NC Medicaid

Fact Sheet
Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1

Claims Submission Guidelines and Resources

As the North Carolina Medicaid program transitions to Medicaid Managed Care, it is critical that we ensure that providers are well-informed about the changes to claims submission in order to be reimbursed in a timely manner.

This fact sheet contains references to resources each Prepaid Health Plan (PHP) has created to inform both in-network and out-of-network providers about their claims submission process and their billing guidelines, and also includes details on where providers should route their claims.

WHERE SHOULD A PROVIDER SEND CLAIMS?

If there are claims for dates of service prior to July 1, 2021, claims should be submitted as they are today, through NCTracks or local management entities/managed care organizations (LME/MCOs).

For dates of service beginning July 1, 2021, claims routing depends on a beneficiary's enrollment at time of service and the service provided. Claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks. Claims for members enrolled in Medicaid Managed Care should be submitted to the assigned health plan as shown on their member ID card and validated through the NCTracks Recipient Eligibility Verification methods outlined below, unless the service provided is a carved-out service.

Recipient Eligibility Verification

There are two methods of Recipient Eligibility Verification available via the NCTracks Secure Provider Portal: Real Time Eligibility Verification and Batch Eligibility Verification. As a reminder, these methods can be used for ***current*** eligibility information – future eligibility information is not available at this time.

1. Real Time Eligibility Verification Method
    a. Log into the NCTracks Provider Portal
    b. Follow the Eligibility > Inquiry navigation
    c. Populate the requested provider, recipient, and time-period information
2. Batch Eligibility Verification Method
    a. Log into the NCTracks Provider Portal
    b. Follow the Eligibility > Batch verify
    c. Upload the file by selecting browse > load from file

Additional information is included in the NCTracks Learning Management System (SkillPort) under the Provider Training Folder, CBTs, Recipient, RCP 131 Viewing Recipient Information Eligibility Providers.

Carved Out Services

NCDHHS has defined services that will be carved out of Medicaid Managed Care and should continue to be billed through NCTracks. The services are defined on the table below.

First Revisted and Restated Section V.C. Table 2: Services Carved Out of Medicaid Managed Care[10]
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

HOW SHOULD AN IN-NETWORK PROVIDER SUBMIT CLAIMS TO A HEALTH PLAN?

Medicaid and NC Health Choice beneficiairy assignment determines claims submission process. Claims for beneficiaries enrolled with a health plan should be submitted to the assigned health plan. Please refer to the resources linked below for detailed information about claims submission and billing information for each health plan.

- **AmeriHealth Caritas of North Carolina:**
  https://www.amerihealthcaritasnc.com/provider/forms/index.aspx
- **Blue Cross and Blue Shield of North Carolina | Healthy Blue:**
  https://provider.healthybluenc.com/north-carolina-provider/resources
- **Carolina Complete Health: Complete Health**
  https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf
- **United Healthcare:**
  https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/NC-UHCCP-Care-Provider-Manual.pdf
- **WellCare of North Carolina:**
  https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims
- **DHHS:**
  https://medicaid.ncdhhs.gov/providers/claims-and-billing

HOW SHOULD AN OUT OF NETWORK PROVIDER SUBMIT CLAIMS TO A HEALTH PLAN?

Out-of-Network Providers will file services covered under Medicaid Managed Care directly with the health plan. Out-of-Network providers are required to get a prior authorization from the assigned health plan before providing services and may need to complete a single case agreement to receive payment. If the provider has engaged in good faith negotiations with the health plan but failed to contract, the out-of-network provider will be paid at 90% reimbursement. If the health plan has not yet engaged in good faith negotiations, the provider would be reimbursed at 100%. Please refer to the appropriate health plan provider directories and websites linked above for additional details.

HOW WILL PRIOR AUTHORIZATIONS WORK?

For standard authorization decisions, the PHP will provide notice as expeditiously as the member's condition requires and no later than 14 calendar days after the receipt of the request of services. However, the PHP may receive a possible extension of up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest.

If the PHP extends the timeframe beyond 14 days, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

HOW DO EXPEDITED AUTHORIZATION REVIEWS WORK?

For expedited authorization decisions, the PHP will provide notice no later than 72 hours after receipt of the request for service. The PHP may extend the 72-hour time period by up to 14 days if the member requests the extension or if the PHP justifies a need for additional information and how the extension is in the member's interest. If the PHP extends the timeframe beyond 72 hours, the PHP will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

WHAT IF I HAVE QUESTIONS?

For general inquiries and complaints regarding health plans, NC Medicaid has created a **Provider Ombudsman** to represent the interests of the provider community. The Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 866-304-7062. The Provider Ombudsman contact information is also published in each Health Plan's Provider Manual.

For questions related to your NCTracks provider information, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into NCTracks (https://www.nctracks.nc.gov) Secure Provider Portal and utilize the Managed Change Request (MCR) to review and submit changes.

For questions related to member eligibility, please call the NCTracks Call Center for more information: 800-688-6696.

For all other questions, please contact the NC Medicaid Help Center at 888-245-0179 or email at Medicaid.HelpCenter@dhhs.nc.gov.

Fact Sheets will be updated periodically with new information. Updated June 2021.For more information, please visit https://www.ncdhhs.gov/assistance/medicaid-transformation