

# *Basic Medicaid*

## *Billing Guide*

*April 2010*



<b>Section 1. Who's Who in Medicaid</b> .....	<b>1-1</b>
What is Medicaid?.....	1-1
Centers for Medicare and Medicaid Services.....	1-1
Department of Health and Human Services.....	1-1
Division of Medical Assistance.....	1-1
Departments of Social Services.....	1-1
HP Enterprise Services.....	1-2
CSC.....	1-2
Piedmont Cardinal Health Plan.....	1-2
Division of Medical Assistance: Organization Roles.....	1-2
Recipient and Provider Services.....	1-2
Clinical Policy and Programs.....	1-2
Managed Care.....	1-3
Quality, Evaluation and Health Outcomes.....	1-4
Finance Management.....	1-4
Budget Management.....	1-4
Program Integrity.....	1-5
Who's Who in Medicaid Prior Approval.....	1-5
Carolinas Center for Medical Excellence.....	1-5
MedSolutions.....	1-6
Prodigy Diabetes Care, LLC.....	1-6
ValueOptions, Inc. ....	1-6
ACS State Healthcare.....	1-6
HP Enterprise Services.....	1-6
<b>Section 2. Recipient Eligibility</b> .....	<b>2-1</b>
Eligibility Determination.....	2-1
When Does Eligibility Begin? .....	2-1
Retroactive Eligibility.....	2-1
Eligibility Reversals.....	2-2
Eligibility Categories.....	2-2
Medicaid for Pregnant Women.....	2-4
Medicaid Family Planning Waiver.....	2-4
Piedmont Cardinal Health Plan.....	2-5
MEDICARE-Aid or Medicare Qualified Beneficiary.....	2-6
Verifying Eligibility.....	2-6
Verification Methods.....	2-6
Medicaid Identification Cards.....	2-7
Example of the Medicaid Identification Card.....	2-8
Medicaid Identification Card Information.....	2-8
County-Issued Medicaid Identification Cards.....	2-9
Program of All-Inclusive Care for the Elderly.....	2-9
Money Follows the Person.....	2-10
Transfer of Assets.....	2-10
Services Included in the Transfer of Assets Policy.....	2-10
Medicaid Recipients Subject to the Policy.....	2-10
Transfer of Assets Determination.....	2-11

Provider Access to Transfer of Assets Information.....	2-11
Annual Visit Limitation.....	2-11
Mandatory Services.....	2-11
Optional Services.....	2-12
CPT Procedure Codes Subject to the Annual Visit Count.....	2-12
Recipients Who Are Not Subject to the Annual Visit Limitation.....	2-12
Requesting an Exception.....	2-12
Notification Process.....	2-12
Copayments.....	2-13
Copayment Exemptions.....	2-13
EPSDT Policy Instructions.....	2-14
Background.....	2-14
EPSDT Features.....	2-14
EPSDT Criteria.....	2-16
Important Points About EPSDT Coverage.....	2-16
EPSDT and CAP Waivers.....	2-18
EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA Services).....	2-20
Procedure for Requesting EPSDT Services.....	2-20
Services Formerly Covered by Children’s Special Health Services.....	2-20
Non-Covered State Medicaid Plan Services.....	2-21
Provider Documentation.....	2-22
For Further Information about EPSDT.....	2-22
Attachments.....	2-22
Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].....	2-23
<b>Section 3. Medicaid Provider Information.....</b>	<b>3-1</b>
Enrollment Procedure.....	3-1
Group Provider Enrollment Packets.....	3-1
Individual Provider Enrollment Packets.....	3-1
Provider Enrollment and Re-enrollment Fee.....	3-1
Qualifications for Enrollment.....	3-1
Licensure.....	3-1
Service Location.....	3-2
Provider Agreements.....	3-2
Attestation Letter.....	3-2
Re-verification and Re-credentialing Requirements.....	3-2
Tax Information.....	3-3
Conditions of Participation.....	3-3
Civil Rights Act.....	3-3
Rehabilitation and Disabilities Acts.....	3-3
Disclosure of Medicaid Information.....	3-4
Medical Record Documentation.....	3-4
Payment in Full.....	3-5
Provider Responsibilities.....	3-5
Verifying Recipient Eligibility.....	3-5

Missed Appointments.....	3-5
Prior Approval.....	3-5
Accepting a Medicaid Recipient.....	3-5
Billing the Recipient.....	3-5
Third-Party Liability.....	3-6
Overpayments.....	3-6
Contacting Medicaid.....	3-7
Provider Forms.....	3-7
Fee Schedule Requests.....	3-7
Reporting Provider Changes.....	3-7
What Changes Must Be Reported.....	3-7
How to Report a Change.....	3-8
Voluntary Termination.....	3-9
Termination of Inactive Providers.....	3-9
Payment Suspension.....	3-9
Licensure Revocation or Suspension.....	3-9
Sanctions.....	3-10
Program Integrity Reviews.....	3-10
Determining Areas for Review.....	3-10
Provider Responsibilities in a Program Integrity Review.....	3-10
Request for Reconsideration.....	3-11
Self-Referral Federal Regulation.....	3-11
Advance Directives.....	3-12
Provider Information—Frequently Asked Questions.....	3-12
<b>Section 4. Managed Care Provider Information.....</b>	<b>4-1</b>
Community Care of North Carolina—Carolina ACCESS.....	4-1
Carolina ACCESS.....	4-1
Community Care of North Carolina—ACCESS II/III.....	4-1
Recipient Enrollment.....	4-2
Recipient Education.....	4-3
Provider Participation.....	4-3
Requirements for Participation.....	4-3
Conditions of Participation.....	4-6
Exceptions.....	4-6
Sanctions.....	4-6
Reasons for Sanctions.....	4-7
Sanction Appeals.....	4-7
Terminations.....	4-7
Provider Reports.....	4-7
Carolina ACCESS Reports Web Portal.....	4-7
Enrollment Report.....	4-8
Emergency Room Management Report.....	4-8
Referral Report.....	4-8
Quarterly Utilization Report.....	4-8
Provider Requirements.....	4-8
Health Check Services/Early and Periodic Screening, Diagnosis, and	

Treatment Services.....	4-8
Adult Preventive Annual Health Assessments.....	4-9
24-Hour Coverage.....	4-9
Standards of Appointment Availability.....	4-10
Emergency Conditions.....	4-10
Urgent Conditions.....	4-10
Standards for Office Wait Times.....	4-10
Hospital Admitting Privileges.....	4-10
Women, Infants, Children Special Supplemental Nutrition Program Referrals.....	4-11
Transfer of Medical Records.....	4-11
Medical Records Guidelines.....	4-11
Referrals and Authorizations.....	4-12
Referrals for a Second Option.....	4-13
Referral Documentation.....	4-13
Submitting Referral Claims.....	4-13
Exempt Services.....	4-13
Override Requests.....	4-14
Medical Exemption Requests.....	4-15
Patient Disenrollment.....	4-15
Carolina ACCESS—Frequently Asked Questions.....	4-16
Modified Sample of Carolina ACCESS Provider Enrollment Report, Section 1, New Enrollees.....	4-18
Modified Example of Carolina ACCESS Provider Enrollment Report, Section 2, Current Enrollees.....	4-19
Modified Example of Carolina ACCESS Provider Enrollment Report, Section 3, Terminated Enrollees.....	4-20
Example of Emergency Room Management Report.....	4-21
Example of Referral Report.....	4-22
Instructions for Quarterly Utilization Report.....	4-23
Example of Quarterly Utilization Report.....	4-24
Example of Quarterly Utilization Report, continued.....	4-25
List of Regional Managed Care Consultants.....	4-26
<b>Section 5. Submitting Claims to Medicaid.....</b>	<b>5-1</b>
Time Limits for Filing Claims.....	5-1
Submitting Claims Electronically.....	5-1
Submitting Claims on Paper.....	5-1
Processing Paper Claims without a Signature.....	5-2
National Drug Code.....	5-2
Billing Professional (CMS-1500/837P) Claims.....	5-3
Modifiers.....	5-3
Instructions for Billing Professional Claims.....	5-3
Definitions.....	5-4
CMS-1500 Claim Example.....	5-5
Quick Reference Guides for Carolina ACCESS Providers.....	5-6
Professional Claims Processed with CA Override.....	5-6
Billing Institutional (UB-04/837I) Claims.....	5-7

Instructions for Billing Institutional Claims.....	5-7
Definitions.....	5-7
UB Claim Example.....	5-8
Quick Reference Guides for Carolina ACCESS Providers.....	5-9
Institutional CA Claims Processed with CA Override Number.....	5-10
Billing Dental (ADA2006/837D) Claims.....	5-10
Definitions.....	5-10
Dental ADA Claim Example.....	5-11
Billing Pharmacy Claims.....	5-12
Medicare Crossover Claims.....	5-12
Professional Claims.....	5-12
Institutional Claims.....	5-13
Copayments.....	5-13
Carolina ACCESS Primary Care Providers.....	5-13
Prior Approval.....	5-13
Annual Visit Limitation.....	5-13
Hysterectomy, Sterilization, and Abortion Consents/Statement.....	5-14
Durable Medical Equipment Span Dates.....	5-14
Optical Refractions.....	5-14
Reimbursement Guidelines.....	5-14
Professional or Dental Claim Denials for Non-covered Services.....	5-15
Medicare Health Maintenance Organization.....	5-15
Professional Services.....	5-15
HMO Example of CMS-1500 Claim Form Without Third Party Insurance, HMO EOB Attached.....	5-16
Institutional Services.....	5-16
HMO Example of UB-04 Claim Form, HMO EOB Attached.....	5-17
<b>Section 6. Prior Approval.....</b>	<b>6-1</b>
Important Points About Prior Approval.....	6-2
Early and Periodic Screening, Diagnosis, and Treatment.....	6-5
General Requests for Prior Approval.....	6-6
Denial of Prior Approval.....	6-6
Requests for Specific Types of Prior Approval.....	6-7
Adult Care Home – Enhanced Care.....	6-7
Adult Care Home – Special Care Unit for Persons with Alzheimer’s and Related Disorders.....	6-7
Auditory Implant External Parts and Accessories (Auditory Brainstem, Bone Anchored Hearing Aid, and Cochlear).....	6-7
Community Alternatives Program Participation.....	6-7
Dental Services.....	6-8
Durable Medical Equipment, Orthotic and Prosthetic Devices, Oral Nutrition Products for Recipients under 21 Years of Age, Pediatric Mobility Devices, and Augmentative and Alternative Communication Devices.....	6-8
Hearing Aids, Frequency Modulation Systems, and Accessories.....	6-9
Hospice Participation.....	6-9
Long-Term-Care Services.....	6-9

Optical Services—Routine Eye Exams with Refractions.....	6-10
Optical Services—Visual Aids.....	6-10
Out-of-State or State-to-State Ambulance Service.....	6-10
Outpatient Specialized Therapies.....	6-10
Over-the-Counter Medication Requests for Recipients under 21 Years of Age.....	6-10
Prescription Drugs.....	6-11
Radiology – Outpatient (Non-Emergency) Diagnostic Imaging Procedures.....	6-11
Surgical Procedures.....	6-11
Transplants.....	6-12
Lab Result Requirements.....	6-12
Solid Organ Transplant Packets.....	6-12
Stem Cell Transplant Packets.....	6-13
Utilization Review for Psychiatric Services.....	6-13
Quick Reference Table—Prior Approval for Certain Medicaid Services.....	6-14
Listing of EPSDT Services Found at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].....	6-21
<b>Section 7. Third-Party Insurance.....</b>	<b>7-1</b>
Third Party Liability – Commercial Health Insurance and Medicare – Medicaid Payment Guidelines for Third Party Coverage.....	7-1
Services Provided to Medicare-Eligible Medicaid.....	7-1
Contracted Fee-for-Service Payments – Commercial Health Insurance.....	7-1
Noncompliance Denials – Commercial Health Insurance and Medicare.....	7-1
Determining Third-Party Liability- Commercial Health Insurance and Medicare.....	7-2
Time Limit Override on Third-Party Insurance – Commercial Health Insurance.....	7-3
Refunds to Medicaid – Commercial Health Insurance and Medicare.....	7-3
Personal Injury Cases.....	7-3
Tort (Personal Injury Liability).....	7-3
Provider’s Rights in a Personal Injury Case.....	7-4
Billing for Personal Injury Cases.....	7-4
Payment for Personal Injury Cases.....	7-4
Refunds and Recoupments for Personal Injury Cases.....	7-5
Third-Party Liability—Frequently Asked Questions.....	7-5
Health Insurance Premium Payments.....	7-9
Payment of Health Insurance Premiums.....	7-9
Eligibility Determination.....	7-9
Qualifying Process.....	7-9
Where to Obtain Information.....	7-9
Medicaid Credit Balance Reporting.....	7-9
Completing and Submitting the Medicaid Credit Balance Report.....	7-10
<b>Section 8. Resolving Denied Claims.....</b>	<b>8-1</b>
Common Denial Codes.....	8-1
Claim Adjustments.....	8-2
Resubmission of a Denied Claim.....	8-2
Instructions for Completing the Medicaid Claim Adjustment Request Form.....	8-2
Tips for Filing Adjustments.....	8-4

RA Requirements for Paper Adjustments.....	8-5
Submitting an Adjustment Electronically.....	8-5
EOB Denials That Do Not Require Filing an Adjustment.....	8-5
Pharmacy Claim Adjustments.....	8-8
Instructions for Completing the Pharmacy Adjustment Request Form.....	8-8
Resolution Inquiries.....	8-9
Time Limit Overrides.....	8-9
Instructions for Completing the Medicaid Resolution Inquiry Form.....	8-10
Eligibility Denials.....	8-10
Step 1—Check for Errors on the Claim.....	8-10
Step 2—Check for Data Entry Errors.....	8-11
Step 3—When All Information Matches.....	8-11
Explanation of Benefits (EOBs) for Eligibility Denials.....	8-11
Recoupments.....	8-13
Automatic Recoupments.....	8-13
Provider Refunds.....	8-13
Submitting Refunds with a Remittance and Status Report.....	8-13
Submitting Refunds with the Medicaid Provider Refund Form.....	8-14
Tips for Submitting Refunds.....	8-14
<b>Section 9. Remittance and Status Report.....</b>	<b>9-1</b>
What Is the Remittance and Status Report?.....	9-1
Remittance and Status Report Sections and Subsections.....	9-1
Paid Claims.....	9-1
Adjusted Claims.....	9-1
Informational Adjustment Claims.....	9-1
Denied Claims.....	9-2
Claims in Process.....	9-2
Financial Items.....	9-2
Claims Summary.....	9-2
Claims Payment Summary.....	9-2
Financial Payer Code.....	9-2
Population Group Payer Code.....	9-2
New Totals Following the Current Claim Total Line.....	9-3
Summary Page.....	9-3
Tax Information.....	9-3
Remittance and Status Report Field Descriptions.....	9-4
Explanation of the Internal Control Number.....	9-5
Explanation of Benefit Codes.....	9-6
How to Request a Duplicate Remittance and Status Report.....	9-7
Examples of Remittance and Status Report.....	9-7
Paid Claims Medical.....	9-7
Denied Claims Medical.....	9-8
<b>Section 10. Electronic Commerce Services.....</b>	<b>10-1</b>
Available Transactions.....	10-1
Electronic Claims Submission.....	10-1
Improved Cash Flow.....	10-1

Saved Time.....	10-1
Ease of Use.....	10-2
Support.....	10-2
Billing Claims Electronically.....	10-2
Trading Partner Agreements.....	10-2
Billing with the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool.....	10-2
Billing with Software Obtained from a Vendor.....	10-2
Billing with Software Written by Your Office or Company.....	10-3
Billing through a Clearinghouse.....	10-3
Electronic Verification of Recipient Eligibility.....	10-3
Verifying Recipient Eligibility Using the North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool.....	10-3
Value Added Networks.....	10-3
Interactive Recipient Eligibility Verification.....	10-3
Approved VANs.....	10-4
Important Telephone Numbers for Electronic Commerce Services.....	10-5
Electronic Funds Transfer.....	10-5
Electronic Commerce Services—Frequently Asked Questions.....	10-5
<b>Section 11. National Provider Identifier.....</b>	<b>11-1</b>
What Is the National Provider Identifier? .....	11-1
The NPI and N.C. Medicaid.....	11-1
Atypical Providers.....	11-1
NPI and Provider Enrollment.....	11-1
Obtaining the NPI.....	11-2
Reporting the NPI.....	11-2
NPI Subparts.....	11-2
Taxonomy and NPI.....	11-2
Unknown NPI Report.....	11-3
Unresolved NPI Report .....	11-3
NPI and the Automated Voice Response System.....	11-4
NPI Effects on the Remittance and Status Reports and the 835 Transaction.....	11-4
NPI and Claim Submission Guidelines.....	11-4
NPI and Carolina Access.....	11-5
Electronic Mailing List for NPI Updates.....	11-5
NPI—Frequently Asked Questions.....	11-5
General Questions.....	11-5
Applying for Your NPI.....	11-6
Reporting Your NPI to N.C. Medicaid.....	11-7
Updating and Verifying Your NPI with DMA Records.....	11-7
Carolina ACCESS.....	11-8
Taxonomy Codes.....	11-8
Filing Claims.....	11-9
Other.....	11-10
<b>Appendix A. Automated Voice Response System.....</b>	<b>A-1</b>

---

<b>Appendix B. Contacting HP Enterprise Services Telephone Instructions</b>	<b>B-1</b>
<b>Appendix C. Glossary of NPI Terms</b>	<b>C-1</b>
<b>Appendix D. HP Enterprise Services Provider Services Representatives</b>	<b>D-1</b>
<b>Appendix E. List of Abbreviations and Acronyms</b>	<b>E-1</b>
<b>Appendix F. Verifying Recipient Eligibility</b>	<b>F-1</b>
Real Time Eligibility Verification (270/271 Transaction)	F-1
Batch Eligibility Verification (270/271 Transaction)	F-1
Recipient Eligibility Verification Web Tool	F-1
Automated Voice Response (AVR) System – 1-800-723-4337, option 6	F-2
AVRS Option 6, Selection 1 – Eligibility and Coordination of Benefits	F-2
AVRS Option 6, Selection 2 – Hospice Eligibility	F-3
AVR Alphabetic Data Table	F-3