

Section 9. Submitting Claims

N.C. Medicaid Implementation of the National Correct Coding Initiative

The Patient Protection and Affordable Care Act [(H.R. 3590) Section 65607 (Mandatory State Use of National Correct Coding Initiative (NCCI))] requires state Medicaid programs to incorporate NCCI methodologies into their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported.

The two components of NCCI are procedure-to-procedure edits (CCI) and medically unlikely edits (MUE).

- CCI procedure-to-procedure edits are for practitioners, ambulatory surgical centers, and outpatient hospital service (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level) that define pairs of HCPCS/CPT codes that should not be reported together.
- MUE are units of service edits for practitioners, ambulatory surgical centers, outpatient hospital service (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level), and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct (e.g., claims for excision of more than one appendix or more than one hysterectomy).

DMA implemented these components on March 31, 2011 to comply with the NCCI mandate. For more information on NCCI, refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/ncci.htm>.

Providers are reminded that:

- services must be reported correctly.
- multiple HCPCS/CPT codes should not be reported when a single comprehensive HCPCS/CPT code describes these services.
- a procedure should not be fragmented into component parts.
- a bilateral procedure code should not be unbundled into two unilateral procedure codes.
- down coding and up coding should be avoided.

CCI and MUE EOBs are reported on the provider's Remittance and Status (RA) Report. An explanation and justification for all NCCI edits are available on a claim and line-level basis using the ConVergence Point Web Portal, which can be accessed through the N.C Electronic Claims Submission Web Tool (NCECSWeb Tool).

Additional Correct Coding Edits Implementation

DMA plans to implement additional correct coding guidelines to enhance our current claims processing system. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These edits will identify any inconsistencies with CPT, AMA, CMS and/or DMA policies and will deny the claim line.

For example, the edits will ensure that:

- The appropriate procedure code is utilized based on age and gender of the patient.
- If a procedure code is submitted that requires a primary procedure code, DMA will verify that the primary procedure code has been submitted.
- Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS. For example, certain procedure codes are not permitted to be performed outside of an inpatient setting.
- Obstetric services including ante partum care, delivery, and postpartum care are billed appropriately according to CMS guidelines and DMA policy.
- The appropriate Evaluation and Management (E & M) codes are utilized for new patients and established patients.
- Certain services related to a surgical procedure are included in the payment of the global surgery package. These services would include E & M and related surgical procedures performed by the same physician for the same patient.
- Duplicate services are not submitted for the same provider, same patient, for the same date of service.
- Providers may refer to the NCCI and Additional Correct Coding Edits webpage on DMA's website, <http://www.ncdhhs.gov/dma/provider/ncci.htm>, for a description of the additional edits module and implementation timeline.

CCI and MUE EOBs are reported on the provider's Remittance and Status (RA) Report. An explanation and justification for all NCCI edits are available on a claim and line-level basis using the ConVergence Point Web Portal, which can be accessed through the N.C Electronic Claims Submission Web Tool (NCECSWeb Tool).

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims 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 inpatient hospital and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

Claims for behavioral health services provided to recipients of a Managed Care catchment area must be filed within 90 days of the date the service was provided.

Submitting Claims Electronically

The N.C. Medicaid Program requires all providers to file claims electronically. HP Enterprise Services will process claims submitted through the NCECSWeb Tool, file transfer protocol and asynchronous dial-up. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed in the next checkwrite. (The checkwrite schedule is available online at <http://www.ncdhhs.gov/dma/provider/calendar.htm>.)

Prior to submitting claims, providers must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission (ECS) Agreement. The ECS Agreement must be submitted and approved prior to submitting claims electronically, regardless of whether claims are submitted – through a clearinghouse, with software obtained from an approved vendor, or through the NCECSWeb Tool. To obtain a copy of this agreement for either a group or an individual, visit NCTracks website at <http://www.nctracks.nc.gov/provider/forms/>.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to **Section 8, Electronic Commerce Services**, for additional information about electronic billing and ECS services.

The rest of this section focuses on paper claim submissions.

Submitting Claims on Paper

There are some situations when a claim must be submitted on paper. Only claims that comply with the exceptions listed on DMA's website (<http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm>) may be submitted on paper. All other claims are required to be submitted electronically.

Paper claims are electronically read using Optical Character Recognition (OCR) equipment. OCR technology requires paper claims to be submitted on standardized claim forms with the appropriate data fields completed. Refer to claim specific manuals for standardized guidelines. Examples of non-standard claim forms are forms that have been individually created and printed by a provider, fax copies, carbon copies or photocopies. Non-standard paper claims will be returned to the provider or may be denied in processing.

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies, and do not highlight the claim or any portion of the claim. For auditing purposes, all claim information must be visible in an archive copy. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at

<http://www.ncdhhs.gov/dma/mp/>. N.C. Medicaid/Health Choice programs and policies are addressed separately and maintained by the authorized sections of DMA.

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File Form**. Providers who file claims electronically are not required to complete this form. Please note that out-of-state providers (providers beyond the 40-mile border of North Carolina border) are required to have a signature on each claim.

Forms that must be signed shall contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number—such as home health agencies, hospitals, and facilities (including adult care) should have the certification signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File Form** has not been submitted), please contact HP Enterprise Services Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available on the NCTracks website at <http://www.nctracks.nc.gov/provider/forms/>. Providers must fax or mail completed certifications two weeks in advance of submitting claims without a signature.

National Drug Code

According to the Deficit Reduction Act of 2005 (DRA), all outpatient physician-administered drugs must be billed with appropriate HCPCS code, National Drug Code (NDC), and NDC units.

Each drug or biologic product approved by the Food and Drug Administration (FDA) is given a unique NDC number. The NDC is found on the package and/or vial of medication.

- Providers billing on a professional claim: When a HCPCS drug code covered under the Physicians Drug Program (PDP) is billed at the detail level, the corresponding 11-digit NDC number and the NDC units must also be indicated for the corresponding detail. Refer to the fee schedule for the Physician's Drug Program for a list of covered PDP drugs (<http://www.ncdhhs.gov/dma/fee/>).
- Providers billing on an institutional claim: When billing outpatient hospital or dialysis services under Revenue Codes 25X, 634, 635, and/or 636, include the corresponding HCPCS code, HCPCS units, NDC, and NDC units for the detail.
- Providers billing for drugs obtained through the 340B Drug Pricing Program are not excluded from the NDC requirement. A modifier of UD must be appended to the detail with the applicable HCPCS procedure code and NDC to properly identify the 340B purchased NDCs.
- Providers should not bill for a drug under a miscellaneous code if a more appropriate HCPCS code is available.
- In general, Medicaid covers only rebatable NDCs.

For more information on NDC requirements, refer to the **March 2009 Special Bulletin, National Drug Code Implementation, Phase III**, and to articles published in the Medicaid bulletin. The Medicaid bulletin and special bulletins are available on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.

Billing Professional (CMS-1500/837P) Claims

The following provider types submit Professional claims:

Ambulatory surgery centers	At-risk case management services
Certified registered nurse anesthetists	Children's Development Services Agencies
Chiropractors	Community Alternatives Program services
Critical Access Behavioral Health Agencies	Direct-enrolled independent behavioral health practitioners
Durable medical equipment suppliers	Federally qualified health centers
Free standing birthing centers	Health departments
Hearing aid dealers	HIV case management services
Home infusion therapy services	Independent diagnostic testing facilities
Independent laboratories	Independent practitioners
Local education agencies	Local management entities
Maternity support services	Nurse midwives
Optical supply dealers	Nurse practitioners
Outpatient behavioral health services provided	Optometrists
by Community Intervention Services Agencies	Orthotics and prosthetics suppliers
Podiatrists	Personal care services
Portable x-ray services	Physicians
Private duty nursing services	Planned Parenthood (non-medical doctor)
Rural health clinics	organizations

Modifiers

Some provider types are mandated to bill Medicaid using modifiers. A modifier allows a provider to indicate that a service rendered to a patient has been altered by some special circumstance(s) while the code description remains the same. If no special circumstances exist and further description of the service rendered is not needed, the code should be billed without a modifier.

For purposes of NCCI, those providers who do not normally bill with modifiers may need to append a modifier to the HCPCS/CPT code to ensure that claims process correctly. A modifier should not be used to bypass an NCCI edit if clinical circumstances do not justify the use of the modifier. For additional information, refer to the Medicaid NCCI Coding Policy Manual on the CMS website at <http://www.cms.gov/MedicaidNCCICoding/>.

For additional billing information, refer to the service-specific clinical coverage policies on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

Instructions for Billing Professional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at <http://www.nucc.org>. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/>.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
1D	Medicaid Provider Number (MPN)
ZZ	Taxonomy Code
N4	NDC – Paper claims only

Note: Qualifiers are not used when submitting claims through the NCECSWeb Tool. Refer to **Section 4, National Provider Identifier**, for additional NPI information.

CMS-1500 Claim Example

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BACKLUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe		3. PATIENT'S BIRTH DATE MM DD YY SEX 01 15 62 M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street) 123 Fun Street	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.		11. INSURED'S DATE OF BIRTH MM DD YY SEX a. EMPLOYER'S NAME OR SCHOOL NAME b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED: _____		13. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		22. OUTSIDE LAB? \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		24. B. PLACE OF SERVICE	
24. C. PLACE OF SERVICE		24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER	
24. E. DIAGNOSIS POINTER		24. F. \$ CHARGES	
24. G. DAYS OR UNITS		24. H. RATE PER UNIT	
24. I. ID. QUAL.		24. J. RENDERING PROVIDER ID. #	
1		ZZ 320000Z NPI 223456722	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT	
27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		28. SERVICE FACILITY LOCATION INFORMATION 123 1st St 1st City, NC 27036-1234	
29. BILLING PROVIDER INFO & PH # Provider Name or Organization 123 Any St Any City, NC 27233-5578		30. BALANCE DUE	
31. SIGNATURE		32. BILLING PROVIDER INFO & PH # 199765430 ZZ 1230000X	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN

17a. 1D qualifier only if entering CA override or an atypical provider number. Otherwise leave blank

17b. NPI for CA authorization or referral. Leave blank for CA overrides or atypical referring providers.

24i and 24j. (shaded) ZZ qualifier and attending taxonomy if applicable

24j. (not shaded) NPI for attending provider if applicable

32. Service facility address and zip+4

33. Billing provider address and zip+4

33a. Billing NPI

33b. ZZ qualifier with billing taxonomy if applicable

Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS primary care provider (PCP) numbers, Carolina ACCESS overrides, and referring provider information on Professional/CMS-1500 claims. Please make note of these filing requirements.

Professional Claims Processed with CA PCP Authorization

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	No	1D	Qualifier 1D represents Medicaid provider number (MPN). This block is only to be utilized if a referring MPN is atypical.
17a (larger shaded box)	PCP Referral Number	No	CA PCP Medicaid provider number	This block is only to be utilized if a referring MPN is atypical.
17b	NPI (National Provider Identifier)	Yes	CA PCP NPI number	Enter the CA PCP NPI linked to the PCP referral number.

Professional Claims Processed with CA Override

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number.
17a (larger shaded box)	CA Override Number	Yes	HP Enterprise Services - issued CA override number.	Contains 2 alpha characters and 5 numeric characters. (ex. CC12345)
17b	NPI	No		Will not have NPI of referring provider.

Billing Institutional (UB-04/837I) Claims

The following provider types submit Institutional claims:

- Adult care homes
- Ambulance services
- Critical Access Behavioral Health Agencies
- Dialysis facilities
- Home health agencies
- Hospice services
- Hospitals
- Inpatient behavioral health services provided by Community Intervention Services Agencies
- Intermediate care facilities for individuals with mental retardation
- Nursing facilities
- Psychiatric residential treatment facilities
- Residential child care (Level II, III, and IV) facilities

Instructions for Billing Institutional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at <http://www.nubc.org>. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at <http://www.ncdhhs.gov/dma/mp/>.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
G2	Medicaid Provider Number (MPN)
DN (Form Locator 78 only)	Referring Provider Information
B3	Taxonomy Code

Note: Qualifiers are not used when submitting claims through the NCECSWeb Tool. Refer to **Section 4, National Provider Identifier**, for additional NPI information.

UB Claim Example

1 Medicaid Facility Provider 123 Any St Any City, NC 27523-5678		2 123 That St That City, NC 27523-5678		3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ID		10 ACCT STATE		11	
12		13		14		15	
16		17		18		19	
20		21		22		23	
24		25		26		27	
28		29		30		31	
32		33		34		35	
36		37		38		39	
40		41		42		43	
44		45		46		47	
48		49		50		51	
52		53		54		55	
56		57		58		59	
60		61		62		63	
64		65		66		67	
68		69		70		71	
72		73		74		75	
76		77		78		79	
80		81		82		83	
84		85		86		87	
88		89		90		91	
92		93		94		95	
96		97		98		99	

FL1. Name and service facility location for provider (must include zip+4)

FL2. Name of billing location for provider if different from FL1 (must include zip+4)

FL50. Two-digit payer codes

FL56. Billing NPI

FL76. (NPI) Attending NPI of Nursing Home on Hospice claims for RC 658 or 659

FL81. (CCa) Qualifier B3 and billing provider taxonomy

FL78 Qualifier DN and CA PCP or Referring NPI

Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on Institutional claims. Please make note of these filing requirements.

Institutional Claims Processed with CA PCP Authorization

Form Locator	Description	Required Field Yes / No	Value	Explanation
78 (blank field 1)	Provider Type Qualifier Code	Yes, if applicable	DN	DN indicates referring provider.
78 (blank field 2)	NPI	Yes, if applicable	CA PCP NPI number	
78 (blank field 3)	Qualifier	No	G2	Qualifier G2 represents Medicaid provider number. This block is only to be utilized if a referring MPN is atypical.
78 (blank field 4)	PCP Referral Number or CA Override Number	No	CA PCP Medicaid provider number	Enter the current CA PCP number This block is only to be utilized if a referring MPN is atypical.
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

Institutional CA Claims Processed with CA Override Number

Form Locator	Description	Required Field Yes / No	Value	Explanation
78(blank field 1)	Provider Type Qualifier Code	No		
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number.
78 (blank field 4)	CA Override Number	Yes	HP Enterprise Services - issued override number	Contains 2 alpha characters and 5 numeric characters. (ex. CC12345)
78 (blank field 5) Last	Last Name of Referring Provider	No		.
78 (blank field 6) First	First Name of Referring Provider	No		

Billing Dental (ADA 2006/837D) Claims

The following provider types submit Dental claims:

- Dentist
- Federally qualified health center (dental services only)
- Health department dental clinic (dental services only)
- Rural health clinic (dental services only)

Refer to Clinical Coverage Policy #4A, *Dental Services*, on DMA's website at <http://www.ncdhhs.gov/dma/services/dental.htm>, for instructions on completing the ADA claim Form.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Please refer to the claim example on the following page.

Note: Refer to **Section 4, National Provider Identifier**, for additional NPI information.

Dental ADA Claim Example

35. Remarks		
AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X _____ Patient/Guardian signature Date		38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment Remaining 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X _____ Subscriber signature Date		TREATING DENTIST AND TREATMENT LOCATION INFORMATION 53. I hereby certify that the procedures as indicated by date on this invoice (for procedures that require multiple visits) or have been completed. X _____ Attending NPI 54. NPI 2987654321 55. License # 56. Address, City, State, Zip Code Main Street Any City, NC 27123-7890 56A. Provider Specialty Code 123D00000X
BILLING 48. Name, Address, City, State, Zip Code Dr. I.M. Smiley P.O. Box 1234 Any City, NC 27123-4567 49. NPI 1234567890 50. License Number 51. SSN or TIN 52. Additional Provider ID 899XXXX 53. Billing NPI		48. Billing address with zip+4 code 54. Attending NPI 56A. Attending Taxonomy. If no attending taxonomy, enter billing taxonomy 56. Service Facility address with zip+4 52A. If using the same form used for PA, cross through the MPN before submitting the claim.

© 2006 American Dental Association
 J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

To Reorder call 1-800-947-4748
 or go online at www.adacatalog.org

Billing Pharmacy Claims

DMA mandates that all providers use the online, real-time point-of-sale (POS) system to process pharmacy claims. Paper and modem claims are allowed only in certain instances.

The online POS system automatically performs eligibility verification, drug validation, pricing, and edits and audits followed by Pro-DUR before the pharmacy dispenses a prescription. Immediate assurance of the amount to be paid for the prescription reimbursement submitted through online claims is sent on the next Medicaid checkwrite.

POS reduces follow-up accounting for Medicaid claims by allowing for the correction of any errors before the recipient receives the prescription. Pharmacists receive all of the reject codes immediately when a claim is submitted through POS; other submission methods are limited to returning the first reject encountered. When billing POS, the following qualifiers are required to precede the values in the table below:

Qualifier	Definition
01	Represents the NPI
05	Represents the MPN
12	Represents the DEA

Where appropriate, a claim may be filed manually. The manual pharmacy claim form allows for billing 10 separate prescriptions within the same month of service. It may be used to bill for prescriptions dispensed to one recipient or for prescriptions dispensed to 10 different recipients.

Additional information on submitting Pharmacy claims can be found on DMA's website at <http://www.ncdhhs.gov/dma/pharmacy/>. Pharmacy newsletters are published monthly on DMA's website at <http://www.ncdhhs.gov/dma/pharmnews/>.

Medicare Crossover Claims

Professional Claims

Professional claims filed to Medicare as the primary payer should be crossed over automatically to Medicaid. In order for the crossover claim to process, the NPI on the Medicare claim must be on file for a North Carolina MPN. It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare.

Providers may verify that their NPI number is on file with Medicaid via the NPI and Address Database on DMA's website at <http://www.ncdhhs.gov/dma/WebNPI/default.htm> or by contacting HP Enterprise Services Provider Services at 1-800-688-6696 or 919-851-8888.

Note: Only one NPI can be reported for each MPN. If you have more than one NPI with Medicare but one MPN with Medicaid, you must choose the appropriate NPI to report to Medicaid.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at <http://wpc-edi.com> and the N.C. Medicaid HIPAA Companion Guide on DMA's website at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm> for instructions on completing the 837 professional transactions.

Claims that do not cross over, have been paid by Medicare and are included on the electronic submission exceptions list (<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>) can also be filed on a

CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached. If claims do not cross over, have been paid by Medicare, and are not included on the electronic submission exceptions list, the claims must be submitted electronically.

Institutional Claims

Not all Institutional claims filed to Medicare will cross over automatically to Medicaid. Following are examples and instructions for Institutional claims that will not cross over automatically to N.C. Medicaid. Refer also to **Reimbursement Guidelines** section and to **Medicare Health Maintenance Organization** section for additional information.

- Outpatient, bill type 13X, claims do not crossover to NC Medicaid. However, providers should file 837 institutional (837I) transactions completing the Coordination of Benefits (COB) loop. Refer to the implementation guide and the N.C. Medicaid HIPAA companion guide for instructions on completing the 837I.
- To submit claims when Medicare Part A or B has paid zero (i.e., 0.00), which results in the Medicare payment completely applied to the deductible and coinsurance, the claim must be submitted on paper with a Resolution Inquiry Form and a copy of the Medicare EOB. In the remarks field please note “Medicare zero paid claim – submit as a special batch.”
- To submit claims when Medicare's EOB describes a negative payment, submit the claim on paper with a Resolution Inquiry Form and a copy of the Medicare EOB. In the remarks field please note “Medicare negative paid claim – submit as a special batch.”
- Institutional claims that are denied by Medicare Part A or B for reasons other than eligibility can be overridden using the appropriate occurrence codes on an 837I.
- If Medicaid denies a claim for Medicare eligibility but Medicare was not in effect on the dates of service, submit a paper claim with a copy of the Common Working File (CWF) and a Resolution Inquiry Form to DMA Claims Analysis.
- Nursing Facility recipients still receiving partial month payments from Medicare Part A – the Medicare Part A claim must be submitted and processed prior to the submission of the Part B only claim.

Copayments

Services covered by **both** Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment.

Carolina ACCESS Primary Care Providers

Services covered by **both** Medicare and Medicaid are not subject to Carolina ACCESS PCP referral authorization. However, if Medicare denies the service and the provider submits the claim to Medicaid, the provider may be responsible for the Carolina ACCESS PCP referral.

Prior Approval

Medicaid does not require prior approval for Part B services that are covered by Medicare, except for those prescription drugs that are covered by Medicare Part B that require prior approval by Medicaid (see **Section 6, Prior Approval**). However, if Medicare does not cover a service and Medicaid requires prior approval, the provider must obtain prior approval.

Annual Visit Limitation

Services covered by **both** Medicare and Medicaid are not subject to the annual visit limit per state fiscal year (July 1 through June 30). However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be subject to the annual visit limitation.

Hysterectomy, Sterilization, and Abortion Consents/Statement

Medicaid does not require sterilization consent forms, hysterectomy statements or abortion statements in order to reimburse the Medicaid allowed amount for these procedures when the procedure is covered by **both** Medicare and Medicaid. However, if Medicare does not cover the procedure, Medicaid requires that the appropriate consent form/statement be submitted.

Durable Medical Equipment Span Dates

If a durable medical equipment claim is billed to Medicare with a span of dates, and the “to” date of service is in the future, providers must refile the claim to Medicaid after the “to” date of service on the claim has passed. Medicaid does not reimburse for future dates of service as Medicare does.

Optical Refractions

Since Medicare does not cover refractions, the service will be denied. Providers must follow Medicare guidelines when billing for a refraction. If the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copayment will be deducted for services not covered by Medicare unless the recipient qualifies for specific copayment exemptions.

Reimbursement Guidelines

Part B – Professional Claims (CMS-1500/837P) – Professional charges are reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B reimbursement schedule. The payment percentages are determined by the provider type and specialty. The payment percentages are available on DMA’s website at <http://www.ncdhhs.gov/dma/fee/> under “Medicaid Crossover Percentage Payment Schedule.” **Providers cannot bill the recipient for any remaining balance. Medicaid’s payment or non-payment is considered payment in full.**

Part B Only Inpatient – Institutional Claims (837I) – Institutional claims do not automatically cross over to Medicaid for payment. Once Medicare has adjudicated the claim, providers must file the claim with Medicaid as a secondary claim. Instructions for filing the claim as a secondary claim are as follows:

- FL4 – Indicate the proper bill type
- FL31 through 36a-b, code A3-C3 – Indicate that the Medicare Part A benefits are exhausted. Lifetime Reserve days must also be exhausted.
- FL50 – Indicate Medicare Part B as a payer.
- FL54 – Indicate the Medicare Part B payment. Do not include the contractual adjustment for the Medicare Part B payment.
- FL80 – Indicate that the patient has “No Medicare Part A benefits”.

Medicaid will process the claim by first calculating the Medicaid allowable as if Medicaid were primary. The Medicare payment is subtracted from the Medicaid allowable. The balance from the subtraction is compared to the patient liability and the lesser of the two amounts is paid.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. The payment (or nonpayment) must be accepted as payment in full.

Condition code D7 may be used to override Medicare Part A and condition code D9 may be used to override Medicare Part B when services are non-covered or services do not meet Medicare criteria. The date that benefits were exhausted must be entered. These codes should not be used to override Medicare eligibility. When a claim denial reports possible Medicare eligibility, please remit claim to DMA Clinical Policy with a copy of the common working file and a copy of the RA.

Professional or Dental Claim Denials for Non-covered Services

If a Professional or Dental claim is denied by Medicare as non-covered, providers may file the claim to Medicaid when the following conditions apply:

- The claim is submitted to Medicaid on paper, providers must submit a Medicaid Resolution Inquiry Form and attach a Medicare voucher indicating the Medicare EOB denial.
- The claim is submitted electronically through the 837 professional transaction (dental providers must file using the 837 dental transaction) refer to the instructions outlined for the PWK segment for the 2300 loop in the N.C. Medicaid HIPAA Companion Guide on DMA's website at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm>.
- The claim is submitted through the NCECSWeb Tool, providers must indicate that paper work related to the Medicare denial as a non-covered service is on file at the provider's site. This is done by selecting the "Yes" button for "Paperwork on file at Provider Site for Medicare Override?" in the Miscellaneous Claims portion of the NCECSWeb Tool.

Providers must not override Medicare when Medicare denies the service for lack of medical necessity.

Medicare Health Maintenance Organization

Medicare Health Maintenance Organization (HMO) billing instructions are different for professional and institutional claims. Reference the appropriate requirements for the applicable claim type.

Professional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill only the **cost share** amount shown on the **Medicare EOB. Medicaid liability is only for the Medicare HMO cost share.** When filing on the CMS-1500 claim form, the following blocks must be completed:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO cost share amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO cost share amount, the claim will be returned to the provider for correction.
- Block 29 should reflect third party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned back to the provider for correction.

HMO Example of CMS-1500 Claim Form Without Third Party Insurance, HMO EOB Attached:

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E.	F.		G.	H.	I.	J.	
	From	To	MM	DD	YY	MM												DD
1	01	01	09	01	01	09	11			99213				15 00	1		ZZ	25100000X
2																	NPI	1234567890
3																	NPI	
4																	NPI	
5																	NPI	
6																	NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <small>(For gov. claims, use back)</small>		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE						
		<input type="checkbox"/>				<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 15 00		\$		\$ 15 00						

All CMS-1500 claims for Medicare HMO should be submitted with the Medicaid Resolution Inquiry Form indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form, as well as the CMS-1500 claim form, **and Medicare HMO EOB** should be mailed to:

HP Enterprise Services
 PO Box 300009
 Raleigh, NC 27622

Institutional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare HMO. Medicaid liability is only for the Medicare HMO cost share.** The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, submit all of the pages of the EOB with the claim.
- All charges should be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by “rolling up” the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays, if applicable.
- FL47 – Indicate the total charges.
- FL 50 – Two digit payer code.
- FL54 – Indicate HMO payment

- FL55 – Indicate the cost share amount.

Note: The amounts listed in FL55 should reflect the Medicare HMO cost share amount only.

- FL56 – Enter your NPI
- FL57 – Enter your Medicaid Provider Number.
- FL80 – Write “This is a Medicare HMO claim”

HMO Example of UB-04 Claim Form, HMO EOB Attached

43 REV. CD.	43 DESCRIPTION	44 HOPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
11U			090109	1	500.00		
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME Medicare HMO Indicator MC		51 HEALTH PLAN ID 123456 123456789A	52 REL. INFO	53 AFF. SOL.	54 PRIOR PAYMENTS 100.00	55 EST. AMOUNT DUE 50.00	56 NPI 1234567890 57 OTHER PRV ID 123XXX 340XXXX
58 INSURED'S NAME		59 REL.	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
66 DX 67 A B C D E F G H I J K L M N O P Q R							
74 ADMIT DK	75 PATIENT REASON DK	76 PPS CODE	77 B3	78	79		
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE CODE	77 OTHER PROCEDURE CODE	78 ATTENDING NPI	79 CLM	80	81
74 DATE	75 DATE	76 DATE	77 DATE	78 LAST	79 FIRST	80	81
74	75	76	77	78 OPERATING NPI	79 CLM	80	81
74	75	76	77	78 LAST	79 FIRST	80	81
80 REMARKS This is a Medicare HMO		81C	82	83	84 OTHER NPI	85 CLM	86
		81C	82	83	84 LAST	85 FIRST	86
		81C	82	83	84 OTHER NPI	85 CLM	86
		81C	82	83	84 LAST	85 FIRST	86

The UB-04 claim form with the Medicare HMO EOB attached should be mailed to:

DMA/Third Party Recovery
 2508 Mail Service Center
 Raleigh, NC 27699-2508