CCH Claims Office Hours

August 2025

carolina complete health™

Agenda

- Basic Claims Information
- Provider Resources
- Tips and Tricks to Avoid Claim Denial
- Top 10 Claims Denials and Guidance
- Q& A (Please No PHI)
- Upcoming Hours
- Appendix

Basic Overview of Claims and Payments

Clean Claim: A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment.

- Clean claims will be **resolved** (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim.
- CCH Medical Claims are paid **weekly** on Monday, Wednesday and Friday.

Ways to Submit Claims

Claims may be submitted in four ways:

1. The secure provider portal: https://provider.carolinacompletehealth.com
2. Availity: https://www.availity.com/providers/
3. Electronic Clearinghouse
   Carolina Complete Health Payer ID: 68069
4. Mail
   Carolina Complete Health
   Attn: Claims
   PO Box 8040
   Farmington, MO 63640-8040

Provider Support Contact Information

Provider Services	**1-833-552-3876**
Provider Relations	**NetworkRelations@CCH-Network.com**
Provider Engagement	**Provider Engagement Contact List**
Prior Authorizations	**Prior Authorization** **1-833-552-3876** **Retrospective Authorization Review Request (PDF)** **CCH Pre-Auth Tool**

Provider Resources:

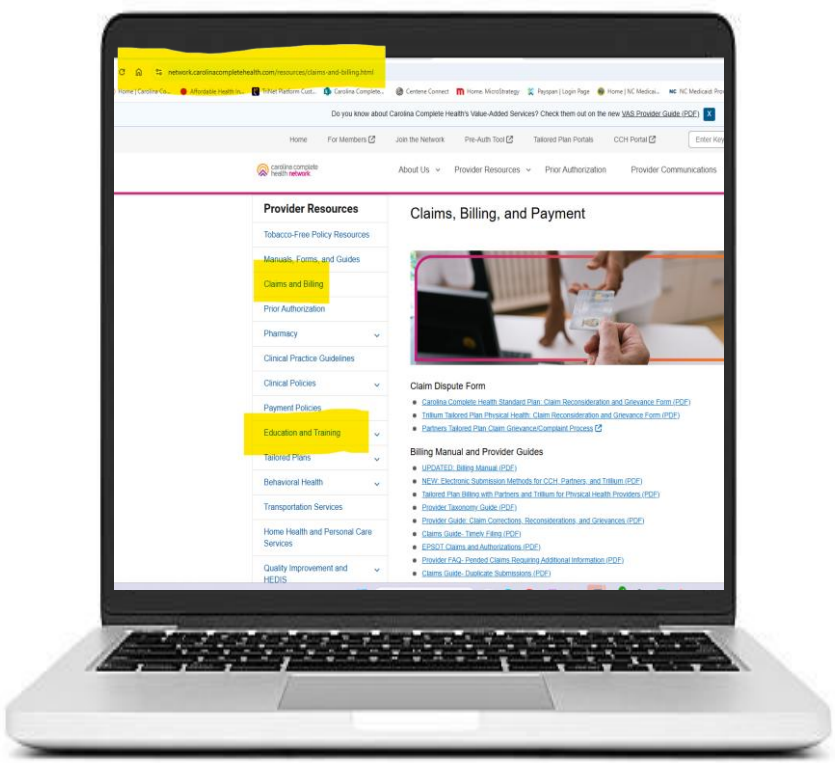
https://network.carolinacompletehealth.com/resources/claims-and-billing.html

Billing Manual: UPDATED: Billing Manual (PDF)

Provider Manual: Provider Manual: Updated 2/25/25 (PDF)

Provider Guides:

- Provider Taxonomy Guide (PDF)
- Claims Guide- Timely Filing (PDF)
- EPSDT Claims and Authorizations (PDF)
- Provider FAQ- Pended Claims Requiring Additional Information (PDF)
- Claims Guide- Duplicate Submissions (PDF)
- Pediatric Provider Billing Guidance (PDF)
- Claims Submission Reminder Guide (PDF)
- Provider Guide for 340B Drug Claims (PDF)
- Guidance for Submitting CLIA Claims (PDF)
- 835 EDI Companion Guide (PDF)
- COB Entry Walkthrough
- Durable Medical Equipment Quick Reference Guide
- **https://network.carolinacompletehealth.com/resources/claims-and-billing/claims-and-billing-frequently-asked-questions.html**



Timely Filing Guidelines

Initial Filing (Contracted Providers)	**365 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Initial Filing (Non-contracted providers)	**180 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Coordination of Benefits (Carolina Complete Health as secondary)	365 calendar days from the primary payer's determination
Claims Corrections	365 calendar days from the date of service to file a timely corrected claim
Claims Reconsideration (Level I)	365 calendar days from the date of the EOP or ERA
Claims Grievance (Level II)	30 calendar days from the date of the reconsidered EOP or ERA

Tips to Avoid Claim Denials:

- ✓ Check if a Prior Authorization is needed! **CCH Pre-Auth Tool**
- ✓ Stay current on NCTracks https://www.nctracks.nc.gov/content/public/providers.html
- ✓ Always check the Known Issues Tracker https://network.carolinacompletehealth.com/
- ✓ Review the Claims Submission Reminder Guide

Secondary Claims Guidance

When submitting a secondary claim from a third-party commercial or Medicare insurance, please follow these instructions:

Filing Deadline

- Providers have **365 calendar days** from the date on the primary insurer's **Explanation of Benefits (EOB)** or **Remittance Advice (RA)**—whether the primary claim was **paid or denied**—to submit the secondary claim to the member's assigned PHP.

Submission Method

- All secondary claims should be submitted electronically.
- A copy of the primary insurer's EOB/RA must be uploaded as an attachment with the claim.
- Coordination of Benefits Walkthrough

Hot Topics:

Modifier Requirements for Doctorate-Level Psychologist

CCH requires Doctoral-Level Licensed Psychologist to include Credentialed-specific modifiers on claims

Required Modifiers:

- **AH-**Doctorate Level or Clinical Psychologist (Ph.D. or Psy.D.)
- **HP-** Psychologist or Doctorate Level (Psy.D. or Ph.D.)

Providers **may submit corrected claims** with the appropriate modifiers and must include the original claim number to ensure timely filing and reprocessing. Corrected claims must be submitted within 365 days from the date of service.

- Refer to Timely Filing Requirements Guide and CCH Billing Manual .
- Provider can file using EDI, Secure Portal or Mail:

Medicaid Claims Department: Carolina Complete Health

PO Box 8040

Farmington, MO 63640-8040

Hot Topics: FQHC/RHC Claim Rejections

Issue:

FQHC's & RHC's claims may be incorrectly rejected with the message **"Submit claim to Trillium for BH processing"**. This is due to incorrect POS codes **(FQHC=50 and RHC=72)**

Resolution:

On **August 28th** claim routing logic will be enhanced to:

- Include FQHC/RHC taxonomy codes and recognize claims as FQHC/RHC even if POS 50 or 72 is not used (provided the taxonomy is present) .

Billing Tips:

- Use the Correct Taxonomy Code
- Include the Correct POS
- Double- Check Claim Details
- Review FQHC RHC Billing Guidance

August 2025 Top Claim Denials

*NOTE Please check the Known Issues Tracker; this document is updated weekly and provides timely information related to known issues that are impacting providers!
https://network.carolinacompletehealth.com/

Claim Denial	Provider Guidance
DX IS NOT COVERED FOR THIS SERVICE - SUBMIT CORRECTED CLAIM	Please review the ICD-10 manual to confirm the accuracy of the diagnosis code(s) and submit a corrected claim accordingly.
ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER	No action needed. Claim will be processed under a new claim number.
DENY: NDC MISSING/INVALID OR NOT APPROPRIATE FOR PROCEDURE	CCH has mirrored the NDC requirements NC DHHS currently has in place. CCH utilizes the NDC/procedure code crosswalk file from the CMS and Reimbursmentcodes.com website monthly and updates configuration accordingly. Please review and submit a corrected claim.
DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)	The service has been billed by multiple providers within the same procedure code range. Please submit a corrected claim along with supporting correspondence or medical records to support the determination of medical necessity.
DENY-REND NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATES	Please ensure your provider data has active credentialing status with NC Tracks and the data on the claim matches what is in NC Tracks. Provider Guide: Provider Enrollment and Data (PDF)

August 2025 Top Claim Denials

Claim Denial	Provider Guidance
DENY:NDC NOT REBATABLE BASED ON CMS LABELER FILE	CCH has mirrored the NDC requirements NC DHHS currently has in place. CCH utilizes the NDC/procedure code crosswalk file from the CMS and Reimbursmentcodes.com website monthly and updates configuration accordingly. Please review and submit a corrected claim.
DENY-BILL NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATES	All taxonomies listed on the claim must be completely registered with the stat for the date of service billed on the claim. If the taxonomy registration was completed after claim process; please submit a corrected claim.
REFERRING PROV NPI NOT ON MEDICAID FILE/NOT ACTIVE ON SVC DATE	Please ensure your provider data has active credentialing status with NC Tracks and the data on the claim matches what is in NC Tracks. Provider Guide: Provider Enrollment and Data (PDF)
NON-ELIGIBLE/NON-REIMBURSABLE SERVICE PER PLAN OR REGULATORY GUIDELINES	Service billed is reportable, but not reimbursable.
DENY:NDC NOT VALID FOR DATE OF SERVICE	CCH utilizes the NDC/procedure code crosswalk file from the CMS and Reimbursmentcodes.com website monthly and updates configuration accordingly. Please review and submit a corrected claim.

*__NOTE Please check the Known Issues Tracker; this document is updated weekly and provides timely information related to known issues that are impacting providers!__ https://network.carolinacompletehealth.com/

Upcoming Office Hours!

October 22nd at 12PM Register Here

Education and Training Page

Please let us know of future topics and trainings you are interested in!
https://www.surveymonkey.com/r/2B8SQGG

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Thank you!

Questions?

Appendix

Provider Resources For Availity & CCH Secure Portal

Availity	CCH Secure Provider Portal
• Availity Provider Training • Register and Get Started with Availity Essentials	• Secure Portal Slide Guide (PDF) • Portal Administrator Guide (PDF) • Third-Party Biller Provider Portal Set-up (PDF) • Checking Member Eligibility and Health Record (PDF) • Submitting a Claim (PDF) • Registering and Logging In (PDF) • Secure Provider Portal Guide Viewing Assessments and Authorizations Provider Guide (PDF)

*For additional support and trainings please contact ProviderEngagement@cch-network.com.

Troubleshooting Frequent Claims Questions/Issues

Confirm that the taxonomy on the claims matches in NCTracks. Please review the Claims Submission Reminder Guide & advise your clearinghouse to make sure the changes made to the taxonomy placement are permanent on the account moving forward!!

Taxonomy Placement:

CMS 1500 Paper Submission:

- Rendering – Box 24i should contain the qualifier "ZZ". Box 24j (shaded area) should contain the taxonomy code.
- Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.
- Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code in the next column.

837 Professional Submission- 837 EDI Companion Guide (PDF)

- Billing –Loop 2000A PRV01="BI" PRV02 = "PXC" qualifier PRV03 = 10 character taxonomy.
- Rendering – Loop 2310B PRV01="PE" PRV02 = "PXC" qualifier PRV03 = 10 character taxonomy code002E.
- Please note that "PXC" is the correct qualifier and that there is no taxonomy number needed for referring physician.

UB-04 Paper Submission

- Billing – Box 81CCa should contain the qualifier of "B3" in the left column and the taxonomy code in the middle column.

837I Electronic Submission

- Billing - Loop 2000A PRV01 = "BI" PRV02 = "PXC" qualifier; PRV03 = 10 character taxonomy code.

Provider Claim Reconsideration (Level I Claim Dispute)

A Claim Reconsideration is a formal expression by a Provider, which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service.

- Contracted providers must submit requests for claim reconsideration within 365 calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).
- Non-Contracted providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA. Providers must complete a claim reconsideration prior to submitting a claim grievance.

Claim reconsiderations may be submitted via provider secure web portal or to the address below.

Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms

For additional guidance & form: Carolina Complete Health Standard Plan: Claim Reconsideration and Grievance Form (PDF)

Provider Claim Grievance (Level II Claim Dispute)

A Claim Grievance is the mechanism following the exhaustion of the claim reconsideration process that allows providers the right to express dissatisfaction regarding the amount reimbursed or the denial of a particular service. All claim grievances must be submitted from the provider within thirty (30) calendar days from the date of the EOP or ERA.

- Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process.

Please submit eligible claim grievances via provider secure web portal or to the address below:

Claim Grievances
Carolina Complete Health
P.O. Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration or grievance through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms.

A decision will be made, and appropriate notification of the decision must be received by the Provider within 30 calendar days of Carolina Complete Health's receipt of the request.

For additional guidance & form: Carolina Complete Health Standard Plan: Claim Reconsideration and Grievance Form (PDF)

Questions During Registration

https://network.carolinacompletehealth.com/resources/claims-and-billing/claims-and-billing-frequently-asked-questions.html

1. **What is the relationship to Partners and Trillium for Tailored plans?** CCH supports physical health claims processing for these 2 tailored plans. *** Partners Provider Services: 877-398-4145 & Trillium Provider Support Services: 855-250-1539
2. **What is the correct way to submit to CCH when there is a primary insurance when CCH is requesting the primary EOB?** Obtain the primary EOB. Make sure you have the EOB from the primary payor & Complete a corrected claim with the primary EOB attached and submit. Review the COB Entry Walkthrough
3. **Denying of FQHC claims when billing medical and behavioral health on same DOS?** For a medical visit, FQHC and RHC core services are billed under the FQHC and RHC provider number using the HCPCS code T1015 (clinic visit/encounter, all-inclusive). FQHC/RHCs can bill up to three T1015 codes per member per day when they have different modifiers
   - 1 – CPT T1015 - No Modifier per day per member –Well Visit
   - 1 – CPT T1015 - Modifier HI per day per member –Behavioral Health
   - 1 – CPT T1015 - Modifier SC per day per member-Non-Behavioral sick visit
   - Telehealth visits Modifier GT should be added to any claim when appropriate.