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Third-Party Liability

Third-Party Liability – Commercial Health Insurance and Medicare – Medicaid Payment Guidelines for Third-Party Coverage

Medicaid is the “payer of last resort” by federal law. This means that all third-party insurance carriers, including Medicare and private health insurance carriers, must process a claim before Medicaid processes a claim. Additionally, providers must report payment or denial details from third party carriers on claims filed for Medicaid payment.

NC Medicaid utilizes various contractors to perform multiple audits and recoveries to ensure that Medicaid is the payer of last resort.

NC Provider Health Insurance Information Referral Form (2057)

Providers are required to submit the **NC Provider Health Insurance Information Referral Form (2057)** when they have been notified that the beneficiary has other insurance, including Medicare or private insurance coverage. The form may also be used to update or add policy information. The [online form](#) is the most efficient way to request that a beneficiary’s policy information is updated in a timely manner. Once the form has been submitted the beneficiary’s information will be updated within 48 hours.

The following criteria are necessary to verify and update the beneficiary’s coverage:

- Medicaid identification number
- Social Security Number
- Policy begin and end date
- Group number
- Insured first and last name
- Employer’s name
- Employer’s address
- Reason for the referral
 - The beneficiary’s Medicaid eligibility file does not list the policy above
 - Beneficiary has never been covered by the policy
 - Beneficiary’s coverage ended (date)
 - Policy lapsed (date)
 - Carrier has changed; new carrier is _____
 - Other

Failure to include the necessary information listed above could result in incorrect billing.

The referral form is available at the following site;

- <https://medicaid.ncdhhs.gov/providers/forms/third-party-insurance-forms>

Determining Third-Party Liability – Commercial Health Insurance and Medicare

The following information helps providers determine if a Medicaid beneficiary has third-party liability insurance:

1. Check the beneficiary's eligibility for third-party insurance information. Refer to NCMMS Provider Claims and Billing Assistance Guide. Review *Verifying Beneficiary Eligibility* Section 10 for additional information on verifying eligibility and checking for third-party insurance. The billing assistance guide is available at:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>
2. Before rendering service, providers should ask the beneficiary if she or he has any additional health insurance coverage or third-party liability (TPL), including Medicare. If the health insurance is indicated on the beneficiary's record in NCTracks, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive the primary carrier's explanation of benefits (EOB) with details regarding the claims payment or denial.
3. Check the Remittance and Status Report (RA). When a Medicaid claim is denied for other insurance coverage (Explanation of Benefits [EOB] 00094), the provider's RA will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number.

If the insurance company or other third-party payer has terminated coverage, the provider should submit an electronic request for updates to a beneficiary's commercial insurance information using the previously mentioned 2057 form.

The TPL contractor for NC Medicaid researches third-party insurance information. Electronic requests will be reviewed and updated if necessary, within 48 hours, and providers may submit claims as soon as the provider receives a confirmation email from the TPL contractor.

A provider's role in the TPL process begins as soon as the provider agrees to treat a Medicaid or NC Health Choice patient. Providers should ask every patient and/ or the patient's responsible party about the existence of other insurance coverage. It is both the patient's responsibility as well as the provider to update NC Medicaid with any changes.

Claims are paid using the "lesser-of" logic which means if the service is covered by Medicaid and Medicare (or a primary health insurance carrier) then Medicaid would pay the lesser of either the Medicare or the other insurance carrier's calculated cost-share or the difference between the amount paid by the other insurance carrier and the Medicaid state plan rate.

Contracted Fee-for-Service Payments – Commercial Health Insurance

The Medicaid program makes payments to enrolled providers on behalf of eligible beneficiaries for covered medical services rendered, but Medicaid is not an "insurer." Per the NC State Plan Amendment participation in the Medicaid program shall be limited to providers who accept the amount paid in

accordance with this plan as payment in full for services rendered to Medicaid recipients. Medicaid is not responsible for any amount for which the beneficiary is not responsible.

Refunds to Medicaid – Commercial Health Insurance and Medicare

When a provider does not learn of other insurance coverage or Medicare entitlement for a beneficiary until after receipt of Medicaid payment, the provider should take the following steps for payment reconciliation.

For commercial health insurance:

1. File a claim with the health insurance company.
2. Upon receipt of payment from the insurance carrier
 - a. Submit an adjusted (void or replacement) claim to NCTracks within 180 days of the insurance carriers EOB posted date.
 - b. Complete the **NC Tracks Provider Refund Form** if it has been more than 180 days from the insurance carriers EOB posted date. The form is available at :
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>
3. If using the **NCTracks Provider Refund Form**, it must contain complete information before mailing with a refund check to the Refund lock box address provided below.

For Medicare:

1. File a claim with Medicare Administrative Contractor.
2. Upon receipt of payment from Medicare:
 - a. Submit an adjusted (void or replacement) claim to NCTracks within 180 days of the insurance carriers EOB posted date.
 - b. Complete the **NC Tracks Provider Refund Form** if it has been more than 180 days from the insurance carriers EOB posted date. The form is available at:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>
3. If using the **NCTracks Provider Refund Form**, it must contain complete information before mailing with a refund check to the Refund lock box address provided below.

Unless NC Medicaid gives specific written instructions for a TPL refund, routine claim adjustment and refund checks should be sent to:

Misc. Medicaid Payments
PO Box 602885
Charlotte, NC 28260-2885

Medicare and Third-Party Liability Overrides

The time allowed to file a Medicare or Third-Party commercial insurance (including a Medicare Part C

Advantage Plan insurer) request claim to Medicaid is 180 days from the Medicare or other Third-party Explanation of Benefits (EOB) posted date, regardless of the service date on the claim and regardless of whether the claim was paid or denied. The section of the Medicare or other Third-party EOB showing the Claim Action Reason Codes (CARC) details must be submitted with the request. When a Medicare claim is denied because the service/procedure is non-covered then a Medicare override can be requested. Providing all of the “other payer” information, including the CARC details, on your electronic claim (See Job Aid How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions) can provide this same override function in a more efficient manner than the paper form. Override requests for the denial of a covered Medicare or other Third-Party service are not acceptable and should be corrected and resubmitted to Medicare.

Time Limit Overrides

All Medicaid claims (except hospital inpatient and nursing facility claims) must be received by NCTracks 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 **last** Remittance Advice (RA) date to refile a claim.

Requests for overrides must document that the original was submitted within the 365-day time limit. If the claim meets the 365-day time limit filing requirement, then it can be resubmitted as a new day claim (no override required) if all the following data is an exact match:

- Beneficiary/Recipient Identification Number (RID)
- National Provider Identifier (NPI)
- Service Dates
- Total Billed Amount

Claims that do not have an exact match to the original claim in the system will be denied and one of the following EOB Codes will be displayed:

EOB Code	EOB Code Description
00018	Claim denied. No history to justify time limit override.
01738	Original transaction for rebill/reversal not posted as an NCPDP transaction
05103	Override request for timely filing is missing documentation

When a claim is denied due to not having an exact match, if the time limit requirements have been met then the claim can be resubmitted via the NCTracks Secure Provider Portal or on paper. The NCTracks Provider Portal will accept claims submission and appropriate documentation with a time limit override request indicated in the Delay Reason field. The Delay Reason Codes currently accepted in NCTracks are

third-party processing delay (#7) and the original claim was rejected or denied due to a reason unrelated to the billing limitation rules (#9).

Note: Effective February 5, 2017, the Medicaid Resolution Inquiry Form is no longer required if the claim requiring the time limit override is submitted electronically through the NCTracks Provider Portal or through a batch X12 transaction. For additional information, please read the [NCTracks Medicaid Resolution Inquiry Form No Longer Required for Time Limit Overrides Announcement](#) posted 02/03/2017.

The Division of Health Benefits (DHB) and NCTracks must adhere to all federal regulations to override the billing time limit; therefore, requests for time limit overrides must document that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DHB or GDIT about the specific claim received that is within 365 days of the date of service.
- An explanation of Medicare or other Third-Party insurance benefits dated within 180 days from the date of Medicare service 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 within the 365-day time limit.

If the claim is a crossover from Medicare or another third-party commercial insurance (including a Medicare Part C Advantage Plan insurer), regardless of the date of service on the claim, the provider has 180 days from the EOB date from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. The claim should be submitted electronically and a copy of the third-party or Medicare EOB can be uploaded as an attachment through the Provider Portal.

Note: For additional information, please refer to one of the following documents:

- Participant User Guide – “Submitting a Time Limit Override Request Using NCTracks page 33; <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>
- Participant User Guide – “Submitting Payments from Other Payers” page 39 <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

Credit Balance - Quarterly Reporting

All providers participating in the Medicaid program are required to submit a quarterly Credit Balance Report to the NC Medicaid Third-Party Recovery Section indicating balances due to Medicaid. Providers must report any outstanding credits owed to Medicaid that have not been reported previously on a

Credit Balance Report. However, hospital and skilled level nursing facility providers are required to submit a report every calendar quarter even if there are no credit balances. The report must be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30 and December 31).

The Medicaid Credit Balance Report is used to monitor and recover “credit balances” owed to the Medicaid Program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance carrier, by Medicare and Medicaid, by Medicaid and a liability insurance policy), if the patient liability was not reported in the billing process, or if computer billing errors occur.

For the purpose of completing the report, a Credit Balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim, it is reflected in the provider’s accounting records (patient accounts receivable) as a “credit.” However, a Credit Balance includes money due to Medicaid regardless of its classification in a provider’s accounting records.

If a provider maintains a Credit Balance account for a certain period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of liability to the Medicaid program. The provider is responsible for identifying and repaying all money owed to Medicaid.

The Credit Balance Reporting process is an electronic process. Health Management Systems (HMS) has completed the development of the Self-Disclosure Portal in its eCenter web application. The application will process Credit Balance Reports more quickly and efficiently. The application will also benefit providers by reducing cost for postage and paper. Once the report has been uploaded it will receive a time and date stamp as evidence of submission by the provider.

In order to submit Credit Balance Reports electronically, each provider will need to register to use the Self-Disclosure application in eCenter.

1. Navigate to HMS eCenter: ecenter.hmsy.com
2. If you have never used eCenter, please click on the link “Start here for new access”
 - a. Fill out the registration form and click submit
 - b. You should receive follow up communication from HMS Help Desk. Please inform the Help Desk that you need access in eCenter to the “Provider Portal Provider Overpayment Reporting-NC”
3. If you are a current user in eCenter, please call the HMS Help Desk at 855-554-6748 to request that your access be updated
 - a. Inform the Help Desk that you need access updated in eCenter to the “Provider Portal Provider Overpayment Reporting-NC”

Submitting the Credit Balance Report does not result in credit balances automatically being reimbursed to the Medicaid program. You will need to indicate the refund method of your choice -- whether you file

a replacement claim, mail a refund check with the NCTracks Provider Refund Form or you request that NC Medicaid adjust the claim on your behalf. A provider-submitted adjustment to the claim through NCTracks is the preferred method of satisfying the credit balance refund requirements. If you would like NC Medicaid to make the adjustment on your behalf, please make sure you report all cost share and overpayment amounts correctly.

Failure to submit Credit Balance Reports will result in the withholding of Medicaid payments until the report is received.

Instructions (2045) and the formatting (2044-ia) for the quarterly credit balance report are located on NC Medicaid's Website at: <https://medicaid.ncdhhs.gov/providers/forms/third-party-insurance-forms>

Personal Injury Cases Tort (Personal Injury Liability)

Medicaid beneficiaries may qualify for other third-party reimbursement because of an accident, illness, or disability. A third-party, other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents, slip and falls, medical malpractice or on-the-job injuries or illnesses not covered by Worker's Compensation.

N.C. General Statute § 108A-57 gives the state subrogation rights, meaning the state has the right to recover any accident-related payments from personal injury settlement awards as an offset to Medicaid payments.

N.C. General Statute § 108A-59 is an assignment of benefits statute. By accepting Medicaid, a beneficiary is deemed to have made an assignment to the state of the beneficiary's right to medical benefits, including both contractual and non-contractual benefits to which the beneficiary is entitled. This includes, but is not limited to, any payments which the beneficiary is entitled from medical payments ("med pay") policy, regardless of the owner of the policy.

Provider's Rights in a Personal Injury Case

When a provider learns that a Medicaid beneficiary has been involved in an accident, the provider must notify the NC Medicaid TPL Section. If the provider has knowledge of the liable third-party at the time of filing the claim, a completed **Third-Party Recovery Accident Information Report (DMA-2043)** must be submitted with the claim to NC Medicaid's TPL Section at the address shown on the form. A completed DMA-2043 must also be submitted with a copy of the bill when anyone requests a copy of the bill. The form is available at <https://medicaid.ncdhhs.gov/forms>.

The following information is required by the TPL section, and will also assist the provider when filing a claim with the liability insurer:

- Name of liability insurer
- Name of the "at-fault" insured person

- Insurance policy or claim number of the “at-fault” insured person Name, phone number and address of the attorney, if applicable.

Note: A copy of a letter sent by an attorney or liability insurer to the provider requesting information will suffice in lieu of the DMA-2043.

Attorney’s and Insurance Company’s Rights in a Personal Injury Case

When an attorney or insurance carrier learns that a Medicaid beneficiary has been involved in an accident, the attorney or the insurance carrier must notify our TPL vendor Health Management Systems (HMS), by submitting a letter of attorney representation or letter requesting NC Medicaid’s claimed amount along with a medical authorization release form.

Through our web portal, <https://submissions.hms.com>, attorneys and insurance companies must register to be authorized to create their own cases and directly upload other case documentation. Once a case is created, an electronic Subrogation Notice Letter is automatically generated in real-time with the unique HMS Maestro Case identification number, along with a bar-coded Medical Authorization release and case information form that can be completed and uploaded at a later date if not submitted initially. The following documentation can be submitted via the web portal on existing cases:

- Case information form
- Medical releases
- Settlement documents Comprise request.

If your submission is unsuccessful through the web portal you may submit documents to the TPL vendor by email at nccasualty@hms.com

Billing for Personal Injury Cases

The provider must choose between billing Medicaid and submitting the bill of charges to the liability insurer. Providers cannot initially file a casualty claim with Medicaid, receive payment, and then submit the bill of charges to the liability insurer (or the beneficiary) for the same injury case, even if the provider refunds Medicaid.

The provider cannot bill the beneficiary, Medicaid, or the liability insurer for the difference between the amount Medicaid paid and the provider’s full charges. (See *Evanston Hospital v. Hauck*, 1 F.3d 540 [7th Cir. 1993]). Providers who withhold billing Medicaid have six months (180 days) from the date of the liability insurer’s denial letter or receipt of payment from the insurance company to file with Medicaid, even if the end of the six months is after the end of the usual 365-day filing deadline.

For the provider to obtain a time limit override, the following requirements must be met:

- The provider must file the claim with the liability insurer or attorney within 365 days from the date of service;
- The provider must make a bona fide and timely efforts to recover reimbursement from the third-party;

- The provider must submit documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

Link to Time Limit override job aid:

<https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-andtraining/fact-sheets.html>

Payment for Personal Injury Cases

When Medicaid payment is received, the provider is considered as paid in full and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement from the liability insurer.

If the provider withholds billing Medicaid and receives payment from a liability insurer, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment received.

When a third-party payer made payments on the claim but Cost Share (Patient Responsibility) does not apply to the claim the “lesser of” logic used to calculate the reimbursement amount should be bypassed. A provider will submit claims with the following specific payer filing indicator Coordination of Benefits (COB) segments to identify third-party claims:

- AM- Automobile Medical
- LM- Liability Medical
- WC-Worker’s Compensation Health Claim
- TV- Title V (All other policies that do not have Cost Share information)

Pursuant to federal regulations and established case law, there is a distinction between private health insurance payments and other liable third-party payments.

Refunds and Recoupments for Personal Injury Cases

If Medicaid discovers that a provider received Medicaid payment and communicated with a third-party payer or attorney in an attempt to receive payment for any account balance, Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third-party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	\$100
Amount paid by Medicaid	\$50
Amount paid by attorney/liability carrier	\$100
Amount to be refunded to Medicaid	\$50

Amount to be refunded to attorney/liability \$50

Estate Recovery

Estate recovery is a federally mandated program in which the assets of deceased Medicaid beneficiaries are used to reimburse the taxpayers for long-term care and pharmaceuticals provided through Medicaid. Funds are recovered from the beneficiary's estate after his or her death to cover the cost of these services.

N.C. General Statute §108A-70.5 gives the state subrogation rights to collect reimbursement from a beneficiary's estate. An estate includes all real and personal property held individually or jointly.

Trust Recovery

Trust Recovery is a Medicaid reimbursement program that is governed by federal Medicaid law. If a disabled Medicaid beneficiary receives assets in an amount that would render the individual ineligible for Medicaid, the individual may maintain eligibility by placing the assets in a Special Needs Trust (SNT) that meets certain requirements specified in federal law. This situation commonly arises when a disabled Medicaid beneficiary receives a substantial personal injury or medical malpractice recovery.

There are two types of trusts that can be established in North Carolina with a beneficiary's assets: (1) a d4A or "self-settled" SNT, which contains the assets of the beneficiary, or (2) a d4C or "pooled trust," in which the beneficiary's assets are pooled together with assets belonging to other persons and the subaccounts are managed by a non-profit trust organization.

Federal law at 42 USC § 1396p(d)(4)(A) governs self-settled SNT's and 42 USC § 1396p(d)(4)(C) governs pooled trusts. In both cases, Medicaid is entitled to reimbursement upon termination of the trust. Trusts established with assets that do not belong to the beneficiary, such as third-party SNTs and testamentary SNTs, do not require Medicaid reimbursement.

Health Insurance Premium Payments

Payment of Health Insurance Premiums

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid beneficiaries with catastrophic illnesses, such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, etc. These beneficiaries are often at risk of losing private health insurance coverage due to nonpayment of premiums. NC Medicaid will evaluate the benefit of paying health insurance premiums for Medicaid beneficiaries plus the cost of the premium, deductible, and co-insurance is less than the anticipated Medicaid expenditure.

To be eligible for Medicaid payment of premiums, the beneficiary must be authorized for Medicaid and have access to private health insurance through an employer. NC Medicaid will pay the premiums only on existing employer-based policies, including COBRA, or those known to be available to the beneficiary.

Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, coinsurance, or cost-sharing obligations.

Medicaid reviews the case of each beneficiary who meets any of the conditions cited above for possible premium payment. NC Medicaid verifies the insurance information, obtains premium amounts, makes the cost effectiveness determination, and notifies the beneficiary and the appropriate referral source.

When NC Medicaid determines that a group health insurance plan available to the beneficiary through an employer is cost effective and the beneficiary is approved for participation in the HIPP program, the beneficiary is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the beneficiary voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The beneficiary is not required to enroll in a plan that is not a group health insurance plan through an employer.

Information about HIPP and the HIPP application are available online at <http://www.mynchipp.com/>, county DSS offices, hospitals and rural health clinics. A copy of the HIPP Application (DMA-2069) is available at <http://dma.ncdhhs.gov/document/third-party-insurance>.

Medicare Buy-in Unit

Medicare is health insurance for people 65 and older, certain people under 65 with disabilities, and people of any age with End-Stage Renal Disease.

Medicare Buy-in is the process by which the State Medicaid Program (Title XIX) notifies the Centers for Medicare and Medicaid Services (CMS) that Medicaid has accepted responsibility for payment of Medicare premiums for a Medicaid recipient. CMS bills the state monthly for Medicare premium payments.

Medicaid pays the Part B premiums for all Medicaid recipients known to be enrolled in Part B. Medicaid pays the Part A premium for Qualified Medicare Beneficiaries with "Q" class of Eligibility who are age 65 and older.

If providers are notified that a Medicaid recipient also has Medicare coverage that has not been added to the recipient's Medicaid eligibility file, the provider should contact the NC Medicaid Buy-in unit to initiate the Medicare coverage span being added to the Medicaid eligibility file. That addition will occur once the Medicare coverage has been verified at 919-527-7690.

Third-Party Liability- Frequently Asked Questions

1. What is TPL and how does it affect claim processing?

TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto, or other liability carriers. There are state and federal laws, rules and regulations setting out TPL requirements, which require responsible third parties to pay for medical services before Medicaid is billed.

The TPR section implements and enforces TPL laws through cost avoidance and recovery methods. Providers aware of private health insurance or Medicare coverage are required to seek payment from those parties prior to seeking payment from Medicaid.

2. Why would a claim deny for EOB 00094?

When EOB 00094 is posted for a claim on a Remittance Advice (RA) Statement, the provider should resubmit the claim indicating the private insurance payment.

The TPL database in NCTracks identifies any beneficiary with third-party insurance on the date of service for which the provider is requesting reimbursement when this type of insurance should cover the diagnosis submitted for payment.

If the service could be covered by the type of insurance indicated, the provider must file a claim with that insurance carrier prior to billing Medicaid. If the provider receives a denial or they are paid for less than their charges, providers should bill the Medicaid program with the appropriate Claim Adjustment Reason Codes as they appear on the insurance EOB and, based on these codes, the claim will be processed.

If the Medicaid-allowable amount is greater than the insurance payment the provider received. Medicaid will pay the difference up to the beneficiary's liability as disclosed on the private insurance plan's EOB. It is the provider's responsibility to secure any additional information needed from the Medicaid beneficiary to file the claim.

3. What can the provider do when the claim is denied for EOB 00094?

Refer to the RA that showed the claim denying for EOB 00094. The insurance information including the policy holder's name, certificate number, and a three-digit insurance code are listed below the beneficiary's name. Lookup this code on the previously mentioned Third-Party Insurance Code list and file a claim with the health insurance company.

4. What are the uses of the Health Insurance Information Referral Form (DMA-2057)?

Form DMA-2057 should be completed:

- To delete insurance information (if the beneficiary does not have third-party insurance, but the beneficiary's eligibility information indicates other insurance);
- To add information (if a beneficiary has the third-party insurance that is not listed in the beneficiary's eligibility information);
- To change existing information (if a beneficiary no longer has third-party coverage and that insurance termination is not indicated in the beneficiary's eligibility information; the effective date is incorrect, the coverage type is incorrect, etc.).

DMA – 2057 is available at:

<https://medicaid.ncdhhs.gov/providers/forms/third-party-insurance-forms>

5. If the Medicaid beneficiary's private health insurance company pays the beneficiary directly, can the provider bill the beneficiary?

No. Providers may bill a patient accepted as a Medicaid patient only in the following situations: (1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan; (2) before the service or supply is provided, the provider has informed the patient that the patient may be billed for a service or supply that is not one covered by Medicaid regardless of the type of provider or is beyond the limits of Medicaid coverage as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b); (3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services or supplies are received but has failed to supply a Medicare number as proof of coverage; or (4) the patient is not eligible for Medicaid as defined in the Medicaid State Plan.

6. May providers have an office policy that states the provider will not accept Medicaid in conjunction with a private insurance policy?

Yes. A provider can refuse to accept Medicaid for beneficiaries who also have third-party coverage, even though they accept Medicaid for beneficiaries who do not have third-party coverage. However, providers must advise the beneficiary of the responsibility for payment before the services are rendered. The provider must obtain proper consent from the beneficiary for this arrangement prior to any services being rendered. The beneficiary-signed acceptance of liability form must be present in the beneficiary's file maintained by the provider.

7. What may providers do when a beneficiary or authorized beneficiary's representative request a copy of a bill that was submitted to Medicaid?

Providers must provide a copy of the Medicaid bill to the beneficiary or authorized beneficiary's representative when requested if the provider has proper patient authorization.

The provider may give a copy of the Medicaid bill only if in compliance with the following requirement.

All copies of any bill that have been submitted to Medicaid **must** state "MEDICAID BENEFICIARY, BENEFITS ASSIGNED" in large, bold print on the bill.

If the provider provides a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

8. If the Medicaid beneficiary is required by their private insurance to pay a copayment amount, can this amount be collected up front at the time the services are rendered?

No. The provider cannot bill the Medicaid beneficiary for the private insurance copayment amount unless the Medicaid payment is denied because the service was a non-covered service, and then, only if the provider has advised the beneficiary in advance that the services are not

covered. The provider must keep documentation in the beneficiary's record that the beneficiary was made aware of this fact before services were rendered.

9. How do providers determine the amount of refund due to Medicaid when Medicaid pays the claim and subsequently receives payment from a liability insurer? (Casualty or liability cases)

Once a provider files a claim with Medicaid and has received payment, the claim has been paid in full. Upon receipt of any payment from the liability insurer or attorney, the provider must return or refund the payment to the payer.

By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider's billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both state and federal laws.

Contact Information

Refunds to Medicaid

Misc. Medicaid Payments
P.O. Box 602885
Charlotte, NC 28260-2885

Overnight Address for Medicaid Refunds

Misc. Medicaid Payments
Lockbox Services (602885)
1525 West W.T. Harris Blvd. – 2C2
Charlotte, NC 28262

Refunds to NC Health Choice

Misc. NC Health Choice Payments
P.O. Box 602861
Charlotte, NC 28260-2861

Overnight Address for NC Health Choice

Misc. NC Health Choice Payments
Lockbox Services (602861)
1525 West W. T. Harris Blvd. – 2C2

Charlotte, NC 28262

Medicaid Casualty Lien Request

P.O. Box 31803
Raleigh, NC 27622
Phone: 855-753-2177
Fax: 919-714-8574
nccasualty@hms.com

Medicaid Casualty Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Medicaid Estate Recovery

P.O. Box 18869
Raleigh, NC 27619
Phone: 866-455-0109
Fax: 919-424-2851

Medicaid Estate Recovery Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Trust Recovery

P.O. Box 18869
Raleigh, NC 27619
Phone: 919-424-2800
Fax: 919-424-2851

Trust Recovery Payments

Office of the Controller
2022 Mail Service Center
Raleigh, NC 27699-2022

Third-Party Recovery Unit NC Medicaid

NC Medicaid Third-Party Recovery
2508 Mail Service Center
Raleigh, NC 27699
Phone: 919-527-7690
Fax: 919-831-1812

Buy-In Unit

NC Medicaid Buy-in Unit
2508 Mail Service Center
Raleigh, NC 27699
Phone: 919-527-7690
Fax: 919-831-1812

Health Insurance Premium Payments (HIPP)

<http://www.mynchipp.com/>

CustomerService@MyNCHIPP.com

Phone: 855-696-2447

Paper Credit Balance Reports

NC Medicaid Credit Balances
2508 Mail Service Center
Raleigh, NC 27699

Please note: All reports are expected to be submitted electronically to HMS eCenter web application. However, if you do not have access to the internet you may mail information to the address provided above.

Appendix

Below is the list of programs or services that is an exception to the general rule Medicaid is the payer of last resort. When a Medicaid beneficiary is entitled to one or more of the following programs or services, Medicaid pays first:

Program or Service	Federal	State
Crime Victims Compensation Fund	X	
Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
Ryan White Program	X	
Indian Health Services	X	
Veteran's Benefits for state nursing home per diem payments	X	
Veteran's Benefits for emergency treatment provided to certain veterans in a non-VA facility	X	
Women, Infants and Children Program	X	
Older American Act Programs	X	
World Trade Center Health Program	X	
Grantees under Title V of the Social Security Act	X	
Division of Service for the Blind		X
Division of Public Health "Purchase of Care" Program		X
Vocational Rehabilitation Services		X
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X