

Provider Frequently Asked Questions for North Carolina Health Choice (NCHC) Changes to the Medicaid Benchmark Benefit Plan

1. What are the major exceptions to the NCHC transition to benefits coverage equivalent to Medicaid?

- No long-term care
- No non-emergency medical transportation
- No Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (but well-child visits and immunizations)
- Dental services provided on a restricted basis
- No screening for and special provision for children with special health care needs (absorbed into Medicaid Benchmark).

2. What are the administrative changes that will take place?

- New claims processing contracts (effective Oct. 1, 2011).
- Six-month run-out period contract amendment with BCBS (effective Oct. 1, 2011).
- Clinical coverage policies are being adopted, amended or terminated as the program transitions to provide Medicaid-equivalent coverage.
- Working with the Attorney General's Office to develop Health Choice rules for the NC Administrative Code.
- Revising NCHC ID cards and Recipient Handbook.
- Creating a Health Choice-specific Medicaid Billing Guide section 12.
- Training DMA staff and outreach contractors about Health Choice Program transitions, policies, and procedures.

3. What new claims processing changes will be in contracts?

- Effective with dates of service on and after Oct. 1, 2011, medical and pharmacy claims will be processed by DMA's fiscal agent, HP Enterprise Services.
- Providers must file all claims for dates of service on or before Sept. 30, 2011, with BCBS by Feb. 29, 2012.

- Any provider who is not currently a Medicaid-enrolled provider and wants to provide care to NCHC recipients must complete the Medicaid Provider enrollment application at www.nctracks.nc.gov. CSC, DMA's enrollment, verification and credentialing vendor, is available at 866-844-1113 to assist providers who want to enroll in NC Medicaid.

4. What changes can providers expect in the Remittance Reports (RA)?

- For claims which have been processed by the MMIS+, the Provider will receive a RA on which both Medicaid and SCHIP claims are displayed. SCHIP and Medicaid claims will be identified by the "SCHIP" or "NCXIX" payer which is displayed on the RA.
- Also, the provider will receive only one electronic payment. The provider will NOT receive a separate electronic payment - one for Health Choice and one for Medicaid claims.

5. What is the run-out period with Blue Cross & Blue Shield to process claims and issues for NCHC?

- DMA's contract with BCBS as fiscal agent will end as of Sept. 30, 2011. The run-out period is a contract amendment so BCBS can provide claims processing services from Oct. 1, 2011 to March 31, 2012.
- Providers must file claims for DOS on or before Sept. 30, 2011, will send those to BCBS.
- Prior authorizations for dates of service on or after Oct. 1, 2011, must be requested through the new vendor, HP Enterprise Services.
- Prior authorizations for dates of service beginning prior to Sept. 30, 2011, however ending on or after Oct. 1, 2011, must be split and submitted to both vendors (BCBS for dates of service on or before Sept. 30 only).

6. Is the Medicaid Billing Guide being revised to reflect program changes?

The fall 2011 *Basic Medicaid Billing Guide* update will include a new section 12 specific to Health Choice. It will cover:

- Health Choice Program Overview
- Eligibility Determination
- When Eligibility Begins
- Eligibility Disqualifications
- Eligibility Categories
- Recipient Co-Payments
- Managed Care / CCNC
- Identification Cards
- Prior Approval Policies and Procedures
- Provider Courtesy Review Policies and Procedures
- Recipient Review Requests Policies and Procedures

7. Will NCHC recipients receive revised ID cards or a new Handbook?

- NCHC recipients will get new ID cards effective Oct. 1, 2011. Current recipients will receive new cards in September.
 - Cards will include assigned PCP name and contact information.
 - Recipient IDs will be Medicaid ID numbers; no more BCBS ID numbers.
 - ID card is *not* proof of eligibility; provider must verify.
- New joint Medicaid-NCHC Handbooks to be distributed in October. Handbooks will reflect benefits/program changes.

8. Why are the co-payments changing?

The co-payment changes were legislated by the North Carolina General Assembly. Not all families will have a change in their co-payment amount. Families should review their child's current NCHC ID card and the notice they received in the mail to determine if the co-payment changes apply to them.

9. Who should I contact with questions about the co-payment changes?

For questions about any changes to co-payments, contact the DHHS Customer Care Service Center at 1-800-662-7030.

10. Will providers know about the new co-payment amounts?

NCHC providers have been notified of the changes in co-payments effective in the September Medicaid Bulletin. However, it is important that families take their child's current NCHC ID card along with any notices they received, so that the provider knows what co-payments apply to them.

11. How will override procedures work for NCHC in the CCNC/CA?

- Overrides will mirror the policy and procedures for Medicaid recipients enrolled in CCNC/CA.
- That means an override request for past dates of service (after 10/1) should be submitted to HP on the override request form that is posted on the web.
- Overrides are usually granted when a course of treatment was begun before enrolling in CCNC/CA, but it is not an automatic override and each situation is reviewed separately.
- Continuity of care is important. For current or future dates of service, the provider contacts DMA override coordinator to request the override.
- A provider requesting an override must contact the PCP for authorization before an override will be approved (unless this is the first time for enrollment of course).
- Most PCPs are already enrolled in Medicaid and in CCNC so these situations would probably be few.
- If a child is not established with their PCP within the first 3 months of enrollment, an override will be granted.
- If the child is not established during that time period the request will be reviewed on an individual basis.

12. What has changed in the NCHC optical coverage?

- NCHC covers a routine eye exam once every 12 months.

13. When can a NCHC child get eyeglasses?

- NCHC covers eyeglasses (frame and lenses) once every 12 months.
- NCHC covers medically necessary contact lenses and back-up eyeglasses once every 12 months.

14. Who should families contact with any questions about a child's eligibility?

Families should call their county DSS caseworker or the DHHS Customer Service Center at 1-800-662-7030.

15. What are some resources we can refer recipient and providers to for assistance with NCHC issues:

○ **Clinical Coverage Policies**

<http://www.ncdhhs.gov/dma/hcmp/index.htm>

○ **What's New in DMA**

For updates on transition changes and enrollment information

<http://www.ncdhhs.gov/dma/provider/index.htm>

○ **NC Healthy Start Foundation**

For NCHC application and eligibility information

www.NCHealthyStart.org

○ **Fee Schedules**

What NCHC pays

<http://www.ncdhhs.gov/dma/fee/index.htm>

○ **Children with Special Health Care Needs Help Line**

For information on children with severe disabilities and needs
1-800-737-3028

○ **Health Choice Review Request and authorization Representative Forms**

<http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm>

○ **Basic Medicaid Billing Guide**

<http://www.ncdhhs.gov/dma/basicmed/>

○ **2011 Health Choice Handbook ("A Consumer's Guide to NC Health Care Coverage Programs for Families and Children")**

<http://www.ncdhhs.gov/dma/healthchoice/NCHChandbook2011.pdf>

○ **DMA What's New on the DMA Website**

For updates and the latest changes within Medicaid and NCHC

<http://www.ncdhhs.gov/dma>