# North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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## Number II

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# **Attention:**

# **Personal Care Service Providers**

# Personal Care Services and PCS-Plus Program Billing Guide

Providers are responsible for informing their billing agency of information in this bulletin.

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## 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.

	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

#### How PCS Differs From PCS-Plus

#### **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).
		<b>Note:</b> 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.

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 <i>not</i> 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 <b>From</b> block. Enter the same date in the <b>To</b> block. <b>Note</b> : 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	<ul> <li>S5125 – Beginning with date of service 08/01/2004 – use</li> <li>S5125 for dates of service rendered under PCS.</li> <li>99509 – Beginning with date of service 08/01/2004 – use</li> <li>99509 for dates of service approved and rendered under PCS-Plus.</li> </ul>
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.	СОВ	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	<ul> <li>The physician, supplier or an authorized representative must either</li> <li>1. sign and date all claims, or</li> <li>2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or</li> <li>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.</li> <li>Printed initials and printed signatures are not acceptable and will result in a denied claim.</li> </ul>
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.

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

### **Example of CMS-1500 Claim Form for PCS**

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## Example of CMS-1500 Claim Form for PCS-Plus

## DO NOT USE FOR CLAIM PROCESSING

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#### 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.

<b>Recipient Informat</b>	ion	
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.

## https://webclaims.ncmedicaid.com/ncecs

Provider Informati	Provider Information						
Field Title	Required	Definition					
Provider Last	Yes	Name of provider agency filing claim for payment.					
Name or Organization Name		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	When applicable	The referring physician provider number is the seven-digit Carolina ACCESS number assigned to the referring physician.					
No. (Carolina Access)	**						
CLIA Number	No	Leave blank.					

Miscellaneous Clair	m Informatio	n
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

E.

Miscellaneous Claim	Miscellaneous Claim Information, continued						
Field Title	Required	Definition					
Claim Submission	Yes,	A code that indicates the reason claim has been submitted. It is					
Reason Code	defaults to	used to differentiate whether a claim is an original, voided or					
	1-Original.	replacement claim.					
	Drop down						
	box allows						
	user to						
	change to						
	8-void or						
	7-						
	replacement						
<b>Rendering/Attending</b>	No	Not required on PCS claims.					
Provider First Name							
<b>Rendering/Attending</b>	No	Not required on PCS claims.					
Provider Last Name							
<b>Rendering/Attending</b>	No	Not required on PCS claims.					
Medicaid Provider							
Number							
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	When	Indicates hierarchy of responsibility.			
Responsibility	applicable				
Sequence					
Recipient	When	Indicates relationship between the Medicaid recipient for whom			
Relationship to the	applicable	claim is being filed and person insured by other health plan.			
Insured		Relationship may be self if the person is the same.			
Other Insurance	When	Drop down selection used to describe the type of policy entered.			
Claim Filing	applicable				
Indicator					
Other Insurance	When	Total amount received from third party sources. Do not enter			
Paid Amount	applicable	Medicaid copayment amount; it will be automatically deducted during claims processing.			
Other Insurance	When	Last name of insured on other insurance health plan. May match			
Allowed Amount	applicable	Medicaid recipient for whom claim is filed.			
Other Insured Last	When	First name of insured on other insurance health plan. May			
Name	applicable	match Medicaid recipient for whom claim is filed.			
<b>Other Insured First</b>	When	Enter the individual identification number for patient, as issued			
Name	applicable	by insurance plan.			
Other Insured	When	Name of other insurance company.			
Member ID	applicable				
Other Insurer Name	When	Identification number from other insurance health plan. Used to			
	applicable	indicate group policy numbers.			
Other Insurer	When	Use only if other insurance is involved in the payment of claim.			
Identification	applicable				
Number					

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 <b>From</b> block. Enter the same date in		
Through Date of Service	Yes	the <b>To</b> block.		
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	<ul> <li>S5125 – Beginning with date of service 08/01/2004 – use S5125 for dates of service rendered under PCS.</li> <li>99509 – Beginning with date of service 08/01/2004 – use 99509</li> </ul>		
		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	CMS-1500
() Main Menu	
Claims Entry	Selection Criteria
Dental	
CMS-1500	Claim Type: CMS-1500 Claim ID: New Save Cancel Delete
DUB-92	cum the one commenter and many react
List Management Reports	
Claim Submission	
Reference Materials	Becipient Information.
	Recipient Last LAST NAME Recipient First FIRST NAME Medicaid ID: MCAID ID #
1. Complete the	Name: Name: Name: PROT NAME NAME
Recipient Last Name,	Date Field:
Recipient First Name,	(Be):
Medicaid ID and	Patient Around PT ACCT # Medical Record Post OP from
Patient Account	Number: Pumber: Date:
Number fields. Other	Prior Authorization Post OP
fields in this section	Number: Through Date:
	Provider Information.
are completed when	1
applicable.	Provider Last Name or Provider First
	Organization Name:
	National Powider
	ID:
	Medicaid Provider Number: PROVIDER#
2. Complete Provider	
Organization Name	Referring Physician Provider No: (Carolina Arcess Physician CLIA Number:
and Medicaid Provider	(Carolina Areess Physician CLIA Number: Number)
Number fields. Other	
fields in this section,	
including the Referring	
Physician (Carolina	
ACCESS Number)	
field are completed	
when applicable.	

NCECS-Web	Claims Entry	Screen	Examples,	continued
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North Carolina Electronic Claims Submission (.) Main Meno (.) Chine Entry Dental (	Misrellazenss China Information       3. Select "Yes" for Release of Information .         EPSDT:       C Fellow-up         EPSDT:       C Yes         EPSDT:       C Yes
<ul> <li>Reports</li> <li>Claim Submission</li> <li>Reference Materials</li> </ul>	Related Causes: Auto Arcident State of Auto Arcident:
4. Select "12" for Place of Service Facility Type Code.	Place of Service Facility Type Code: 12-Hame Chain Submission Reason Code: 1-Original Rendering/Attending Information
	RiA Provider First Name:

# NCECS-Web Claims Entry Screen Examples, continued

North Carolina Electronic Claims Submission () Maia Meas () China Endry () Datal (* CMS-1200 (* 1018-92) (* Edit Management (* Exports (* China Submission (* Exformed Materials	Information R/A Provider First Name: R/A Provider Last Name: R/A Medicaid Provider Number: Number:						
	CMS-1990 Insurance Detail 5. Use only when a payment has been made from a Third Party source.						
	Diagrania Codes         6. Enter the ICD-9-CM code with no decimal points.           Principal:         PCD9						
	Additional         1						
	CMS-1500 Denal 7. Click here to enter the details of the service provided. See the next page for more instruction. Chain Nete						

#### NCECS-Web Claims Entry Screen Examples, continued

#### CMS-1500 Add/Edit Details for PCS

North Carolina Electronic Claims Submission (1) <u>Main Mens</u> (1) <u>Claime Entry</u> (1) <u>Claime Entry</u> (1) <u>Claime Entry</u> (1) <u>Claime Entry</u> (1) <u>Claime Entry</u>	CMS 1500 . Please complete "Cancel" button	the following	; forma to creasta/aciti	: CMS 1500 denal :	tense. Click the "Save" button to save the second	and return to the main edit pa	p. Click the
NUE-92 Liet Managementi Especie Claim Submission Reference Materials	Claim Type: Becipient Inf Last None: CMS 1500 Det	8. 1 Pro field	cedure Coo	de – then s	Date of Service, Place of croll to the right to complet next screen print.		
		*	From Date of Service	Through Dute Of Service	Place of Service	BCPCS/CPT	Modil
	Edit Copy	Del A 1	08012004	08012004	12	\$5125	
	Edit Cepy	Del A 2	08022004	08022004	12	85125	
	Báit Cepy	Del A 3	08032004	08032004	12	85125	
	Bdit Cepy	Del A 4	08042004	08042004	12	\$5125	
	Edit Cepy	Del A 5	08072004	08072004	12	85125	
	Báit Cepy	Del A 6	08082004	08082004	12	85125	
	Add Clear					×	-

CMS-1500 Add/Edit Details for PCS, continued



#### NCECS-Web Claims Entry Screen Examples, continued

#### CMS-1500 Add/Edit Details for PCS-Plus

North Carolina Electronic Claims Submission () Main Mens () Claims Entry () Decid () Color 100	CMS 1500 Add E dit Details Please couplets the following from to create/edit CMS 1500 detail items. Click the "Save" button to save the records and actum to the main edit page. Click the "Cancel" button to abort the transaction.						
Chil5-1200 Chil5-1200 Child Managementi Chile Managementi Chile Submission Reference Materiale	Claim Type: Recipient Inform Last Name:	8. pr	ocedure co	ode – then	To Date of Service, Place of Ser scroll to the right to complete the he next screen print.		
	CMS 1990 Detail	_					
		*	From Date of Service	Through Date Of Service	Place of Service	BCPCS/CPT	Mod1
	Bdit Copy Del	1	08012004	08012004	12	99509	
	Edit Copy Del A	2	08022004	08022004	12	99509	
	Bdit Cepy Del	3	08032004	08032004	12	99509	
	Edit Cupy Del	4	08042004	08042004	12	99509	
	Edd Copy Del	5	08072004	06072004	12	99509	
	Bdit Cepy Del	6	08082004	06082004	12	99509	
	Add Clear				2		-

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



# TIPS FOR REDUCING CLAIM DENIALS

Eligib	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.		

## 17

Carol	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	The Medicaid recipient is enrolled with Carolina ACCESS for the dates of service rendered, but the Carolina ACCESS PCP's authorization number is <b>missing</b> from block 19 of the CMS-1500 or form locator 83B on the UB-92.		
	authorization number in 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 <b>invalid</b> .		
		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.		

Gener	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.	<ul> <li>This EOB is similar to EOBs 21 and 22 with the following exceptions:</li> <li>There is more than one detail on the same claim with the same date of service. Both details will deny with EOB 1198.</li> <li>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</li> </ul>		
		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.	<ul> <li>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.</li> <li>For more information about EOB 18 and EOB 8918, refer to Section 8 of the <i>General Medicaid Billing/Carolina</i> ACCESS Policies and Procedures Guide on DMA's website www.dhhs.state.nc.us/dma/medbillcaguide.htm.</li> </ul>		

Program	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.	

Gary H. Fughay, Director Division of Medical Associate Department of Health and Human Services

<u>Cheryll Collier</u> Executive Director EDS