

# Claim Submission

Submit CCHP claims to: CCHP  
P.O. Box 56099  
Madison, WI 53705

## Completing Claims

Children's Community Health Plan (CCHP) understands providers want to receive prompt and accurate payments for services. Here are some helpful hints on how to minimize claim rejection and/or claim payment errors.

1. When submitting claims, CCHP requires the correct and complete Medicaid ID number. This will help CCHP ensure correct claim payment.
2. Include correct provider identification when submitting claims. The individual provider name and provider number goes in Field 31 of the CMS-1500 claim form. Field 32 should be filled out with the name and address of the facility where services were rendered (if other than office). Field 33 should be used for the name and billing address of your office. Field 33 is also used for your vendor number and individual CCHP provider number. Failure to use the correct provider identification could result in unnecessary delays in claim processing. It is also possible that claims will be returned to your office if they lack the above requested information.
3. It is important for services to be coded accurately with valid Medicaid codes. Services are reimbursed according to Medicaid guidelines.
4. CCHP will accept the two digit place of service codes only. Contact our Customer Service Department if you would like a listing of these codes.
5. CCHP does not identify the code 99070 as a specific service. If the correct HCPCS code is not used, services billed with 99070 will be denied and an explanation of the services must be resubmitted for review.

## Initial Claims Submission

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- When submitting claims use the correct and complete member number. Using the correct member number on the claim helps ensure correct and timely claim payment.
- CCHP requires providers file claims in a timely manner. Claims must be submitted in accordance with the claim-filing limit outlined in your Network Agreement.

- Claims related to work related injuries or illness should be submitted to the Worker’s Compensation carrier. Claims denied by the Worker’s Compensation carrier, should be submitted to CCHP along with the denial for consideration. Members are required to follow CCHP’s referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.
- Subrogation claims should be sent to CCHP for processing. CCHP will pursue recovery of those expenses from the at-fault party and/or their liability insurer. Members are required to follow CCHP’s referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

The table below indicates the list of data elements that are required on each claim submission. Listed are the appropriate box number from the CMS-1500 and UB 92 claim forms for each required element.

Required Information	CMS 1500 Claim Form	UB92 Claim Form	Note
Member Name	Box 2	Box 12	
Date of Birth	Box 3	Box 14	
Member Number	Box 1.a	Box 60	10 for MA
Diagnosis Code	Box 21	Box 67	
Date of Service	Box 24.A	Box 6	
Place of Service	Box 24.B	N/A	2 digit
Type of Bill	N/A	Box 4	
Service Code	Box 24.D	Box 42	4 digit revenue code on UB-92
Billed Amounts	Box 24.E	Box 47	
Units	Box 24.G	Box 46	
Provider Name	Box 31	Box 1	
Provider Billing Address	Box 33	Box 1	
Provider Number	Box 33 in Pin # field or Box 24.K	Box 51	
Vendor Number	Box 33 in GRP # field	Box 51	

**Individual provider numbers are required** under the Pin # field in Box 33. Vendor number must be entered under the GRP # field in Box 33 of the CMS form. If you bill on a UB92, the vendor should be listed under Box 51. Failure to use the correct provider identification could result in claim payment denials or reduction in payments. Claims will be returned to providers if they lack the above requested information. Please contact the Provider Service Department at 1-800-482-8010 with any questions regarding the required claim form fields.

## **Timely Filing Guidelines for Initial Submission**

The initial submission of a claim is subject to CCHP timely filing guidelines. CCHP will give providers proof of receipt and confirmation of claims via the Electronic Claims Confirmation Report, Paper Confirmation Report, and Rejected Claims Reports. The date CCHP received the claim is on the reports.

During claims processing, claims go through an initial editing phase that checks for valid patient information, correct identification numbers, provider information, etc. If the claim fails initial editing, it is rejected. The provider is notified of the rejection via the Rejected Claims Report. Rejected claims can be resubmitted to CCHP or the correction can be made on the Rejected Claims Report within the filing limit for improper submission and sent back to CCHP at PO Box 56099, Madison, WI 53705.

When you receive your confirmation reports back from CCHP, retain them for your records in case you need to file an untimely filing waiver request. If a provider fails to submit a claim timely, rights to payment from CCHP are forfeited and the provider may not seek payment from the members for these covered services.

## **Exceptions to Initial Claim Submission Timely Filing Guidelines**

- A Provider can request, in writing, a temporary extension of the claim-filing limit for just cause as determined CCHP. This includes computer system conversions or other short-term circumstances. These requests should be made to the CCHP Manager of Operations.
- Coordination of Benefit (COB) claims must be received within the timely filing limit outlined in your agreement with CCHP; beginning with the date noted on the primary payor's explanation of benefits.
- Provider experiences complications obtaining patient insurance information from the member, claims must be received within the timely filing limit beginning with the date the CCHP coverage is identified, but not longer than 180 days from the date of service. Provider shall submit supporting documentation that demonstrates measures taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the timely filing limit outlined in their agreement.
- When members change physicians during their pregnancy, claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately since the member changed physicians. The claims must be submitted within timely filing limit, beginning with the date of delivery. CCHP will not accept a global obstetrical charge from a provider in this situation.

## **Timely Filing Guidelines for Claim Resubmissions/Corrections**

All resubmitted/corrected claims need to be received by CCHP within the filing limit. The first day of the filing limit for resubmissions/corrections begins with the date upon which CCHP notifies the provider a claim has failed processing. You will find this date on the Explanation of Payment (EOP) or Rejected Claims Reports.

The provider can make resubmissions and/or corrections in the following ways:

1. Directly on the Rejected Claims Reports
2. On the Explanation of Payment received, or
3. Use the “yellow resubmission stickers.” Indicate it is a “Corrected Claim” and circle the correction (indicating the claim number) or a “Tracer Claim.”

Exceptions to Timely Filing Guidelines on Claim Resubmissions:

- When a claim is rejected or denied as a result of CCHP’s error, the submitted/corrected claim must be reviewed within one year of the Rejected Claims Reports or the EOP date.
- If the provider is a hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital-based provider who must wait for the inpatient discharge of member to file a claim, claims must be confirmed as having been received within sixty (60) calendar days from the discharge date of the member’s inpatient confinement.
- When the provider discovers new or additional information and requests additional payment on a processed and paid claim, such information must be received within sixty (60) calendar days of provider’s receipt of information.
- HealthCheck claims are exempt from the claim filing limit.
- Newborn claims will be accepted up to 14 months from the date of birth.

## **Claim Submission Reports**

CCHP provides 100% confirmation on all new claim submissions. Confirmation of receipts are generated and sent to providers for all claims received by CCHP, whether it is filed on paper or through Electronic Claims Transmission (ECT). There are three reports generated daily based on claims received: the ECT Confirmation Report, Paper Confirmation Report, and Rejected ECT.

### **Electronic Claims Transmission (ECT) Confirmation Report**

Providers that submit claims electronically will receive a Confirmation Report showing all of their claims that were loaded into the claims system. All claims that CCHP receives from a provider’s transmission will be on this report. The ECT Report is used as a confirmation tool of the number of claims received and the total dollar amount associated with those claims. Claims submitted on a CMS-1500 form will be listed alphabetically and totaled. Claims submitted on a UB92 will be listed together alphabetically and totaled. If the totals on the report do not match the provider’s totals, this may indicate that there was a problem with the transmission. If you have questions on how to get set

up to submit electronically or are experiencing problems with transmitting, **please contact CCHP at (800) 482-8010.**

**The following is an example of our ECT Confirmation Report:**

ECT CONFIRMATION REPORT		RUN DATE		06/07/2005		PAGE		2	
ABC Clinic 123 Main Street Anywhere, WI 55555									
VENDOR #: 12345									
MEMBER NAME NUMBER	MEMBER #	PAT ACCT#	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM			
Bessy Dressy 007 52	12345678901	B123	02/17/2005	1	\$250.15	060705			
Jones Sally 007 51	98765432101	J456	01/15/2005	2	\$213.25	067005			
Smith Johnny 007 50	45632178901	S789	02/01/2005	5	\$456.21	060705			
TOTAL CMS TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:			\$919.61			
MEMBER NAME NUMBER	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM			
Cosmo Killian 15	12544789201	C458	01/01/2005	1	\$2,504.00	060705 010			
Know Cooper 16	78521469801	K759	01/15/2005	1	\$3,567.33	060705 010			
Sullivan Sammy 14	23658471901	S478	01/31/2005	6	\$23,467.99	060705 010			
TOTAL CMS TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:			\$29,539.32			

## Paper Claims Confirmation Report

Providers that submit paper claims receive a Paper Confirmation Report from CCHP. This report is similar to the ECT Confirmation Report, except the Paper Confirmation Report indicates the "received date" of each claim. Providers should review the Paper Confirmation Report, to confirm all claims were received by CCHP and entered into claims processing system. Also, retain confirmation reports incase a timely filing waiver is requested. CCHP will only honor this report in disputes relating to the timely filing receipt of claims.

PAPER CONFIRMATION REPORT		RUN DATE	06/07/2005	PAGE	2			
ABC Clinic 123 Main Street Anywhere, WI 55555								
VENDOR #: 12345								
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE	
Bessy Dressy	12345678901	B 123	02/17/2005	1	\$250.15	060705 600 52	5/15/2005	
Jones Sally	98765432101	J456	01/15/2005	2	\$213.25	067005 607 51	4/30/2005	
Smith Johnny	45632178901	S789	02/01/2005	5	\$456.21	060705 640 50	6/1/2005	
TOTAL HCFA TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:		\$919.61			
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE	
Cosmo Killian	12544789201	C458	01/01/2005	1	\$2,504.00	060705 610 15	5/15/2005	
Know Cooper	78521469801	K759	01/15/2005	1	\$3,567.33	060705 600 16	4/30/2005	
Sullivan Sammy	23658471901	S478	01/31/2005	6	\$23,467.99	060705 620 14	6/1/2005	
TOTAL HCFA TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:		\$29,539.32			



## Problem Claim Request Form/Claim Resubmission

Below is an example of CCHP Problem Claim Request Form. The purpose of this form is to make claim payment adjustments more efficient. When a claim has been paid incorrectly (zero payment, underpayment, or overpayment) this form can be completed in lieu of resubmitting the claim or sending a refund check. When this form is used, adjustments are made on future remittances.

If possible, please indicate the claim number of the denied claim. This prevents resubmitted claims from being denied as a duplicate or for untimely filing. This form must be resubmitted within 60 days of the date of the denial.

### *Children's Community Health Plan Problem Claim Request Form*

If confirmation of receipt for this submission is desired, please indicate how you wish to receive confirmation:  mail  fax

Provider/vendor name \_\_\_\_\_ Vendor# \_\_\_\_\_

Provider Address

\_\_\_\_\_

Fax number \_\_\_\_\_

Date sent \_\_\_\_\_

Who should CCHP contact with questions regarding the information provided on this form?

\_\_\_\_\_, at (\_\_\_\_) \_\_\_\_\_, extension \_\_\_\_\_

**This form must be filled out in its entirety for the reversal(s) to be completed.**

Claim Number	Date of Service	Patient Name	Member Number	Amount to Reverse	Description of Problem

Reversals of overpayments will result in an automatic offset against future payments

## **Explanation of Payment**

Children's Community Health Plan produces Explanation of Payments (EOP) on a weekly basis. If your office would like to check the status of a claim or questions an item on the EOP, please contact our Provider Service Department at 1-800-482-8010 or call our Integrated Voice Response (IVR) **system**. Examples of the EOP's for paid services, denied services, claim reversal/adjustments and claim overpayment, refund & adjustments can be found under Forms and Reports.

## **Claim Adjustments**

If a provider believes they were underpaid, they can contact Customer Service and request an adjustment. Providers that identify they were overpaid should promptly return the overpayment to CCHP. In cases when CCHP discovers an overpayment, CCHP may offset the overpayment against other amounts due to the provider. (Please refer to your Network Agreement for the handling of overpayments.) These adjustments will appear on the provider's EOP following the processing of future provider's claims.