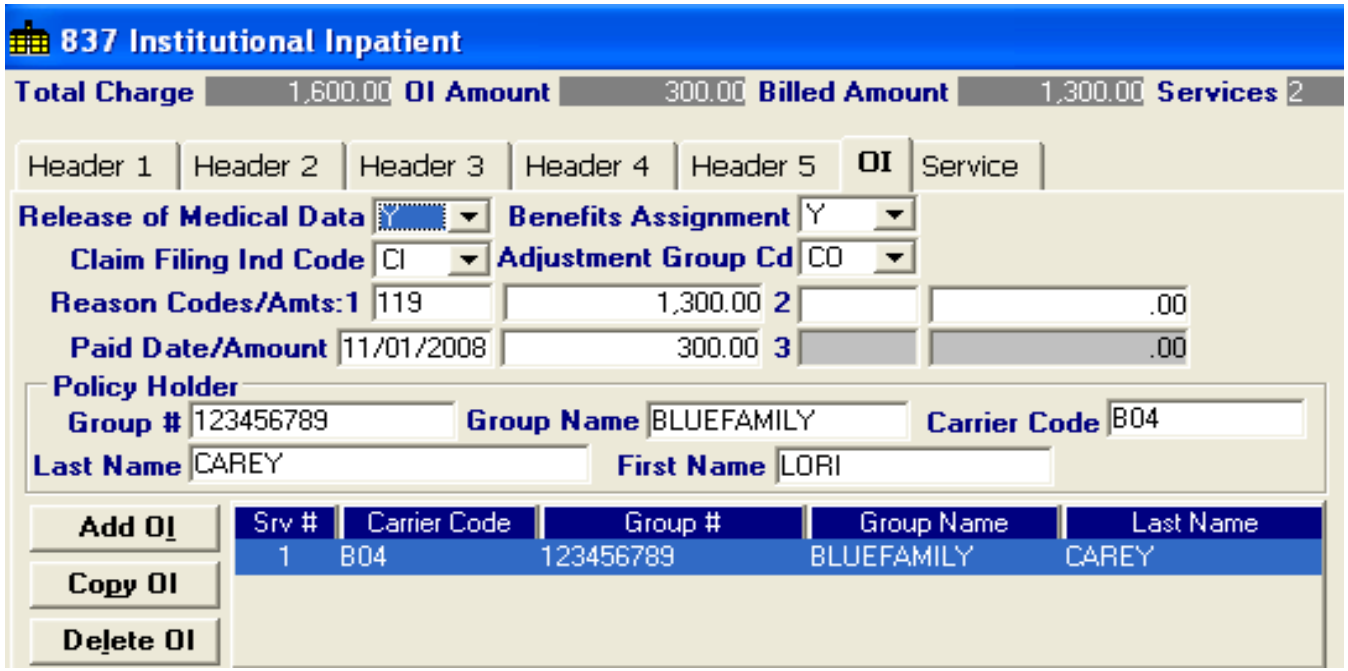
- The following example illustrates a single OI payment of 300.00 from carrier code B04 with an OI paid date of 11/1/2008.



Other Insurance Billing Instructions cont.

Other insurance payment – Provider Electronic Solutions claim submission

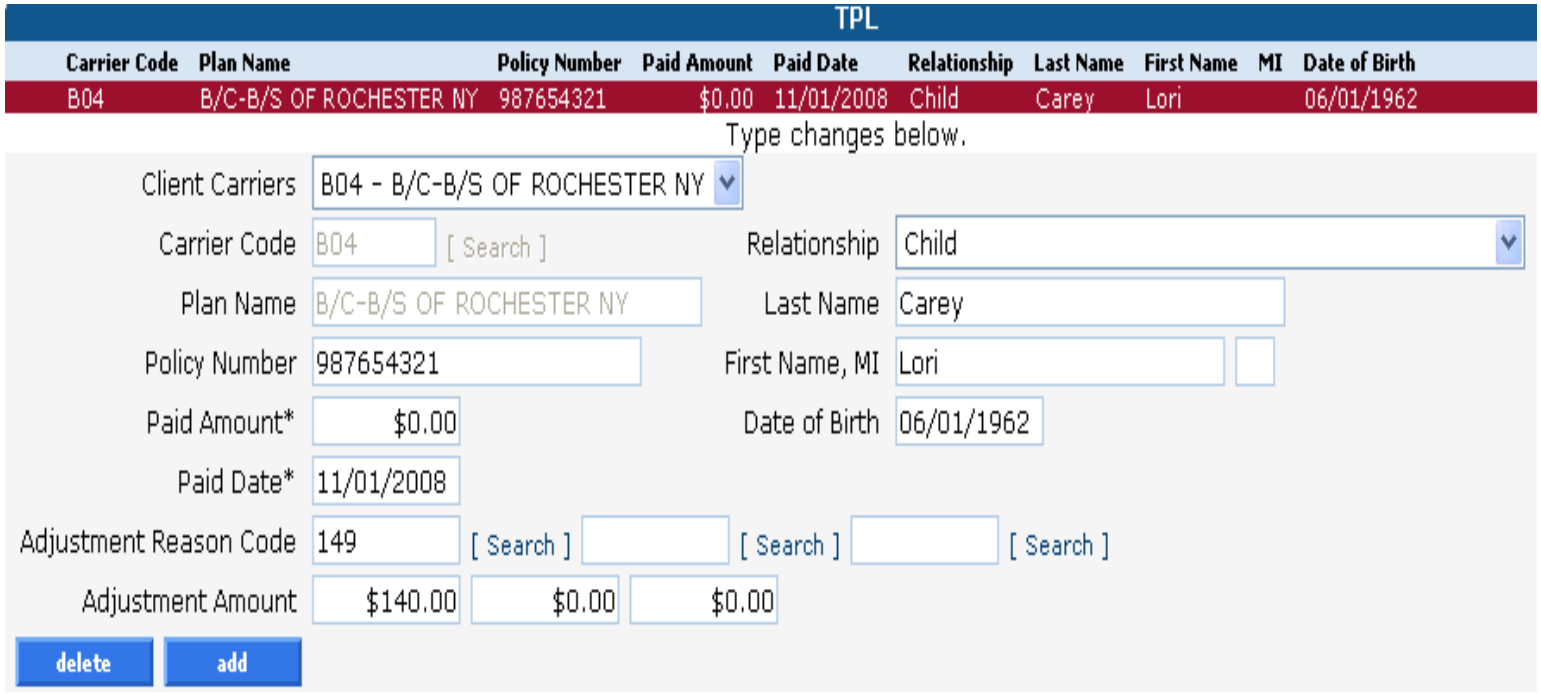
- Entry indicating OI Payment



Other Insurance Billing Instructions cont.

Other insurance denial – Web claim submission

- The following example illustrates a single OI denial from carrier code B04 with an OI denial date of 11/1/2008.



Other Insurance Billing Instructions cont.

Other insurance denial – UB-04 claim submission

- The following example illustrates a single OI denial from carrier code B04 with an OI denial date of 11/1/2008.

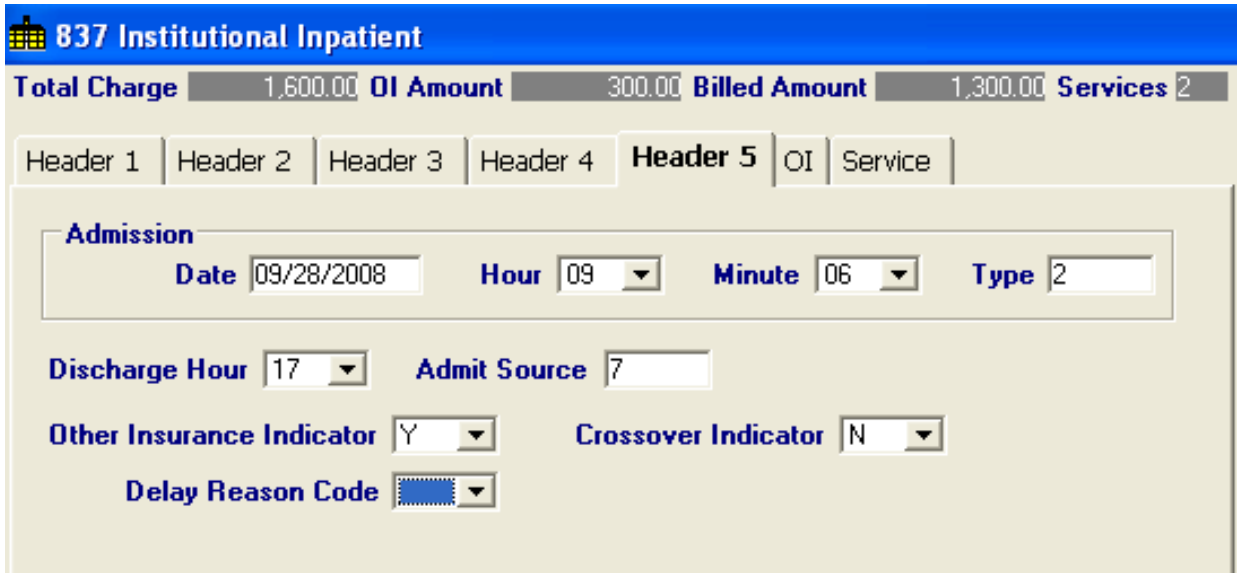
31 OCCURRENCE CODE	DATE
24	11/1/2008

50 PAYER NAME
B04 Not Applicable

Other Insurance Billing Instructions cont.

Other insurance denial – Provider Electronic Solutions claim submission

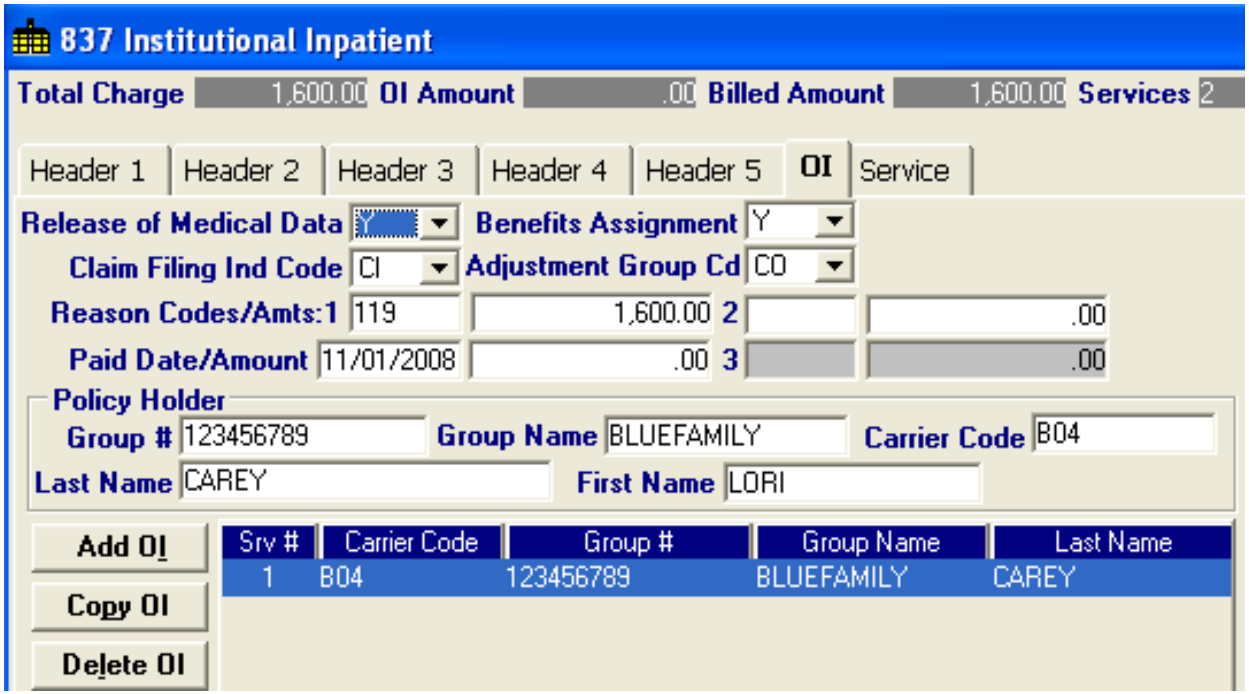
- The following example illustrates a single OI denial from carrier code B04 with an OI denial date of 11/1/2008.



Other Insurance Billing Instructions cont.

Other insurance denial – Provider Electronic Solutions claim submission

- Entry indicating OI Denial



Other Insurance Billing Instructions cont.

Other Insurance multiple policies – Web claim submission

- The following example illustrates one OI payment of 300.00 from carrier code B04 with an OI paid date of 11/1/2008 and one OI denial from carrier code 060 with an OI denial date of 11/10/2008.
  - First TPL entry indicating OI Payment:

TPL

Carrier Code	Plan Name	Policy Number	Paid Amount	Paid Date	Relationship	Last Name	First Name	MI	Date of Birth
B04	B/C-B/S OF ROCHESTER NY	123456789	$300.00	11/01/2008	Child	Carey	Lori		06/01/1962
060	BC/BS OF CONNECTICUT	XGM000B361	$0.00	11/10/2008	Child	Carey	Lori		06/01/1962

Type changes below.

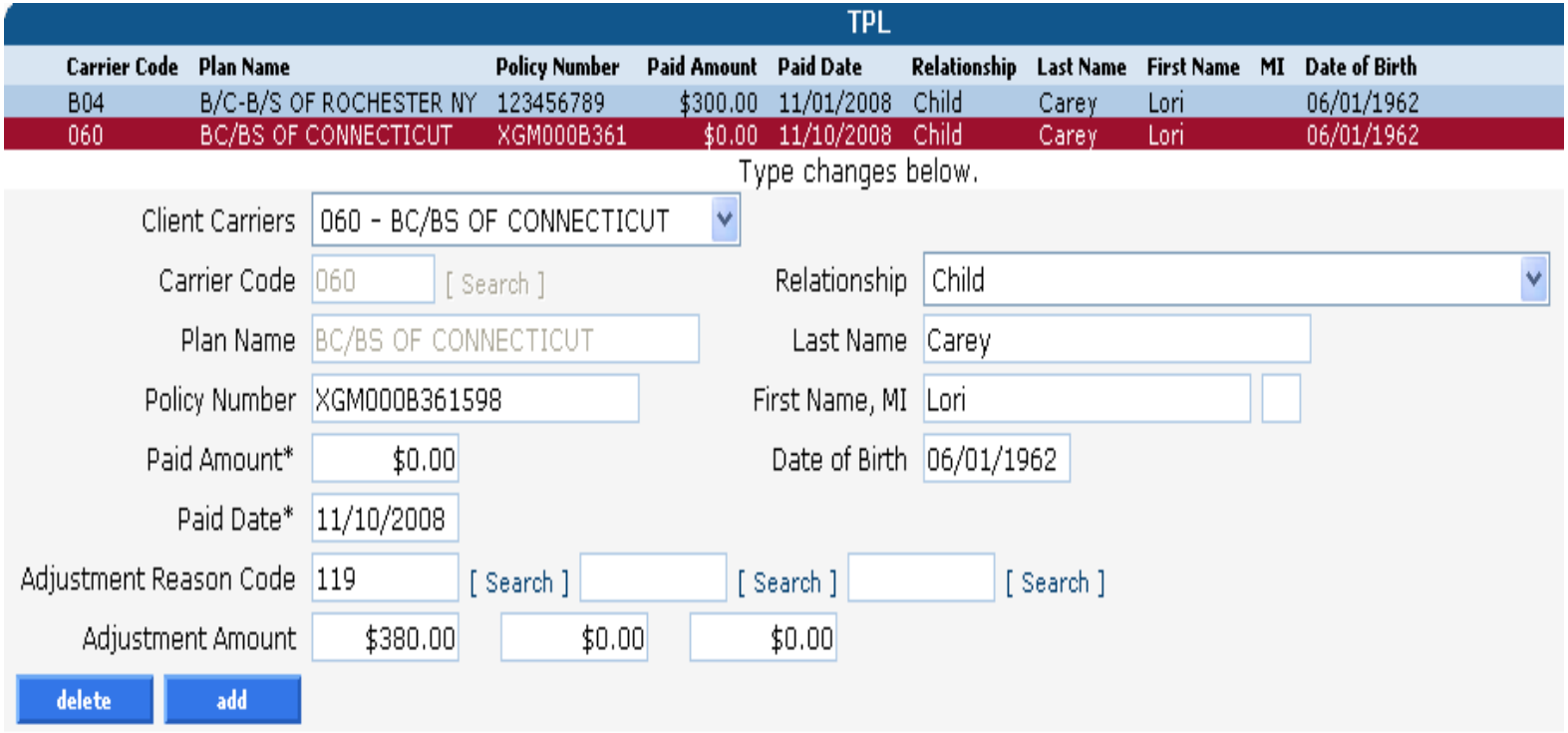
Client Carriers	B04 - B/C-B/S OF ROCHESTER NY		
Carrier Code	B04 [Search]	Relationship	Child
Plan Name	B/C-B/S OF ROCHESTER NY	Last Name	Carey
Policy Number	123456789	First Name, MI	Lori
Paid Amount*	$300.00	Date of Birth	06/01/1962
Paid Date*	11/01/2008		
Adjustment Reason Code	149 [Search]	[Search]	[Search]
Adjustment Amount	$80.00	$0.00	$0.00

delete add

Other Insurance Billing Instructions cont.

OI multiple policies cont. – Web claim submission

- Second TPL entry indicating OI Payment:



Other Insurance Billing Instructions cont.

Other insurance multiple policies – UB-04 claim submission

- The following example illustrates one OI payment of 300.00 from carrier code B04 with an OI paid date of 11/1/2008 and one OI denial from carrier code 060 with an OI denial date of 11/10/2008.

31 OCCURRENCE CODE	DATE
24	11/1/2008

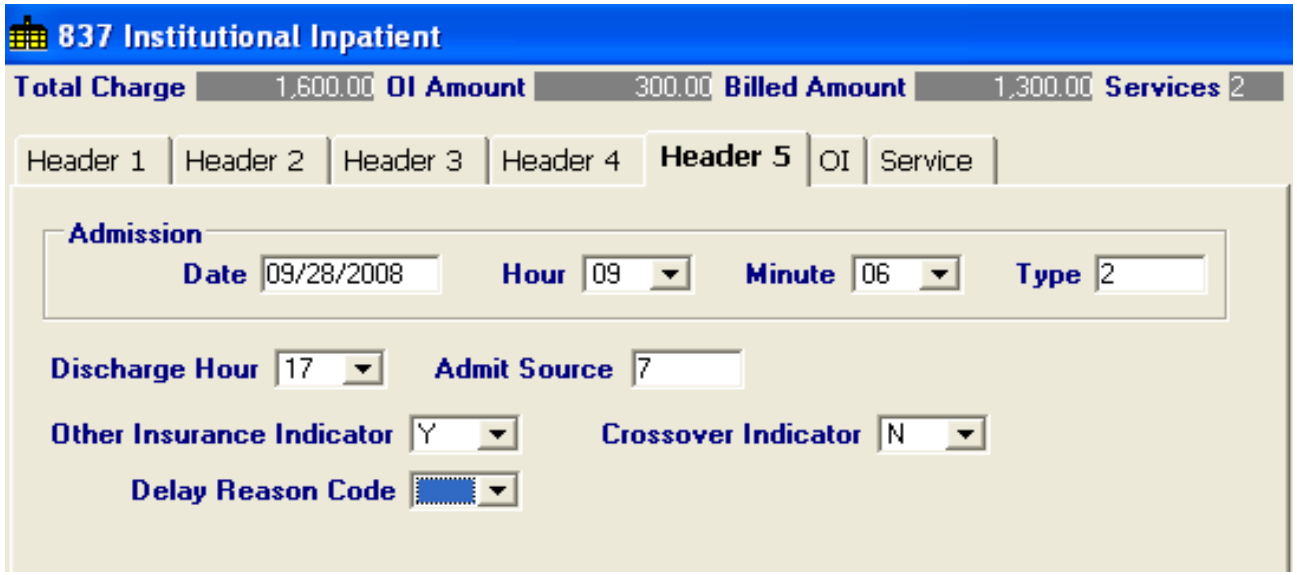
50 PAYER NAME	54 PRIOR PAYMENTS
B04	300 00
060 Not Applicable	

80 REMARKS
11/1/2008

Other Insurance Billing Instructions cont.

Other insurance multiple policies – Provider Electronic Solutions claim submission

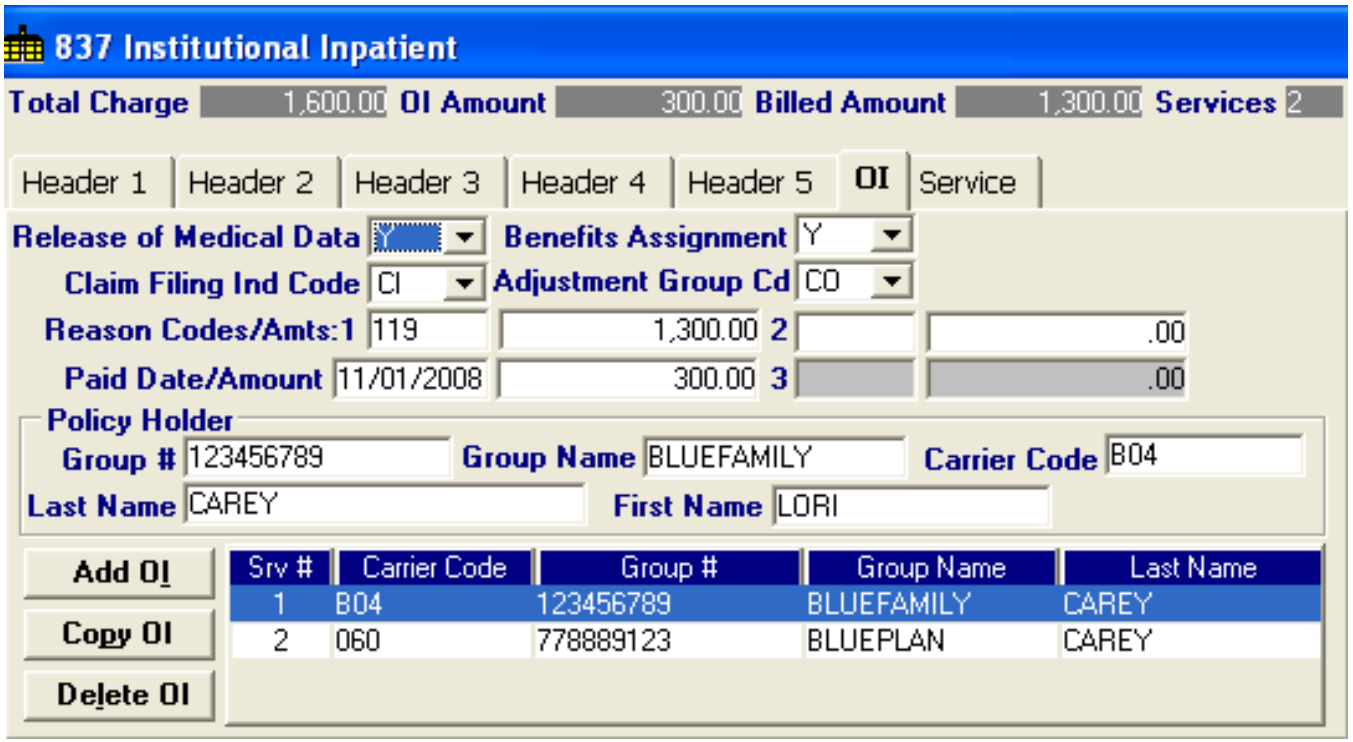
- The following example illustrates one OI payment of 300.00 from carrier code B04 with an OI paid date of 11/1/2008 and one OI denial from carrier code 060 with an OI denial date of 11/10/2008.



Other Insurance Billing Instructions cont.

Other insurance multiple policies – Provider Electronic Solutions claim submission

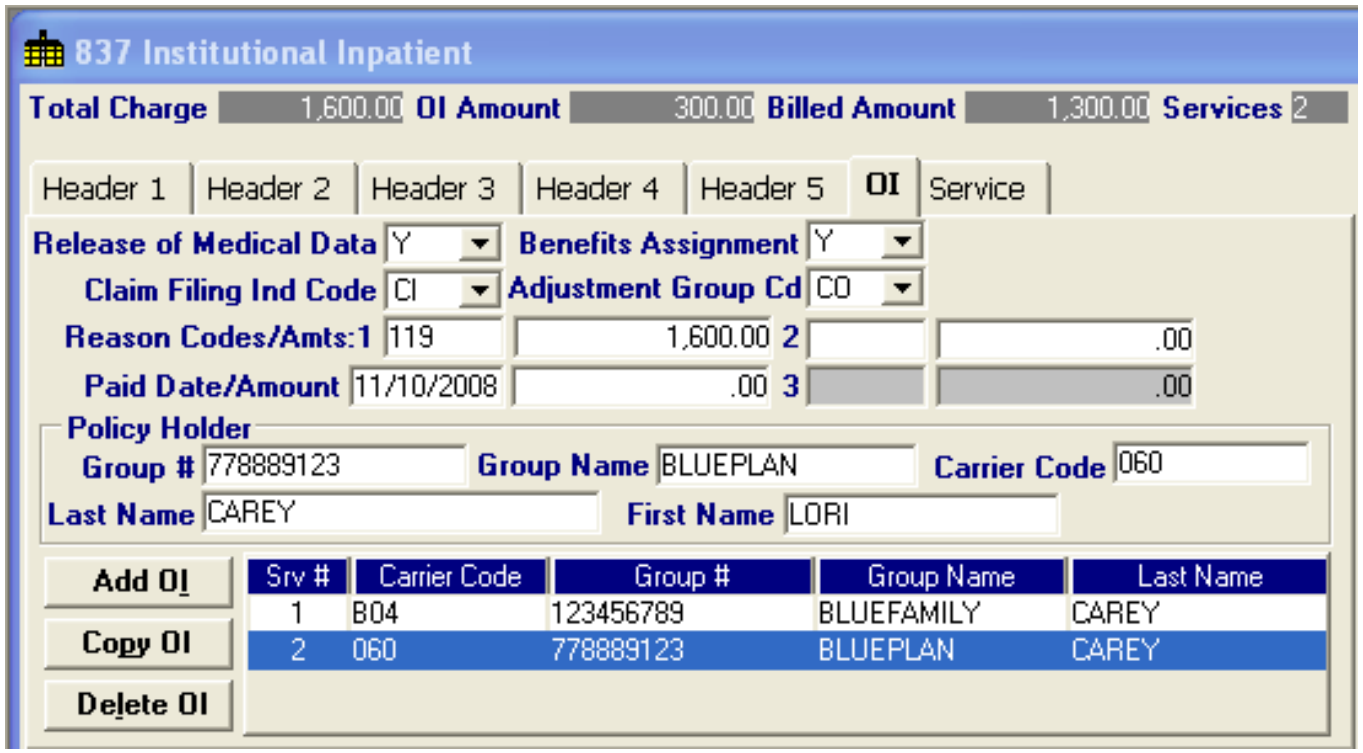
- Entry indicating OI Payment



Other Insurance Billing Instructions cont.

Other insurance multiple policies – Provider Electronic Solutions claim submission

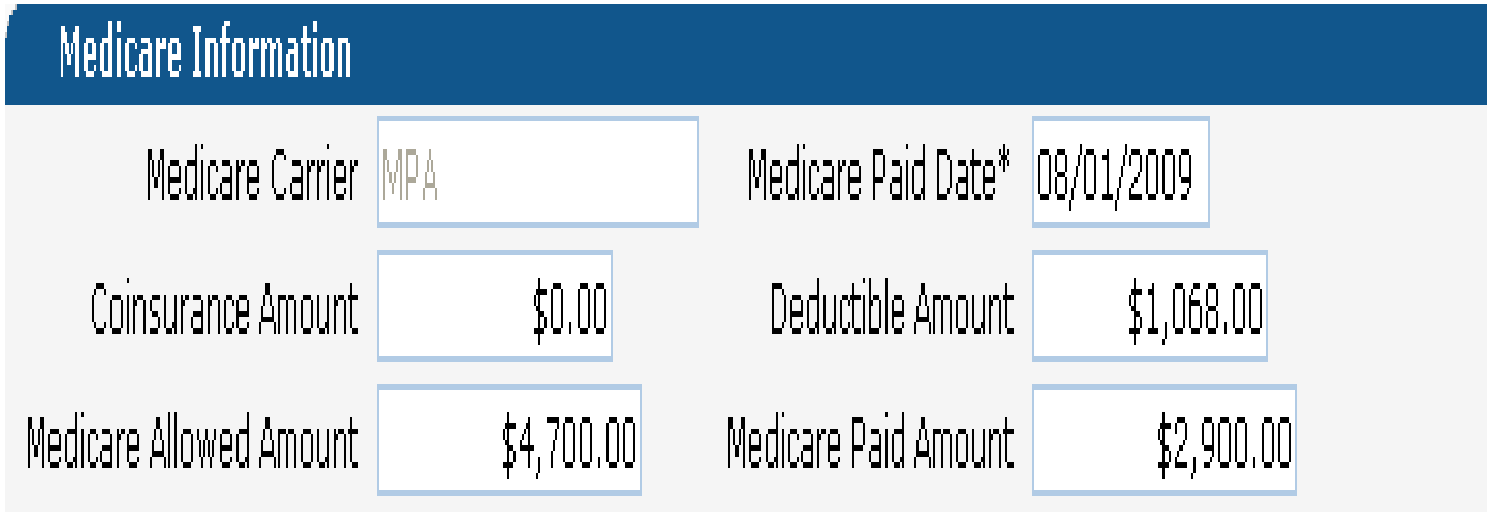
- Entry indicating OI Denial



Medicare Billing Instructions

Medicare Part A payment – Web claim submission

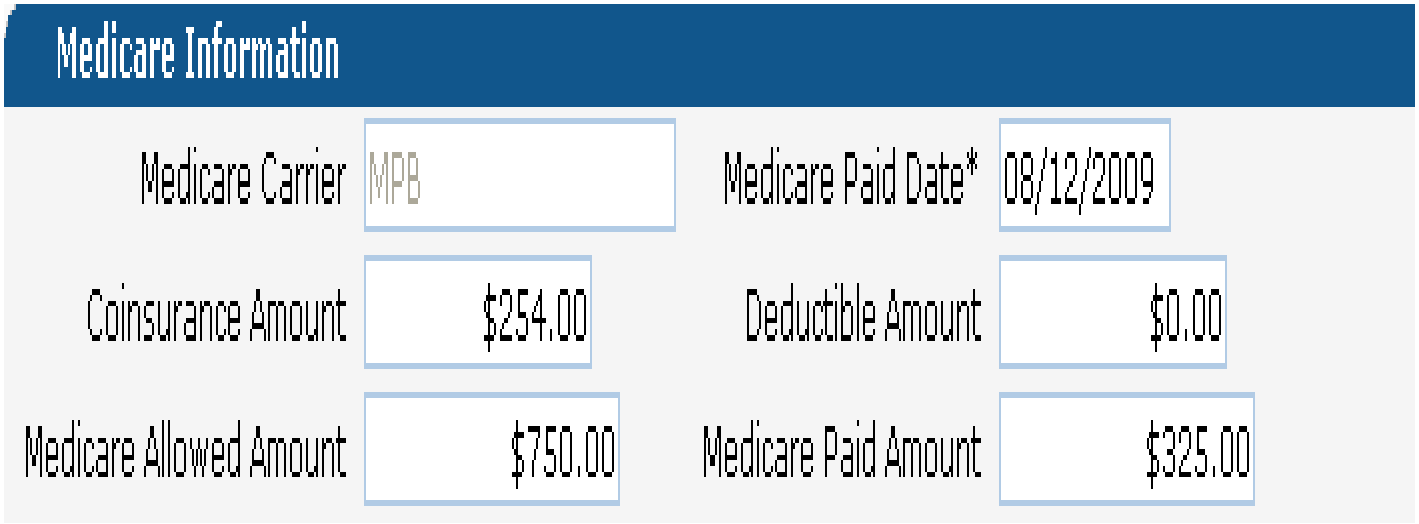
- The following example illustrates an Inpatient **crossover** claim that contains Medicare Part A deductible in the amount of $1,068.00, a Medicare Allowed amount of $4,700.00 and a Medicare paid amount of $2,900.00.
  - Claim type: Institutional Crossover Claim
  - Medicare information



Medicare Billing Instructions cont.

Medicare Part B payment – Web claim submission

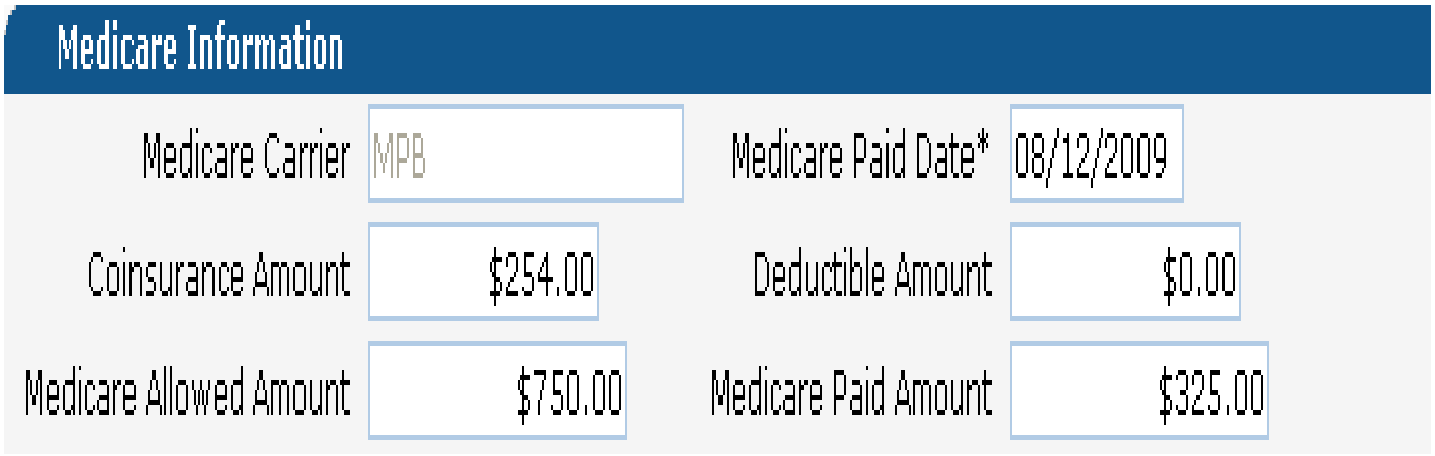
- The following example illustrates an Outpatient crossover claim that contains Medicare Part B coinsurance in the amount of $254.00, a Medicare allowed of $750.00 and a Medicare paid as $325.00.
  - Claim Type Outpatient Crossover Claim
  - Medicare information



Medicare Billing Instructions cont.

Medicare HMO payment – Web claim submission

- The following example illustrates an Outpatient **crossover** claim that contains Medicare HMO Part B coinsurance in the amount of $254.00 and a Medicare HMO paid amount of $325.00. If Medicare HMO Part A made a payment the carrier would be MPA.
  - Claim Type Outpatient Crossover Claim
  - Medicare information



Medicare Billing Instructions

Medicare Part A payment – UB-04 claim submission

- The following example illustrates an Inpatient crossover claim that contains Medicare Part A deductible in the amount of $1,024.00.

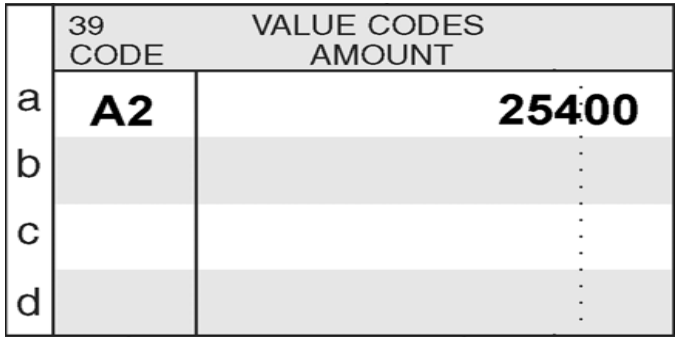
	39 CODE	VALUE CODES AMOUNT
a	A1	102400
b		
c		
d		

50 PAYER NAME
Medicare Part A

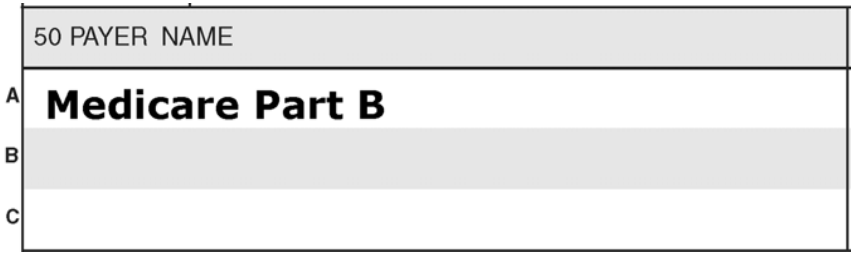
Medicare Billing Instructions cont.

Medicare Part B payment – UB-04 claim submission

- The following example illustrates an Outpatient crossover claim that contains Medicare Part B coinsurance in the amount of $254.00.



	39 CODE	VALUE CODES AMOUNT
a	**A2**	**25400**
b		
c		
d		

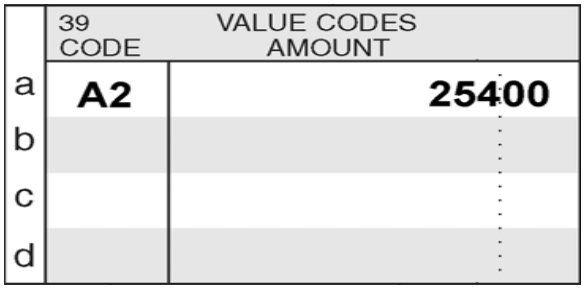


	50 PAYER NAME
A	**Medicare Part B**
B	
C	

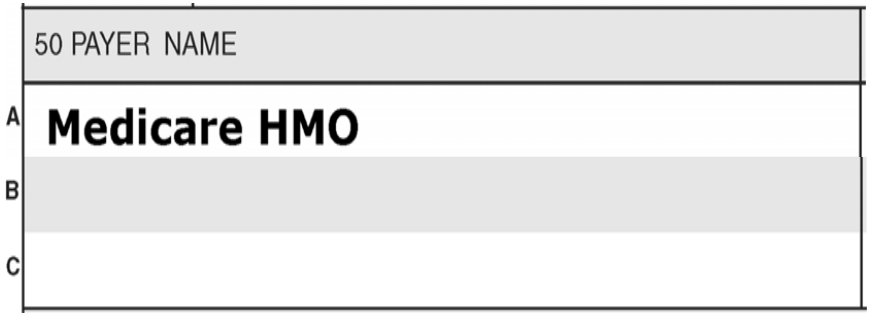
Medicare Billing Instructions cont.

Medicare HMO payment – UB-04 claim submission

- The following example illustrates an Outpatient crossover claim that contains Medicare HMO coinsurance in the amount of $254.00.



	39 CODE	VALUE CODES AMOUNT
a	A2	25400
b		
c		
d		

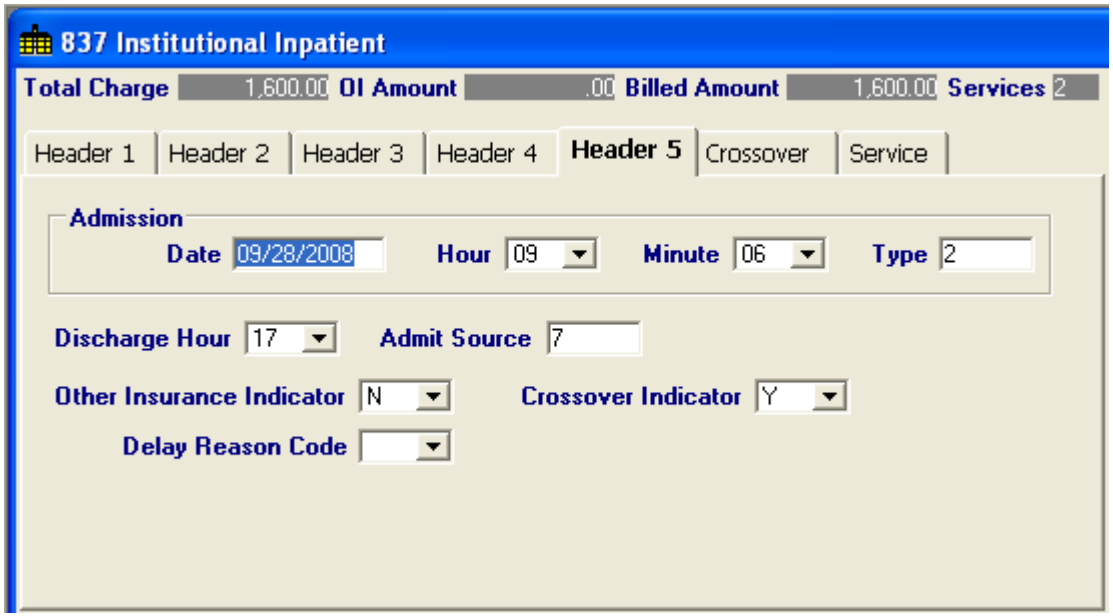


	50 PAYER NAME
A	Medicare HMO
B	
C	

Medicare Billing Instructions cont.

Medicare Part A payment – Provider Electronic Solutions claim submission

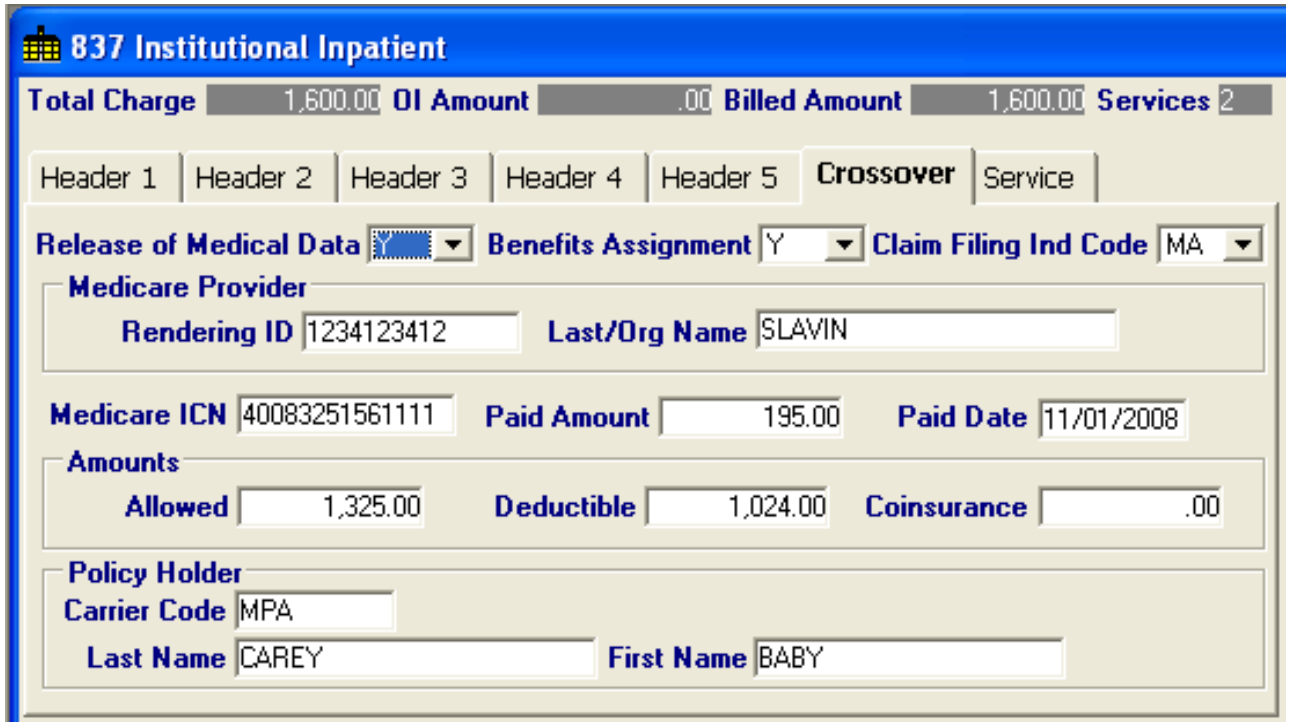
- The following example illustrates an Inpatient crossover claim that contains Medicare Part A deductible in the amount of $1,024.00.



Medicare Billing Instructions cont.

Medicare Part A payment – Provider Electronic Solutions claim submission

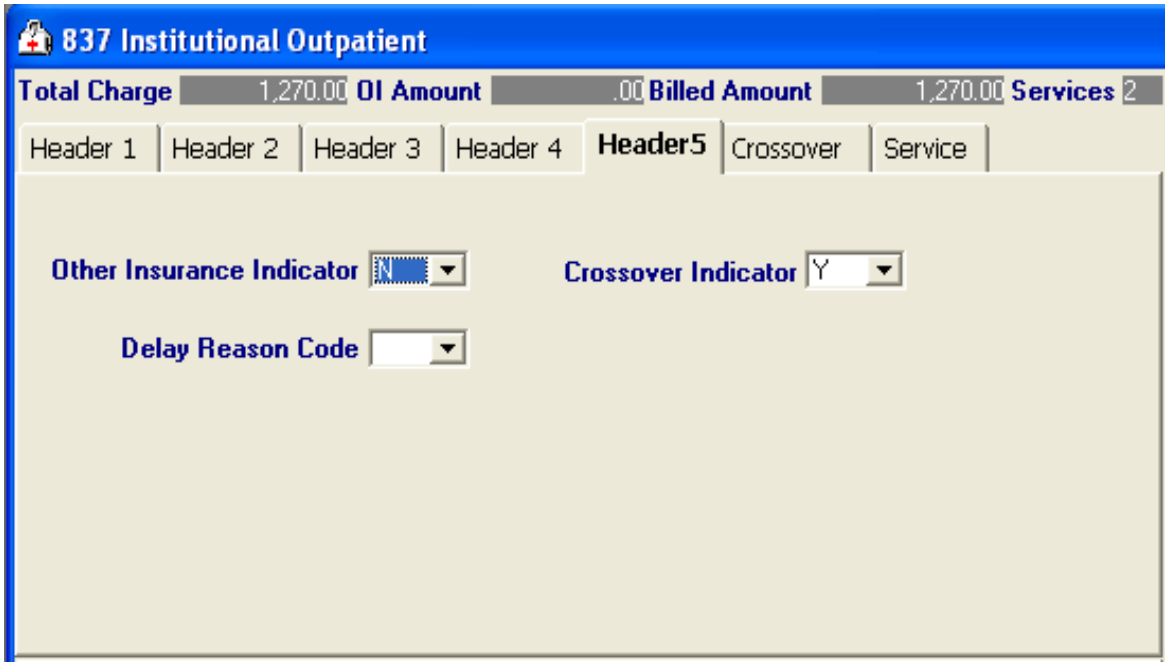
- Entry indicating Medicare Payment



Medicare Billing Instructions cont.

Medicare Part B payment – Provider Electronic Solutions claim submission

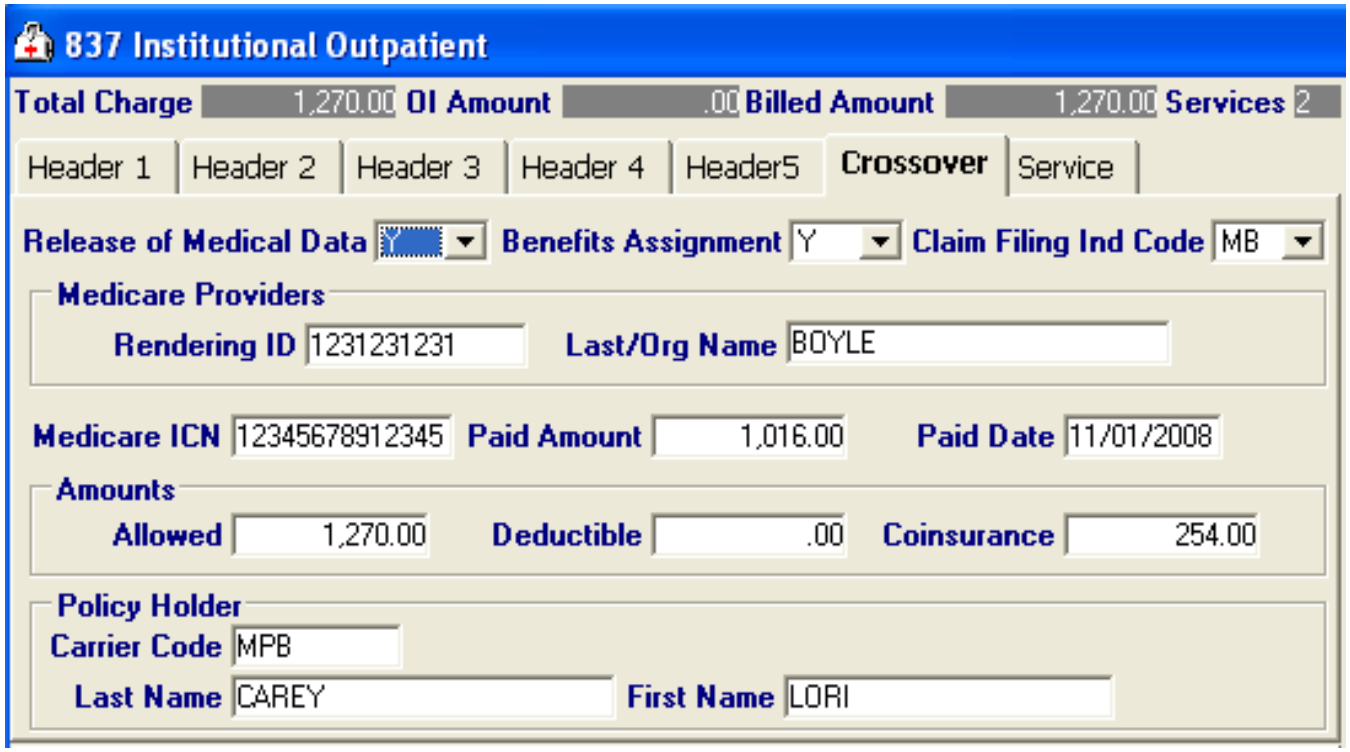
- The following example illustrates an Outpatient crossover claim that contains Medicare Part B coinsurance in the amount of $254.00.



Medicare Billing Instructions cont.

Medicare Part B payment – Provider Electronic Solutions claim submission

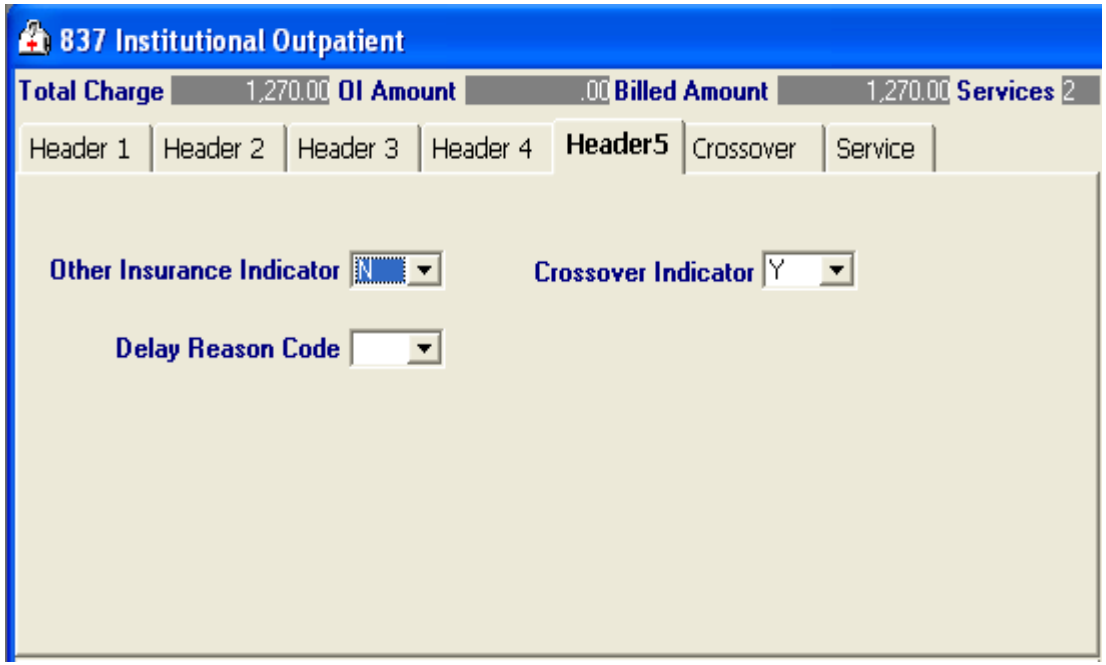
- Entry indicating Medicare Payment



Medicare Billing Instructions cont.

Medicare HMO payment – Provider Electronic Solutions claim submission

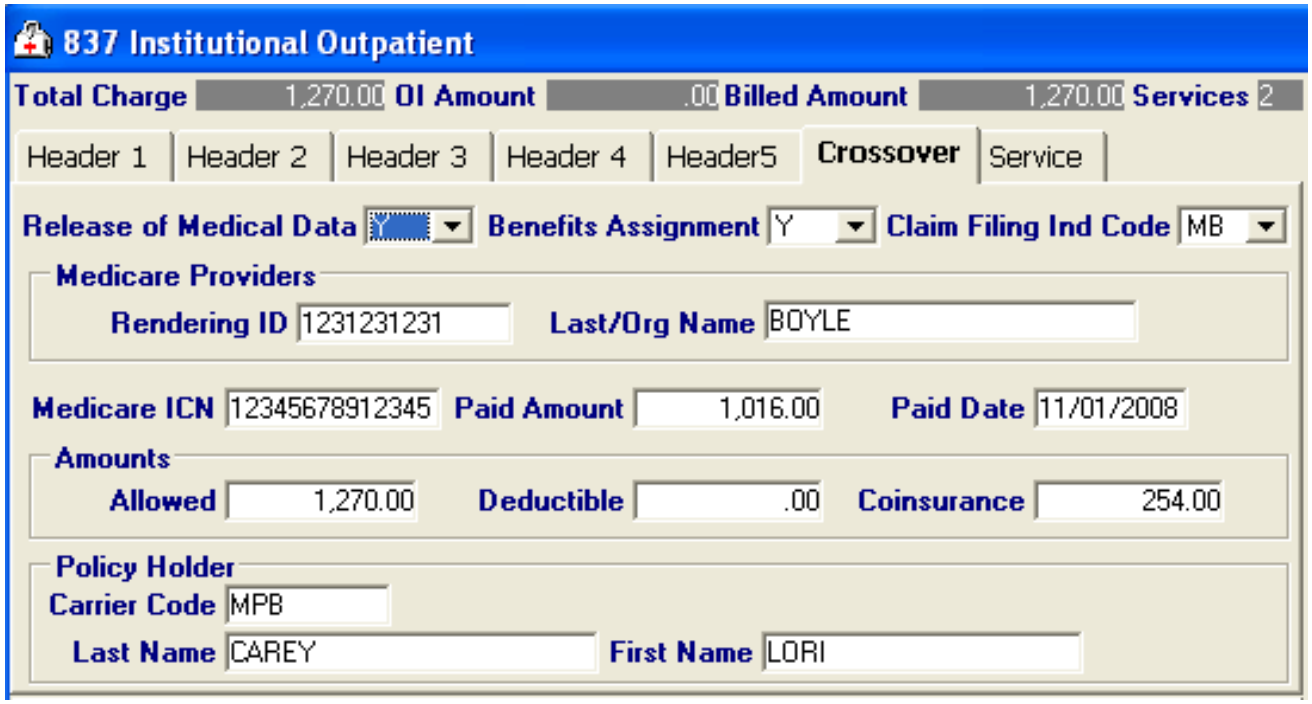
- The following example illustrates an Outpatient crossover claim that contains Medicare HMO coinsurance in the amount of $254.00.



Medicare Billing Instructions cont.

Medicare HMO payment – Provider Electronic Solutions claim submission

- Entry indicating Medicare HMO Payment - using claim filing code MB and carrier code MPB.



Medicare Billing Instructions cont.

Medicare Part A or B denial – Web claim submission

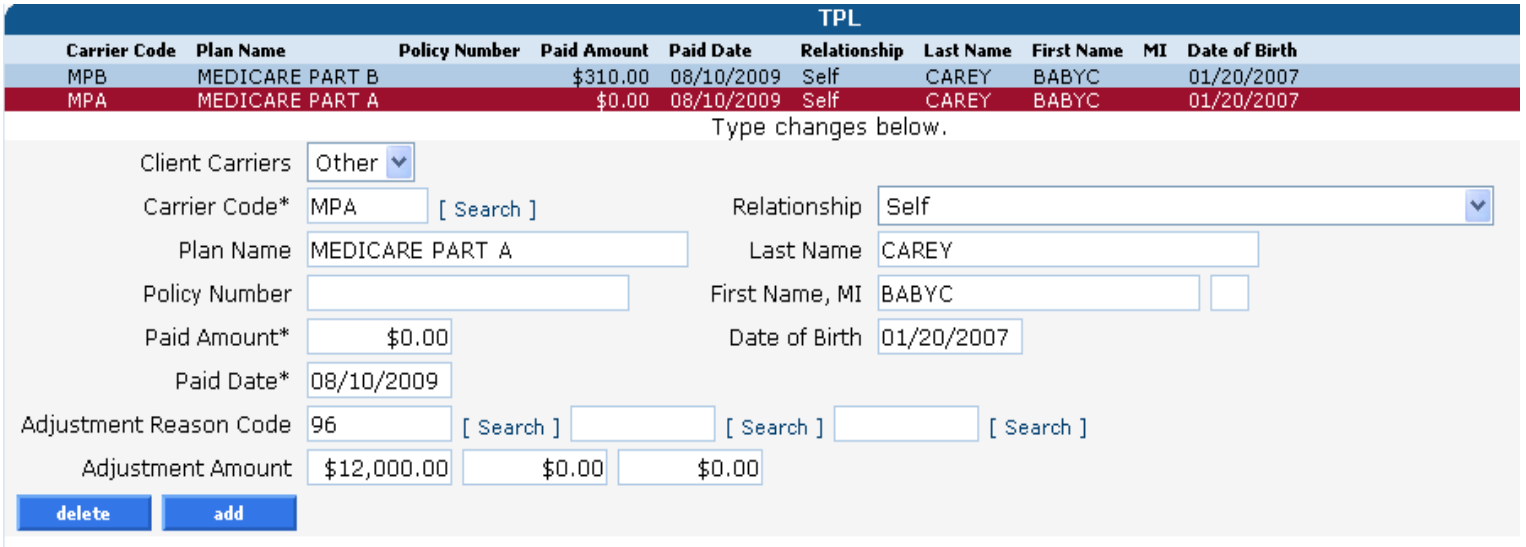
- The following example illustrates a non-crossover claim where Medicare Part A denied payment. A Part B denial would reflect MPB in the carrier code field.

- Claim type: Inpatient Claims

Medicare Billing Instructions cont.

Medicare Part A denial with Part B payment – Web Claim submission

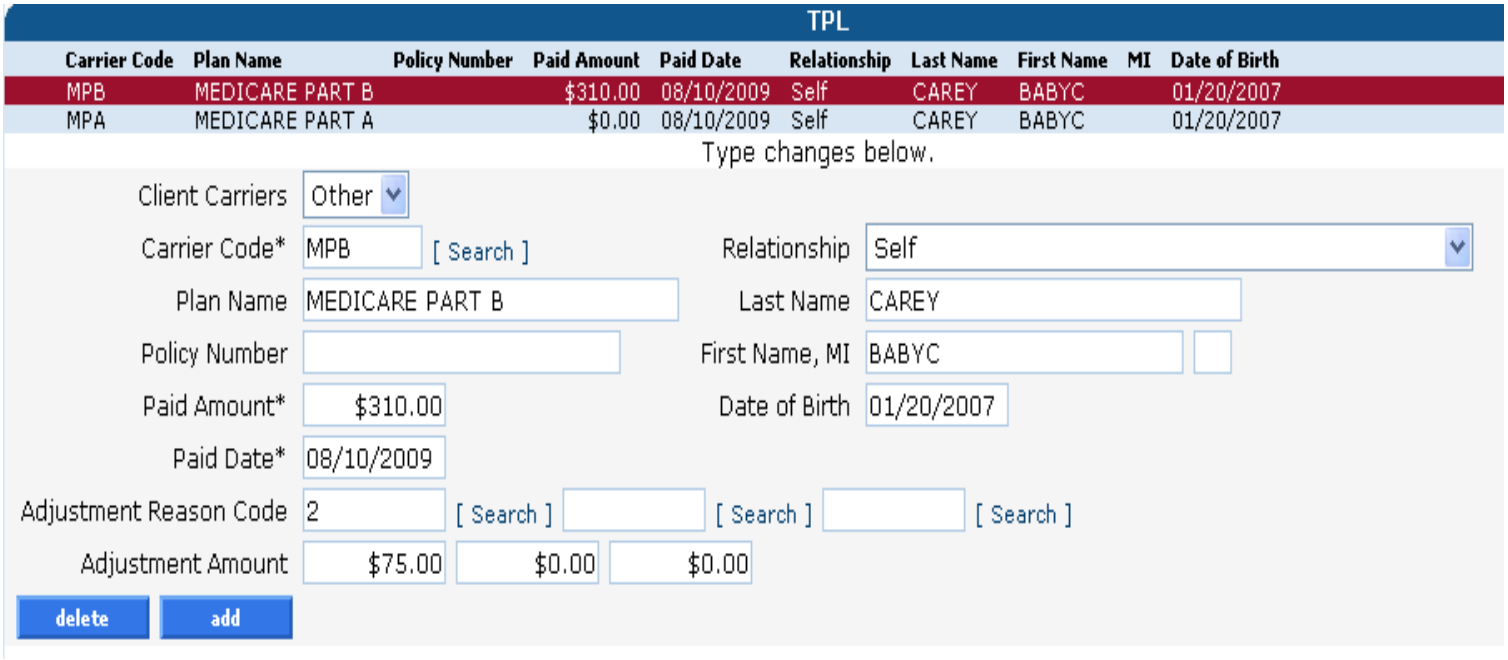
- The following example illustrates a **non-crossover** Inpatient claim where Medicare Part A denied payment, but Medicare Part B made a payment of $200.00 with a coinsurance amount of $110.00 on the claim. The total prior payments must be entered as $310.00.
- Claim type: Inpatient Claims
- First TPL entry indicating Medicare Part A Not Applicable:



Medicare Billing Instructions cont.

Medicare Part A denial with Part B payment – Web claim submission

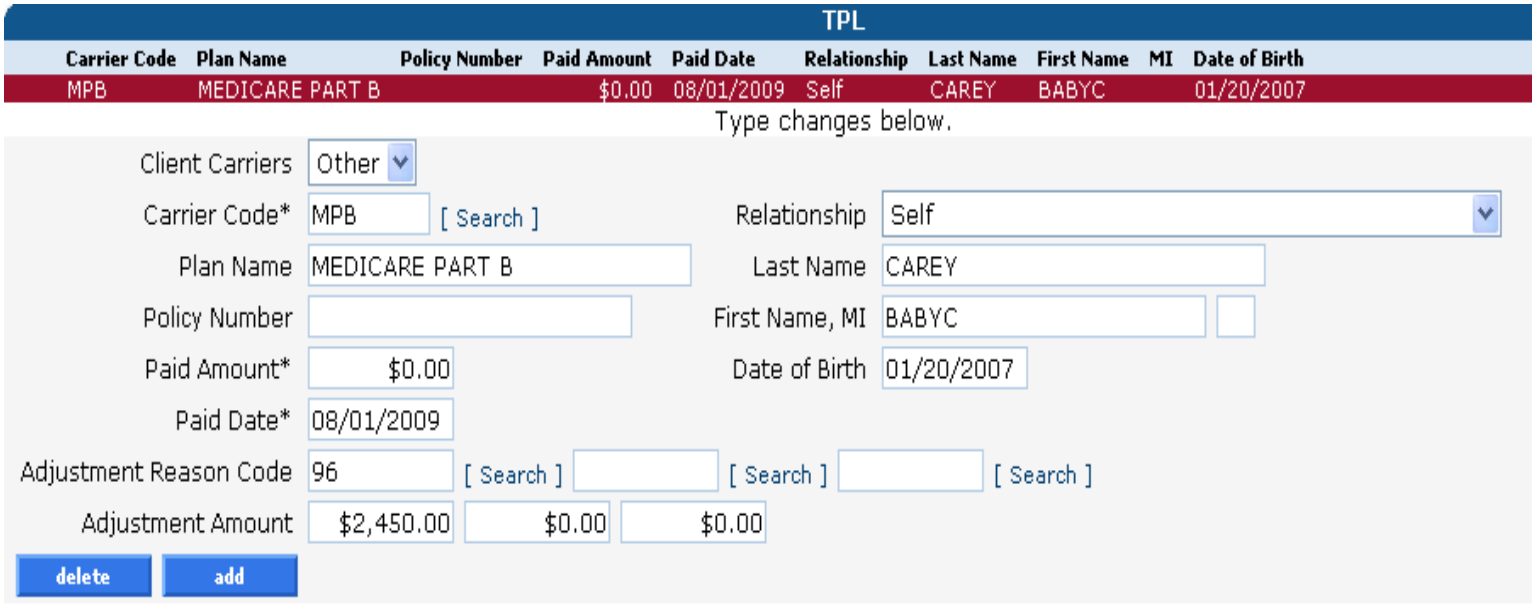
- Second TPL entry indicating Medicare Part B payment:



Medicare Billing Instructions cont.

Medicare HMO denial – Web claim submission

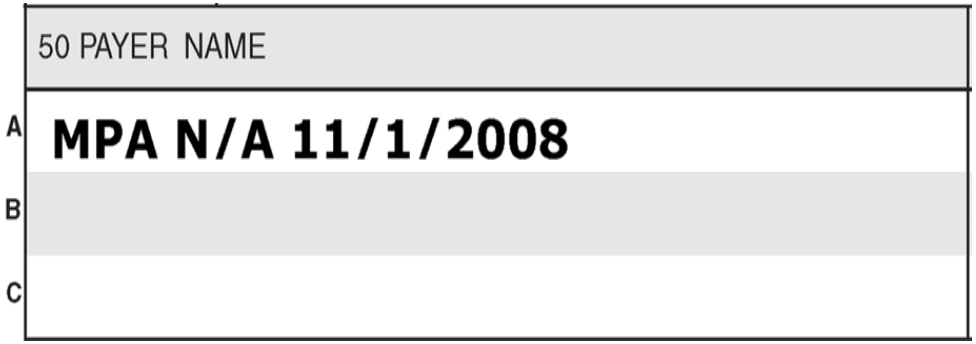
- The following example illustrates a non-crossover outpatient claim where Medicare HMO part B denied payment.
  - Claim type Outpatient
  - HMO Part A denial would reflect MPA in the carrier code field.



Medicare Billing Instructions cont.

Medicare Part A or B denial – UB-04 claim submission

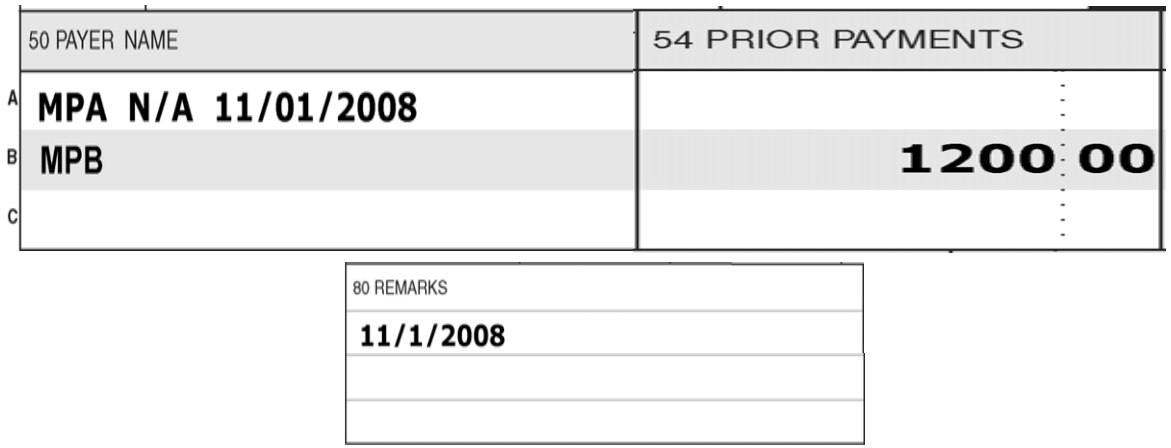
- The following example illustrates a non-crossover claim where Medicare Part A denied payment. A Part B denial would reflect MPB N/A in field 50.
  - The Explanation of Medicare's Benefits (EOMB) is not required to be attached to the claim when Medicare denies the services



Medicare Billing Instructions cont.

Medicare Part A denial with Part B payment – UB-04 claim submission

- The following example illustrates a non-crossover claim where Medicare Part A denied payment, but Medicare Part B made a payment of $900.00 with a coinsurance amount of $300.00 on the claim. The total prior payments must be entered as $1,200.00.
  - The Part A Explanation of Medicare Benefit (EOMB) indicating the denial and the Part B EOMB, indicating the payment **should not** be sent with the paper claim.



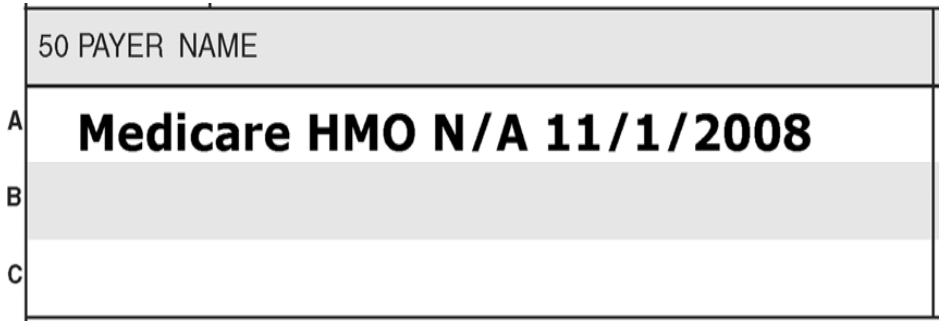
	50 PAYER NAME	54 PRIOR PAYMENTS
A	MPA N/A 11/01/2008	
B	MPB	1200 00
C		

80 REMARKS
11/1/2008

Medicare Billing Instructions cont.

Medicare HMO denial – UB-04 claim submission

- The following example illustrates a non-crossover claim where Medicare HMO denied payment.
  - The Explanation of Medicare's Benefits (EOMB) is not required to be attached to the claim when Medicare denies the services

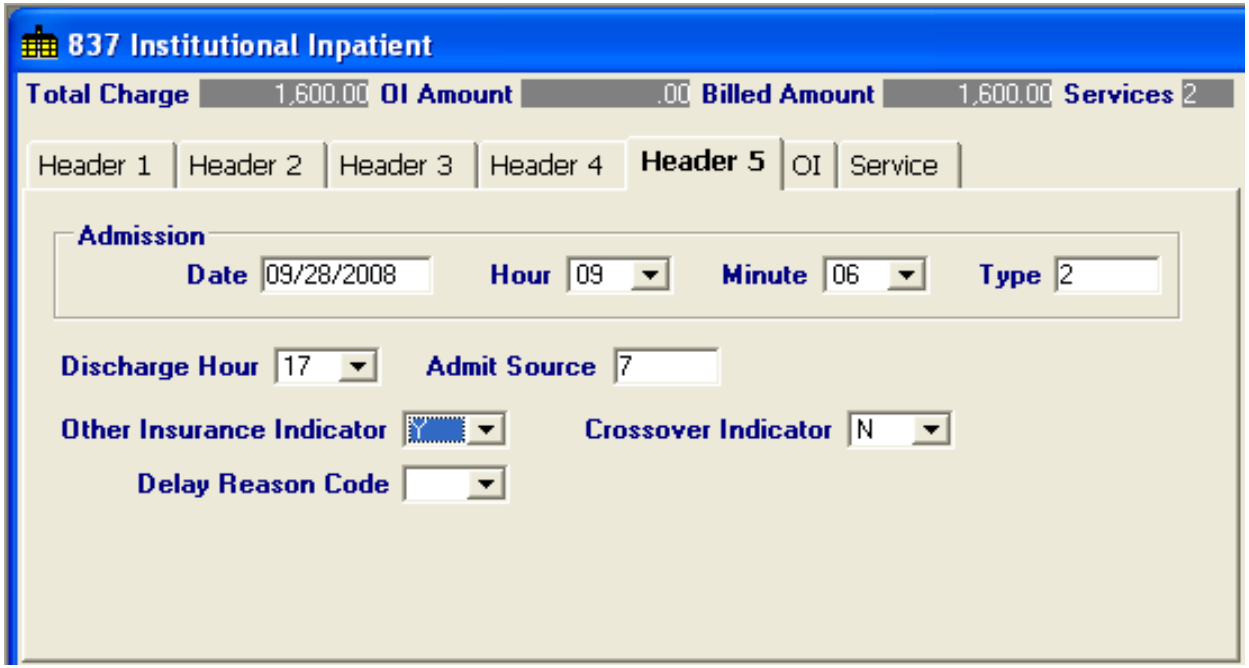


	50 PAYER NAME
A	**Medicare HMO N/A 11/1/2008**
B	
C	

Medicare Billing Instructions cont.

Medicare Part A or Part B denial – Provider Electronic Solutions claim submission

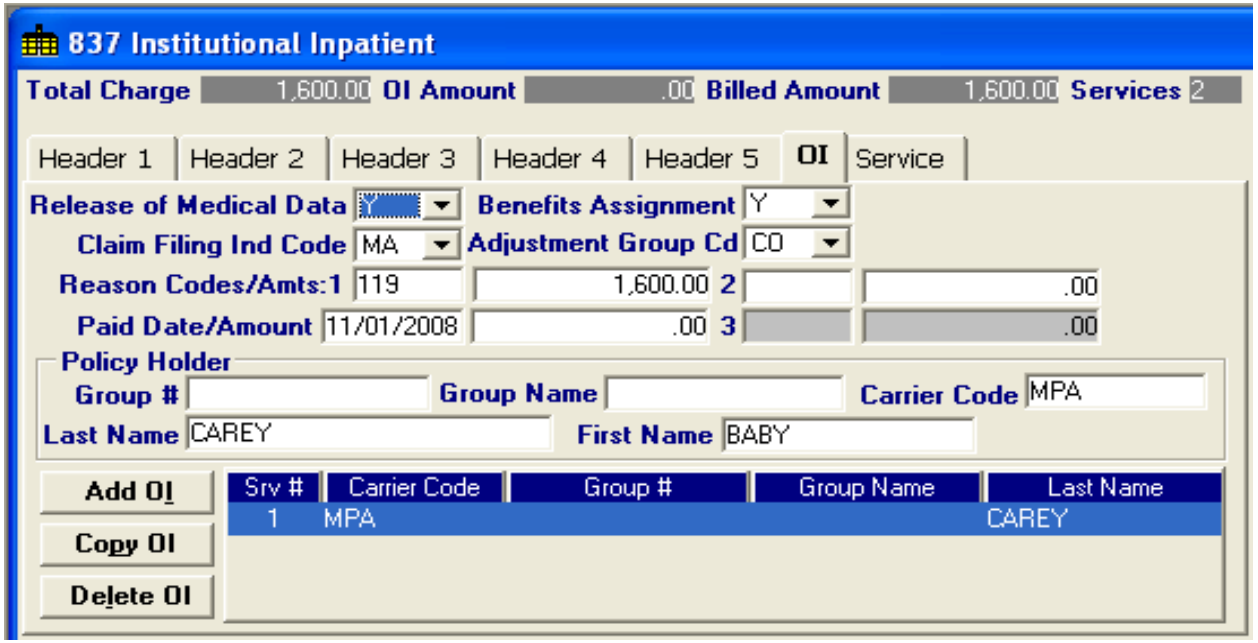
- The following example illustrates a non-crossover claim where Medicare Part A denied payment.



Medicare Billing Instructions cont.

Medicare Part A or Part B denial – Provider Electronic Solutions claim submission

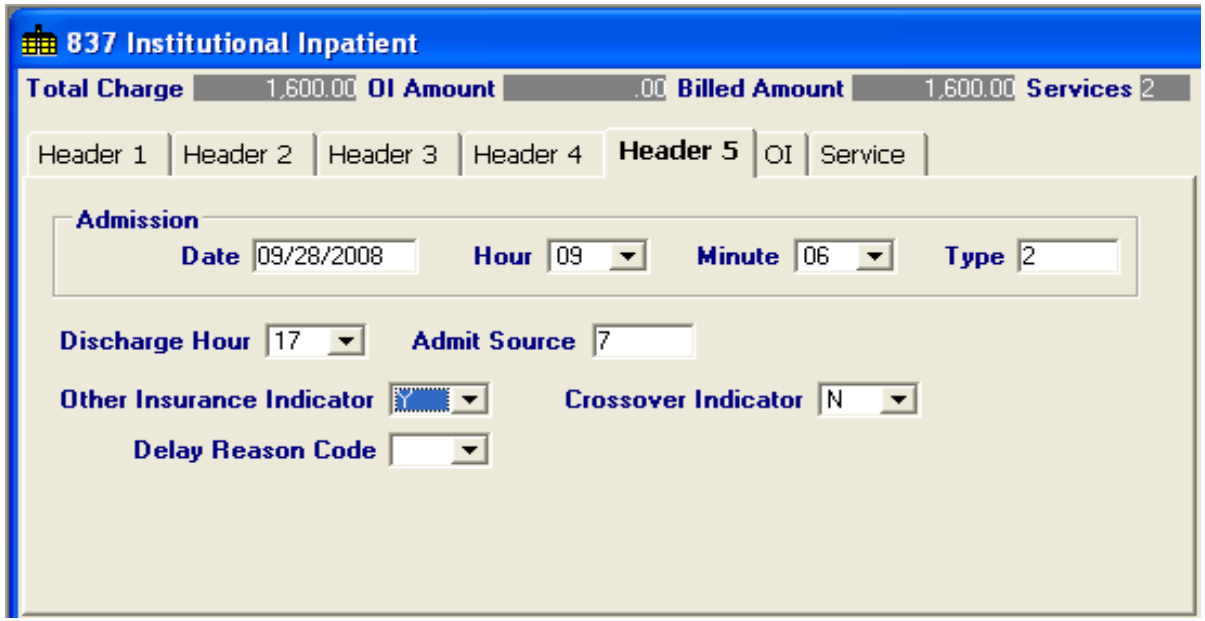
- The following example illustrates a non-crossover claim where Medicare Part A denied payment. A Part B denial would reflect MB in the Claim Filing Ind Code and MPB in the Policy Holder Carrier Code field.



Medicare Billing Instructions cont.

Medicare Part A denial with Part B payment – Provider Electronic Solutions claim submission

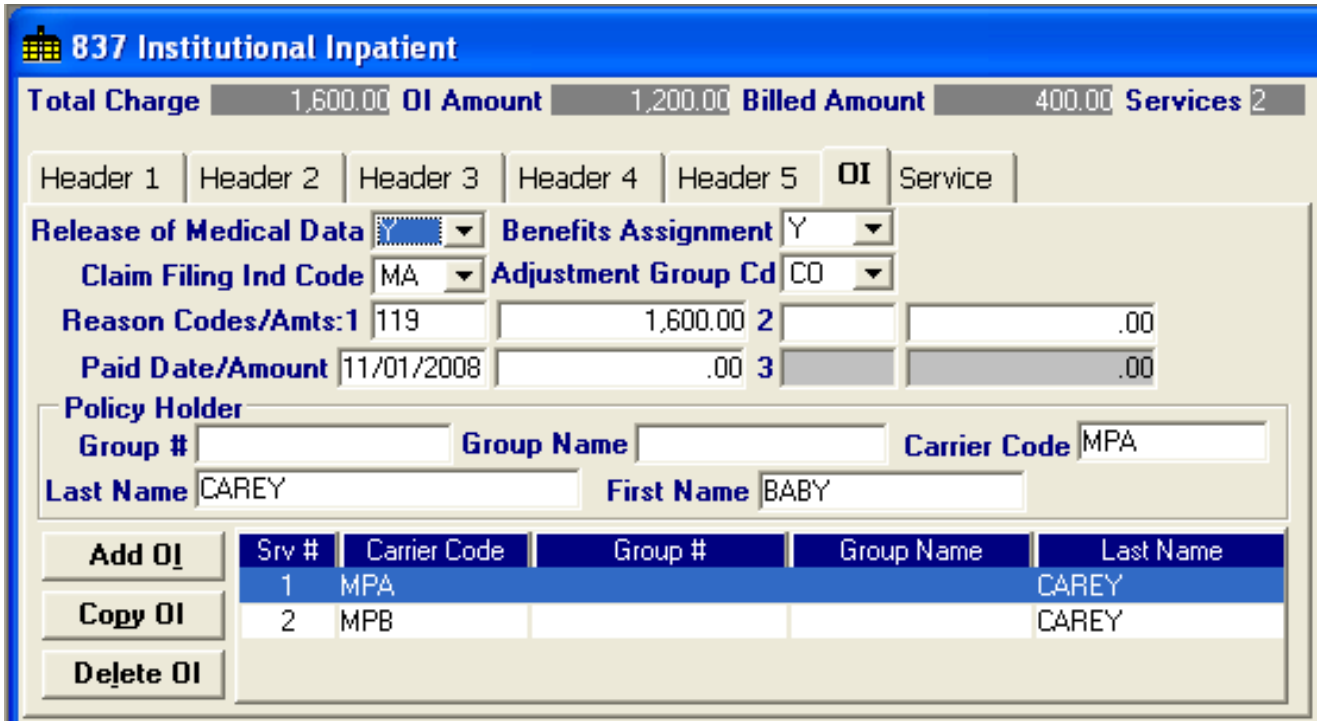
- The following example illustrates a non-crossover claim where Medicare Part A denied payment, but Medicare Part B made a payment of $900.00 with a coinsurance amount of $300.00 on the claim.



Medicare Billing Instructions cont.

Medicare Part A or Part B denial – Provider Electronic Solutions claim submission

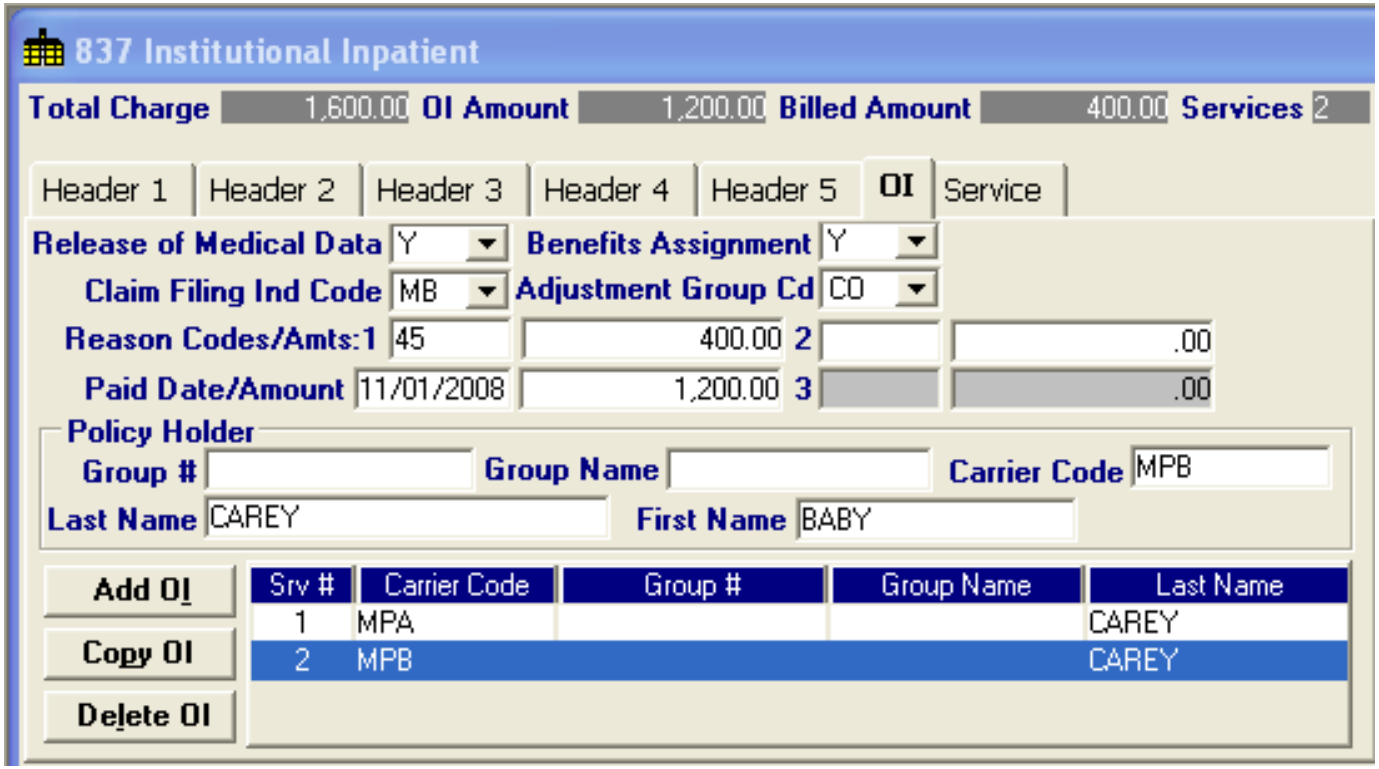
- First entry indicating Medicare Part A not applicable



Medicare Billing Instructions cont.

Medicare Part A or Part B denial – Provider Electronic Solutions claim submission

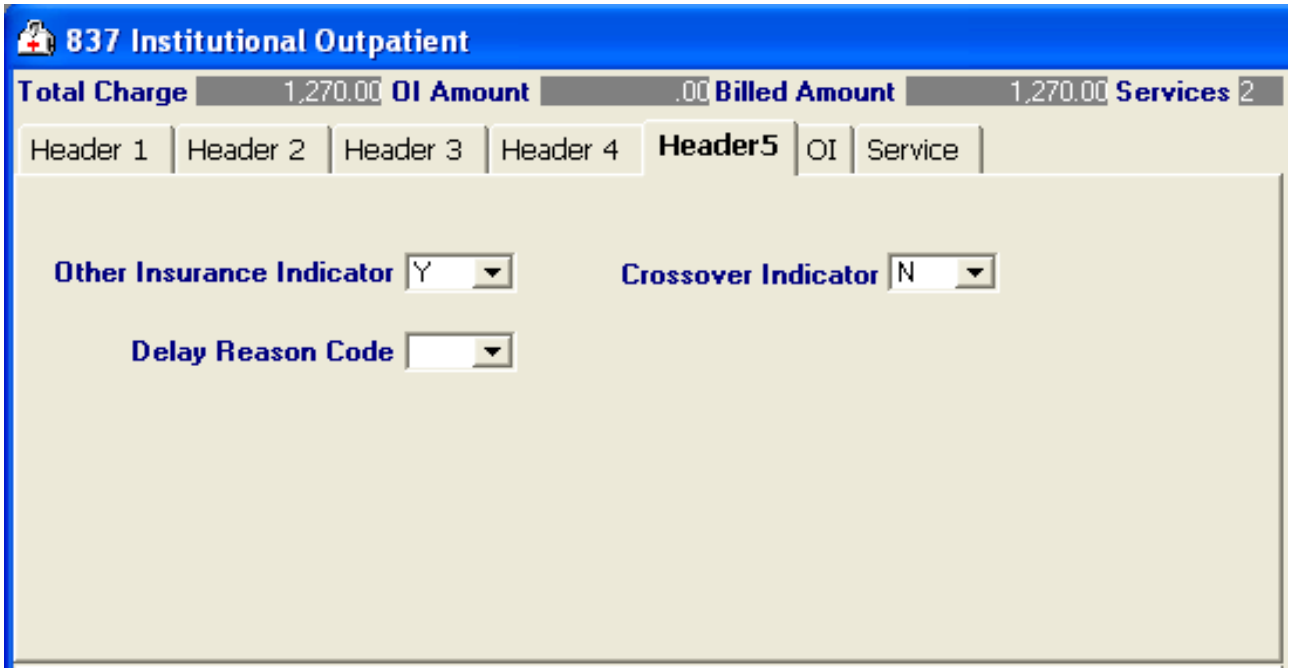
- Second entry indicating Medicare Part B payment



Medicare Billing Instructions cont.

Medicare Part HMO denial – Provider Electronic Solutions claim submission

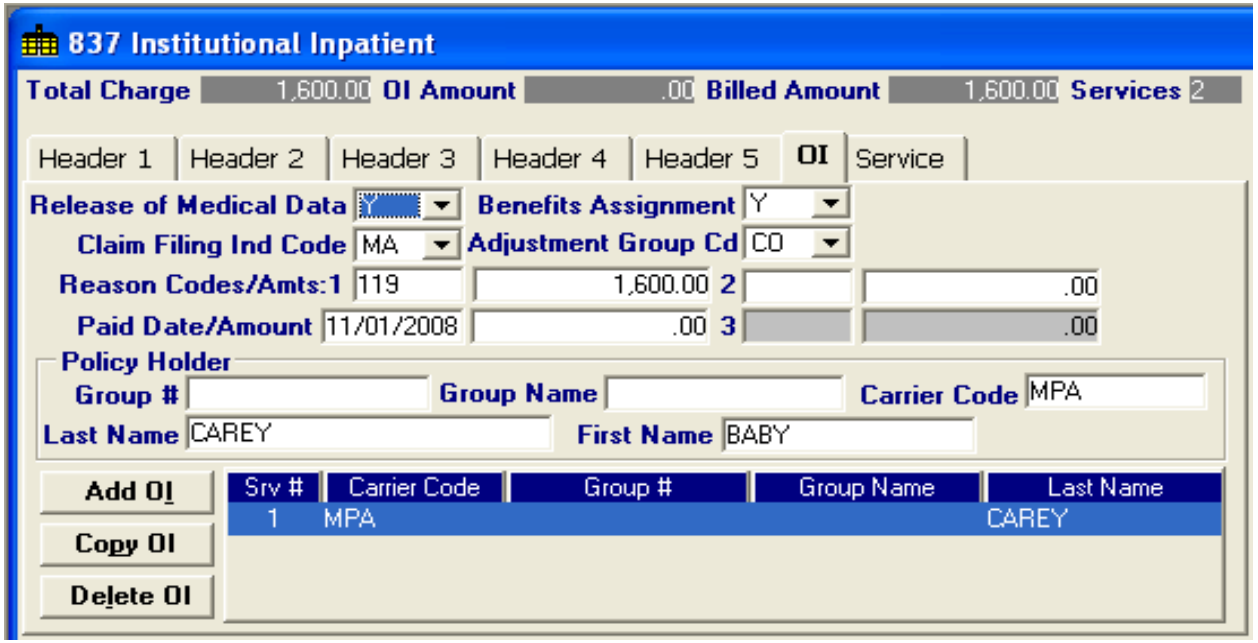
- The following example illustrates a non-crossover claim where Medicare HMO denied payment.



Medicare Billing Instructions cont.

Medicare HMO Part A denial – Provider Electronic Solutions claim submission

- The following example illustrates a non-crossover claim where Medicare HMO Part A denied payment. A Part B denial would reflect MB in the Claim Filing Ind Code and MPB in the Policy Holder Carrier Code field.



Timely Filing Requirements

Previously claims that denied for timely filing Explanation of Benefits (EOB) codes 512 ““Claim exceeds timely filing limit” and 555 “Claim is past behavioral health timely filing guidelines” needed to be submitted on paper with attachments to support a timely filing override.

Providers may now submit claims with dates of service over one year old (Fee for Service) or 120 days (CTBHP) electronically, using Web claim submission or on paper without attachments.

Timely Filing System Enhancement

Fee for Service - Claims will bypass timely filing EOB 512 “Claim exceeds timely filing limit”

- Original claim with no TPL:
  - ICN Julian date is within 366 days from the detail through date(s) of service on the claim.
- Client eligibility file change:
  - Client eligibility has been added or updated where the ICN Julian date is within 366 days of the change and the claim date of service is between the effective dates of the change.
- Medicare and/or Other Insurance Payment:
  - OI or Medicare paid amount is greater than $0.00 and the paid date is within 366 days of the ICN Julian date of the claim.
    - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny with EOB 512.

Timely Filing Requirements cont.

- Other Insurance denial:
  - OI denial date is within 366 days of the from date of service on the claim and within 366 days of the ICN Julian date.
    - If multiple carriers exist and if any one does not meet the above criteria, the claim will deny with EOB 512.

- Medicare denial:
  - Medicare (carrier code MPA or MPB) denial date on the claim is within 549 days of the from date of service on the claim and within 366 days of the ICN Julian date.

- Prior claim history:
  - When paid or denied claim in history with same client, provider, billed amount, detail from and through date of service and RCC or RCC/Procedure code where ICN Julian date on the current claim is less than or equal to 366 days from the previous claims Remittance Advice (RA) date and the previous claim did not deny for timely filing.

Timely Filing Requirements cont.

- Claim adjustments:
  - When the number of days between the paid date of the claim and the adjustment's ICN Julian date is less than 366 days.

Timely Filing Requirements cont.

Connecticut Behavioral Health Partnership (CTBHP) Claims will bypass timely filing EOB 555 “Claim is past behavioral health timely filing guidelines.”

- Original claim:
  - Detail through dates of service on the claim is within 120 days prior to the ICN Julian date.

- Claim History:
  - Adjudicated claim for same client, provider, billed amount, detail from and through date of service, Revenue Center Code (RCC) or RCC/HCPC (procedure code) where the ICN Julian date on the current claim is less than or equal to 120 days from the previous claims Remittance Advice date and the previous claim did not deny for timely filing.

Most Frequent Claim Denials

- EOB 3004 “Inpatient Claim Requires Authorization”

Please note the following instructions apply when the hospital received an approved Prior Authorization letter from Qualidigm, but the submitted claim has denied for EOB 3004.

- Providers need to check the PA inquiry on the Web site to verify if there is an Authorization on file.
  - *If Prior Authorization is not on our Web site, contact Qualidigm*
  - *If Prior Authorization is on the provider secure Web site:*
    1. Verify the Prior Authorization effective and end dates with the inpatient admission date and the dates of service being billed.
    2. If the admission date doesn’t fall between the authorized effective and end dates, contact Qualidigm.
    3. Confirm when the authorization was approved. If it was approved after the claim was processed, re-submit the claim for processing.

Most Frequent Claim Denials

- EOB 2017 “Service is included in MCO coverage”

Claims should be verified to determine if they should be processed by HP or the MCO (Managed Care Organization).

- Verify client eligibility to determine if client is enrolled in a managed care organization.
  - If yes, and it is a medical claim, submit the claim to the client’s MCO.
  - If yes, and it is a behavioral health claim, you will need to resolve any Prior Authorization requirements. Once Prior Authorization is in place, EOB 2017 may also be corrected at the same time.
  - If no, client eligibility could have been updated at some point. Re-submit the claim to the appropriate responsible party according to the client eligibility reference guide.

Most Frequent Claim Denials

- EOB 4227 “The RCC (Revenue center codes) billed is not a covered service under the client’s benefit plan”

  - Hospital should verify client eligibility to determine if claim should be billed to HP per client’s benefit plan and RCC being submitted.

  - To assist provider in determining coverage refer to eligibility response quick reference guide located on the Public Web site at www.ctdssmap.com.

  - Please verify that you are submitting the correct RCC. If the RCC is incorrect, correct the claim and re-submit to HP.

Most Frequent Claim Denials

- EOB 570 “Header total days less then covered days” or EOB 876 “Header quantity disagrees with days elapsed”

  - The hospital will need to verify the following claim fields that might cause this error if entered incorrectly:

    1. Statement cover period – From and through dates of service.
    2. Patient status – discharge (01) vs. still patient (30).
    3. Room and Board RCC number of units entered on claim.

If submitted incorrectly, hospitals would need to correct and re-submit the claim for processing.

Most Frequent Claim Denials

- EOB 2504 “Bill private carrier first”

  - The hospital should verify client eligibility to identify the client’s Third Party Liability (TPL) coverage through the secure Web site at www.ctdssmap.com.

  - If the client has other insurance, the hospital needs to submit to the primary carrier first and then to Medicaid as the secondary carrier.

  - If the claim was submitted to the primary carrier, the claim to HP must contain the same other insurance carrier code as returned in the client eligibility response, the amount paid, if any and the date the other insurance paid/denied the claim.

Most Frequent Claim Denials

- EOB 2057 “Client ineligible for portion of claim. Re-submit for covered days only”

  - Please verify the client’s coverage by verifying eligibility through the secure Web site at www.ctdssmap.com.

    - If the client loses eligibility during the hospital stay, the claim submitted to HP must only contain dates of service that the client was eligible.

Most Frequent Claim Denials

- EOB 2500 “Bill Medicare first”

  - The hospital should verify client eligibility to identify if the client has Medicare coverage through the secure Web site at www.ctdssmap.com.

  - If the client has Medicare, the eligibility verification will show Medicare effective for the date of service on your claim.

  - If the claim was submitted without the Medicare information, you will need to correct the claim and re-submit the claim to HP.

Reminder: Medicare primary with Medicaid as secondary payer can be submitted to HP through the provider secure Web site.

Most Frequent Claim Denials

- EOB 513 “Client’s name and number disagree”

  - Please verify client eligibility through the secure Web site at www.ctdssmap.com.

  - Best way to ensure claims will not deny with EOB code 513 is using the provider secure Web site at www.ctdssmap.com to submit your claims to HP.

    - When you enter the client ID through Web claim submission this will auto-populate with the client’s first and last name that is loaded in our system. Please validate this information is correct before submitting the claim for processing.

SAGA Transitioning to Medicaid

- Processing of SAGA inpatient and outpatient medical claims for dates of service prior to April 1, 2010 will continue to be processed during April and May 2010 based on the existing SAGA allotment reimbursement process. The last SAGA hospital payment will be made in the June 4, 2010 claim cycle

- Medical inpatient and outpatient hospital claims and paid claim adjustments for SAGA clients received with dates of service prior to April 1, 2010 will be denied when received on or after June 1, 2010. Providers are strongly encouraged to submit all SAGA medical claims and paid claim adjustments for dates of service prior to April 1, 2010 by May 31, 2010 to obtain payment.

SAGA Transitioning to Medicaid

- Claims for hospital stays which span April 1, 2010 must be split billed. SAGA claims submitted with dates of service spanning into April (e.g., DOS 03/31/2010 - 04/02/2010) will be denied in their entirety.
  - The SAGA claim should be billed as two claims on as a TOB 112 with DOS 03/31/2010 – 03/31/2010, patient status 30 and the other as a TOB 114 with DOS 04/01/2010 – 04/02/2010 and patient status 01.

- Paid claim adjustments submitted after May 31, 2010 for previously paid claims with dates of service prior to April 1, 2010 will be recouped in full and no payment will be made.

Web Claim Submission

Online Claim Submission allows providers to:

- Submit claims to HP directly from their secure Provider Web site.
  - Receive immediate response
    - Pay
    - Deny
    - Suspend
- Copy claim for new submission
- Adjust claim (correction to paid claim)
- Void claim (cancel/recoup paid claim)
- Resubmit claim

Online Help – Web Claim Submission

Quick Links

- Instructions for submitting Institutional claims
  - Link in upper left of window for Web claim instructions

- Internet Claim Submission FAQ
  - Frequently Asked Questions on Web claim submission

Training Session Wrap Up

- Where to go for more information
  www.ctdssmap.com

- HP Provider Assistance Center (PAC):

Monday through Friday, 8 a.m. to 5 p.m. (EST), excluding holidays:

1-800-842-8440 (in-state toll free)

(860) 269-2028 (local to Farmington, CT)

Time for Questions

- Questions & Answers