Carolina Complete Health Standard Plan Provider Guidance for Timely Filing, Claim Corrections, and Claim Disputes

Action	Definition	Timely Filing	Method	Additional Notes
Initial Filing (Contracted Providers)	First time claim submission for a contractor provider	365 calendar days from the date of service (DOS) (Professional) or date of discharge (Hospital)	Claims can be submitted in one of following ways: 1) Secure Provider Portal 2) Availity Essentials 3) Electronic Clearinghouse Carolina Complete Health Payer ID: 68069 4) Mail: Carolina Complete Health Attn: Claims PO Box 8040 Farmington, MO 63640-8040	A clean claim is a claim that is received for adjudication in a nationally accepted format incompliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or 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.
Initial Filing (Non-contracted providers)	First time claim submission for a non-contracted provider	180 calendar days from the DOS (Professional) or date of discharge (Hospital)	Claims can be submitted in one of following ways: 1) EDI Clearinghouse: Submit CCH claims using Payer ID 68069 2) Availity Essentials 3) Paper Form Mail to: Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Contracting Information found here. https://network.carolinacompletehealth.com/join-cchn.html Refer to CCH Standard Plan Out of Network Provider Guide

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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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Claims Reconsideration (Level I Claim Dispute)	A formal request submitted by a provider when disputing Carolina Complete Health's claim determination. Examples include, but are not limited to, claims paid at an incorrect amount, incorrect eligibility status at the date of service, denial for no prior authorization when one was obtained, or denial for no authorization when not required. For full details, please refer to the CCH Billing Manual	Contracted Providers: Providers must submit claim reconsiderations within 365 calendar days from the date of the EOP or ERA. Non-Contracted Providers: Providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA.	Submit via EDI, Secure Provider Portal or to the address below: Medicaid Claims Reconsiderations/Disputes Department Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Claim reconsideration do not include decisions related to retro authorization and adverse medical necessity determination. *NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance Form. Claim disputes submitted directly to the health plan will not be processed.
Claims 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 providers have 30 calendar days from the date of the reconsidered EOP or ERA to submit.	Submit using the PrSecure Provider Portal or to the address below: Claim Grievances Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Claim reconsiderations do not include decisions related to retro authorization and adverse medical necessity determination *NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance Form. Claim disputes submitted directly to the health plan will not be processed.

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