



PROVIDER ALERT

Alert # 11 – 2005 – 11 – 08 - HCAD, HCAL, HCBK, HCCH, HCYO & ALDA

Attention: Billing/Finance Department
CLAIMS – SECONDARY BILLING

It is expected that secondary claims will be submitted to Community Care within the timely file guidelines for the county where the member resides,

Contract	Days from DOS for Initial Claims	Days from DOS to Adjudicate Claim (if initial submission met timely file)
Adams HealthChoices	90	180
Allegheny HealthChoices	90	180
Allegheny ALDA	90	180
Berks HealthChoices	60	120
Chester HealthChoices	60	180
York HealthChoices	90	180

The Community Care member and the provider both have a responsibility to follow the guidelines of the primary carrier. All avenues to receive payment from the primary must be completed BEFORE billing the secondary claim to Community Care.

If the Community Care fee schedule indicates an authorization or notification is required, the requirement also pertains to secondary claims. If you are unsure of the procedure for obtaining an authorization for the level of care you will be rendering, please contact your Network Representative for instructions.

The secondary submission should be a claim with Community Care procedure codes. The date span and gross charge of the claim MUST match the date span and gross charge of the primary explanation of benefits (EOB). A copy of the EOB including the page with the definition for the denial code, MUST accompany the secondary Community Care claim but should NOT be stapled or paper clipped, as the back page will not be scanned. The initial secondary claim is sent to Community Care Behavioral Health, P.O. Box 383096, Birmingham, AL. 35238.

An EOB is not the only document that can be sent to document a denial from the primary insurance. You can also use a letter from the primary detailing why they won't pay, a screen print from the primary's system stating the claim cannot be paid or is denied, or a copy of the member's handbook from the carrier as long as you link the policy to the handbook.

There are procedure codes on the Community Care fee schedule that are not billable to other third parties. Community Care is primary for those codes. Do NOT bill the primary insurance and do NOT attach a primary EOB. Bill Community Care as primary.

If the primary claim adjudicates outside of the *initial timely file guideline* for the county where the member lives, the secondary claim to Community Care should be submitted within 30 days from the date of primary (EOB). The submission to Community Care should include the same components as a timely secondary claim plus documentation of timely submission to the primary insurance and follow-up with the primary carrier at 45-day intervals. Secondary claims outside of initial timely file should be submitted to Community Care Behavioral Health, One Chatham Center, Suite 700, Attn: Patti Wypych, Pittsburgh, PA 15219

- If you submit a secondary claim, with the EOB and the explanation of the denial code is attached but there is no authorization on file for the service rendered, the claim will deny with the explanation **NA1 – Services Not Authorized**
- If the date span and gross charges on the primary EOB do not match the date span and gross charges on the secondary claim to Community Care, the claim will deny with the explanation **P6E – Primary EOB Doesn't Match Community Care Claim**
- If the primary EOB is not attached the claim will deny with the explanation **CP1 - Commercial Insurance Primary** or **MC1 - Medicare is primary**, whichever is applicable
- If you bill Community Care as secondary for a procedure code that is billable to Community Care as primary, the claim line will deny with the explanation **C2E – Community Care primary for this code**
- If you send a secondary claim with an EOB but do not include the page explaining what the denial code means, the claim line will deny with the explanation **CE1 – Primary Denial Definition Required**
- If the primary denial is for no authorization, the claim line will deny with the explanation **C3E – Primary Denied No Authorization Obtained**
- If the primary denial states the provider is not enrolled, the claim will deny with the explanation **P3E – Primary Denied Provider No Enrolled**
- If your secondary claim is outside of timely file and is sent directly to Community Care in Birmingham, AL, the claim will deny with the explanation **FX1 – Exceed Timely Filing Limit**. FX1 is a system-generated denial and is referencing the initial filing guideline. The system feels this was the first time a claim was submitted for that charge.
- If the secondary claim is submitted after the initial timely file guideline *and* beyond 30 days from the date of the primary EOB/denial the claim line will deny with the explanation **C6E – Primary EOB Not Submitted Timely**
- If the documentation accompanying an untimely secondary claim is not complete, the claim will deny with the explanation **P8E – Documentation Insufficient For Timely File Exception**

If you have questions regarding the billing of a secondary claim or questions regarding an alternative document as a denial, please contact Patti Wypych at Community Care in Pittsburgh. She can be contacted by phone at 412 454-2544 or by email at wypychpj@ccbh.com.