North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention:

Personal Care Service Providers

Personal Care Services and PCS-Plus Program Billing Guide

TABLE OF CONTENTS

INTRODUCTION

Effective with date of service August 1, 2004, providers of Personal Care Services (PCS provided in private residences) must bill on the CMS-1500 claim form using HCPCS code S5125 "Attendant care services; per 15 minutes" for PCS and 99509 "Home Visit for Assistance with Activities of Daily Living and Personal Care" for PCS-Plus. Dates of service through July 31, 2004 must be billed on the UB-92 claim form using revenue code 599.

The Division of Medical Assistance (DMA) must make these changes to comply with the implementation of the national code sets mandated by the Health Insurance Portability and Accountability Act (HIPAA). This article revises the applicable billing instructions listed in the *N.C. Medicaid Community Care Manual*.

Providers attending the PCS seminar will learn about:

- how to file the new billing guidelines on the paper CMS-1500

- how to file the new billing guidelines using the NCECS-Web electronic claims entry tool

- tips for decreasing claim denials

Note: This seminar will only focus on new billing guidelines. Please refer to Section 6 of the *N.C. Medicaid Community Care Manual* for information describing N.C. Medicaid's policy coverage of the Personal Care Services program.

PCS and PCS-Plus Background

Program History

Over the past several years, there has been enormous growth in PCS. Due to this rapid program growth, the N.C. General Assembly implemented a 3.5-hour daily limit on PCS in January 2002. In December 2002, the N.C. General Assembly reduced the monthly limit on PCS hours from 80 hours to 60 hours. However, since those reductions were implemented, it has become clear that there are many PCS clients that need more than 60 hours of PCS a month in order to remain at home. Please refer to the December 2003 Special Bulletin V, *Personal Care Services-Plus Program,* for additional information about the PCS-Plus Program.

How PCS Differs From PCS-Plus

PCS	PCS-Plus
• 60 hour monthly limit (240 units)	• 80 hour monthly limit (320 units)
• 3.5 hours daily limit (14 units)	• No daily limit on hours
• No prior approval required	• Prior approval required
• Basic eligibility criteria	• More stringent eligibility criteria

Billing Reminders for PCS and PCS-Plus

- Dates of service provided through **07/31/2004** will continue to be billed using the **UB-92** claim.

- Dates of service provided through **07/31/2004** will continue to be billed using the revenue code **599.**

- Dates of service provided on and after **08/01/2004** will be billed on the **CMS-1500** claim.

- Dates of service provided on and after **08/01/2004** will be billed using code **S5125** for **PCS.**

- Dates of service approved and provided on and after **08/01/2004** will be billed using code **99509** for **PCS-Plus.**

- PCS and PCS-Plus cannot be billed on the same date of service.

- Prior approval is required for PCS-Plus.

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BILLING INSTRUCTIONS

CMS-1500 Paper Claim Billing Instructions for PCS and PCS-Plus

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
1.	**Type of Coverage**	Place an (X) in the Medicaid block.
1a.	**Insured's ID Number**	Enter the recipient's ten-character identification number found on the MID card.
2.	**Patient's Name**	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
3.	**Patient's Birth Date**	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). **Note:** A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
	Sex	Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).
4.	**Insured's Name**	Leave blank.
5.	**Patient's Address**	Enter the recipient's street address including city, state, and zip code.
	Telephone	Entering the recipient's telephone number is optional.
6.	**Patient Relationship to Insured**	Leave blank.
7.	**Insured's Address/Telephone**	Leave blank.
8.	**Patient Status**	Leave blank.
9.	**Other Insured's Name**	Leave blank.

10.	**Is Patient's Condition Related To**
	   a. Employment?
	   b. Auto Accident?
	   c. Other Accident?
		If applicable, check the appropriate block.

11.	**Insured's Policy Group of FECA Number**	Leave blank.
12.	**Patient's or Authorized Person's Signature**	Leave blank.
13.	**Insured's or Authorized Person's Signature**	Leave blank.
14.	**Date of Current Illness…**	Leave blank.
15.	**If Patient Has Had Same or Similar Illness, Give First Date**	Leave blank.

CMS-1500 Paper Claim Billing Instructions for PCS and PCS-Plus, continued

Block	Block Name	Explanation
16.	**Dates Patient Unable to Work in Current Occupation "From" and "To"**	Leave blank.
17.	**Name of Referring Physician**	Leave blank.
17a.	**ID Number of Referring Physician**	Leave blank.
18.	**Hospitalization Dates…**	Leave blank.
19.	**Reserved for Local Use**	If the Medicaid recipient is a Carolina ACCESS enrollee on the date the service is rendered, enter the current PCP's referral authorization number. If the Medicaid recipient is *not* a Carolina ACCESS enrollee on the date the service is rendered, leave blank.
20.	**Outside Lab?**	Leave blank.
21.	**Diagnosis or Nature of Illness or Injury**	Enter the ICD-9-CM code for the principle diagnosis. "V" codes are not acceptable.
22.	**Medicaid Resubmission Code…**	Leave blank.
23.	**Prior Authorization Number**	Leave blank.
24A.	**Date(s) of Service "From" and "To"**	Use a separate detail line for each day that the service is provided. Enter the date of service in the **From** block. Enter the same date in the **To** block. **Note**: A two-digit year is acceptable on paper claims. A four-digit year is required for electronic claims.
24B.	**Place of Service**	Enter a 12 as the Place of Service code.
24C.	**Type of Service**	Enter a 01 as the Type of Service.
24D.	**Procedures, Services, or Supplies**	**S5125** – Beginning with date of service 08/01/2004 – use S5125 for dates of service rendered under PCS. **99509** – Beginning with date of service 08/01/2004 – use 99509 for dates of service approved and rendered under PCS-Plus.
24E.	**Diagnosis Code**	Leave blank.
24F.	**Charges**	Enter the total charge for the units for each date of service on the detail line. (The charges are calculated by multiplying the provider agency's unit rate by the number of units.)
24G.	**Days or Units**	Enter the number of 15-minute units billed on the detail line.
24H.	**EPSDT Family Plan**	Leave blank.
24I.	**EMG**	Leave blank.
24J.	**COB**	Leave blank.

CMS-1500 Paper Claim Billing Instructions for PCS and PCS-Plus, continued

Block	Block Name	Explanation
24K.	**Reserved for Local Use**	Leave blank.
25.	**Federal Tax ID Number**	Leave blank.
26.	**Patient's Account No.**	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
27.	**Accept Assignment**	Leave blank.
28.	**Total Charge**	Enter the total charges listed in 24F.
29.	**Amount Paid**	Enter the total amount received from third party sources.
30.	**Balance Due**	Optional. Enter the difference between item 28 and 29.
31.	**Signature of Physician or Supplier Including Degrees or Credentials**	The physician, supplier or an authorized representative must either 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Provider Certification for Signature on File form has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
32.	**Name and Address of Facility…**	Optional.
33.	**Physician's or Supplier's Billing Name, Address, Zip Code & Phone #.**	Enter the billing provider's name, street address including zip code, and phone number. PIN #: Leave blank. GRP #: Enter the seven-character agency provider number used for Medicaid billing purposes.

Example of CMS-1500 Claim Form for PCS

DO NOT USE FOR CLAIM PROCESSING

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PCS Claim Example

HEALTH INSURANCE CLAIM FORM

PICA   PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
(Medicare #)	☒ (Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)	123456789K	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY SEX
03 11 1969 M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
123 Any Street

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY Any City STATE NC

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE 12345 TELEPHONE (Include Area Code) (555) 555-5555

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (INCLUDE AREA CODE) (   )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☒ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE
8909999

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 715.9
2. ___.__
3. ___.__
4. ___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE						B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
From MM	DD	YY	To MM	DD	YY										
08	01	04	08	01	04	12	01	S5125		16 00	4				
08	02	04	08	02	04	12	01	S5125		16 00	4				
08	03	04	08	03	04	12	01	S5125		20 00	5				
08	04	04	08	04	04	12	01	S5125		16 00	4				
08	07	04	08	07	04	12	01	S5125		16 00	4				
08	08	04	08	08	04	12	01	S5125		16 00	4				

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $

31. 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.)

Signature on File
SIGNED _____ DATE 8/9/04

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PCS Agency
123 Any Street
Any City, NC 12345
PIN# GRP# 6600XXX

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PATIENT AND INSURED INFORMATION → CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

Example of CMS-1500 Claim Form for PCS-Plus

<div align="center">

DO NOT USE FOR CLAIM PROCESSING

</div>

Billing for PCS and PCS-Plus Using the NCECS-Web Claims Entry Tool

With the implementation of standard electronic transactions mandated by HIPAA, N.C. Medicaid launched a web-based claim entry tool called NCECS-Web. The new NCECS-Web claim entry tool requires certain elements for all providers who submit electronic claims. The following guide has been created to assist PCS providers using the NCECS-Web claims entry tool. The guide follows the CMS-1500 claim format.

Specific values are listed, if applicable.

https://webclaims.ncmedicaid.com/ncecs

Recipient Information		
Field Title	**Required**	**Definition**
Recipient First Name	Yes	Enter the recipient's first name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Recipient Last Name	Yes	Enter the recipient's last name exactly as it appears on the Medicaid ID card. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Medicaid ID	Yes	Enter the recipient's ten character Medicaid ID number as it appears on the Medicaid ID card. There are nine numbers followed by one letter in a Medicaid ID number. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Date Field	No	Leave blank.
Patient's Weight (lbs)	No	Leave blank.
Patient Account Number	Yes	Enter the recipient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of the payment. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Prior Authorization Number	No	Leave blank.
Post OP From Date	No	Leave blank.
Post OP Through Date	No	Leave blank.
Medical Record Number	Optional	Enter the recipient's medical record number as assigned by the provider. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.

Provider Information		
Field Title	**Required**	**Definition**
Provider Last Name or Organization Name	Yes	Name of provider agency filing claim for payment. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
Provider First Name	No	Leave blank.
Medicaid Provider Number	Yes	Billing Provider Number as assigned by Medicaid. NCECS-Web users may utilize the List Management feature to populate this field, or free key the information.
National Provider ID	No	Reserved for future use.
Referring Physician Provider No. (Carolina Access)	When applicable	The referring physician provider number is the seven-digit Carolina ACCESS number assigned to the referring physician.
CLIA Number	No	Leave blank.

Miscellaneous Claim Information		
Field Title	**Required**	**Definition**
EPSDT: Follow-up/No	No	Leave blank.
Release of Information, Yes/No	Yes	Does the provider have a signed release from the patient/recipient allowing the release of information for claims processing? Select "Yes."
EPSDT referral given to patient? Yes/No	No	Leave blank.
EPSDT Referral Type	No	Leave blank.
Paperwork on file at provider site for Medicare override?	No	Leave blank.
Original ICN	Required only when the Claims Submission Reason Code is a 7 or 9	Original Internal Control (claim) Number as assigned to claims by Medicaid.
Place of Service Facility Type Code	Yes	For PCS claims, select 12-Home

Miscellaneous Claim Information, continued		
Field Title	**Required**	**Definition**
Claim Submission Reason Code	Yes, defaults to 1-Original. Drop down box allows user to change to 8-void or 7-replacement	A code that indicates the reason claim has been submitted. It is used to differentiate whether a claim is an original, voided or replacement claim.
Rendering/Attending Provider First Name	No	Not required on PCS claims.
Rendering/Attending Provider Last Name	No	Not required on PCS claims.
Rendering/Attending Medicaid Provider Number	No	Not required on PCS claims.
Principal Diagnosis	Yes	Enter the ICD-9-CM code for the principle diagnosis that is responsible for the services rendered. "V" codes are not acceptable.
Additional		Fields for up to 11 additional diagnoses.

Insurance Detail Screen (This screen is required when there are other health plans/payers, in addition to Medicaid, involved in payment for services.)		
Field Title	**Required**	**Definition**
Other Insurance Responsibility Sequence	When applicable	Indicates hierarchy of responsibility.
Recipient Relationship to the Insured	When applicable	Indicates relationship between the Medicaid recipient for whom claim is being filed and person insured by other health plan. Relationship may be self if the person is the same.
Other Insurance Claim Filing Indicator	When applicable	Drop down selection used to describe the type of policy entered.
Other Insurance Paid Amount	When applicable	Total amount received from third party sources. Do not enter Medicaid copayment amount; it will be automatically deducted during claims processing.
Other Insurance Allowed Amount	When applicable	Last name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured Last Name	When applicable	First name of insured on other insurance health plan. May match Medicaid recipient for whom claim is filed.
Other Insured First Name	When applicable	Enter the individual identification number for patient, as issued by insurance plan.
Other Insured Member ID	When applicable	Name of other insurance company.
Other Insurer Name	When applicable	Identification number from other insurance health plan. Used to indicate group policy numbers.
Other Insurer Identification Number	When applicable	Use only if other insurance is involved in the payment of claim.

Service Detail Screen		
Field Title	**Required**	**Definition**
From Date of Service	Yes	Use a separate detail line for each day that the service is provided. Enter the date of service in the **From** block. Enter the same date in the **To** block.
Through Date of Service	Yes	
Place of Service	Yes	Indicates location where service was rendered. Drop down box offers all valid place of service codes under HIPAA. PCS providers enter 12 to show the services were provided in the patient's residence.
HCPCS	Yes	**S5125** – Beginning with date of service 08/01/2004 – use S5125 for dates of service rendered under PCS. **99509** – Beginning with date of service 08/01/2004 – use 99509 for dates of service approved and rendered under PCS-Plus.
Mod 1 through Mod 4	No	Leave blank.
Charge	Yes	Enter the total charge for the units for each date of service on the detail line. (The charges are calculated by multiplying the provider agency's unit rate by the number of units.)
Units	Yes	Enter the number of 15-minute units billed on the detail line.
E/F	No	Leave blank.
DME Days	No	Leave blank.
Claim Note	No	Leave blank.
Line Item Control Number	Optional	Used by provider to enter internal tracking number for service.

NCECS-Web Claims Entry Screen Examples

North Carolina Electronic Claims Submission menu:
- Main Menu
  - Claims Entry
    - Dental
    - CMS-1500
    - UB-92
  - List Management
  - Reports
  - Claim Submission
  - Reference Materials

CMS-1500

Selection Criteria

Claim Type: CMS-1500   Claim ID: New   [Save] [Cancel] [Delete]

Recipient Information

1. Complete the Recipient Last Name, Recipient First Name, Medicaid ID and Patient Account Number fields. Other fields in this section are completed when applicable.

- Recipient Last Name: LAST NAME
- Recipient First Name: FIRST NAME
- Medicaid ID: MYCAID ID #
- Date Field:
- Patient weight (lbs):
- Patient Account Number: PT ACCT #
- Medical Record Number:
- Post OP from Date:
- Prior Authorization Number:
- Post OP Through Date:

Provider Information

2. Complete Provider Organization Name and Medicaid Provider Number fields. Other fields in this section, including the Referring Physician (Carolina ACCESS Number) field are completed when applicable.

- Provider Last Name or Organization Name: PCS AGENCY NAME
- Provider First Name:
- National Provider ID:
- Medicaid Provider Number: PROVIDER #
- Referring Physician Provider No: (Carolina Access Physician Number)
- CLIA Number:

NCECS-Web Claims Entry Screen Examples, continued

NCECS-Web Claims Entry Screen Examples, continued

North Carolina
Electronic Claims Submission
Main Menu
    Claims Entry
        Dental
        CMS-1500
        UB-92
    List Management
    Reports
    Claim Submission
    Reference Materials

Information

R/A Provider First Name: [   ]   R/A Provider Last Name: [   ]

R/A Medicaid Provider Number: [   ]

CMS-1500 Insurance Detail

[Add/Edit Other Insurance]

No Other Insurance

> 5. Use only when a payment has been made from a Third Party source.

Diagnosis Codes

Principal: [ICD9]

> 6. Enter the ICD-9-CM code with no decimal points.

Additional 1 [   ] 2 [   ] 3 [   ] 4 [   ] 5 [   ]

6 [   ] 7 [   ] 8 [   ] 9 [   ] 10 [   ]

11 [   ]

CMS-1500 Detail

[Add/Edit Details]

No CMS-1500 Detail

> 7. Click here to enter the details of the service provided. See the next page for more instruction.

Claim Note

[   ]

NCECS-Web Claims Entry Screen Examples, continued

CMS-1500 Add/Edit Details for PCS

8. Input the From and To Date of Service, Place of Service, and Procedure Code – then scroll to the right to complete the other fields listed below on the next screen print.

CMS-1500 Add/Edit Details for PCS, continued

9. Input the total charge for the day and the total units (1 unit = 15 minutes). Either hit "enter" or scroll back to the left and click on "Add" to record the detail line.

NCECS-Web Claims Entry Screen Examples, continued

CMS-1500 Add/Edit Details for PCS-Plus

CMS-1500 Add/Edit Details for PCS-Plus, continued

TIPS FOR REDUCING CLAIM DENIALS

Eligibility Related Denials		
EOB	**Message**	**Explanation**
11	**Recipient not eligible on service date.**	Compare the recipient's MID card to the information entered on the claim. Compare the RA to the information entered on the claim. Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system.
120	**Recipient MID number missing. Enter MID and submit as a new claim.**	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
143	**MID number not on state eligibility file.**	Follow the explanation for EOB 11 above. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the social security number and date of birth. If the recipient's social security number is unknown, call the DMA Claims Analysis unit to obtain the correct MID number.
191	**MID number does not match patient name.**	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid records since the MID card was issued. Call EDS to verify the patient's name. Correct and resubmit to EDS as a new claim.

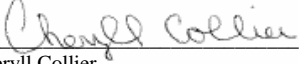| Carolina ACCESS Related Denials		
EOB	**Message**	**Explanation**
270	**Billing provider is not the recipient's Carolina ACCESS PCP. Contact the PCP for authorization; enter authorization number in block 19 of the CMS-1500 or form locator 83B on the UB-92.**	The Medicaid recipient is enrolled with Carolina ACCESS for the dates of service rendered, but the Carolina ACCESS PCP's authorization number is **missing** from block 19 of the CMS-1500 or form locator 83B on the UB-92. Contact the Carolina ACCESS PCP's office to obtain the correct authorization number. Either recheck the most up-to-date MID card for the services rendered to get the Carolina ACCESS PCP's phone number or call the AVR system at 1-800-723-4337, select transaction #6 and select the prompt for recipient enrollment information to get the Carolina ACCESS PCP's phone number. Enter the correct Carolina ACCESS PCP authorization number in block 19 of the CMS-1500 or form locator 83B on the UB-92 and resubmit the claim. If filing electronically using NCECS-Web, enter the number in the field designated for the Carolina ACCESS number.
286	**Incorrect authorization number in block 19 of the CMS-1500 or form locator 83B on the UB-92 . Verify number and refile claim.**	The Medicaid recipient is enrolled with Carolina ACCESS for the dates of service rendered, but the Carolina ACCESS PCP's authorization number entered in block 19 of the CMS-1500 or form locator 83B on the UB-92 is **invalid**. Contact the Carolina ACCESS PCP's office to obtain the correct authorization number. Either recheck the most up-to-date MID card for the services rendered to get the Carolina ACCESS PCP's phone number or call the AVR system at 1-800-723-4337, select transaction #6 and select the prompt for recipient enrollment information to get the Carolina ACCESS PCP's phone number. Enter the correct Carolina ACCESS PCP authorization number in block 19 of the CMS-1500 or form locator 83B on the UB-92 and resubmit the claim. If filing electronically using NCECS-Web, enter the number in the field designated for the Carolina ACCESS number.

General EOBs		
EOB	**Message**	**Explanation**
21	**Duplicate of claim.**	This EOB alerts the provider that another claim for the same recipient, same date of service, same service, same number of units has already been paid on a previous checkwrite. The claim number and checkwrite date of the previously paid claim will appear directly on the Remittance Advice (RA).
22	**Duplicate of claim.**	This EOB alerts the provider that another claim for the same recipient, same date of service, same service, same number of units has already been submitted, usually on the same checkwrite or the next scheduled checkwrite. The claim number and checkwrite date do not appear on the RA since the claim is duplicating against the paid claim on the same RA or next scheduled checkwrite.
1198	**Service billed multiple times. If on this claim, combine units on single detail and submit new claim. If paid on previous claim, combine units and file adjustment.**	This EOB is similar to EOBs 21 and 22 with the following exceptions: • There is more than one detail on the same claim with the same date of service. Both details will deny with EOB 1198. • The detail on the current claim is denying with EOB 1198 because it is duplicating against a previously paid claim for the same recipient, same date of service, same service, but for a different number of units. This often happens when a provider is paid for a set number of units, then realizes that they should have billed for more units and tries to resubmit for the greater number of units. The correct procedure is to file an adjustment for the greater number of units (not to exceed the normal limitations of the PCS program).
18	**Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.**	If the claim was initially received and processed within the 365-day time limit, that claim can be refiled on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for EOB 18.
8918	**Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing - a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.**	EOB 8918 can also be affected by the explanation above for EOB 18, but it is generally more flexible than EOB 18. The claim denying with EOB 8918 will generally find another claim that has been submitted within timely filing that is almost a match, but it is different enough to warrant the provider to have to prove timely filing. For more information about EOB 18 and EOB 8918, refer to Section 8 of the *General Medicaid Billing/Carolina ACCESS Policies and Procedures Guide* on DMA's website www.dhhs.state.nc.us/dma/medbillcaguide.htm.

Program Specific Related Denials for PCS Providers			
	EOB	**Message**	**Explanation**
PCS	1537	**Units were changed to allow a maximum of 14 units per day**	This EOB is assigned when the detail is partially payable; the detail units will be cutback so that the 14-unit per day limitation is met, but not exceeded.
PCS	1543	**Only 14 units allowed per date of service**	This EOB is assigned when the detail will cause the 14-unit per day limitation to be exceeded. No additional payment will be made.
PCS	5328	**Units cutback. Exceeds maximum units allowed per month**	This EOB is assigned when the detail is partially payable; the detail units will be cutback so that the 240-unit per month limitation is met, but not exceeded.
PCS	7007	**Exceeds maximum units allowed per month.**	This EOB is assigned when the detail will cause the 240-unit per month limitation to be exceeded. No additional payment will be made.
PCS-Plus	803	**Maximum 320 units per month limit has been reached**	This EOB is assigned when the detail will cause the 320-unit per month limitation to be exceeded for those recipients who have been approved for the PCS-Plus program. No additional payment will be made.
PCS-Plus	806	**Units were changed to allow a maximum of 320 units per month**	This EOB is assigned when the detail is partially payable; the detail units will be cutback so that the 320-unit per month limitation is met, but not exceeded for those recipients who have been approved for the PCS-Plus program.
Both PCS and PCS-Plus	1895	**Claim denied because it is subject to Transfer of Asset Penalties**	Effective with date of service February 1, 2003, payments for specified home care services may be affected by a transfer of assets policy that applies to certain Medicaid recipients. Refer to the article titled Amended Implementation of "Transfer of Assets Policy for Specified Home Care Services" in the February 2003 general Medicaid bulletin for additional information.

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