Frequently Asked Questions - Electronic Claims Submission and Electronic Remittances

Q. What are the benefits of electronic claims filing?

A. It saves you money, claims process more accurately the first time and you can get paid faster.

Q. If I currently submit paper claims and electronic claims, am I required to submit all claims electronically?

A. Yes, effective July 1, 2016 all medical providers are required to submit all claims electronically.

Q. What will happen if I submit a paper claim on or after July 1, 2016?

A. Paper claims received after July 1, 2016 will not be processed. CCI will not return any non-electronic (paper) claims received on or after July 1, 2016. You will be solely responsible for resubmitting claims in an approved electronic format. As part of these changes, CCI will now allow 365 days for submission of initial claims, corrected claims, and secondary claims (to align with Medicare payment practices).

Q. Which Member IDs are accepted by Community Care Inc. (CCI) for electronic submission?

A. Medicare, Medicaid, Account number (located on the authorization/referral), Social Security Number (not a preferred method but accepted)

Q. With Community Care's timely filing change to 365 days as of 7/1/16, will Community Care adjust claims previously denied for timely filing?

A. No, the change to timely is effective as of 7/1/2016. Any claims denied prior to 7/1/2016 for timely filing will not be adjusted based upon the change to 365 days.

Q. How can I obtain a member ID to submit claims?

A. The member ID can be found on the member's ID cards for our PACE/Partnership members. If the member doesn't present card and/or this information is not on file, the information can be looked up by logging into the Forward Health portal.

https://www.forwardhealth.wi.gov/WIPortal/

Note: You will need to create an account for with Forward Health to access this information.

Q. With which clearinghouses does CCI have contracts?

A. A clearing house is a company that takes claims information from any doctor, hospital, etc. and sends the claims on their behalf to "payers" as electronic files. We have contracts with two clearinghouses:

-Change Healthcare (formerly Emdeon)
-Office Ally

Community Care's payer ID is 39126.

Q. What if I already use a clearinghouse other than Change Healthcare or Office Ally?

A. To submit electronic claims to CCI, your clearinghouse needs to contact Change Healthcare or Office Ally to arrange transmission of the claims (837 file) and remittances (835 file).

Q. What is an 837 file?

A. An 837 is a HIPAA standard electronic claims file providers to use to submit claims electronically. HIPAA requires health plans and EDI submitters to use the latest version, called "X12N 837 version 5010." There are very specific rules about what kind of information can go in an 837 and exactly where that information should be put. Doctors who bill using the paper CMS-1500 form would use an 837p (the "p": stands for Professional) format. Hospitals and facilities which use the paper UB-04 form would use an 837i (the "i" stands for Institutional). If you cannot produce an 837 file, you can enter claims through Office Ally at no cost to you and they will send CCI an 837 file. The current HIPAA-compliant 837 file format has these numerical designations:

837p: 005010X222A1
837i: 005010X223A2

Q. What is an 835 file?

A. The Electronic Remittance Advice (ERA), or 835, is the electronic transaction which provides claims payment information in the HIPAA mandated ACSX12 005010X221A1 format.

Q. Must I submit corrected claims electronically?

A. Yes, corrected claims must be submitted electronically. A corrected claim can only be submitted for fully or partially paid claims. If you are correcting a denied claim, you must resubmit it as a new claim.

Q. How do I submit a corrected claim electronically?

A. Contact your clearinghouse for instructions on how to submit a corrected claim.

CCI has seen a recurrence of some common errors and is including some guidance below:

Corrected Claim Criteria on the ANSI 837 electronic File:

1) In the **2300 Loop**, the CLM segment (Claim Information), the **CLM05-3** (Claim Frequency Type Code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is a Replacement or a Voided claim as follows:

   "**7**" – REPLACEMENT *(Replacement of Prior Claim)*
   "**8**" – VOID *(Void/Cancel of Prior Claim)*

2) In the **2300 Loop**, the **REF01** will have a qualifier of F8 and the **REF02** segment (Original Reference Number (DCN)) **must include the Original DCN Number** issued to the claim being corrected. The original DCN number can be found on your Remittance Advice.
   (Example: REF*F8*123456789~)

Q. Is the patient always the subscriber for Community Care Inc. plan coverage's?

A. The subscriber and patient must always be the same. On the 2000B Subscriber loop, the SBR02 should always equal 18 (SELF). Do not include a 2000C Patient loop as this will cause your claim to fail loading in the CCI claim processing system.

Q. How can I get Electronic Remittance Advices (835 files)?

A. As part of this initiative, you will no longer receive paper remittance advices – you will only receive electronic remittance advices (835). Providers whose claims go through Change Healthcare (formerly Emdeon) and Office Ally will get remittances through those clearinghouses. If you have an arrangement with another clearinghouse, you are required to work with your clearinghouse to obtain remittances through either Change Healthcare or Office Ally.

- If you utilize Office Ally, you will be automatically enrolled to receive electronic remittances.
- If you utilize Change Healthcare (Emdeon), follow this link and complete the appropriate ERA enrollment form (found in "setup forms"): www.emdeon.com/enrollment
- If you utilize any other clearinghouse, your clearinghouse will need to work with Change Healthcare (Emdeon) for enrollment: www.emdeon.com/enrollment

Q. What if I need help reading an Electronic Remittance Advices (835s)?

A. An 835 can be converted using Medicare Easy print for an easy to read version. To download a version of easy print, follow the link below:

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html

Community Care has also created a crosswalk document mapping our claim message codes to the Remittance Advice Remark Codes (RARC). Follow the link below:

http://www.communitycareinc.org/for-providers/medical-services

References for the industry standard healthcare code list can be found by following the link below:

http://www.wpc-edi.com/reference/

Q. Does Community Care accept Medicare crossover?

A. No, Community Care doesn't accept Medicare crossover. We do accept secondary claims which can be submitted through a clearinghouse by completing the other insurance payment information.