

Section 12. Resolving Denied Claims

Common Denial Codes

The following explanations of benefit (EOB) codes used by N.C. Medicaid/Health Choice are listed below with suggested resolution. Although the suggested resolution is for common denial cases, each claim may propose a unique processing scenario. For further information or claim research, contact HP Enterprise Services Provider Services for claim-specific analysis.

EOB	EOB Description	Resolution
69	Bill Medicare PART A Carrier	Submit claim to Medicare Part A Carrier then resubmit claim to N.C. Medicaid reporting payment, include necessary documentation when required.
153	Ancillary charges included in per diem rate	Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
270	Billing provider is not the recipient's Carolina Access PCP. Authorization is missing or unresolved. Contact PCP for authorization or HPES Prov. Svcs. if authorization is correct	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
286	Incorrect authorization number on claim form. Verify number and refile claim	Referring NPI on processed claim does not match the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim.
1108	POS - Denial Due To DUR ALERT	(Informational EOB, no resolution)
1121	POS – Denied due to same week reversal	(Informational EOB, no resolution)
4102	You are attempting to Adjust a Claim that is not on our file or not on our file as previously paid	Review payment history, correct and resubmit corrected claim or adjustment with documentation as appropriate.
21	Exact Duplicate	Review payment history and resubmit corrected claim if required.
8700	Per legislative mandate this Medicaid claim must be filed electronically for adjudication	Resubmit electronically or verify all necessary documentation was sent in with the paper claim, adjustment or override request.
8925	Allowable reduced for deductible/patient liability	Prior payment amount exceeds the N.C. Medicaid allowable, or reduces the N.C. Medicaid allowable by the prior payment amount. No action necessary.

EOB	EOB Description	Resolution
9271	Payment included in DRG reimbursement on first accommodation detail	Informational EOB - Refer to first accommodation detail. If payment is indicated, no action necessary. If denial code is indicated, correct and resubmit claim based on EOB description given.
9294	DRG Recoupment	Informational EOB – applies to replacement and void ICNs, no resolution required

Claim Adjustments

The claims adjustment process affords providers an opportunity to request a review or correct a previously processed claim that have either paid or denied, in whole or in part. Adjustment requests may be submitted either electronically or on paper. Please note, not all denials can be addressed through this process. Primary examples are non-adjustable EOBs and CCI/MUE denials discussed further later in this section.

Resubmission of a Denied Claim

The **Medicaid Claim Adjustment Request Form** is used to make an adjustment to all previously paid claims or certain denied claims. Not all denials require an adjustment request. If adjustments are submitted for certain EOBs, the claim will be denied for EOB 998, which states, “Claim does not require adjustment processing, resubmit claim with corrections as a new day claim,” or EOB 9600, which states, “Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting.” In the future, resubmit a new or corrected claim in lieu of sending an adjustment request. Please contact HP Enterprise Services Provider Services at 1-800-688-6696 or 919-851-8888 if there are any questions on how to resolve a specific denial.

Do not use the **Medicaid Claim Adjustment Request Form** to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Use the **Medicaid Resolution Inquiry Form** if you have exceeded the filing time limit.

When submitting adjustment requests, always attach a copy of any Remittance and Status Report (RA) related to the adjustment, as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment, but it is not required if the claim was filed electronically.

Within 30 days of filing a **Medicaid Claim Adjustment Request Form**, the status of the claim listed on the RA is “pending.” If the status code does not appear as pending, verify that the recipient’s Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, refile the adjustment request with the correct information.

Submitting an Adjustment Electronically

With the implementation of standard claims transactions to comply with the Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. Electronic adjustments are the preferred method to report an overpayment or underpayment to NC Medicaid.

There are two separate actions that may be filed:

1. Void – in order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental ADA 2006 and CMS-1500) and Type of Bill (UB-04) on the 837 electronic claim transaction. The ICN for the original claim to be voided must

also be provided. When processed, the claim associated with the original ICN will be recouped from the patient's record and the payment will be recouped from the provider's RA.

2. Replacement – a replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental ADA 2006 and CMS-1500) and Type of Bill (UB-04) on the 837 electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient's record and shown as a recoupment on the RA when the replacement claim processes and pays without error. If the replacement claim is denied, the entire replacement process will be denied, including the recoupment.

Submitting a Paper Adjustment Request

N.C. Medicaid will continue to accept and process paper adjustments. Providers are required to file adjustments on paper when documentation is required to support the claim or adjustment request. Also attach a copy of any Remittance and Status Report (RA) related to the claim as well as any medical records that could justify the reason for paying a previously denied claim. Please note: N.C. Medicaid does not accept 835s as a substitute for the N.C. Medicaid RA. If a third party is involved with the claim, either paid or denied, that RA/835 should be attached. It is suggested that providers include a corrected claim when submitting an adjustment, but it is not required if the claim was filed electronically.

The **Medicaid Claim Adjustment Request Form** is used to adjust a previously paid claim or a denied claim. If your paid or denied claim was for one of the explanations of benefits (EOBs) listed at the end of this section, do **not** file as an adjustment; these claims should be refiled as new claims. If your EOB is not listed below, please use the **Medicaid Claim Adjustment Request Form** to process these claims when paper filing is required. Do not use the **Medicaid Claim Adjustment Request Form** to inquire about the status of a claim, to add late charges or to submit a claim for dates of service that have exceeded the filing time limit. Use the **Medicaid Resolution Inquiry Form** if you have exceeded the filing time limit.

Within 30 days of filing a **Medicaid Claim Adjustment Request Form**, you should see the status of the claim listed on the RA as "pending." If the status code does not appear as pending, verify that the recipient's Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, refile the adjustment request with the correct information.

Instructions for Completing the Medicaid Claim Adjustment Request Form

The instructions for completing the **Medicaid Claim Adjustment Request Form** are listed below. A copy of the **Medicaid Claim Adjustment Request Form** is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Line	Instruction
Provider Number	Billing provider's number
Provider Name	Name of billing provider
Recipient Name	Recipient's name
Recipient ID	Recipient's MID number
Claim Number	The ICN followed by the 5-character financial payer code as shown on the RA. Always reference the original ICN even if you have a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number.
Date of Service	Beginning and ending date of service covered on the original claim
Billed Amount	Amount billed on the original claim
Paid Amount	Amount paid on the original claim

Line	Instruction
RA Date	Date the original claim was paid
Reason for Adjustment Request:	Reason for the adjustment (overpayment, full recoupment, etc.)
Units	Correct number of units
Dates of Service	Correct date of service
Third Party Liability (TPL)	Indicate TPL amount on the adjustment form and include a copy of the TPL voucher showing payment.
Procedure/ Diagnosis Code	Indicate the combined procedure code or revenue code and the corrected billed amount.
Patient Liability	<p>Include the latest Patient Monthly Liability Form (DMA-5016) pertaining to the date of service. Include all related RAs showing a liability amount applied to the claim.</p> <p>The adjustment request will be reviewed by DMA's Claims Analysis Unit. If your RA indicates an EOB 9607 adjustment being reviewed for a change in patient liability, do not refile or resubmit the adjustment; it will be processed for you.</p>
Medicare Adjustment	<p>Attach the original and the adjusted Medicare vouchers. Use the ICN for the previously paid claim for the claim referenced on the adjustment form.</p> <p>Indicate all related Medicare vouchers. If Medicare processing necessitates an adjustment payment on two separate claims, send both claim copies and both Medicare vouchers. Use the ICN for the denied duplicate claim for the claim references on the adjustment form.</p>
Billed Amounts	Show the total billed amount on the adjustment request form. Do not use the difference between the original claim and the adjusted claim as the billed amount.
Further Medical Review	Submit only the medical records, operative notes, anesthesia records, etc., that may affect the claims payment. These records are used by medical staff to determine whether to reimburse the providers or deny the adjustment as paid correctly.
Other Duplicate Denials	When filing an adjustment for a duplicate denial, attach medical records or radiology reports for the dates of service in question. Do not submit the adjustment form or medical records with front and back copies. All records and forms are scanned on the front side only.
Specific Reason for Adjustment Request	Reason for the adjustment. If the adjustment is a result of procedures' not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim along with the corrected billed amount and the correct date of service.
Signature of Sender	Name of the person filling out the form
Date	Date the adjustment request is submitted or mailed
Phone number	Area code and telephone number for the person filling out the form.

Tips for Filing Adjustments

The following tips will assist in completing the adjustment form

- Complete only one adjustment request form per claim; a separate adjustment request form for each line item on a single claim is not necessary and may result in a delay/denial of the request, so one ICN - submit one adjustment.
- Reference only one ICN per adjustment request form.
- If requesting a review of a previously denied adjustment, reference the original ICN and resubmit with all supporting documentation related to the adjustment.
- Do not reference the ICN for the denied adjustment.
- Include a copy of the appropriate RA with each adjustment request. If multiple RAs were involved in the claim payment process, include copies of each RA.
- Include a copy of the claim that is referenced on the adjustment request.
Note: This is not required for electronically submitted claims.
- When the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not obliterate previously paid details on the claim.
- Include pertinent information on a separate sheet of paper. Do not write information on the back of the adjustment form, RAs, etc.
- Ensure that all of the information submitted with the adjustment request is legible.
- Send only the medical records that pertain to the services rendered. If it is necessary to send records with other information included, identify the portion of the record that is significant to the adjustment request.
- Only the claim that pertains to the payment or denial in question should be submitted with the adjustment request. Do not submit any other claims with the adjustment request. Claims for service dates that have not been submitted should be filed on a new day claim, including late charges for codes not previously filed.
- When submitting an adjustment to Medicaid due to a Medicare-adjusted voucher, attach both the original voucher and the adjusted Medicare voucher. Reference the ICN of the original voucher.
- If requesting a review of a previous partial payment or a partial recoup adjustment, reference the ICN for the adjustment and resubmit with all supporting documentation related to the adjustment.
- Adjustments equal to or less than \$1.00 will be denied.
- When submitting an adjustment regarding a refund check mailed to Medicaid, send a copy of the front and back of the referenced check.

The most common mistakes that are made when filing adjustments are:

- Incomplete or invalid MID information or ICNs
- Multiple ICNs on the same form
- Unspecified or too-general reason for the adjustment request
- Missing copy of the RA related to the request
- Missing reference to the original ICN, or use of a denied adjustment ICN
- A partial payment or partial recoupment number is not referenced as the original ICN
- Filing the adjustment after the 18-month time limit

Note: If an adjustment is not filed until the 17th month from the date of service, the original claim may no longer be available in the system for adjustment. Submit adjustments as soon as possible so they can be processed within the 18-month time limit.

- Missing required documentation (Medicare vouchers, medical records, operative records, etc).
- Sending an 835 instead of the NC Medicaid RA
- An adjustment request can be made to change or delete a detail. However, you cannot add a detail through the adjustment process
- Requesting a partial recoupment of a single detail with no supporting documentation
- Referencing the NPI on the adjustment request

Note: This form requests the MPN in the blank specified for Provider Number.

Remittance and Status Report Requirements for Paper Adjustments

- Adjustment processing procedures require that providers attach a copy of all paper Medicaid RA pages related to the referenced claim. Providers must attach the Medicaid RA page that is generated through the NCECSWeb Tool in PDF format. Refer to **Section 11, Remittance and Status Report**, for additional information.
- A provider-generated RA, or a copy of the electronic RA (835 transaction) is **NOT** an acceptable substitute for the paper copy that is generated through the NCECSWeb Tool in PDF format. Provider-generated RAs have varied formats and do not include all information necessary for manual adjustment processing.
- Paper adjustments that do not include the required RA will be denied with EOB 812, “Adjustment denied. Please refile with all related RA’s, including original processing.” Providers receiving this denial should resubmit a copy of their adjustment with the requested RA.
- If you do not have a copy of the paper RA, contact HP Enterprise Services Provider Services to request a replacement. (There is a per-page charge for RA requests that are more than 10 checkwrites old. RA reprints for the last 10 checkwrites are available through the NCECSWeb Tool in PDF format. Refer to **How to Request a Duplicate Remittance and Status Report** in **Section 11, Remittance and Status Report**, for additional information).

CCI/MUE Denials

Five EOBs have been created to indicate a claim that was denied for a CCI/MUE or other National Correct Coding Initiative (NCCI) edit. Providers will have the ability to view the denials via the NCECSWeb Tool, which will provide a detailed explanation of why the edit was invoked and the supporting industry (CMS, American Medical Association, etc.) standards justifying the denial.

EOB	EOB Description
9988	Payment of procedure code is denied based on CCI editing
9953	Payment of procedure code is denied based on MUE editing
9954	Payment of procedure code is denied based on correct coding standards editing
9955	Claim recouped based on CCI editing
9956	Detail recouped based on CCI editing

CCI Denials for EOB 9988

Providers must determine if the denied claim can be resubmitted to N.C. Medicaid for reconsideration by viewing the following link from the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html>.

By selecting the code, the provider can determine based upon the modifier column how the CCI denial may be resolved.

Column 1	Column 2	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
90378	G0345	20050101	20050101	9
90378	G0347	20050101	20050101	9
90378	36000	20021001	*	1
90378	36410	20021001	*	1
90378	90780	20010701	20041231	1
90378	90783	20010701	20041231	0
90378	90784	20010701	20041231	0
90378	90788	20010701	20041231	0
90460	G0008	20110101	*	1
90460	G0009	20110101	*	1
90460	G0010	20110101	*	1

If the NCCI edit responsible for a CCI denial has a modifier indicator of "1," the provider can make modifications to the previously submitted claim by submitting a new day claim with an appropriate modifier appended to the procedure code.

If the NCCI edit responsible for a CCI denial has a modifier indicator of "0," the claim cannot be corrected and resubmitted as a new day claim. Refer to **Appealing a CCI/MUE Denial** in this section for additional information.

Modifier Indicator	Definition
"0" Not Allowed	There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
"1" Allowed	The modifiers associated with NCCI are allowed with this code pair when appropriate.

MUE Denials for EOB 9953

Providers must determine the allowed units of service by viewing the appropriate MUE table from the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html>.

The screenshot shows the Medicaid.gov website interface. At the top, there is a search bar and navigation links for Home, About Us, CMS.gov, and Archive. Below this is a menu with categories like Federal Policy Guidance, Medicaid & CHIP Program Information, State Resource Center, Affordable Care Act, and Need Health Insurance?. The main content area is titled 'Medicaid Nation Correct Coding Initiative'. It features a sidebar on the left with 'Medicaid & CHIP Program Information' and 'By Topic' (Eligibility, Benefits, Cost Sharing, Waivers, Long-Term Services & Support, Delivery Systems). The main content area has a heading 'NCCI Edits' and a paragraph explaining the initiative. It lists two types of edits: NCCI procedure-to-procedure (PTP) edits and Medically Unlikely Edits (MUE). A 'Data and Systems Content' sidebar on the right lists various links like Medicaid Statistical Information Systems (MSIS), Medicaid Managed Care Enrollment Report, etc.

Following is an example of the data listed in the MUE tables.

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HCPSCS/CPT Code	Outpatient Hospital Services MUE Values
0019T	1
0030T	2
0042T	1
0054T	2
0055T	2
0058T	1
0059T	1
0071T	1
0072T	1
0073T	2
0099T	2
0100T	2

If the claim is denied because the billed units of service exceed the allowed units, the provider can make modifications in the previously submitted claim by submitting a new day claim with the corrected units of service. If the provider feels that the exceeded units of service are medically reasonable, the denial may be appealed.

Appealing a CCI/MUE Denial

Providers may submit a letter requesting reconsideration of a CCI/MUE denial to DMA at the address listed below. The request must include documentation supporting medical necessity.

Division of Medical Assistance
 Appeals Unit
 Clinical Policy and Programs
 2501 Mail Service Center
 Raleigh, NC 27699-2501

Pharmacy Claim Adjustments

A **Pharmacy Adjustment Request Form** is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the **Pharmacy Adjustment Request Form** to do the following:

- Credit Medicaid for a billed and paid prescription that was never dispensed
- Credit Medicaid for a billed and paid prescription for drugs that were unused
- Correct National Drug Code (NDC), quantity, days supply, date of service, billed amount, Rx number, or third-party payment

Instructions for Completing the Pharmacy Adjustment Request Form

The instructions for completing the **Pharmacy Adjustment Request Form** are shown below. A copy of the Pharmacy Request Form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Outpatient Pharmacy Providers).

Line	Instruction
Recipient Medicaid Number	Enter the recipient's MID number as it appears on the RA from the original claim.
Recipient Name	Enter the recipient's name exactly as it appears on the RA.
Pharmacy Name and Provider Number	Enter the name of the pharmacy and the pharmacy's Medicaid provider number.
Rx Number	Enter the prescription number as it appears on the RA.
Drug Name	Enter the name of the drug dispensed, including the strength and the dosage form (abbreviated).
NDC	Enter the 11-digit NDC as it appears on the RA.
Quantity	Enter the original quantity billed as it appears on the RA.
Billed Amount	Enter the original total billed amount as it appears on the RA.
Date Filled	Enter the original date the prescription was filled, as it appears on the RA, using the MM/DD/YY format.
Claim Number	Enter the ICN of the claim that is submitted to be adjusted. When referencing a claim number, it is important to use the most current ICN in relation to the pharmacy adjustment request.
Denial EOB	Do not enter information in this block unless the claim was denied with EOB 0985, "Exceeding Prescription Limitation."

Line	Instruction
Insurance Paid	Indicate a correction of omission of Other Payer Amount by placing an “X” in this box. Indicate in the “Adjustment Reason” block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payer amount to the adjustment request.
Adjustment Reason	State what correction is needed and the reason.
Paid Amount	Enter the amount of the original Medicaid payment for the claim identified by the ICN listed in the “Claim Number” block as it appears on the RA.

Medicaid Resolution Inquiries

The **Medicaid Resolution Inquiry Form** is used to submit Medicaid claims for

- Time limit overrides
- Medicare overrides
- Third-party overrides
- Medicare HMO (Part C) CMS-1500 claims (see **Section 10, Submitting Claims**)

When submitting inquiry requests, always attach the claim and a copy of any RAs related to the inquiry request, as well as any other information related to the claim. (Electronic RAs [835 transaction] are not accepted). Refer to **Section 11, Remittance and Status Report**, for information on accessing and downloading RAs.

Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). When requesting a Third Party override, attach a copy of the TPL EOBs definitions with your request. Since these documents are scanned, attach only single-sided documents to the inquiry request. **Do not attach double-sided documents to the inquiry request.** A copy of the **Medicaid Resolution Inquiry Form** is on DMA’s website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Time Limit Overrides

All Medicaid claims, except hospital inpatient and nursing facility claims must be received by HP Enterprise Services within 365 days of the date of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim.

If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed.

Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOBs:

- 0018** Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to HP Enterprise Services Provider Services Unit
- 2930** POS-claim or reversal greater than 365 days old. Refile claim (paper) with proper documentation for time limit override.
- 8918** Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing—a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.

Since DMA and HP Enterprise Services must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA or HP Enterprise Services about the specific claim received that is within 365 days of the date of service
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received by HP Enterprise Services within the 365-day time limit.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, you have **180** days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. You must include the Medicaid Resolution Inquiry Form, copy of the claim, and a copy of the Third-Party or Medicare EOB in order to request a time limit override.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry Form and mail to the address indicated on the inquiry form.

Instructions for Completing the Medicaid Resolution Inquiry Form

The instructions for completing the **Medicaid Resolution Inquiry Form** are shown below. A copy of the Medicaid Resolution Inquiry Form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Line	Instruction
Provider Number	Enter the billing provider's number.
Provider Name and Address	Enter the name and address of the billing provider.
Recipient Name	Enter the recipient's name exactly as it appears on the MID card.
Recipient ID	Enter the recipient's MID number as it appears on the MID card.
Date of Service	Enter the beginning and the ending date of service.
Claim Number	If the claim was previously processed, enter the ICN followed by the 5-character financial payer code as indicated on the RA. If this is the first submission, this information is not required.
Billed Amount	Enter the amount billed on the claim.
Paid Amount	If applicable, enter the amount paid on the original claim.
RA Date	If applicable, enter the date the original claim was paid.
Specific Reason for Inquiry	Indicate the reason for the inquiry (time limit override, TPL override, Medicare override, etc.). Identify attachments RAs, medical records, TPL or Medicare vouchers, etc.).
Signature of Sender	Indicate the name of the person filling out the form.
Date	Indicate the date the adjustment request is submitted or mailed.

Line	Instruction
Phone number	Indicate the area code and telephone number for the person filling out the form.

NC Health Choice Resolution Inquiries

A separate Resolution Inquiry form is used for Health Choice claims. Instructions are the same as above, except the only possible override for Health Choice claims is time limit.

Mail Health Choice Resolution Inquiries to:

HP Enterprise Services
 Attn: Health Choice
 P O BOX 300001
 Raleigh, NC 27622

Eligibility Denials

If claims are denied for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

Step 1 – Check for Errors on the Claim

Compare the recipient's eligibility information to the information entered on the claim.

If the information on the claim and the recipient's eligibility information do not match, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, request a time limit override by submitting the claim and a completed **Medicaid Resolution Inquiry Form** (<http://www.ncdhhs.gov/dma/provider/forms.htm>). Include a copy of the RA or other documentation of timely filing.
- If the claim was originally received and processed within the 365-day claim filing time limit, resubmit the claim on paper or electronically as a new day claim, ensuring that the recipient's MID number, provider number, "from" date of service, and total billed match the original claim exactly.

Step 2 – Check for Data Entry Errors

Compare the RA to the information entered on the claim.

If the RA indicates that the recipient's name, MID number, or date of service has been keyed incorrectly, correct the claim and resubmit on paper or electronically as a new day claim.

- If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override.
- If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.

Step 3 – When All Information Matches

Verify that the recipient's eligibility information has been updated in the state eligibility file by utilizing the NCECS/Recipient Eligibility Verification Web Tool or by calling the AVR system.

If the NCECS/Recipient Eligibility Verification Web Tool or the AVR system indicates that the recipient is ineligible, submit a **Medicaid Resolution Inquiry Form** to DMA Claims Analysis. Include the recipient eligibility information, the claim, and the RA. Mail to:

Division of Medical Assistance
 Claims Analysis
 2501 Mail Service Center
 Raleigh NC 27699-2501

The Claims Analysis unit will review and update the information in EIS and resubmit the claim.

Do not mail eligibility denials to HP Enterprise Services, as this will delay the processing of your claim.

For further information, refer to **Appendix F, Verifying Recipient Eligibility** and **Appendix A, Automated Voice Response System**.

EOBs for Eligibility Denials

EOB	Message	Explanation
10	Diagnosis or service invalid for recipient's age.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to HP Enterprise Services as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.
11	Recipient not eligible on service date.	Follow the instructions outlined in Steps 1, 2, and 3 above.
12	Diagnosis or service invalid for recipient sex.	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to HP Enterprise Services as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.
84	Recipient is partially ineligible for service dates. Resubmit a new claim billing for only eligible dates of service.	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	Patient deceased per state eligibility file.	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to HP Enterprise Services as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis.
120	Recipient MID number missing. Enter MID and submit as a new claim.	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to HP Enterprise Services as a new claim.
139	Services limited to presumptive eligibility.	Verify that on the date of service the recipient was eligible for all prenatal services, as well as for services required for conditions that may complicate the pregnancy on the date of service. Send the claim, eligibility information and a copy of the RA to DMA Claims Analysis.

EOB	Message	Explanation
143	MID number not on state eligibility file.	Follow instructions in Steps 1 and 2 above. Make corrections, if necessary, and resubmit to HP Enterprise Services as a new claim. The MID number may be obtained through the NCECS/Recipient Eligibility Verification Web Tool or AVR system by using the Social Security Number (SSN) and date of birth. If recipient's SSN is unknown, call DMA Claims Analysis to obtain the correct MID number.
191	MID number does not match patient name.	Verify the recipient's name and MID number. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid's records. Call HP Enterprise Services Provider Services (1-800-688-6696) to verify the patient's name. Correct and resubmit to HP Enterprise Services as a new claim.
292	Qualified Medicare Beneficiary—MQB recipient	If services billed are covered by Medicare, file charges to Medicare first. Attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the co-insurance and deductible in accordance with the Part B reimbursement schedule.
953	Individual has restricted coverage - Medicaid only pays the part B premium.	Medicaid is limited to payment of Medicare Part B premiums only.

Recoupments

Automatic Recoupments

If previously paid claims would cause a current claim to be denied during the audit review, HP Enterprise Services will initiate an adjustment to recoup the previously paid charges. This procedure ensures proper payment for services rendered. The following list shows examples of automatic recoupments. The list is not all inclusive.

- A current claim is filed for dialysis treatment, which includes previously paid charges. HP Enterprise Services will initiate an adjustment to recoup the previous payments in order to pay the dialysis treatment code (i.e., lab, supplies, etc.).
- A hospital files an inpatient claim on the same date of service as an outpatient claim. HP Enterprise Services will recoup the outpatient charges to pay the inpatient claim.
- A physician submits a claim and is paid for lab services that were performed at an independent lab. The independent lab also files a claim, which is denied as a duplicate. HP Enterprise Services will initiate an adjustment to recoup the charges paid to the attending physician for the lab services and pay the claim submitted by the independent lab.
- The assistant surgeon's or anesthesiologist's claim is filed without the appropriate modifier and is paid as though it were the primary surgeon, subsequently causing the primary surgeon's claim to deny as a duplicate. When an adjustment request is received from the primary surgeon, HP Enterprise Services will initiate a recoupment of the incorrect payment from the assistant surgeon or the anesthesiologist in order to pay the surgeon. The assistant surgeon or anesthesiologist must then submit a corrected claim with the appropriate modifiers.

Provider Refunds

Overpayments, third party reimbursements, and incorrect claim submissions may occur in the processing of Medicaid claims. If the provider is not aware of other insurance coverage or liabilities for the recipient

until after the receipt of Medicaid payment, the provider must still file a claim with the health insurance company, then refund to Medicaid the lesser of the two amounts received.

For example:

Amount billed by provider to Medicaid	\$50.00
Amount paid by Medicaid	\$40.00
Amount paid by private insurance	\$45.00
Amount to be reimbursed to Medicaid	\$40.00

Note: Although the refund process is available to send monies back to Medicaid, **the preferred method is through the void or replacement electronic adjustment process.**

Submitting Refunds with a Remittance and Status Report

When submitting a refund request using the RA, follow these instructions:

- Highlight the appropriate recipient name and MID number, claim information (ICN), and dollar amount of the refund to apply to that recipient.
- Ensure that the check amount and notations on the RA agree to the same total being refunded.
- Attach a copy of the RA to the check and submit.
- Refund checks must be payable to HP Enterprise Services – Refund. Mail the refund with the requested information to:

HP Enterprise Services
ATTN: Finance - REFUND
P.O. Box 30968
Raleigh NC 27622-0968

Submitting Refunds with the Medicaid Provider Refund Form

If a copy of the RA is not available, providers are able to submit a refund request using the **Medicaid Provider Refund Form**. This form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> (under Claims and Claim Adjustment forms).

When completing the **Medicaid Provider Refund Form**, follow these instructions:

- Enter the data electronically before printing the form to reduce questions from HP Enterprise Services when the check and form are received.
- Enter information for each claim by detail line. As entries are made into the form, the total refund amount will be automatically calculated.
- The sum of the entries **must** equal the amount of the refund check submitted with this form.
- Once the form entries are completed, compare the total amount on the refund check to the calculated total refund amount in cell L13 on the form. This will cross check the entries on the form with the intended refund amount.
- Print a copy of the completed **Medicaid Provider Refund Form** and submit.
- Refund checks must be payable to HP Enterprise Services– Refund. Mail the refund with the requested information to:

HP Enterprise Services
ATTN: Finance - REFUND
P.O. Box 30968
Raleigh NC 27622-0968

Tips for Submitting Refunds

- If refunding from a central office for multiple provider numbers, submit separate refunds for **each provider**, as questions regarding one of the providers may impact the processing of all of the refunds when submitted on one check.
- Refund checks must be payable to HP Enterprise Services– REFUND. The bank may reject check made out otherwise, and your refund will not be processed.
- If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter.
- If DMA, the DHHS Controller, the Attorney General, or a third-party collections agency has requested a payment, either refund or amount due, make the check payable as the correspondence indicates and mail it to the address indicated. Checks received by HP Enterprise Services are processed as refunds. Payments misdirected to HP Enterprise Services could result in additional actions by DMA, other government agencies, or their agents.
- If a refund is sent due to a claim billing error, it is important to ensure that the credit has processed on the RA, as noted above, prior to resubmitting the claim. This will eliminate any possibility of the resubmitted claim being denied due to a duplicate claim.
- If completing the **Medicaid Provider Refund Form**, save a copy of the form to the computer local drive so that providers have easy access to the form.

Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:

- The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction, including those applied to history.
- Refunds on claims older than 18 months (or about 540 days) must be applied to claims history unless there is a more recent adjustment on the claim to which the refund can be applied. Refunds applied to claims history will not automatically bring about any penalties and interest from being assessed.

Note: Although the refund process is available to send monies back to Medicaid, **the preferred method is through the void or replacement electronic adjustment process.**