Frequently Asked Questions (FAQ): Electronic Claims Submission and Electronic Remittance Files

Community Care, Inc (CCI) will only accept medical claims submitted electronically through a clearinghouse. In addition, we will only send you electronic remittances (ERA 835) and issue payment via electronic funds transfer (EFT). Medical claims include but are not limited to: Durable Medical Equipment (DME), Outpatient Hospital services, Skilled Nursing Facilities and Therapy.

What is CCI's payer ID?

CCI's Payer ID is **39126**.

What is a clearinghouse?

A clearinghouse is a company that takes claims information from a provider and sends claims on the provider's behalf to "payers" as electronic files, known as 837 files. A clearinghouse will also provide a remittance file in return once the claims are processed and paid. This is known as an 835 file.

Which clearinghouses does CCI partner with?

We partner with two clearinghouses: **Change Healthcare or Office Ally.**

What if I use a different clearinghouse?

To submit electronic claims to CCI, your clearinghouse will need to contact Change Healthcare or Office Ally to arrange transmission of the claim files (837 file) and remittance files (835 file).

Am I required to submit all claims electronically?

Yes, all medical providers are required to submit claims electronically.

What will happen if I submit a paper claim?

Paper claims will not be processed. You will be responsible for resubmitting claims in an approved electronic format.

What are the benefits of electronic claim submission?

Electronic claim submission reduces costs for both providers and payers. Claim entry and processing timeframes are greatly reduced, resulting in more accurate and faster payments compared to manual keying and processing.

Does CCI accept Medicare crossover (COBA) claims?

Yes, CCI does accept Medicare Crossover (COBA) claims. We automatically receive claims from Medicare to process as secondary. There is not a need to submit Medicare crossover claims to us.

Does CCI accept secondary claims from other payers?

Yes, CCI does accept secondary claims (non-Medicare crossover) which can be submitted through a clearinghouse by completing the other insurance payment information. The provider is responsible for submitting these claims directly to CCI within timely filing limits.

Which Member IDs will CCI accept?

- Medicare Beneficiary ID (MBI)
- Medicaid ID
- CCI Member ID – For Pace/Partnership members, see member's ID card
- CCI Account Number - located on the authorization/referral
- Social Security Number- not a preferred method but accepted

If the member does not present a card or the information is not on file, their information can be retrieved from the Forward Health portal*: https://www.forwardhealth.wi.gov/WIPortal/

**A Forward Health account is required to access this information.*

Is the patient always the subscriber for CCI's plans?

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 claims processing system.

What is an 837 file?

An 837 file is an electronic file that contains patient claim information. This file is submitted to an insurance company or to a clearinghouse instead of printing and mailing a paper claim.

What is an 835 file?

An 835 is also known as Electronic Remittance Advice (ERA). It is the electronic transaction that provides claim payment information and documents the EFT (electronic funds transfer). An 835 is sent from insurers to the healthcare provider.

How to I obtain the 835 file?

As part of an initiative to reduce the costs both to our providers and Community Care, Inc., you will no longer receive paper remittance advices – you will only receive electronic remittance advices (835). Providers whose claims go through Change Healthcare 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.

Change Healthcare & Office Ally – you will be automatically enrolled to receive electronic remittance files.

Other Clearinghouse(s) – it is important that you work with your clearinghouse to ensure they have a connection with Office Ally or Change Healthcare and that they are retrieving your remittance files from them. Your clearinghouse should provide instructions on how to locate the remittance files.

What if I need help reading the 835 file?

An 835 file can be converted using Medicare Easy Print software for an easy-to-read version. To download Easy Print, see Medicare Easy Print.

CCI has also created a crosswalk document mapping our claim message codes to the Remittance Advice Remark Codes (RARC), see CCI Remittance Mapping.

References for the industry standard healthcare code listings, including Claim Adjustment Reason Codes (CARC), can be found here.

Can I submit corrected claims electronically?

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.

How do I submit a corrected or voided claim electronically?

Refer to the following process for submitting corrected or voided claims.

ELECTRONIC REPLACEMENT/CORRECTED CLAIM SUBMISSIONS

The claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

CLAIM FREQUENCY CODES

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim.

Use the below frequency codes for claims that were previously **adjudicated**.

Claim Frequency Codes			
Code	**Description**	**Filing Guidelines**	**Action**
5 Late Charge(s) (Institutional Providers Only)	Use to submit additional charges for the same date(s) of service as a previous claim.	File electronically. Include only the additional late charges that were not included on the original claim.	CCI will process the late charges. Not a recommended process based on pricing rules for claims.
7 Replacement of Prior Claim	Use to replace an entire claim (all but identity information).	File electronically. File the claim in its entirety, including all services for which you are requesting reconsideration.	CCI will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 Void/Cancel of Prior Claim	Use to entirely eliminate a previously submitted claim or a claim billed in error	File electronically. Include all charges that were on the original claim.	CCI will void the original claim from records based on request.

SUBMITTING ELECTRONIC REPLACEMENT CLAIMS

When submitting claims noted with claim frequency code 7 or 8, the original CCI claim number, also referred to as the Document Control Number (DCN) ***must*** be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The DCN can be obtained from the 835 Electronic Remittance Advice (ERA) or Electronic Payment Summary (EPS). Without the original CCI DCN, adjustment requests will generate a compliance error and the claim will reject. CCI only accepts claim frequency code 7 to replace a prior claim or 8 to void a prior claim.

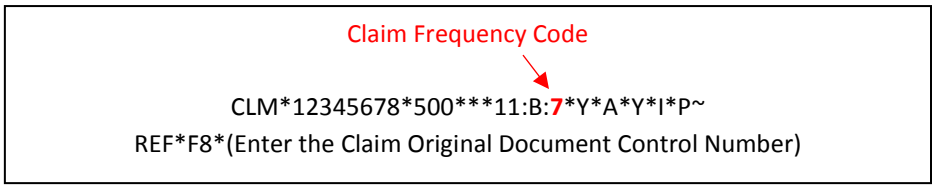
Specific information and examples for **Professional** and **Institutional** claims are included below.

Professional Claims (837P):

Claim corrections submitted without the appropriate frequency code will deny and the original CCI claim number will not be adjusted. For additional information on submitting electronic replacement claims refer to the table and example below.

Code	Action
7 Replacement of Prior Claim	CCI will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 Void/Cancel of Prior Claim	CCI will void the original claim from records based on request.

An example of the ANSI 837 CLM segment containing the Claim Frequency Code 7, along with the required REF segment and Qualifier in Loop ID 2300 – Claim Information, is provided below.

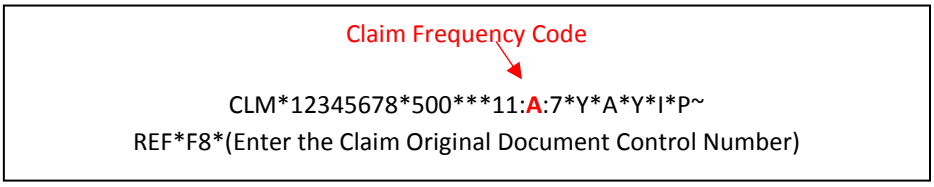


Institutional Claims (837I):

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original CCI claim number will not be adjusted. For additional information on submitting electronic replacement claims, refer to the table and example below.

Code	Action
5 Late Charge(s) (Institutional Providers Only)	CCI will add the late charges to the original claim processed claim. Note: Not a recommended process based on pricing rules for claims.
7 Replacement of Prior Claim	CCI will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 Void/Cancel of Prior Claim	CCI will void the original claim from records based on request.

When submitting corrected **institutional** claims, take note of CLM05-2, the Facility Code Qualifier. In this instance, the CLM05-2 field would require a value of **"A"** indicating an institutional claim – along with the appropriate frequency code (7) as illustrated in the example below.



Note: If a charge was left off the original claim, submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim. Frequency Code 5 representing Late Charge(s) applies to institutional claims ONLY and is an option to submit charges left off the original claim. However, this is not a recommended practice based on pricing rules for claims.