

Connecticut B23 Providers- Early Intervention Billing and Claiming Guide

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REVISION HISTORY

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PURPOSE

The purpose of this manual is to support Early Intervention (EI) Service Programs through the billing and claiming process for early intervention services by identifying all processes and procedures that occur to support payment for services provided. It is meant to be a resource document that can be used to address claiming and billing issues prior to Lead Agency and/or PCG escalation.

CONVERTING SERVICES TO CLAIMS

A claim is created in EI Billing after data is received from the CT B23 Data System. The data from the CT B23 Data System is delivered daily via a Secure File Transfer Protocol (SFTP) file from CT B23. The data files received from the CT B23 Data System must contain complete information regarding the child, visit, insurance, B23 Provider Agency, and therapist. Inaccurate or missing data for the child, visit, insurance, provider agency, and therapist, can delay billing and reimbursement.

The current status of a claim in EI Billing indicates where the claim lies in the billing process. A claim will be in a current status of Original, Insurance, Medicaid, Escrow, Voided or Closed.

The billed amount and procedure code are added to a claim in EI Billing by referencing the rate table and validating the discipline and service type. Per the CT B23 personnel standards, when a discipline is not authorized to perform a service, the claim in EI Billing will remain in current status = 'ORIGINAL' and the amount billed, and procedure code will not be added to the claim.

Provider agency staff will need to review the visit in error in the B23 Data System. If a new visit needs to be created, the provider will void the visit in error and create a new visit in the B23 Data System with accurate information. Provider users can look up claims in ORIGINAL current status at any time by going to EI Billing > Reports > Claiming > Claim Research. Filter by Status = 'ORIGINAL'.

FILING A CLAIM FOR PAYMENT

There are three main payment sources; private or commercial insurance, public coverage such as Medicaid, or Escrow.

PRIVATE OR COMMERCIAL INSURANCE

When a family has authorized consent to bill insurance and the child has active coverage starting on or before the date of service, an insurance billing record is created and sent to the clearinghouse, then forwarded to the insurance company. A child's insurance record must have at a minimum a valid insurance company name, a policy number, and a start date. An insurance billing record will not be sent to an insurance company when the family/parent has declined consent to bill insurance.

Multiple insurances can be billed for reimbursement, but they must be billed sequentially—not simultaneously. The user must designate the primary insurance in the B23 Data System. This insurance will be billed first. If there is a remaining balance after the primary insurance processes the claim, the secondary insurance may be billed—but only if consent to bill the secondary insurance has been obtained.

Importantly, secondary insurance should never be billed as the primary source of reimbursement if the parent has not given consent to bill the primary insurance. In such cases, none of the insurances—primary, secondary, or tertiary—will be billed, and the claim will be filed with Escrow.

Quick Tip: *To stop claims from continuing to bill to insurance, an end date must be added to the insurance record in the B23 Data System. When the parent informs the B23 provider agency that the insurance policy is linked to an HSA/HRA, the family must give consent to bill insurance, indicate the policy is linked to an HSA/HRA and authorize to bill their insurance. When a family/parent no longer wants claims billed to insurance, the provider agency must take the appropriate steps to end date the insurance record in the B23 Data System.*

PUBLIC INSURANCE OR MEDICAID

When a child has Medicaid coverage, an insurance billing record is created, when the start date is on or before the date of service. A child's Medicaid insurance record within the B23 Data System must have at minimum a valid insurance company name, and a policy number.

Quick Tip: *Information entered into the B23 Data System must match what is on the insurance card for billing insurance and reimbursement. Inconsistencies will lead to claim rejections and denials from an insurance company. (I.e., Name, Date of Birth, Policy Number, Group Number, etc.)*

Quick Tip: *When a billing record is created and there is an issue with data from the B23 Data System, the billing record will move to the workable claims queue. Agency users should frequently monitor Category 1 workable claims queues for their agency.*

ESCROW (PAYOR OF LAST RESORT)

When a billing record is not sent to Private Insurance or Medicaid, the billing record is moved into the escrow process, and the billing record is paid by escrow funds. This occurs because there is no insurance coverage, the date of service is not within the insurance start and end date, consent to bill insurance was declined, or in some cases the insurance record was added after the date of service occurred.

Escrow is the payor of last resort when no other payment source is available. If the primary private insurance pays only a portion of the billed amount and there is no secondary insurance, a new billing record is created with the status set to Escrow. Additionally, if a claim was billed to insurance and no payment is received from the primary insurance within 90 days from the date of service, a new billing record is also created and marked as Escrow.

Once a billing record is eligible to move to Escrow, a monthly process runs on the first of each month to check the status of all billing records. If a record is in Escrow, it is updated with the balance to be paid using Escrow funding.

CHECKING ELIGIBILITY

Each month PCG checks eligibility with private insurance and Medicaid for a child that had a service provided in the previous month. PCG will check eligibility for a child if the insurance information from the CT B23 Data System indicates the record is active, and if there is validation to indicate the insurance can be billed.

An important factor to remember is that PCG utilizes a third-party vendor. The third-party vendor may not have access to all insurance companies to check eligibility. PCG will only create an eligibility request if the third-party vendor can forward the request to the insurance company.

Once the eligibility verification process has been completed, PCG will send an email and provide each B23 agency with a report of eligibility responses that were received from an insurance company. Each record contains a status of 'Active', 'Inactive', 'Unverified'.

- Active status – indicates the child currently has active insurance with the insurance company.
- Inactive status - indicates the child does not have coverage with the insurance company.
- Unverified status - indicates there was an issue with the data, and the insurance company was unable to identify the information provided in their system.

If a provider discovers an error with the data in the report, please contact PCG support and create a support ticket. Any updates other than data errors should be worked through by service coordinator staff.

VOIDED CLAIMS

If a service entered into the B23 Data System is inaccurate or did not occur, the billing provider must take corrective action to void the entry. To do this, users must follow the procedures outlined by B23 for deleting a visit in the system. Once the void request is added to EI Billing, the billing system uses its void functionality to process the record as a voided claim.

A new billing record is created in EI Billing with the correct claim frequency value. When the billing record needs to be returned to a payment source in EI Billing, the original billing record must contain the insurance company's claim number, commonly referred to as the ICN or claim reference number. A billing provider user must check to see if the insurance company has sent an adjudication response, and the response is added to EI Billing.

When a billing provider is unable to void a record in EI Billing, the provider agency user must submit a web-to-case support ticket to PCG. PCG will attempt to void the billing record on behalf of the provider. In certain cases, PCG can assist with voiding a claim—but only if there is supporting data in EI Billing confirming that the service was voided in the CT B23 Data System.

CORRECTED CLAIMS

When information about a service is inaccurate for a date of service, that date of service will need to be voided and a new service visit will need to be created and sent from the CT B23 Data System. When the billing record needs to be returned to a payment source in EI Billing, the original billing record must contain the insurance company's claim number, commonly referred to as the ICN or claim reference number. A billing provider user will need to check to see if the insurance company has sent an adjudication response and the response is added to EI Billing.

Billing providers should review an insurance company's timely filing limits. In some cases, the insurance company will not adjust the payment of the original claim and will initiate a full reversal of payment. When this happens, a billing record will be created, and the billing record will be moved to escrow.

If a billing provider is unable to correct a record in EI Billing, the provider agency user must submit a web-to-case support ticket to PCG. PCG will attempt to correct the billing record on behalf of the provider. In certain cases, PCG can assist with correcting a claim—but only if there is supporting data in EI Billing confirming that the service was corrected in the CT B23 Data System.

Quick Tip: *Billing providers must ensure that all claim data—including statuses, billing order, payments, and denials—is entered accurately. Maintaining accurate data helps keep accounts payable as precise as possible. If a payment discrepancy is identified, the provider agency user must submit a web-to-case support ticket to PCG through EI Billing.*

To support these efforts, the following reports available in the Billing and Claiming System can be used:

Claim Status

- *Claims Awaiting EOBs*
- *Claims In Progress*
- *Claims Needing Attention-Insurance*
- *Claims Needing Attention-Medicaid*
- *Workable Claims Summary*
- *Visit Payment Summary*
- *Provider Payment Profile*
- *Provider Payment Summary*
- *Provider Payments to Date*

THIRD PARTY CLAIMS PROCESSING

For each 837 file (private insurance) that is received, the third party will validate the file then create and send a 999 report back to the originator, (PCG). The 999 report indicates whether the 837 file was accepted or rejected. When an 837 file is accepted on a 999, the claims in the file are moved onto claim editing. When the 837 file is rejected on a 999 report, PCG attempts to correct the data in error on the day of the rejection and resends the 837 files until a 999 report indicates the 837 file was accepted.

After a file is validated, the individual claims are run through a validation process. Insurance companies scrub various validation points in their systems against the data presented in the 837 such as billing provider enrollments, valid names, policy numbers, procedure codes, diagnosis codes, timely filing etc. There is no one set of validation points an insurance company uses to validate a claim. A 277-claim status acknowledgement is created for each claim that was validated, and the 277-claim status report is returned to the originator, (PCG). Both the third party vendor and the insurance company may provide a 277-claim status report. 277 reports indicate whether a claim was accepted and forwarded onto adjudication or if the claim was rejected.

When a 277 report indicates a claim is rejected, the claim is no longer an active claim considered for adjudication and must either be corrected and resent to the insurance company, or it will become a non-billable claim for reimbursement sent to the insurance company. Claims considered workable in EI Billing can be found under Claims > Insurance > Workable Claims > 277 Claim Rejections. Agency users will need to frequently monitor the workable claims queues for any claim rejection they can correct.

After the claims are validated, they move to the adjudication cycle. Reimbursement is determined by policies, procedures and regulations outlined by the insurance company based on the plan type and eligible benefits included for each plan and policy. Once adjudication is completed an explanation of the determination will be provided to the billing provider and the patient/subscriber.

When PCG enrolls the billing provider through the PCG submitter to receive the adjudication responses, PCG receives the 835 claims remittance advice. Both the 277-claim status and the 835 responses are posted to the insurance billing claim record. Any payment amount applied to the claim in the 835 response is added to the amount paid in EI Billing. When an 835 response is not obtained through the third-party vendor, it is the billing provider's responsibility to send PCG a copy of the Estimation of Benefits (EOB) or an Explanation of Payment (EOP). The information is entered into EI Billing. Failing to submit a copy of an EOB/EOP could result in payment discrepancies by the insurance company and lead to Escrow Funds being utilized to pay the billed amount.

Quick Tip: *Not all insurance companies will return a 277-claim status acknowledgement but, will provide an adjudication report either by a printed explanation of payment document, or an electronic remittance data file known as an 835 claims remittance advice.*

Quick Tip: *Not every adjudication response will initially be added to the billing record. This can occur when insurance companies do not provide the exact data that was submitted on the billing record.*

ADDING AN INSURANCE PROVIDER TO THE CT DATA SYSTEM

If a user is unable to locate an insurance company name in Spider, the user needs to create a web to case support ticket with PCG in EI Billing requesting that the insurance company be added. A scanned copy of the front and back of the insurance card is requested, so that PCG

can verify the insurance company name and electronic payer ID, mailing address etc. for the insurance company.

In the event there is not an electronic payer ID, PCG will set the electronic payer ID to 00010 which will alert the third-party vendor to send claims via paper CMS-1500, to the mailing address provided on the insurance card. Once the insurance company has been added to EI Billing, PCG will send a notification to a Birth to Three lead agency associate to have the insurance company added to the B23 Data System.

CODES FREQUENTLY LISTED IN “NEEDS ATTENTION”

CO-31: Medicaid is not active. Service coordinator follows B23 Policy and Procedures.

CO-140: Medicaid shows name or birthdate is different than what is listed on the claim. Service coordinator follows B23 Policy and Procedures.

PR-200: Lapse in Coverage. Service coordinator follows B23 Policy and Procedures. **CO-26:** Expenses incurred prior to coverage. Service coordinator follows B23 Policy and Procedures.

CO-27: Expenses incurred after coverage terminated. Service coordinator follows B23 Policy and Procedures.

CO-109: Claim/service not covered by this payer/insurance company. Service provider follows B23 Policy and Procedures.

CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Service provider follows B23 Policy and Procedures.

PR-226: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. Service provider follows B23 Policy and Procedures.

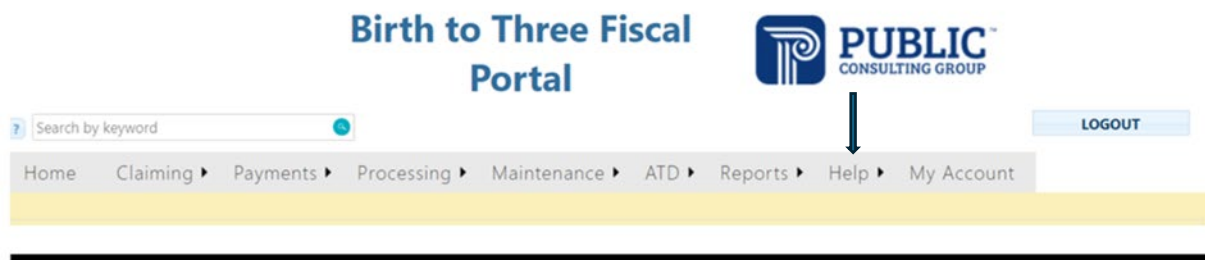
PR-227: Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. Service coordinator follows B23 Policy and Procedures.

CO-252: An attachment or other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided. Service provider follows B23 Policy and Procedures. Additional codes can be researched on the following website; [External Code Lists | X12](#)

QUESTIONS AND SUPPORT

Provider agencies have two sources of support when questions arise. For any issues directly related to information generated from the CT B23 Data System agencies will follow B23 guidance to determine appropriate lead agency staff to address the issues.

For any issues directly related to information generated from the EI Billing and Claiming System agencies may submit a request through the HelpHub Web-2-Case customer service application in the link provided under the **Help Menu** in the CT B23 Fiscal Portal.



Once submitted the user will see a screen notification that the submission has been successful.

DEFINITIONS

Claim Reference Number or ICN: a unique identifier assigned to each insurance claim. It helps track and reference claims during communication with insurance providers and support teams.

Commercial Insurance 270 Eligibility Request: contains patient data for which detailed eligibility information is requested from insurance companies.

Commercial Insurance 271 Eligibility Response: is the response file from insurance to an inquiry about the health care eligibility and benefits associated with a subscriber or dependent.

Commercial Insurance 277: a report acknowledging a receipt of claims from a clearing house.

Commercial Insurance 835: a receipt sent by payors to healthcare providers to provide information about healthcare services being paid for, denied, reduced or adjusted.

Commercial Insurance 837: is an electronic document used by healthcare organizations and medical providers to communicate information about a patient's healthcare claim. Essentially, it serves as an electronic record of a claim.

Commercial Insurance 999 Report File: confirms the initial receipt of the claim file by the contractor, it indicates whether the claim file was accepted or rejected.

Connecticut B23 Data System: system of origin for all insurance coverage information and service delivery documentation.

Escrow: funds provided by the State of Connecticut B23 program to pay for services identified on a child's Individualized Family Service Plan (IFSP) that are not paid for by private or public insurance.

Estimation of Benefits (EOB): a document sent by a health insurance company after you've received a healthcare service for which a claim was submitted.

Estimation of Payment (EOP): is an approximate calculation of the cost for a service provided to the customer before committing to the purchase.

HRA: A Health Reimbursement Account is an employer funded plan that reimburses employees for qualified expenses and, in some cases, insurance premiums.

HSA: A Health Savings Account is a tax advantaged account designed for individuals covered under high deductible plans.

Medicaid Insurance 270 Eligibility Request: contains patient data for which detailed eligibility information is requested from insurance companies.

Medicaid Insurance 271 Eligibility Response: is the response file from insurance to an inquiry about the health care eligibility and benefits associated with a subscriber or dependent.

Medicaid Insurance 835: a receipt sent by payors to healthcare providers to provide information about healthcare services being paid for, denied, reduced or adjusted.

Medicaid Insurance 837: is an electronic document used by healthcare organizations and medical providers to communicate information about a patient's healthcare claim. Essentially, it serves as an electronic record of a claim.

Medicaid Insurance 999 Report File: confirms the initial receipt of the claim file by the contractor, it indicates whether the claim file was accepted or rejected.

Private or Commercial Insurance: refers to insurance provided by private companies rather than government entities.

Public or Medicaid Insurance: refers to plans provided by the government for low-income individuals or families, the elderly, and other eligible individuals.

ADDITIONAL RESOURCES

[CT BILLING PORTAL PAYMENT CYCLE DIAGRAM](#)

[ELIGIBILITY DIAGRAM](#)

[MEDICAID RESULTS DIAGRAM](#)

[PROCESS CLAIM DIAGRAM](#)