

## **Summary of Changes**

The 12 sections that comprise the billing guide have been reordered. NC Health Choice was changed from section 12 to section 3. Please review the Table of Contents.

References to NC Health Choice throughout the guide were updated to Health Choice.

### **Section 1. Who's Who in Medicaid**

#### **What is Medicaid**

Medicaid is a “health insurance program” was renamed to Medicaid is a” health care program”.

The description of the roles and responsibilities of the Behavioral Health Unit within DMA Clinical Policy was updated.

#### **Health Information Technology (HIT)**

The Health Information Technology (HIT) team is responsible for overseeing the N.C. Medicaid Electronic Health Record (EHR) Incentive Program. The EHR Incentive Program is a 10-year program started in 2011 that was created by the Federal government as part of the American Recovery and Reinvestment Act of 2009. The goal of the program is to encourage eligible professionals and hospitals to adopt, implement, or upgrade to a certified EHR technology, and then to demonstrate meaningful use of that technology. This section was added to provide information about the roles and responsibilities of the Health Information Technology team.

#### **Medicaid Contractors**

The description of the roles and responsibilities for Public Consulting Group (PCG) was updated.

Ingenix – Health Spotlight, OmniAlert and DRIVE was changed to OptumInsight – Health Spotlight, OmniAlert and DRIVE

The description of the roles and responsibilities of CSC was updated.

#### **Behavioral Health Managed Care Organizations (MCO)**

Sandhills Center and Mountain LME were added to the list of Local Management Entities (LMEs) transitioning to DMA managed care vendors (MCOs) in the coming year (January 2011 through July 2012)

#### **Roche Diagnostics Corporation Diabetes Care**

Prodigy Diabetes Care LLC was deleted and Roche Diagnostics Corporation Diabetes Care was added. Roche Diagnostics Corporation Diabetes Care, has been designated by DMA to be N.C. Medicaid and NCHC ‘s preferred manufacturer for glucose meters, diabetic test strips, control solutions, lancets, and lancing devices.

## **Who's Who in Medicaid and NC Health Choice Prior Approval**

### **Value Options Inc.**

Removed the fax numbers listed for Value Options and added the webpage addresses for Medicaid and Health Choice.

## **Section 2. Recipient Eligibility**

### **Requesting an Exception**

The exception must be approved before the service is rendered. If a claim is submitted prior to receiving approval for an exception, and the claim is denied for exceeding the visit limit, providers may submit a Medicaid Claim Adjustment Form was rephrased.

“It will be returned to provider via address in the system (not necessarily the address on the form” was added to the third sentence in paragraph two.

### **Copayments**

When providers collect the copayment from a Medicaid recipient and the reimbursement amount reflected on your Remittance Advice is less than the copayment amount collected in advance, providers should credit the difference to the Medicaid recipient's account or reimburse the difference was added.

### **MHDDSAS Health Plan Waiver (1915 (b)/(c))**

Sandhills Center and Smoky Mountain LME were added to the list of Local Management Entities (LMEs) transitioning to DMA managed care vendors (MCOs).

## **Section 3. NC Health Choice Program (Title XXI State Children's Health Insurance Program)**

NC Health Choice Program was reordered from Section 12 to Section 3.

### **NC Health Choice Eligibility Determination**

This section was updated to clarify Health Choice recipients do not qualify for Medicaid, Medicare, Private Insurance or other federal government sponsored health insurance.

## NC Health Choice Secondary Insurance

Pursuant to N.C. GEN. STAT. §108A – 70.18(8): Health Choice *does not allow secondary insurance*. It is the recipient's duty to notify the Department of Social Services (DSS) prior to approval, and/or within 10 days of receipt of the other health insurance. The DSS, upon receipt of notice, shall disenroll the child from the Program.

“Uninsured” means the applicant for Program benefits is not covered under any private or employer – sponsored comprehensive health insurance plan on the date enrollment.

## Pharmacy

As of November 2011, both the Medicaid and Health Choice Programs have the same Preferred Drug List (PDL). Unlike Medicaid, the Health Choice Program cannot receive supplemental rebates. However, the Health Choice Program may enter into contracts with drug manufacturers who wish to voluntarily participate in a rebate program for Health Choice pharmacy transactions. Please go to <http://www.ncdhhs.gov/dma/pharmacy/index.htm> to access a current copy of the PDL.

Prior authorization is now required for certain drugs prescribed to North Carolina Medicaid and Health Choice recipients. For assistance in understanding the process required to obtain prior authorization providers can access NCHC Pharmacy PA at <http://www.ncmedicaidpbm.com/home.htm>.

## North Carolina Immunization Program/Vaccines for Children Program

Because of the availability of these vaccines for Medicaid children, Medicaid does not routinely reimburse for vaccines available from the NCIP/VFC program. Medicaid does, however, reimburse for the administration of these vaccines. CPT codes for vaccine products must always be included on the claim (**without the EP modifier**). Remember that some purchased vaccines require the SC modifier was deleted.

CPT codes for vaccine products must always be included on the claim (**without the EP modifier**) was added.

Prior approval is not required for allergy immunotherapy (allergy shot). No copay is required for office visits; however, copayment(s) may apply to covered prescription drugs and services was added.

## North Carolina Health Choice Optical Service

Health Choice provides a yearly routine eye exam. There is a \$5.00 co-pay for the exam visit (no copay for visual aids or for dispensing of prescriptions). Provider offices no longer routinely make glasses and contact lenses are no longer covered unless medically necessary. Medicaid/Health Choice PA forms must be mailed to HP for approval and Nash Optical will make the glasses. If medically justified, exception to this process can be made, refer to *Optical Services Manual* on the DMA's website <http://www.ncdhhs.gov/dmaservices/optical/> for information on services and limitations. Health Choice providers can still send paper claims. However, submitting claims electronically allows for faster turnaround of and greater accuracy in claims payment. If paper claims are necessary, mail PA

forms to HP:

HP Enterprise Services  
P.O. Box 322490  
Raleigh, NC 27622

## **NC Health Choice Behavioral Health**

The Division of Medical Assistance is working to align all Behavioral Health policies and service definitions for Health Choice recipients with Behavioral Health Medicaid policies. All requests for authorization submitted to ValueOptions on or after October 1, 2011, will use the Medicaid service criteria. **As a reminder, the EPSDT Special Provision and the Important Notes on EPDST documented in Medicaid clinical coverage policies do not apply to Health Choice.**

For outpatient treatment services, the count of unmanaged visits will be limited to 16. These visits are defined by the number of procedure codes paid for services rendered to the recipient and not by the individual units of service provided. The data system counts each procedure code as one visit with the exception of the following codes for group therapy: 90849, 90853, 90857, H0005, and H004 HQ. These five codes are counted as ½ visits for the unmanaged unit counts. When the recipient reaches the maximum number of unmanaged units, the following visits will be denied unless prior approval is obtained. Once prior approval is on file for the recipient, the system considers the unmanaged count as “used” for that calendar year, regardless of the amount of previous services provided.

## **Home and Community-based Health Care Services**

This new section was added to provide information about home and community-based health care Services. Health Choice requires prior approval (PA) for home health specialized therapies (OT/PT/ST). Home health visits are limited to 60 visits per fiscal year, but additional visits will be considered on an individual basis with prior approval. PA is provided by the Carolina Center for Medical Excellence (CCME).

## **Inpatient Services/ Long Term Care (LTC)**

This new section was added to provide information about inpatient services and long term care. Health Choice does not provide Inpatient/Long-term care services, this also excludes LTC under Private Duty Nursing, and Personal Care Services.

## **Transportation Services**

This section was added to provide information about transportation services. Health Choice recipients are ineligible for Non-emergency medical transportation. Prior approval is required for ambulance transportation via air or for in-state ground transportation over a distance greater than 50 miles.

## **Prenatal Care and Pre-Pregnancy Service and Supplies**

This section was added to provide information about prenatal care and pre-pregnancy service and supplies. Health Choice does not provide coverage for prenatal care and childbirth; however, pregnant recipients will be transitioned to the Medicaid for Pregnant Women program. For information, refer to the Medicaid Billing Guide Page 2-7.

## **Out of Country Service**

*North Carolina Health Choice does not provide Out of Country services.* This new section was added to provide information about out of county services.

## **Recipient Eligibility Verification Tool**

The updated December 2011 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide* was referenced.

## **Automated Voice Response System**

NC Health Choice eligibility can be verified using the Automated Voice Response (AVR) system sentenced was revised.

Health Choice Provider Courtesy Review (PCR) Process was removed.

## **N.C. Health Choice Recipient Review Requests**

In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Health Choice recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review “process: an internal first level review and an external second level review was added.

## **Health Choice Recipient Review Requests**

Recipients have the right to request an internal first level review of the decision with the Department followed by an external second level review with the DHHS Hearing Office was deleted.

## **Requesting a Recipient Review Requests Process**

Recipients and/or legal guardians or authorized representatives may submit completed request forms for an internal first level review or external second level review was added.

## **Internal First Level Review**

This section was updated to provide information regarding the recipient and/or legal guardian or authorized representative right to a first level review.

## **External Second Level Review**

This section was updated to provide information regarding the recipient and/or legal guardian or authorized representative right to a external second level review.

## **Section 4. Medicaid Provider Information**

Medicaid Provider Information was changed from section 3 to section 4.

Removed all instances where the actual \$500 + dollar amount was given.

The entire section 4 was updated to reflect CSC's processes.

### **Enrollment Application**

The department was identified as the Division of Medical Assistance.

This section was updated to reflect current enrollment application procedures.

### **In Addition to the Enrollment Application**

The first paragraph was rephrased.

### **Provider Enrollment and Re-enrollment Fee**

Replaced "Session Law 2009-451" with "Session Law 2011-145".

## **Licensure, Accreditation, Endorsement and Certification**

This section was updated.

### **Re-credentialing Requirements**

Re-verification was removed from the subtitle.

This section was updated to reflect the re-credentialing requirements.

## **Section 5. National Provider Identifier**

National Provider Identifier changed from section 4 to section 5.

### **NPI and Claim Submission Guidelines**

**North Carolina Electronic Claims Submission Web Tool (NCECSWeb Tool) Users:** Refer to the December 2011 Special Bulletin *NCECSWeb Instruction Guide* was updated.

### **NPI and Carolina ACCESS**

Add the word "NOTE:" to "The taxonomy code for the referring..."

## **NPI- Frequently Asked Questions**

Updated question # 14.

## **Section 6. Program Benefits Management at DMA**

Community Care of North Carolina/Carolina ACCESS Provider Information has been renamed to Program Benefits Management at DMA.

Information was added to this section to provide information about the management of behavioral health services, pharmacy benefits, radiological benefits and community based services.

### **Community Care of North Carolina/Carolina ACCESS**

Removed the CCNC Initiatives implemented in 2010 section.

### **Recipient Enrollment in CCNC/CA**

This section was renamed to Recipient Enrollment in CCNC/CA.

The Mandatory and Optional tables that identifies the recipients enrollment by program aid was updated.

#### **Enrollment at the participating practice:**

The third and fourth bullets were updated.

### **Recipient Education**

Replaced “strongly encouraged” with “expected”.

### **Provider Participation in CCNC/CA**

This section was renamed to Provider Participation in CCNC/CA.

Replaced “a specific service or test” with “one or more of the preventive and ancillary services listed on the application”.

### **Medical Records Guidelines**

This section was updated. See **Section 4, Medicaid Provider Information**, for medical records standards that apply to all providers

### **Services Exempt From CCNC/CA Authorization**

This section was renamed to Services Exempt From CCNC/CA Authorization

## List of Regional DMA CCNC/CA Consultants

The list of regional DMA CCNC/CA consultants was removed.

## Section 7. Prior Approval

Prior Approval was changed from section 6 to section 7.

### Important Points about Prior Approval

Emergent admissions for inpatient psychiatric services was updated.

Number 10 was updated to “Providers should supplement the information requested on prior approval forms and plan of care forms with other recent clinical information (if needed) in order to document medical necessity.”

Added NC Health Choice to the ACS PA section under Prescription Drugs.

## Quick Reference Table – Prior Approval for Certain Medicaid Services

Inserted table - Dental and Orthodontic Services.

If transport needs is emergent, contact HP Enterprise Services 72 hours (three business days) following provision of service was added.

### General Requests for Prior Approval

See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must be requested again at least 10 calendar days **PRIOR** to the end of the current authorization period in order for services to continue without interruption. Requests for CAP, inpatient or emergent services are not subject to this 10 calendar day requirement. Requests for prior approval for these services must be submitted in accordance with the applicable Clinical Coverage Policy or CAP Manual.

For additional information about prior approval, refer to the websites specified below. <http://www.ncdhhs.gov/dma/provider/priorapproval.htm>  
<http://www.ncdhhs.gov/dma/provider/URVendorInstruct.pdf>

## Section 8. Third-Party Insurance

Third-Party Insurance was changed from section 7 to section 8.

## Noncompliance Denials – Commercial Health Insurance and Medicare

Common noncompliance denials include failure to get a referral from a participating primary care provider (PCP), failure to go to a participating provider, failure to obtain a second opinion, and failure to obtain prior approval was deleted from last paragraph

## **Third-Party Liability – Frequently Asked Questions**

**Why was my claim denied for EOB 094, “Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance denial required submit with claim on provider inquiry form?”** was deleted and added after EOB 94.

## **Estate Recovery**

Estate Recovery was added.

Estate recovery is a federally mandated program, in which the assets of deceased Medicaid members are used to reimburse the taxpayers for long term care provided through Medicaid. Funds are recovered from the member’s estate after his/her death to cover the cost of these services.

NC General Statute 108A-70.5 gives the state subrogation rights to collect reimbursement from a member’s estate. Estate included all real and personal property held individually or jointly.

## **Section 9. Electronic Commerce Services**

Electronic Commerce Services was changed from section 8 to section 9.

## **Available Transactions**

Updated NCPDP D.0 reference

## **HIPAA 5010 Implementation**

On January 16, 2009, the US Department of Health and Human Services (DHHS) published two final rules in the Federal Register related to HIPAA which became effective on March 17, 2009. One was to adopt ASC X12 version 5010 and NCPDP version D.0. for HIPAA covered electronic transactions. The other rule was to adopt ICD-10-CM for diagnosis reporting and ICD-10-PCS for inpatient procedures. The compliance date for the implementation of ASC X12 5010 and NCPDP D.0. transactions was January 1, 2012. On November 17, 2011, DHHS’ Office of E-Health Standards and Services (OEHS) announced a 90 day discretionary enforcement period of compliance with 5010 and NCPDP D.0. This announcement clearly stated that the compliance date was still January 1, 2012. Given this OEHS notice, the North Carolina Division of Medical Assistance (DMA) decided to continue with the dual processing of 4010A1 and 5010 837 transactions ONLY until March 31, 2012. The ASC X12 4010A1 and 5010 834 and 820 transactions are being processed in dual mode ONLY for the month of January, 2012. The remaining HIPAA covered ASC X12 4010A1 transactions and NCPDP 5.1 transactions are no longer being accepted as of January 4, 2012, after business hours. During this extended dual processing period for 4010A1 837 transactions, a new MMIS+ edit has been implemented with effective date February 10, 2012. This edit suspends adjudication of all claims submitted in the ASC X12 4010A1 format for a two week period and then based on the checkwrite schedule final adjudication will be reported. Providers

who continue to submit 4010A1 837 transactions after the January 1, 2012 date are required to submit a transition plan documenting their plan to reach 5010 compliance by the March 31, 2012 date.

## **Electronic Funds Transfer – Frequently Asked Questions**

Remove the word “chosen” from question # 1.

Added “official bank letter” and specified “billing” provider in question # 2.

Corrected address in question # 3.

Inserted “the day after” to question # 4.

Inserted EFT # to question # 5.

Deleted “Providers may fax questions to the HP Enterprise Services Finance unit at 919-816-3186, Attn: Finance – EFT. Providers may e-mail questions to NCXIXEFT@hp.com from question # 8.

## **Section 10. Submitting Claims to Medicaid**

Submitting Claims to Medicaid was changed from section 9 to section 10.

### **Additional Correct Coding Edits Implementation**

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) was removed due to duplicate wording.

### **Processing Paper Claims without a Signature**

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 was removed.

### **National Drug Code**

Referenced the updated bulletin for NDC requirements in the **January 2012 Special Bulletin, *National Drug Code Implementation, Phase III***

### **Billing Pharmacy Claims**

Removed “modem” from the first paragraph

## Payment for Provider Preventable Conditions

Payment for Provider Preventable Conditions was added.

## Providers Needing to Report Never Events and Bill Type Requirements

Effective January 1, 2011 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Never Events (NE), Other Provider Preventable Conditions (OPPC) and Additional Other Provider-Preventable Conditions (AOPPC).

In accordance with N.C. State Plan, Attachment 3.1-A, Page 4, Hospital Services payments are allowed except for the following conditions outlined below:

- NEs are defined by the National Coverage Determination (NCD) manual for Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Outpatient Hospital claims must bill a separate claim as a Bill Type 130 or as designated by the National Uniform Bill Committee for a non-payment/zero claim.
- ASCs and their practitioners are included in the category of OPPC claims. NEs for ASCs and practitioners are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s).

PA: Surgery Wrong Body Part

PB: Surgery Wrong Patient

PC: Wrong Surgery on Patient

Practitioners are defined in Attachment 4.19-B, Section 5, Section 6, and Section 17.

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for NEs, OPPCs, and AOPPCs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions contained in 4.19B.

For more in-depth reporting instructions please refer to the April 2011 Medicaid Bulletin on Never Events and Hospital Acquired Conditions at: <http://www.ncdhhs.gov/dma/bulletin/0411bulletin.htm#never> .

## Present on Admission (POA) vs Healthcare Acquired Conditions (HCAC) and Never Events (NE)

Effective January 1, 2011 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903, and 42 CERs 434, 438, and 447, Medicaid will make no payment to providers for services related to PPCs which includes HCACs and NEs.

In accordance with N.C. State Plan, Attachment 3.1-A, Page 1, Hospital Services payments are allowed except for the following conditions outlined below:

## POA and HCAC Reporting

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges. Peer Review Organization (PRO) review for POA is not required.

PPCs, which includes HCAC, with diagnosis codes designated with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnosis codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. PPCs will not be approved by the PRO. Providers must identify and report PPC occurrences.

## Never Event Reporting

NEs are defined by the NCD manual for inpatient Hospitals and practitioners, and these providers will be required to report NEs. NEs for Inpatient Hospital claims will bill separate claims using Bill Type 110 or as designated by the National Uniform Bill Committee for a non-payment/zero claim. The non-covered Bill Type 110 must have one of the ICD-9 diagnosis codes.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for PPCs, HCACs and NEs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

For more in-depth reporting instructions, please refer to the April 2011 Medicaid Bulletin on Never Events and Hospital Acquired Conditions at:

<http://www.ncdhhs.gov/dma/bulletin/0411bulletin.htm#never>.

## Institutional Claims

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, 2501 Mail Services Center, Raleigh NC 27699-2501. In the remarks field provider needs to note “Patient is not eligible on date of service” was updated

## Medicare Health Maintenance Organization

Medicaid liability is only for the Medicare HMO cost share, which includes copayment, coinsurance, and/or deductible was added.

## Section 11. Remittance and Status Report

Remittance and Status Report was changed from section 10 to section 11.

## **Section 12. Resolving Denied Claims**

Resolving Denied Claims was changed from section 11 to section 12.

“Unit dose” was removed from this section.

### **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 was added.

### **Resubmission of a Denied Claim**

Resubmission of a denied claim was updated in this section.

### **Instructions for Completing the Medicaid Claim Adjustment Request Form**

Instructions for completing the Medicaid claim adjustment request form was updated.

### **Tips for Filing Adjustments**

Sending an 835 instead of the NC Medicaid RA was added.

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 was added.

### **EOB Denials That Do Not Require Filing an Adjustment**

Entire section was removed

### **CCI Denials for EOB 9988**

This section was updated to reflect the correct CMS website address (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Nation-Correct-Coding-Initiative.html>) for providers to determine if denied claims can be resubmitted to N.C. Medicaid for reconsideration.

### **MUE Denials for EOB 9953**

This section was added to reflect the correct CMS website address for providers to determine if denied claims can be resubmitted to N.C. Medicaid for reconsideration.

## **Submitting Refunds with a Remittance and Status Report**

Zip code was corrected .

## **Submitting Refunds with the Medicaid Provider Refund Form**

Zip code was corrected .

## **Appendix A**

No changes were made to this section

## **Appendix B**

No changes were made to this section

## **Appendix C**

No changes were made to this section

## **Appendix D**

List of HP Enterprise Services Provider Services Representatives and areas updated.

## **Appendix E**

### **List of Abbreviations and Acronyms**

Functional Acknowledgment Electronic Transactions (ASC X12 999) was added.

## **Appendix F**

### **Batch Eligibility Verification (270/271 Transaction)**

Providers that bill HIPAA-compliant transactions directly to N.C. Medicaid are required to complete and submit a Trading Partner Agreement (TPA) to HP Enterprise Services. The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. ECS will work with the trading partner's staff to exchange and analyze technical information. The TPA Form is available on DMA's website at <http://www.ncdhhs.gov/dma/hipaa/>.

## **Recipient Eligibility Verification Tool**

Reference to the December 2011 Special Bulletin, *North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide* was added.