CCH Claims Office Hours

October 2025

carolina complete health™

Agenda

- Basic Claims Information
- Timely Filing Guidelines
- Ways to Submit Claims
- Tips and Tricks to Avoid Claim Denial
- Provider Resources
- Claims Denials for September/October and Provider Guidance
- Q& A (Please No PHI)
- 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 and Thursday.

Timely Filing Guidelines

*NEW Provider Guide: Timely Filing, Claim Corrections, Reconsiderations, and Grievances (PDF)

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

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

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

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:

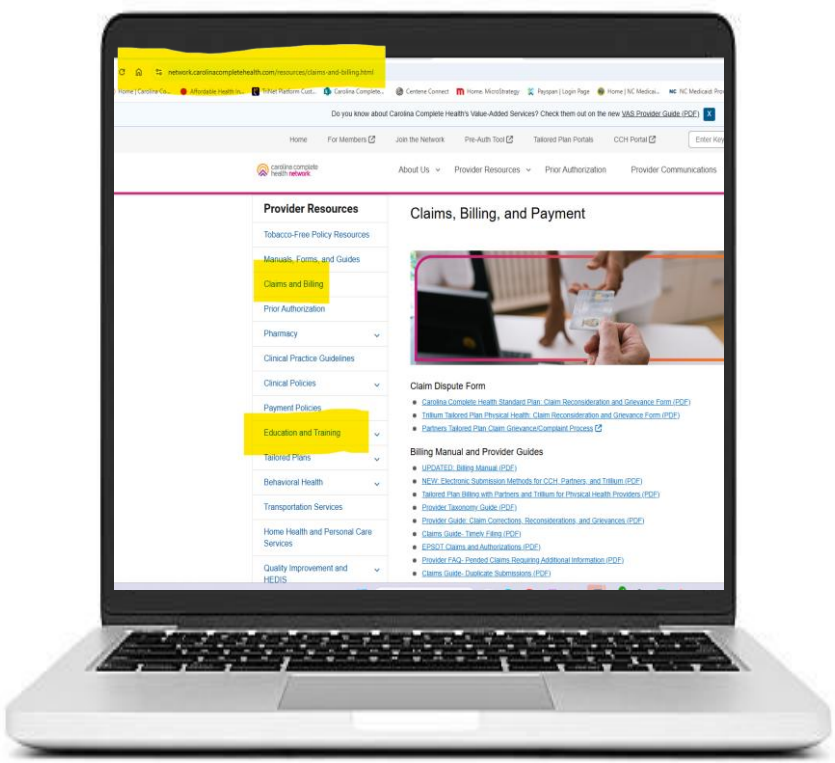
https://network.carolinacompletehealth.com/resources/claims-and-billing.html

Billing Manual Updated 10/25: Provider Manual (PDF)

Provider Manual Updated 10/25 : Billing Manual (PDF))

Provider Guides:

- Provider Taxonomy Guide (PDF)
- EPSDT Claims and Authorizations (PDF)
- Provider FAQ- Pended Claims Requiring Additional Information (PDF)
- Claims Guide- Duplicate Submissions (PDF)
- Pediatric Provider Billing Guidance (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
- Provider Guide: Timely Filing, Claim Corrections, Reconsiderations, and Grievances (PDF)



October 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 UNDER NEW CLAIM NUMBER	This isn't considered a denial, but an adjustment. No action is needed on this trend. Your claim will be processed under a new claim number.
DENY: NDC MISSING/INVALID OR NOT APPROPRIATE FOR PROCEDURE	CCH mirrors NC DHHS & NDC requirements. Updates occur monthly using the CMS NDC/procedure code crosswalk and at Reimbursementcodes.com. Please be sure to review the NDC and submit a corrected claim.
DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)	This denial occurs when service has been billed by multiple providers for the same/similar procedure code, date of service and for the same member. Please submit a corrected claim along with supporting correspondence or medical records to support the determination of medical necessity.
DENY-RENDERING 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 information on your claim mirrors what is in NC Tracks. If provider has been updated after your claims processed, please submit corrected claims. Provider Guide: Provider Enrollment and Data (PDF)

October 2025 Top Claim Denials

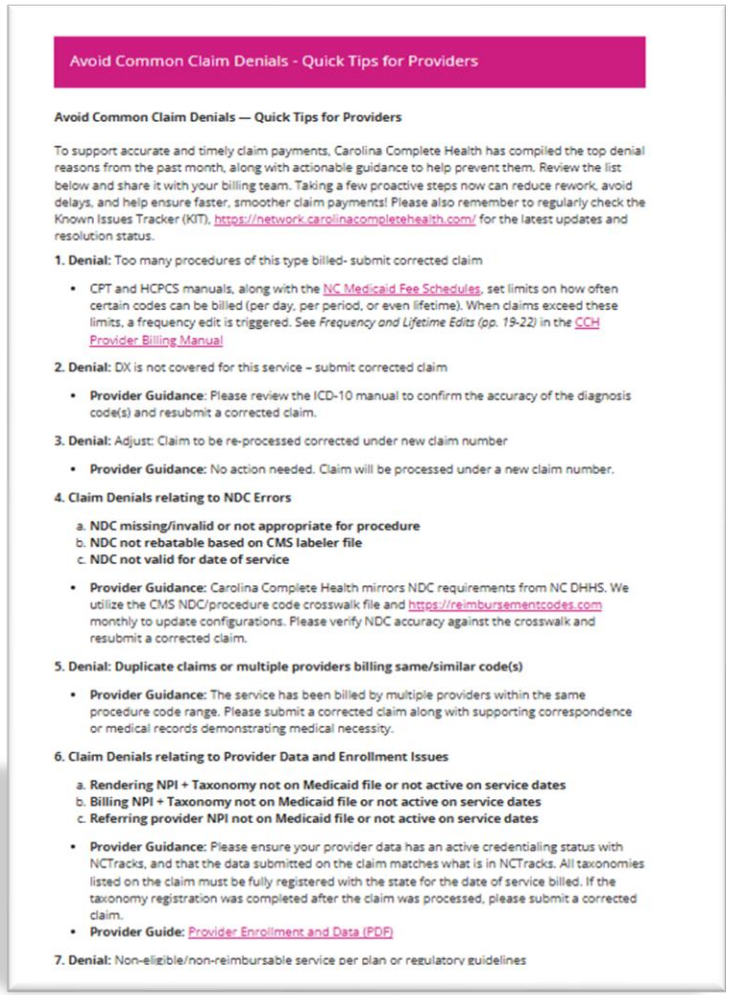
Claim Denial	Provider Guidance
NON-ELIGIBLE/NON-REIMBURSABLE SERVICE PER PLAN OR REGULATORY GUIDELINES	The service is reportable but not payable. These services are reported for performances and reporting measures. No action needed.
TOO MANY PROCEDURES OF THIS TYPE BILLED - SUBMIT CORRECTED CLAIM.	Procedure & services were paid or processed on a previous claim already. Please check claim history.
DENY: NDC NUMBER MISSING OR INVALID	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.
DIAGNOSIS CODE INCORRECTLY CODED PER ICD10 MANUAL	Please review the ICD-10 manual to confirm the accuracy of the diagnosis code(s) and submit a corrected claim accordingly

***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/

No more Office Hours this year! We will continue to run top claim denials trends with provider guidance in the CCH Newsletter, to subscribe, please fill out this form

Education and Training Page

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



Avoid Common Claim Denials - Quick Tips for Providers

Avoid Common Claim Denials — Quick Tips for Providers

To support accurate and timely claim payments, Carolina Complete Health has compiled the top denial reasons from the past month, along with actionable guidance to help prevent them. Review the list below and share it with your billing team. Taking a few proactive steps now can reduce rework, avoid delays, and help ensure faster, smoother claim payments! Please also remember to regularly check the Known Issues Tracker (KIT), https://network.carolinacompletehealth.com/ for the latest updates and resolution status.

1. **Denial:** Too many procedures of this type billed- submit corrected claim
   - CPT and HCPCS manuals, along with the NC Medicaid Fee Schedules, set limits on how often certain codes can be billed (per day, per period, or even lifetime). When claims exceed these limits, a frequency edit is triggered. See *Frequency and Lifetime Edits (pp. 19-22)* in the CCH Provider Billing Manual
2. **Denial:** DX is not covered for this service – submit corrected claim
   - **Provider Guidance**: Please review the ICD-10 manual to confirm the accuracy of the diagnosis code(s) and resubmit a corrected claim.
3. **Denial:** Adjust: Claim to be re-processed corrected under new claim number
   - **Provider Guidance:** No action needed. Claim will be processed under a new claim number.
4. **Claim Denials relating to NDC Errors**
   a. **NDC missing/invalid or not appropriate for procedure**
   b. **NDC not rebatable based on CMS labeler file**
   c. **NDC not valid for date of service**
   - **Provider Guidance:** Carolina Complete Health mirrors NDC requirements from NC DHHS. We utilize the CMS NDC/procedure code crosswalk file and https://reimbursementcodes.com monthly to update configurations. Please verify NDC accuracy against the crosswalk and resubmit a corrected claim.
5. **Denial: Duplicate claims or multiple providers billing same/similar code(s)**
   - **Provider Guidance:** 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 demonstrating medical necessity.
6. **Claim Denials relating to Provider Data and Enrollment Issues**
   a. **Rendering NPI + Taxonomy not on Medicaid file or not active on service dates**
   b. **Billing NPI + Taxonomy not on Medicaid file or not active on service dates**
   c. **Referring provider NPI not on Medicaid file or not active on service dates**
   - **Provider Guidance:** Please ensure your provider data has an active credentialing status with NCTracks, and that the data submitted on the claim matches what is in NCTracks. All taxonomies listed on the claim must be fully registered with the state for the date of service billed. If the taxonomy registration was completed after the claim was processed, please submit a corrected claim.
   - **Provider Guide:** Provider Enrollment and Data (PDF)
7. **Denial:** Non-eligible/non-reimbursable service per plan or regulatory guidelines

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Thank you!

Questions?

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.

Action	Definition	Timely Filing	Method	Additional Notes
Coordination of Benefits (COB) when CCH is secondary payor	COB is the process used to determine responsibility for paying claims when a person has coverage under two or more health insurance plans. Medicaid is always the "payer of last resort," therefore primary insurance coverage must be billed first.	Providers have 365 calendar days from the primary payer's insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to the member's assigned PHP.	Submitted in one of the following ways • CCH Secure Provider Portal • Availity Essentials	View our Coordination of Benefits Walkthrough for additional instructions for submitting via the CCH Secure Provider Portal
Claims Corrections	For claims that include a correction to the initial claim submission. For example, to correct invalid or incorrect information in the initial submission.	Contracted Providers: Submitters have 365 calendar days from the date of service to file a timely corrected claim. Non-Contracted Providers: submitters have 180 calendar days from the date of service to file a timely corrected claim	Submitted in one of the following ways: • CCH Secure Provider Portal • Paper claim form via mail to: Medicaid Claims Department Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040 • EDI	View our Claims and Billing Provider Guide on Duplicate Submissions and Correcting Claims

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