Claims 2.0 Frequently Asked Questions

Q1: What is Claims 2.0?

A1: Claims 2.0 is our enhanced claims platform in which we have updated our claim processing technology to provide new features and benefits to our providers.

Q2: Will my fee schedule reimbursement change under Claims 2.0?

A2: No, the migration to our Claims 2.0 enhanced clams platform does not change your fee schedule.

Q3: Why did CareCentrix change its claims platform?

A3: Our Claims 2.0 enhanced claims platform was designed to improve the efficiency of our claims payment process and to expand our ability to provide quality service to our network providers. Many of the enhancements were made in direct response to the feedback we received from our network providers and payors on how the claims process could be improved.

Q4: When will these changes go into effect?

A4: Initial changes went into effect on 11/1/14 when Florida Blue migrated its business to the 2.0 claims platform in early November 2014. Our other contracted payors will migrate to our new claims platform over time. We will notify you in advance as each of our contracted payors migrates.

Q5: Will Claims 2.0 affect the process for collecting the patient out of pocket responsibility?

A6: No, the migration to our enhanced claims platform does not change the current process where CareCentrix collects the patient out of pocket amounts.

Q6: What are the key benefits providers can experience with the Claims 2.0 enhanced claims platform?

A7: The benefits and enhanced features of our Claims 2.0 enhanced claims platform include:

1. Additional claims submission and payment process support
2. Enhanced electronic capabilities
3. Increased operational efficiency and transparency
4. Fewer claim recoupments

Q7: Are the clean claim submission requirements different for the Claims 2.0 enhanced claims platform?

A8: No, the same industry standard clean claim requirements will apply to our existing claims platform and our enhanced Claims 2.0 claims platform.

Q8: What are some frequently made provider claim submission errors?

A9: Based on our analysis of existing claims activity, the following are some of the most common claims billing errors:

1. Incorrect **claim format** (837I or 837P).
    - FL Blue THH Providers must bill via 837I or on the UB04 form

Claims 2.0 Frequently Asked Questions

- FL Blue HME, O&P, HIT Providers must bill via 837P or on the CMS 1500 form.

2. Failure to submit a **Revenue Code** when billing on an institutional format.
3. **Failure to include the Taxonomy** number
4. **Failure to bill with the correct Subscriber ID** number.
5. Failure to bill with the **correct place of service**
6. Incorrect **HIPPS qualifier** for a Medicare Advantage member on an instituitional format
7. Date spans do not match units authorized
8. Incorrect HCPC and modifier combinations

Q9: How will this affect my Secondary claims process?
A10: Secondary claims can be submitted electronically for any payor that has migrated to our Claims 2.0 enhanced claims platform.

Q10: How do I submit a corrected claim under the Claims 2.0 platform?
A11: Claims 2.0 supports industry standard frequency code billing for void and replace claims.
The preferred method for submitting corrected claims is through EDI utilizing Frequency Code 7.
Corrected claims cannot be submitted via the portal.

Q11: What does Frequency Code 7 and Frequency Code 8 mean? (Where do I enter it on EDI? Which box needs to be completed?)
A12: Frequency Code 7: Void and Replace
Frequency Code 8: Void
Frequency Code 7 or 8 must be entered under the "Claim Frequency Type Code" Header.
Please refer to our EDI Companion Guide for detailed instructions on where to reflect Frequency Codes.

Q12: What changes will occur with my Explanation of Payment (EOP)?
A13: Explanations of payment for both our existing claims platform and the Claims 2.0 enhanced claims platform will utilize industry standard ANSI codes (Claim Adjustment Reason Codes (CARC) and Remittance Adjustment Reason Codes (RARC)

Q13: Why are there more claim lines on my Claims 2.0 EOP than originally submitted?
A14: Sometimes a claim line must be split in order to accurately process the claim against the patient's health plan benefits. For example: Provider bills one line of service with 30 units. In order to accurately process the claim against the benefits, the Payor splits the line into 30 lines with 1 unit on each line.

Q14: Does the way I receive my payment change?
A15: No, under both our existing claims platform and our Claims 2.0 enhanced claims platform, providers can enroll in ERA and EFT to enable electronic payments from CareCentrix or can continue to receive paper remittances.

Q15: My claim status button on the portal has been removed. How do I check my claims status?

Claims 2.0 Frequently Asked Questions

A16: The “Claim Status” button is replaced by a “Claim” link which will direct you to a page where you can view your claim status.

Q16: What is changing about my ability to check claim status via the portal?

A17: The improved Claims 2.0 Provider Portal utilizes a claim status chevron to communicate detailed claim status changes to the Provider. The status is updated as the claim moves throughout the claims lifecycle.