Community Care Plan

The Health Plan with a Heart

Ambulatory Surgical Center (ASC) Services Provider Training

Training **Topics**

1. Verifying member eligibility
2. Authorizations
3. Timeliness of decision
4. Electronic claim submission
5. Timely Filing
6. Claims reconsideration
7. Claims payment: EFT & ERA

Non-Emergency Dental Services in ASC and Outpatient Hospital Settings

Beginning October 1, 2025, payment responsibility for non-emergency outpatient dental anesthesiology and sedation services performed in Ambulatory Surgical Centers (ASC) or hospital settings will transition from Medicaid dental plans to Medicaid health plans.

Dental plans will continue to cover these services when provided in an office setting. Both health and dental plans must ensure continuity of care for at least 60 days following the transition.

For additional details, please refer to the **CCP Provider Manual**.

Verifying Member Eligibility

Community Care Plan (CCP) requires all providers to verify a member's eligibility before rendering any services. This verification must be completed each time a member schedules an appointment and again upon their arrival for services. Verifying eligibility is essential to ensure that the member is actively enrolled in the plan and that the services provided will be covered

Providers should use the PlanLink provider portal to verify eligibility

If you are the Primary Care Provider (PCP) of record, your name will be displayed in the PlanLink portal as the member's "CCP-Assigned PCP," confirming your designation within the CCP network

Registered providers verify member eligibility by using **CCP secure provider portal**

Office staff without portal login credentials can go to **CCP guest eligibility portal**

Authorizations

Providers may request authorizations through our secure provider portal PlanLink.
Please note that all services by out of network providers require prior authorization from CCP.
To determine services that required authorization,
please refer to our **Service Requiring Prior Authorization List**

- Submit online authorization requests: **planlink.ccpcares.org/**
- For cases where a participating provider is not available in our network or a non-participating provider is submitting the request, please use our: **Pre-Certification/Authorization Request Form**
- For Behavioral Health and Substance Use Services that require prior authorization, please review our: **Behavioral Health Authorization Guidelines**
- For Ambulatory Surgical Center (ASC) Services, please refer to the: **Services Requiring Prior Authorization**
- For Physician Administered Drugs, please refer to the: **Pharmacy Services Requiring Prior Authorization**
- Online verification of authorization status: **planlink.ccpcares.org/** or you may also contact Community Care Plan at **1-866-899-4828** Customer Experience

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Timelines of Decision

Requests for prior authorization are managed by the CCP Utilization Management (UM) Department

UM addresses authorization requests within the timeframes set by NCQA guidelines and AHCA requirements for all Medicaid services

The turnaround times for authorization of requested services are as follows:

- Expedited requests will be processed within 2 business days
- Standard requests will be processed within 5 calendar days
- Retrospective/Post Service requests will be finalized within 30 calendar days

Electronic Claim Submission

Claims Clearinghouse	**Availity**
Payer Name	Community care Plan (CCP)
Payer ID	59065
Claims Registration	**Availity or 1800.282.4548**

Claims submitted after six months will be denied
Ensure claims include :
Enrollee ID
Diagnosis codes
highest level of authenticity and authorization numbers

Timely Filing

To ensure prompt processing, adhere to the specified timeframes in your provider agreement when submitting claims. For Medicare claims transitioning to Medicaid, the filing limit is 36 months from the service date or 12 months from Medicare's adjudication date

Guideline	Filing Deadline
Participating Providers	6 months from DOS/discharge from hospital setting
Plan as secondary payor	90 days from the primary determination
Medicare crossover	36 months from the original Medicare submission
Corrected claims	90 days from denial
Return of additional information	90 days from denial

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Claims Reconsideration

To correct claims, use the Planlink provider portal within 90 days of the original explanation of payment

Guideline	Filing Deadline
Medical necessity appeals	90 days from EOB/Remit exception: 365 days from underpayment disputes
Billing Disputes Appeals	90 days from EOB/Remit
Authorization Appeals	90 days from EOB/Remit

Claims Payment
EFT & ERA

Direct Deposits
Receive payments via direct deposit into the bank account of your choice

Faster Payments
Get paid up to 7 days faster than mail

Reduce risk
Reduce the risk of lost or stolen checks

Electronic Funds Transfer registration:
EFT Request form

HIPPA Complaint
Receive HIPAA compliant ERA transactions

View Online
Have remittances sent to your clearinghouse or view them online

Save Time
Reduce paper mail and time spent on manual processes

Thank You

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