

Sec. 17b-262-529. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department's fiscal agent within twelve months of the date the service was provided or the good was delivered and shall include all information required by the department to process the claim for payment, as set forth in the Regulations of Connecticut State Agencies and specified in the department's provider billing manuals. The date of service is the actual date on which the service was provided.

(b) Exceptions to the procedures set forth in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies shall be as follows:

(1) when an individual is an applicant of the Medical Assistance Program or an applicant for a categorically related program which qualifies the individual for the Medical Assistance Program, and the determination of eligibility comes after the last date of service and eligibility is retroactive, the provider shall submit claims for goods or services received within one year of the effective date of the determination of eligibility or effective date of award, whichever comes later;

(2) when there is an issue related to Medical Assistance Program eligibility or to payment for goods or services which is subject to the grievance process, the provider shall submit claims within the guidelines in subsection (a) of section 17b-262-529 of the Regulations of Connecticut State Agencies or within twelve months of the effective date of the resolution in favor of Medical Assistance Program payments for goods or services, whichever is later; and

(3) when a provider has submitted a claim to a third party insurer and has not received a response within a reasonable time, the one year shall begin twelve months from the date of receipt of the explanation of benefits form. The provider shall be responsible for any followup to the third party insurers.

(Adopted effective February 8, 1999; Amended April 1, 2003)