

NC MEDICAID

Managed Care Billing Guidance to Health Plans

Revision 30.0

Contents

| | | |
|----------|---|----------|
| 2 | Medicaid Managed Care Billing Guidance..... | 4 |
| 3 | Impacted Service Areas..... | 5 |
| 3.0 | Abortions..... | 5 |
| 3.1 | Autism screenings..... | 5 |
| 3.2 | Care Management Payments..... | 5 |
| 3.3 | Child Medical Evaluation and Medical Team Conference for Child Maltreatment (CMEP) | 5 |
| 3.3.1 | Law Enforcement Referred CME Claims | 6 |
| 3.4 | Special Pricing | 6 |
| 3.4.1 | Durable Medical Equipment (DME) Miscellaneous Codes | 6 |
| 3.4.2 | DME Manual Pricing Rules | 8 |
| 3.4.3 | Unlisted CPT Codes: | 8 |
| 3.4.4 | Multiple Procedure Code Reductions | 8 |
| 3.5 | Dental Operating Room Facility Services | 9 |
| 3.5.1 | Claims Submission for Ambulatory Surgical Centers (ASC)..... | 9 |
| 3.5.2 | Claims Submission for Hospital Dental Treatment | 9 |
| 3.5.3 | Billing for Anesthesia Services in an Ambulatory Surgical Center for Dental Surgeries | 10 |
| 3.6 | Adjudicating Claims Based on Codes Submitted | 10 |
| 3.6.1 | Federal Guidance on Emergency Conditions | 11 |
| 3.6.2 | NCCI and MUE Edits | 11 |
| 3.7 | Copayment Rules | 12 |
| 3.7.1 | Emergency Department Copay | 12 |
| 3.7.2 | Copayment Rules and Exemptions | 13 |
| 3.8 | Federally Qualified Health Centers and Rural Health Clinics (RHCs) | 15 |
| 3.8.1 | FQHC/RHC Core Service Payments: | 15 |
| 3.8.2 | FQHC/RHC Wraparound (Wrap) Payments | 15 |
| 3.9 | HCPCS/NDC Crosswalk Guidance by Claim Type | 19 |
| 3.10 | Hospital Acquired Conditions | 21 |
| 3.11 | Hysterectomy..... | 21 |
| 3.12 | Hospital Claims..... | 21 |
| 3.12.1 | Inpatient Hospital Billing..... | 21 |
| 3.12.2 | DRG Payment Methodology | 21 |
| 3.12.3 | Clinical Services Billing and Reimbursement Guidance for NC Select Drugs (including Cell & Gene Therapies)..... | 22 |
| 3.12.4 | Lower Level of Care..... | 24 |
| 3.13 | Lab Test Codes | 24 |
| 3.14 | Medical Home Fees..... | 25 |
| 3.15 | Newborns..... | 25 |
| 3.15.1 | Newborn Clinical Information..... | 25 |
| 3.16 | Pregnancy Global Bundle | 25 |

| | | |
|--------|---|----|
| 3.17 | Pregnancy Management Program Payments | 26 |
| 3.18 | Procedure Codes | 26 |
| 3.18.1 | Covered Procedure Codes | 26 |
| 3.19 | Revenue Codes | 26 |
| 3.19.1 | Revenue Codes and NDC Codes | 26 |
| 3.19.2 | Covered Revenue Codes | 27 |
| 3.19.3 | Institutional Hospital Outpatient Claims | 27 |
| 3.19.4 | Institutional Claims and Revenue Codes | 27 |
| 3.20 | Sterilizations | 33 |
| 3.21 | Skilled Nursing Facilities | 33 |
| 3.21.1 | Short Term Skilled Nursing Facilities | 33 |
| 3.22 | Taxonomy Claims Guidance: | 33 |
| 3.22.1 | Professional Claims Pricing | 35 |
| 3.23 | Tribal Payment Policy | 35 |
| 3.24 | Value-Based Payments/Alternative Payment Models | 39 |
| 3.25 | Well Child Visit | 39 |
| 3.25.1 | Vaccines for Children | 39 |
| 3.26 | 340B Drugs | 39 |
| 3.26.1 | Long-Acting Reversible Contraception (LARCs) | 40 |
| 3.27 | Other Insurance | 40 |
| 3.27.1 | Explanation of Benefits (EOB) | 40 |
| 3.27.2 | Pay and Chase | 40 |
| 3.27.3 | Program and Service Exceptions for TPL and Coordination of Benefits | 41 |
| 3.27.4 | Third Party Liability (TPL) Bypass Rules | 42 |
| 3.28 | Electronic Attachments | 48 |
| 3.29 | Transaction Fees | 48 |
| 3.30 | Line Service Unit and NDC Fields on Claims and Encounters | 48 |
| 3.31 | Claims Guidance for Provider Enrollment File | 49 |
| 3.31.1 | Provider Location Matching Guidance: | 49 |
| 3.31.2 | Out of Network Provider Affiliation Guidance | 49 |
| 3.31.3 | NPI Attending Provider Field for Prepaid Inpatient Health Plan (PIHP) ONLY | 50 |
| 3.32 | Psych/Rehab Hospital Reimbursement Guidelines for Inpatient Hospital Claims | 50 |
| 3.33 | High Dollar Review and Itemized Bills Guidance | 50 |
| 3.34 | Independent Lab Reimbursement | 51 |
| 3.35 | Known System Issues | 52 |
| 3.36 | Payments for Non-Rate Floor Permanent Rates | 52 |
| 3.36.1 | Lesser of Payment Methodology | 53 |
| 3.37 | Rate Floors | 53 |
| 3.38 | Rate Differentials | 53 |
| 3.39 | Telehealth Codes and Modifiers | 53 |
| 3.40 | Pended Claims | 54 |

| | | |
|-----------------|---|---------------|
| 3.41 | Clean Claim Date Guidance..... | 55 |
| 3.42 | Adjustments..... | 55 |
| 3.43 | DPU vs. Non-DPU Inpatient Stays with Both Behavioral Health and Physical Health Services .. | 55 |
| 3.44 | Inpatient Stays with Enrollment or Eligibility Changes | 56 |
| 3.45 | Remittance Advice Guidance | 58 |
| 3.46 | Professional Dispensing Fee..... | 58 |
| 3.47 | Endoscopy Codes and Pricing | 59 |
| 3.48 | Behavioral Health vs Physical Health Claims Guidance | 60 |
| 3.49 | Personal Care Services (PCS) Reimbursement Methodology | 74 |
| 3.50 | Tailored Care Management (TCM) | 74 |
| 3.50.1 | General Guidance for Health Plans..... | 74 |
| 3.50.2 | Procedure Codes and Claims Submissions..... | 75 |
| | Others | 76 |
| 4 | Provider Education | 77 |
| 4.1 | Provider Training..... | 77 |
| 4.2 | Inclusion in Provider Contract/Manual..... | 77 |
| 5 | Versions | 77 |

2 MEDICAID MANAGED CARE BILLING GUIDANCE

The Department’s Managed Care Billing Guidance to health plans is designed to:

- Supplement clinical coverage policies and Medicaid provider bulletins,
- Reduce provider administrative burden,
- Ensure consistency in provider billing practices for key Medicaid services, and
- Allow for accurate and complete NC Medicaid and Centers for Medicare & Medicaid Services (CMS) reporting.

The billing guide references requirements to adhere to NC Medicaid Direct clinical coverage policies which reference to NCTracks or GDIT (the Department’s fiscal agent). Unless specifically noted within this billing guide, the health plan should not interpret this requirement as requiring the health plan or provider to submit information through NCTracks, but rather to provide direction for how providers should submit to the health plan claims platform. Any reference to adhere to an NC Medicaid Direct clinical coverage policy does not alleviate the health plan’s responsibility to accept and adjudicate all NC Medicaid Managed Care claims for their enrolled members.

The billing guidance may be updated by the Department to include additional requirements based on feedback from health plans, providers, or other stakeholders.

Health plans should refer to and comply with the health plan contract for billing requirements.

3 IMPACTED SERVICE AREAS

3.0 Abortions

The health plan shall require providers to complete and submit the Abortion Statement outlined in Clinical Coverage Policy 1E-2 Attachment C of the policy to the health plan ([NC Medicaid: Obstetrics and Gynecology Clinical Coverage Policies \(ncdhhs.gov\)](#)) and maintain records of completed consent form consistent with the health plan contract and federal statute. The health plan shall not pay claims for this service without (1) receipt of the form from the provider, and (2) review and validation of the form by the health plan.

3.1 Autism screenings

Providers must perform routine screening for Autism Spectrum Disorder (ASD) at 18 and 24 months of age. An ASD screen may be administered at a “catch-up” visit if the 18- or 24-month visit was missed. Providers may screen for developmental risk for ASD at ages greater than 30 months when the provider or caregiver has concerns about the child. The structured screening tool should be validated for the child’s chronological age.

The health plan shall require providers to use CPT Code 96110 and EP modifier when conducting a general developmental or an ASD screen. Additional information on developmental screening can be found in the [Health Check Program Guide](#).

3.2 Care Management Payments

In addition to the payment for services provided, the health plan shall pay each Tier 3 Advanced Medical Home (AMH) practice a care management fee as described in Section V.D.4.p. of the Revised and Restated Health Plan Contract. The health plan shall pay each Tier 3 AMH a care management fee on a per member per month (PMPM) basis without requiring the AMH to bill for the care management fee.

3.3 Child Medical Evaluation and Medical Team Conference for Child Maltreatment (CMEP)

When a child is referred for an exam for suspected maltreatment by the child welfare agency, the Health Plan shall require the rostered CMEP providers to follow the Child Medicaid Evaluation (CME) and Medical Team Conference for Child Maltreatment Policy and bill according to 1A-5 Attachment A., i.e., requiring the CME claim be submitted with the Child Medical Evaluation Checklist (Attachment B). The Health Plan shall reimburse both in-network and out-of-network providers for the service consistent with the requirements of Session Law 2017-57 and the resulting June 2017 Joint Conference Committee report.

Additionally, health plans shall not require providers to enroll in the health plan’s network to provide this service to their members. Once a CME claim is received, the health plan can confirm that the submitted checklist was signed off by someone within the CMEP program; a list of the CMEP staff who can sign the CME form is maintained on the [CME website](#).

For coverage and claims processing guidance please refer to the [UNC School of Medicine Pediatrics Reimbursement for CMEs webpage](#).

3.3.1 Law Enforcement Referred CME Claims

[Clinical Policy 1A-5](#) should not be referenced for law enforcement cases. There are no specific requirements for CME claims referred through law enforcement. These claims should be processed as any other claim for services rendered.

3.4 Special Pricing

3.4.1 Durable Medical Equipment (DME) Miscellaneous Codes

When reporting claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DME/POS) Miscellaneous services, health plans shall direct providers to submit both the National DME Miscellaneous and corresponding Local W Codes based on the chart below. When both codes represent miscellaneous services, e.g. E1399 and W4047, a description of the product/service must also be included. As with all claims processed by the health plan, these claims must be reported to the Encounter Processing System. For direction on how to include these codes on the Health Plan encounter record, please see the [Encounter Data Submission Guide](#). If the encounter is submitted without a valid combination, the health plan will be required to correct the claim and resubmit the encounter.

| National | Description | Local | Local Description |
|----------|--|-------|---|
| E1399 | Durable medical equipment, miscellaneous | W4001 | CO/2 SATURATION MONITOR WITH ACCESSORIES, PROBES |
| E1399 | Durable medical equipment, miscellaneous | W4002 | MANUAL VENTILATION BAG (e.g. AMBU BAG) |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4005 | UNLISTED REPLACEMENT OR REPAIR PARTS |
| E1399 | Durable medical equipment, miscellaneous | W4016 | BATH SEAT, PEDIATRIC (e.g. TLC) |
| E1399 | Durable medical equipment, miscellaneous | W4047 | MISCELLANEOUS FOR DME |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4117 | WHEELCHAIR SEAT WIDTH, GREATER THAN 27" |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4118 | WHEELCHAIR SEAT DEPTH, GREATER THAN 25" |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4119 | WHEELCHAIR SEAT HEIGHT, COST ADDED OPTION FROM MANUFACTURER |
| E1399 | Durable medical equipment, miscellaneous | W4120 | DISPOSABLE BAGS FOR INSPIREASE INHALER SYSTEM, set of 3, |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4130 | CONTOURED OR 3-PIECE HEAD/NECK SUPPORTS WITH HARDWARE, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4131 | BASIC HEAD/NECK SUPPORT WITH HARDWARE, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4132 | CONTOURED OR 3-PIECE HEAD/NECK SUPPORT WITH MULTI-ADJUSTABLE HARDWARE, EACH |

| | | | |
|-------|--|-------|--|
| K0108 | Wheelchair component or accessory, not otherwise specified | W4133 | BASIC HEAD/NECK SUPPORT WITH MULTI-ADJUSTABLE HARDWARE, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4139 | SUB-ASIS BARS WITH HARDWARE, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4140 | ABDUCTOR PADS WITH HARDWARE, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4141 | KNEE BLOCKS WITH HARDWARE, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4143 | SHOE HOLDERS WITH HARDWARE, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4144 | FOOT/LEGREST CRADLE, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4145 | MANUAL TILT-IN-SPACE OPTION, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4150 | MULTI-ADJUSTABLE TRAY, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4152 | GROWTH KIT, EACH |
| E1399 | Durable medical equipment, miscellaneous | W4153 | TRACHEOSTOMY TIES, TWILL, EACH |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4155 | ADDUCTOR PADS WITH HARDWARE, PAIR |
| B9998 | NOC for enteral supplies | W4211 | LOW PROFILE GASTROSTOMY EXTENSION/REPLACEMENT KIT FOR CONTINUOUS FEEDING, EACH |
| B9998 | NOC for enteral supplies | W4212 | LOW PROFILE GASTROSTOMY EXTENSION/REPLACEMENT KIT FOR BOLUS FEEDING, EACH |
| E1399 | Durable medical equipment, miscellaneous | W4670 | STERILE SALINE, 3 CC VIAL, EACH |
| E1399 | Durable medical equipment, miscellaneous | W4678 | REPLACEMENT BATTERY FOR PORTABLE SUCTION PUMP ADAPTIC AND TRANSPARENT TYPE SUCH AS TEGADERM OR OPSITE for use with external insulin pump, EACH |
| E1399 | Durable medical equipment, miscellaneous | W4688 | SINGLE POINT CANE FOR WEIGHTS 251# TO 500# |
| E1399 | Durable medical equipment, miscellaneous | W4689 | |
| E1399 | Durable medical equipment, miscellaneous | W4690 | UNDERARM CRUTCHES FOR WEIGHTS 251# TO 500# |
| E1399 | Durable medical equipment, miscellaneous | W4691 | FIXED-HEIGHT FOREARM CRUTCHES FOR WEIGHTS TO 600# |
| E1399 | Durable medical equipment, miscellaneous | W4695 | GLIDES/SKIS FOR USE WITH WALKER |

| | | | |
|-------|--|-------|--|
| K0108 | Wheelchair component or accessory, not otherwise specified | W4713 | OVERSIZED FOOTPLATES FOR WEIGHTS 301# AND GREATER, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4714 | SWINGAWAY SPECIAL CONSTRUCTION FOOTRESTS FOR WEIGHTS 401# AND GREATER, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4715 | SWINGAWAY REINFORCED LEGREST, ELEVATING, FOR WEIGHTS 301# TO 400#, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4716 | SWINGAWAY SPECIAL CONSTRUCTION LEGRESTS, ELEVATING, FOR WEIGHTS 401# AND GREATER, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4717 | OVERSIZED CALF PADS, PAIR |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4718 | OVERSIZED SOLID SEAT |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4719 | OVERSIZED SOLID BACK |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4722 | OVERSIZED FULL SUPPORT FOOTBOARD |
| K0108 | Wheelchair component or accessory, not otherwise specified | W4723 | OVERSIZED FULL SUPPORT CALFBOARD |
| E1399 | Durable medical equipment, miscellaneous | W4733 | REPLACEMENT OVERSIZED INNERSPRING MATTRESS FOR HOSPITAL BED W/ WIDTH TO 39" |

3.4.2 DME Manual Pricing Rules

Rules for DME manual pricing can be found in the [2017 May Medicaid bulletin](#) on page 16. Questions about DME manual pricing should be directed to the Medicaid Contact Center at 888-245-0179 or Medicaid.DMEREquest@dhhs.nc.gov.

3.4.3 Unlisted CPT Codes:

The health plan shall require providers to bill the CPT that most accurately describes the service or procedure provided. If such a code does not exist, the provider should bill with the unlisted CPT from the appropriate section of the CPT book. The health plan shall direct providers to follow the instructions for submission of these codes as described in the current CPT manual, published by the American Medical Association.

3.4.4 Multiple Procedure Code Reductions

Professional Claim Multiple Procedure Code Reductions: Information about the use of the CPT, HCPCS, and ICD-10 books for the choice of correct codes and modifiers for professional claims is included in Attachment A of NC Medicaid Clinical Coverage Policies. Modifier 51 is used to indicate a procedure performed in addition to the primary procedure. There are CPT codes that can be billed without modifier 51. These codes are published in Appendix E of CPT book published annually by the AMA. Modifiers are defined, along with information about usage, in Appendix A of the CPT book.

Institutional Claim Multiple Procedure Code Reductions: The hospital base rates do not assume that multiple procedure reductions for inpatient and outpatient services occur. Applying multiple procedure reductions for inpatient or outpatient facility services would be in violation of the rate floor requirements in Section 11.4.1 of the Contract.

3.5 Dental Operating Room Facility Services

3.5.1 Claims Submission for Ambulatory Surgical Centers (ASC)

~~“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”~~

Health plans are expected to process claims for Dental Operating Room Facility Services billed by an Ambulatory Surgical Center according to the details outlined in the Ambulatory Surgical Center Fee Schedule located on the [DHB Fee Schedule and Covered Code Portal](#)

| Field | Information Submitted |
|------------------|---|
| Claim Type | Professional CMS-1500 Claim |
| Place of service | “24” for the Ambulatory Surgical Center |
| Procedure Codes | HCPCS code G0330 (Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room). |
| Modifier | SG |
| Units | <p>Effective Jan. 1, 2024 – Current: Only “1” unit should be submitted on detail line 1 of the claim as the total number of units. *These claims are reimbursed using the fee schedule flat rate.</p> <p>Effective Oct. 4, 2023 – Dec. 31, 2023: The total operating room time on detail line 1 of the claim (1 unit = 1 minute). <i>(Inclusion of this data on the claim is for informational purposes only)</i> *These claims are reimbursed using the fee schedule flat rate.</p> <p>Effective Jan. 1, 2023 - Oct. 4, 2023: The total operating room time on detail line 1 of the claim (1 unit = 1 minute). *These claims are reimbursed based on total time for the service using fee schedule rate groups.</p> |
| Fee | All charges are indicated on detail line 1 of the claim |

These claims are reimbursed based on the Ambulatory Surgical Center Dental Fee Schedule located on the [DHB Fee Schedule and Covered Code Website](#).

3.5.2 Claims Submission for Hospital Dental Treatment

If a Medicaid beneficiary covered under Managed Care is seen in a hospital setting for dental treatment, the following three claims are generated:

1. **Dentist (ADA Claim Form)** These services are carved out of Managed Care and processed in the NCTracks system and submitted on the Dental ADA claim.

2. **Anesthesiologist (CMS 1500 Claim Form)** services are covered under managed care. Claims are processed by the health plan and submitted on a Professional CMS-1500 claim.
3. **Hospital (Institutional UB Claim Form)** facility services are covered under managed care. Claims are processed by the health plan and submitted on an Institutional UB claim.

Example of a Hospital Claim for Dental Facility Charges:

| Field | Information Submitted |
|----------------|---|
| Claim Type | Institutional UB-04 837-I |
| Revenue Code | As appropriate for a dental operating room case (eg. 0360 – OR services general) |
| Procedure Code | As appropriate for a dental operating room case (eg. 41899 – dental surgical procedure) |

Reimbursement: pricing determined by ratio of cost to charge (RCC)

3.5.3 Billing for Anesthesia Services in an Ambulatory Surgical Center for Dental Surgeries

Anesthesiologists and certified registered nurse anesthetists (CRNAs) bill for anesthesia services rendered in ambulatory surgical centers using a CMS-1500 claim form. Claims are paid based on total anesthesia time.

Anesthesia time begins when the anesthesiology provider prepares the beneficiary for induction of anesthesia and ends when the beneficiary can be placed under postoperative supervision and the anesthesiology provider is no longer in personal attendance.

Providers must complete the CMS-1500 claim form as follows:

- a. Enter a dental ICD-10-CM diagnosis codes in block 21.
- b. Enter place of service code “24” for the ambulatory surgical center in block 24B.
- c. Enter CPT anesthesia code “00170” (anesthesia for intraoral procedures, including biopsy; not otherwise specified) in block 24D.
- d. Enter one of the following modifiers in block 24D:
 - QX—Services performed by CRNA with medical direction by a physician
 - QZ—Services performed by CRNA without medical direction by a physician
 - QY—Medical direction of one CRNA by an anesthesiologist
 - QK—Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
 - AA—Anesthesia services performed personally by anesthesiologist
 - QS—Monitored anesthesia care service (must be billed along with one of the modifiers listed above)
- e. Enter total anesthesia time in minutes in block 24G on the claim form

3.6 Adjudicating Claims Based on Codes Submitted

“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”

It is the Department's expectation that health plans shall not change any data element that comes in on a claim during pre- and post-adjudication reviews. NC Medicaid requires that claims are adjudicated and paid based on codes submitted by the provider on the claim. The codes submitted by the provider to the health plans are chosen based on medical record clinical documentation of the member's presenting condition as well as services received. Processing claims based on codes that were not submitted may be in violation of rate floors.

3.6.1 Federal Guidance on Emergency Conditions

The term "emergency medical condition" means—

- A. a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
 - i. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - ii. serious impairment to bodily functions, or
 - iii. serious dysfunction of any bodily organ or part; or
 - iv. with respect to a pregnant woman who is having contractions—
 - a. that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - b. that transfer may pose a threat to the health or safety of the woman or the unborn child. 42 USC § 1395dd(e)(1)

Further, the Department notes the following the guidance on this subject provided in the Federal Register:

As stated in 42 CFR 438.114: The Health Plan "may not limit what constitutes an emergency medical condition...on the basis of lists of diagnoses or symptoms"

"While this standard encompasses clinical emergencies, it also clearly requires managed care plans and states to base coverage decisions for emergency services on the apparent severity of the symptoms at time of presentation, and to cover examinations when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. The final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis. The purpose of this rule is to ensure that enrollees have unfettered access to health care for emergency medical conditions, and that providers of emergency services receive payment for those claims meeting that definition without having to navigate through unreasonable administrative burdens."

3.6.2 NCCI and MUE Edits

NC Medicaid reimburses Professional and DME services on the basis of a HCPCS or CPT fee schedule; therefore, NCCI and MUE editing will be applied to these claims.

NC Medicaid policy only requires outpatient lab, drug and radiology claims to be submitted with a revenue code and valid HCPCS or CPT code. Since NC Medicaid is capturing the HCPCS or CPT on these services the State only applies NCCI and MUE editing to these claim details.

PHPs shall apply NCCI edits as outlined above. Therefore, OP Hospital NCCI edits are only applicable to OP lab, drug, and radiology claims.

3.7 Copayment Rules

3.7.1 Emergency Department Copay

State Plan Definition - The health plan shall use the following basis to define non-emergency, emergency, and psychiatric emergency conditions:

- **Non-Emergency Services:** Non-emergency services are all services or care not considered Emergency Services as determined by the attending physician when an enrollee visits the emergency department. Definition of non-emergency care is defined as any health care services provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospitals will operationalize this process by performing the required screening on the patient and if they determine the condition non-emergent (determined by medical professionals at the hospital), the ER staff (either a nurse, doctor, or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic), call their managed care organization when they are open, or locating an urgent care clinic that may be available.

Note: With the exception of behavioral health, intellectual/development disability (I/DD) and traumatic brain injury (TBI) services, all non-emergency services are NOT exempt from copayment.

- **Emergency Medical Services:** Emergency medical conditions are medical or behavioral health conditions, regardless of diagnoses or symptoms, that manifest in acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or serious harm to self or others. The hospital may not impose limits on what constitutes an emergency medical condition.

Note: These services are exempt from copayment.

- **Psychiatric Emergency Services:** Psychiatric emergency condition are symptoms characterized by an alteration in the perception of reality, feelings, emotions, actions, or behavior requiring immediate therapeutic intervention in order to avoid immediate damage to the patient, other persons, or property. A psychiatric emergency shall not be defined on the basis of lists of diagnoses or symptoms.

Note: These services are exempt from copayment.

3.7.2 Copayment Rules and Exemptions

The following copay exemption rules apply for Medicaid. The list below contains exemptions that should be applied; however, it is not intended to be comprehensive.

General Rules: The following general copay exemption rules apply for Medicaid:

- A copay is not deducted on any details when a multiple line claim for the same date of service is received with a qualifying reason for bypass (e.g., Member is under 21 years or member is enrolled in the Medicaid Annual Family Planning Determination in North Carolina (MAFDN)).
- On a multi-line claim with the same date of service, each line is evaluated separately for copay. If a line on the claim is not exempt, then the copay will be deducted from the claim, even if other lines on the claim are exempt from copay. Only one copay can be deducted per date of service per billing provider.
- On a multi-line claim with different dates of service each line is evaluated separately for copay. If a line on the claim is not exempt, then the copay will be deducted from the claim, even if there are other lines on the claim which are exempt from copay. A copay can be deducted for each service date per provider when multiple service dates are billed on a single claim.
- A copay is not deducted from a claim when a claim in history with the same provider, same date of service, same member has already deducted a copay.
- Copay exemption criteria can be determined at either the claim header or claim detail. If the copay exemption is at the claim header level such as the beneficiaries age is < 21 or the billing provider is a Federally Qualified Health Center (FQHC), then claim line copay criteria is not considered. If no claim header copay exemption exists, then each claim line will be evaluated for a copay.
- The following claim types are copay exempt: inpatient, nursing facility, hospice, home health, personal care services, behavioral health, Medicare crossover, durable medical equipment ambulance and non-emergency medical transportation (NEMT) claims
- Members required to pay a premium to receive Medicaid, are exempt from copays once they meet the threshold for out-of-pocket medical expenses.

Copay Exemptions Effective Oct. 1, 2023:

- Please see Contract Amendment 15/16 Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing

Copay Exemption Effective Nov. 1, 2023:

Please see Contract Amendment 16/17 Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, i. Cost Sharing

Member Eligibility Copay Exemptions

Members that fall under the following populations are exempt from copays:

- a recipient who is under the age of 21 years
- a recipient who is enrolled in MPW (Medicaid for Pregnant Women)
- a recipient who is enrolled in the Innovations Waiver
- a recipient who is enrolled in the TBI Waiver Program
- a claim for a recipient residing in a nursing facility, ICF/MR, or mental health hospital
- a recipient who is a tribal member or has previously received tribal services in the past

Provider Driven Copay Exemptions

Claims billed with the following providers are copay exempt:

- the billing provider is an Indian Health Provider (IHP)/Tribal Provider
- the billing provider is an FQHC
- the billing provider is a Rural Health Center
- the billing provider is NC Correction Enterprises (Nash Optical)
- a service is rendered at a tribal free-standing facility or tribal provider-based facility
- The billing provider is providing a 1915(C) HCBS Service
- The billing provider is a Comprehensive Outpatient Rehabilitation Facility
- The billing provider is a Health Dept billing for tuberculosis or a sexually transmitted disease or infection

Service Copay Exemptions

Copay is exempted for outpatient claims when

- a claim is billed for emergency services
- a claim billed for postoperative, out of hospital care management associated with a surgical procedure
- a claim billed for family planning services
- a claim is billed with condition code AJ (member exempt from copay)
- a claim is billed for care/case management services
- a claim is billed for non-physician patient education
- a claim is billed for mental health crisis intervention
- a claim is billed pathology or other lab testing procedures
- a claim is billed for radiology, echocardiography, or other imaging services
- a claim is billed for vaccine administration
- claims billed with diagnosis codes associated with pregnancy, childbirth, and puerperium, to include prenatal care.
- a claim is billed for dialysis procedures or from a dialysis facility
- Medications billed as professional claims [PADP medications]
- A claim is billed for DME, orthotics and prosthetics
- A claim is billed for Home Infusion Therapy
- A claim is billed for an annual adult wellness exam
- A claim is billed for any pandemic-related services
- A claim is billed by a Health Department for tuberculosis or sexually transmitted disease or infection
- A claim billed for HIV antiretroviral medication

3.8 Federally Qualified Health Centers and Rural Health Clinics (RHCs)

3.8.1 FQHC/RHC Core Service Payments:

~~*“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”*~~

For Standard Plans: Standard Plans will operate under the existing FQHC/RHC payment methodology found in steps 1 – 4 found in section 3.8.1 FQHC/RHC Core Services through July 31, 2024. Beginning Aug. 1, 2024, the Standard Plans will adopt the new FQHC/RHC wrap payment methodology found in section 3.8.2.

- The health plan shall define FQHC/RHC core services as defined in [Clinical Coverage Policy No: 1D-4](#).
- The health plan shall require the use the T1015 HCPCS code, including HI and SC modifiers, when appropriate, as defined in Clinical Coverage Policy No: 1D-4 Attachment A to bill for Core Services.
- If services are provided on the same day, the health plan shall follow the Department’s defined billing guidelines outlined in Clinical Coverage Policy No: 1D-4 Attachment B.
- FQHC/RHC core services are exempt from copayments.

For Tailored Plans: Tailored Plans will operate under the existing FQHC/RHC payment methodology found in steps 1 – 4 found in section 3.8.1 FQHC/RHC Core Services through Nov. 30, 2024. Beginning December 1, 2024, the Tailored Plans will adopt the new FQHC/RHC wrap payment methodology found in section 3.8.2.

1. The health plan shall define FQHC/RHC core services as defined in [Clinical Coverage Policy No: 1D-4](#).
2. The health plan shall require FQHC/RHCs to use the T1015 HCPCS code, including HI and SC modifiers, when appropriate, as defined in Clinical Coverage Policy No: 1D-4 Attachment A to bill for Core Services.
3. If services are provided on the same day, the health plan shall follow the Department’s defined billing guidelines outlined in Clinical Coverage Policy No: 1D-4 Attachment B.
4. FQHC/RHC core services are exempt from copayments.

3.8.2 FQHC/RHC Wraparound (Wrap) Payments

For Standard Plans: Standard Plans will operate under the new FQHC/RHC wrap payment methodology found in section 3.8.2 FQHC/RHC Wrap Payments beginning August 1, 2024, and will reimburse FQHC/RHC providers under the new wrap payment methodology for claims with a date of service (DOS) on or after August 1, 2024. The fee schedules for the wrap payment methodology have an effective date of July 1, 2023. Standard Plans will not be required to reprocess claims for this fee schedule update back

to the July 1, 2023 effective date; instead, the Department will perform a reconciliation for the period between July 1, 2023 through July 31, 2024

For Tailored Plans: Tailored Plans will operate under the new FQHC/RHC wrap payment methodology found in section 3.8.2 FQHC/RHC Wrap Payments beginning December 1, 2024, and will reimburse FQHC/RHC providers under the new wrap payment methodology for claims with a date of service (DOS) on or after December 1, 2024. The fee schedules for the wrap payment methodology have an effective date for Tailored Plans of December 1, 2024. Tailored Plans will not be required to reprocess claims for the period between July 1, 2024 through November 30, 2024; instead, the Department will perform a reconciliation for this period.

FQHC/RHC Wrap Payment Calculations: The new FQHC/RHC Wrap Payment methodology will require PHPs to pay wrap payments in addition to statewide base rate payments for Core Service Visits and Well Child Visits, up to the provider specific Prospective Payment System Alternate Payment Methodology (PPS-APM) Rate to FQHC and RHC providers for eleven procedure (or procedure: modifier) codes, which include Core Service Visits (T1015), including HI and SC modifiers, when appropriate as defined in [Clinical Coverage Policy No: 1D-4](#) and Well Child Visits (99381-99385 and EP as one of the modifiers; 99391-99395 and EP as one of the modifiers).

1. The Base Rate for Core Service Visits and Well Child Visits are standard for all providers and are documented in the North Carolina State Plan.
2. The “wrap” payment shall be equal to the difference between the Base Rate and a separate, provider specific Prospective Payment System – Alternate Payment Methodology (PPS-APM) rate (maximum allowable rate) whereby the total amount paid to the FQHC/RHC must equal the PPS APM rate. *(see Fig. 1)*
 - a. Calculations shall include:
 1. T1015 or Well Child base rate which is either paid in full by PHP or reduced because there is Third Party Payment. *(see Fig. 2 and Fig. 3)*
 - b. “Wrap” payments do not apply to the following ancillary services.
 1. Pharmacy claims remain separately billed and payable.
 2. Diagnostic lab services remain separately billed and payable – even if on the same claim as T1015/Well Child.
 3. Physician hospital services remain separately billed and payable – even if on the same claim as T1015 / Well Child.
 1. FQHC or RHC physician-professional services which are performed in a hospital inpatient ~~(Place of Service (POS) 21)~~ or outpatient setting ~~(POS 19, 22)~~ and billed under the taxonomy 193200000X (Multi-Specialty) are separately reimbursable under the Physician Services Fee Schedule; not the FQHC/RHC fee schedules.

2. FQHC or RHC physician-professional services that are not performed in a hospital inpatient or outpatient setting and billed under the FQHC or RHC taxonomy with non-hospital place of service are not separately reimbursable and will be reimbursed under the FQHC/RHC PPS rate.
3. The provider's unique maximum allowable rate (PPS-APM rate) will be published on the FQHC/RHC Core Service Fee Schedule.
4. The provider shall not bill for a Core Service and a Well Child Visit on same DOS for same recipient.
5. The "wrap" payment shall be paid on Core Service and Well Child visits where Base Rate Payment is not equal to zero. If the Base Rate Payment is zero, a "wrap" payment should not be made.

Figure. 1: Wrap Payment equal to Provider Specific PPS APM less Base Rate (Allowed Amount):

| Provider Type | Service | Service Codes | Statewide Base Rate (Allowed Amount) | Sample Provider Specific PPS APM Rate | Paid Wrap Payment Amount |
|---------------|--------------|----------------------------------|--------------------------------------|---------------------------------------|--------------------------|
| FQHC | Core Service | T1015 | \$117.32 | \$305.00 | \$187.68 |
| RHC | Core Service | T1015 | \$83.30 | \$305.00 | \$221.70 |
| FQHC / RHC | Well Child | 99381EP-99385EP, 99391EP-99395EP | \$80.33 | \$305.00 | \$224.67 |

Fig. 2: Wrap Payment equal to Provider Specific PPS-APM rate less Base Rate (Allowed Amount):

| Procedure Code | Claim Line Status | Billed Amount | Allowed Amount (Base Rate) | Medicaid Co-pay Amount | Other Payor Paid Amount | Base Rate Payment = Base Rate - Other Payer Paid Amount | Sample PPS APM rate | Paid Wrap Payment Amount (PPS APM Rate – Allowed Amount) |
|----------------|-------------------|---------------|----------------------------|------------------------|-------------------------|---|---------------------|--|
| T1015 | PAID | \$200.00 | \$117.32 | \$0.00 | \$101.55 | \$15.77 | \$350.00 | \$232.68 |

Fig. 3: Wrap Payment equal to zero when (Base Rate less Third-Party Payment <0); Note: Example includes Lab Service (85018) that is paid separately from wrap payment.

| Procedure Code | Claim Line Status | Billed Amount | Allowed Amount | Medicaid Co-pay Amount | Other Payor Paid Amount | Base Rate Payment = Base Rate - Other Payer Paid Amount | Sample PPS APM rate | Paid Wrap Payment Amount | Amount Billed and Paid Separately from Wrap Payment | Notes |
|----------------|-------------------|---------------|----------------|------------------------|-------------------------|---|---------------------|--------------------------|---|--------|
| T1015 | PAID | \$200.00 | \$117.32 | \$0.00 | \$150.00 | \$0.00 | \$350.00 | \$0.00 | N/A | Note 1 |
| 90460 | PAID | \$20.45 | \$0.00 | \$0.00 | \$15.00 | \$0.00 | N/A | N/A | N/A | Note 2 |

| Procedure Code | Claim Line Status | Billed Amount | Allowed Amount | Medicaid Co-pay Amount | Other Payor Paid Amount | Base Rate Payment = Base Rate - Other Payer Paid Amount | Sample PPS APM rate | Paid Wrap Payment Amount | Amount Billed and Paid Separately from Wrap Payment | Notes |
|----------------|-------------------|---------------|----------------|------------------------|-------------------------|---|---------------------|--------------------------|---|--------|
| 90651 | PAID | \$0.00 | \$0.00 | \$0.00 | \$30.00 | \$0.00 | N/A | N/A | N/A | Note 2 |
| 85018 | PAID | \$5.00 | \$2.95 | \$0.00 | \$1.00 | N/A | N/A | N/A | \$1.95 | Note 3 |

Note 1: Wrap payment is zero because Other Payor payment > Base Rate

Note 2: Pays zero from Medicaid Fee Schedule and is included in PPS APM Rate

Note 3: Diagnostic Lab Pays separately pursuant to Medicaid Fee Schedule and is excluded from PPS APM Rate

FQHC/RHC Wrap Payment Claims Submissions:

1. Wrap Payment adjustments should be submitted for both paid and voided claims.
2. The “wrap” payment amount should be reported on the provider’s ASC x12 835 Electronic Remittance Advice:
 - a. Under the Service Payment Information in the Service Adjustment segment at the line level on a CAS segment with:
 - Claim Adjustment Group Code (CAGC) ‘CO’ (Contractual Obligation)
 - and Claim Adjustment Reason Code (CARC) 172 with Adjustment Amount *that will* be negative to show additional funds were remitted to the provider. Reference section 3.2.4 of the Encounter Data Submission Guide for additional information.
 - b. The Provider Paid amount reported on the provider’s remittance shall equal the Base Rate amount for a Core Service Visit or a Well Child Visit plus the “wrap” amount (full PPS amount).
 - i. Note: remittance advice should reflect the full payment amount to the provider inclusive of the base rate plus the wrap payment amount.
3. PHPs shall continue to process claims from FQHCs and RHCs for those services not listed above, however, payment for those ancillary services shall be set at “\$0”; the PPS APM rate has been grossed up to reimburse for those services not listed (ex: 99212, w/ ‘25’ Modifier or PADP Drugs). See *Figures 1-2* for additional examples (note that examples do not include TPL).
 - a. The previous utilization of ancillary services has been factored into the maximum allowable rate (PPS-APM rate) for each provider.

- b. FQHCs and RHCs shall continue to bill for services not listed. Utilization of these services going forward will be used for future calculations of the maximum allowable rate (PPS-APM rate).
- c. There is no change to Pharmacy Point of Sale reimbursement; these shall continue to be reimbursed per the approved NC Medicaid State Plan methodology.
- d. There is no change to Lab Service reimbursement; these shall continue to be reimbursed per the approved NC Medicaid State Plan methodology.
- e. Pregnancy Medical Home Incentive Payments (S0280 / S0281) shall continue to be reimbursed per the approved NC Medicaid State Plan Methodology.
- f. FQHCs and RHCs should submit claims to health plans with their NPI listed as the Billing Provider.

Fig. 1: Allowed Amount [T1015 Base Rate] less Provider-Specific PPS APM Rate [Paid Amount] equals Adjustment Amount [“wrap” payment]

| Core Service Example | | | | | | | | |
|----------------------|---------------|--------------|----------|---------------|----------------|--------------------|-----------------------|-----------------|
| Provider Type | Service | Service Code | Modifier | Billed Amount | Allowed Amount | Adjustment Amount* | Total Net Paid Amount | Adjustment Code |
| FQHC | Core Service | T1015 | | \$200 | \$117.32 | -\$187.68 | \$305 | 172 |
| FQHC | Vaccine Admin | 90460 | EP | \$20.45 | \$0 | \$0 | \$0 | 45 |
| FQHC | Vaccine | 90651 | | \$0 | \$0 | \$0 | \$0 | 45 |
| FQHC | Lab | 85018 | | \$5.00 | \$3.01 | \$0 | \$3.01 | 45 |

Fig. 2: Allowed Amount [Well Child Base Rate] less Provider-Specific PPS APM Rate [Paid Amount] equals Adjustment Amount [“wrap” payment]

| Well Child Example | | | | | | | | |
|--------------------|------------|--------------|----------|---------------|----------------|--------------------|-----------------------|-----------------|
| Provider Type | Service | Service Code | Modifier | Billed Amount | Allowed Amount | Adjustment Amount* | Total Net Paid Amount | Adjustment Code |
| FQHC | Well Child | 99381 | EP | \$115 | \$80.33 | -\$224.67 | \$305 | 172 |
| FQHC | EPSDT | 96110 | EP | \$0 | \$0 | \$0 | \$0 | 45 |
| FQHC | Sick Visit | 99212 | 25 | \$21.54 | \$0 | \$0 | \$0 | 45 |
| FQHC | Lab | 85018 | | \$5.00 | \$3.01 | \$0 | \$3.01 | 45 |

3.9 HCPCS/NDC Crosswalk Guidance by Claim Type

Medical Claim Types and HCPCS/NDC Clarification:

- The HCPCS/NDC crosswalk is adapted primarily to be used for professional claims. Health plans cannot load the HCPCS/NDC crosswalk to adjudicate claims. The below guidance is to

support usage of the HCPCS/NDC Crosswalk and applies to drugs/products covered under the medical pharmacy benefit.

- Professional
 - Billed on the CMS 1500 or 837P.
 - Drugs are rebate eligible.
 - Note: Per the PADP policy 1B, there are some drugs/products which are excluded from the rebate eligibility requirement.
 - The PADP program applies to professional claims.
 - Drugs pay per the PADP fee schedule.
 - All HCPCS/NDC combinations for acceptable drugs are on the crosswalk table.
- Outpatient Dialysis Centers
 - Billed on a UB-04 or 837I with a Dialysis taxonomy (261QE0700X).
 - Dialysis Center claims pay based on the composite rates per the Dialysis policy, 1A-34.
 - If a HCPCS code is not included in the composite rate(s) and allowed per the Dialysis policy, the system pays per line item off the PADP fee schedule.
 - Drugs not included in the composite rate(s) and billed separately must be rebate eligible and paid based on the PADP fee schedule.
 - Note: Per the PADP policy 1B, there are some drugs/products which are excluded from the rebate eligibility requirement.
 - Health plans must check for a valid HCPCS code and a valid/active NDC on outpatient drug claim lines since NC Medicaid collects rebates on these drug agents.
 - Health plans should not deny an outpatient dialysis claim line because the HCPCS/NDC combination is not active on the crosswalk table.
- Outpatient Hospital (excluding Dialysis)
 - Billed on a UB-04 or 837I.
 - Drugs are rebate eligible.
 - Note: Per the PADP policy 1B, there are some drugs/products which are excluded from the rebate eligibility requirement.
 - Outpatient Hospitals can bill for covered outpatient drugs and they are not restricted to the drugs listed on the PADP.
 - Hospitals may use the drug information (HCPCS and NDC) listed in the PADP Fee Schedule; however, OP hospital payment is based on the Ratio of Cost to Charge (RCC) methodology.
 - Health plans must check for a valid HCPCS code, a valid and active NDC, etc. on outpatient drug claim lines since NC Medicaid collects rebates on these drug agents.
 - Health plans should not deny an outpatient hospital claim line because the HCPCS/NDC combination is not active on the crosswalk table.
 - Outpatient hospital claims should be reimbursed at RCC.
- Inpatient Hospital Claims
 - Billed on a UB-04 or 837I.
 - Rebates are not collected for inpatient drugs.
 - The PADP program is not applicable to inpatient claims.
 - DRG pricing is applied.
 - Inpatient hospital claims for rehab and psych are reimbursed under the per diem methodology.
 - The HCPCS/NDC crosswalk does not apply to inpatient claims.

3.10 Hospital Acquired Conditions

The health plan shall require providers to follow the requirements for reporting and reimbursing for hospital acquired conditions as outlined in [Clinical Coverage Policy 2A-1](#). Specific examples are noted in the following sections of Attachment B:

- C. Reporting of Never Events and Hospital-Acquired Conditions
- D. Procedures to Follow for Reporting Avoidable Errors (Never Events)
- E. Procedures to Follow for Report POA and HAC Indicators

3.11 Hysterectomy

The health plan shall require providers to complete and submit the Hysterectomy Statement outlined in [Clinical Coverage Policy 1E-1 Attachment B](#) to the health plan (NC Medicaid: Obstetrics and Gynecology Clinical Coverage Policies) and maintain completed statements consistent with the health plan contract and federal statute. The health plan shall not pay claims for this service without (1) receipt of the form from the provider, and (2) review and validation of the form by the health plan.

3.12 Hospital Claims

~~“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”~~

Health plans are required to stay current with the annual October 1 update and any periodic CMS MS DRG Grouper versions. The current Grouper version can be found in the Grouper DRG Weight Table fee schedule.

3.12.1 Inpatient Hospital Billing

The health plan shall pay for an inpatient length of stay for their members even when the member disenrolls after the hospital admission. If a health plan receives a retroactive disenrollment effective date which precedes the date of the hospital admission, then the health plan is not responsible for the inpatient length of stay.

3.12.2 DRG Payment Methodology

DRG Payment:

Inpatient claims are categorized into a diagnosis-related group (DRG) for payment purposes by an ICD10 MS DRG Grouper software. Each DRG has a payment weight assigned that is calculated from the average cost to treat patients with conditions that fall into that DRG.

To calculate the DRG base payment for a claim, the following formula is used:

$$\text{Hospital-Specific DRG Base Rate} * \text{DRG Weight}$$

Outlier Payment:

If a service qualifies for both cost outlier and day outlier payments, the outlier payment shall be determined by selecting the greater of the cost or day outlier payment.

When a hospital stay is for an exceptionally high cost or long length of stay and meets the outlier criteria, the claim is eligible for an outlier payment in addition to the DRG base payment, if the cost or number of days exceeds the threshold.

To calculate the Cost Outlier payment for a claim, the following formula is used:

- Allowable Charges * Inpatient Cost to Charge (IPRCC) = Calculated Cost Outlier
- Calculated Cost Outlier – Cost Outlier Threshold = Cost Over Threshold
- Cost Over Threshold * 75% = Payable Cost Outlier Amount
- Total DRG Payment + Payable Cost Outlier Amount = Total DRG Payment

To calculate the Day Outlier payment for a claim, the following formula is used:

- Total Covered Days – Day Outlier Threshold = Days Over Threshold
- Total DRG Amount / Average Length of Stay (ALOS) = DRG Per Diem
- DRG Per Diem * 75% = Day Outlier Per Diem
- Day Outlier Per Diem * Days Over Threshold = Day Outlier Amount
- Total DRG Amount + Payable Day Outlier Amount = Total DRG Payment

When health plans disallow a service for non-allowable charges or billing errors on a claim line, they shall supply the provider with a clear explanation of the reason the service was not allowed.

3.12.3 Clinical Services Billing and Reimbursement Guidance for NC Select Drugs (including Cell & Gene Therapies)

1. Drugs on the NC Select Drug List, including but not limited to Cell & Gene Therapies (CGTs), which meet the definition of a covered outpatient drug, as defined in 42 CFR § 447.502, are covered under the NC Medicaid Benefit.
 - a. NC Medicaid maintains a NC Select Drug List, which can be modified by the State for inclusion or exclusion of additional drugs.
2. Health plans should notify the State when:
 - a. Hospital providers request prior approval (PA) for a NC Select Drug,
 - b. Claims are received for an NC Select Drug, and
 - c. Claims are paid for an NC Select Drug.
3. Billing and Claims Submission
 - a. Inpatient services related to the administration of NC Select Drugs will be reimbursed using the existing DRG payment methodology and will be based on the primary diagnosis code and grouped to the appropriate DRG. The PA number shall be included on the claim.
 - b. **Hospital** outpatient services related to the administration of NC Select Drugs will be reimbursed using the existing **Revenue Ratio of Cost to Charge (RCC)** Outpatient payment methodology. The PA number shall be included on the claim.

- c. For NC Select Drugs, the cost of the drug shall be submitted on the claim, with the corresponding HCPCS code and NDC.
 - i. NC Select Drugs shall be carved out of the inpatient DRG or outpatient RCC **and listed on a separate line for drug reimbursement, specifying the drug with the appropriate HCPCS and NDC to be claimed-reimbursed-separately to- by NC Medicaid. Total reimbursement will consist of both DRG-based reimbursement and AAC drug invoice reimbursement.**
 - ii. An invoice must be attached to the claim to support the actual drug acquisition cost.
 - iii. The cost submitted on the claim line must equal the NC Select Drug cost as documented on the invoice of purchase, net of any discounts or rebates received by the hospital/provider.
 - iv. **Providers shall file inpatient claims for NC Select Drugs with the product-specific ICD-10-PCS code, if one has been assigned. If a product-specific code has not been assigned, providers shall file inpatient claims with the most specific available billing code.**
 - v. **Providers shall file outpatient claims for NC Select Drugs with the product-specific HCPCS code, if one has been assigned. If a product-specific code has not been assigned, providers shall use HCPCS J3590.**
- d. NC Select Drugs administered in the hospital setting, either inpatient or outpatient, should be claimed by the hospital provider directly to the appropriate Medicaid plan the member is enrolled in.
 - i. Inpatient and outpatient hospitals cannot “white bag” or leverage specialty pharmacies as an administrative vehicle for billing the drug. NC Medicaid will not reimburse point of sale pharmacies, including Specialty Pharmacies, directly for NC Select Drugs.
 - ii. The hospital CEO, CFO, or appropriate designee is required to attest that the net invoice cost reflects the actual costs incurred by the hospital for the drug, to include all cost offsets such as rebates received by the hospital, or discounts. The hospital designee can attest to the validity of the invoice cost by signing the submitted invoice, including their printed name and title.
 - iii. **Bona Fide Service Fees (meeting federal definition in 42 CFR § 423.501) ~~shall not be included in the net invoice cost.~~ are not required to be reported as cost offsets by the provider.**

4. Reimbursement Guidance

- a. Drugs administered in an inpatient setting shall be reimbursed by the plan based on the ingredient component of the NC Select Drug at the Actual Acquisition Cost (AAC) net of all costs such as rebates received by the hospital, and discounts.
- b. Drugs administered in an outpatient hospital setting shall be reimbursed by the plan based on the ingredient component of the NC Select Drug at the lesser of the AAC or Average Sales Price (ASP) net of all costs such as rebates received by the hospital, or discounts.

- c. Drugs administered in a professional outpatient setting shall be reimbursed by the plan based on the ingredient component of the NC Select Drug at the lesser of the AAC or the ASP net of all costs such as rebates, received by the provider, or discounts.
- d. The plan shall reimburse drugs added to the NC Select Drug List according to the reimbursement logic provided in this section within 45 Calendar Days of notification from the Department that the NC Select Drug List has been amended.

3.12.4 Lower Level of Care

The health plan shall pay for an inpatient length of stay for their members even when the member disenrolls after the hospital admission. If a health plan receives a retroactive disenrollment effective date which precedes the date of the hospital admission, then the health plan is not responsible for the inpatient length of stay.

When a member is reduced to Lower Level of Care (LLOC), the hospital must indicate on the claim that the member was discharged and then readmitted, resulting in multiple claims for billing, even though the member continues to receive care in the facility.

Lower Level of Care Billing:

- **Taxonomy with associated Specialties:** 282N00000X, 273R00000X, 273Y00000X, 284300000X, 283Q00000X, 282NC0060X
- **Bill Types:** 66X Nursing Facility Level of Care, 28X Ventilator Level of Care

Lower Level of Care Payment Methodology:

- Obtain the 'All Inclusive Per Diem' rate from Hospital Lower Level of Care Rate fee schedule.
- Multiply the claim approved days (reimbursable units) by per diem rate to get the calculated allowed amount.

*Note: Swing Bed Hospital Fee Schedule/Taxonomy is provider specific. LLOC policy applies to Acute Care hospitals.

3.13 Lab Test Codes

NC Medicaid reimburses in office labs in accordance with the CLIA certification of that office. For example, the following codes are covered in the office setting if the office is CLIA certified to perform the test. The Department has historically reimbursed the lab codes below in an in-office place of service. There is no policy denying lab tests for place of service 11.

- 80061 – Lipid Panel
- 80305 – Drug Test PRSMV Dir Opt Obs
- 82248 – Bilirubin Direct

- 82962 – Glucose Blood Test
- 87081 – Culture Screen Only
- 87086 – Urine Culture/Colony Count
- 87425 – IAAD IA Rotavirus
- 87502 – Influenza DNA AMP Probe
- 87634 – RSV DNA/RNA AMP Prove
- 87651 – Strep A DNA AMP Probe
- 87651QW - Strep A DNA AMP Probe
- 87633 - RESP Virus12-25 Targets

3.14 Medical Home Fees

In addition to the payment for services provided, the health plan shall pay an AMH practice of any tier a medical home fee as described in Section V.D.4.p. of the Revised and Restated Health Plan Contract. The health plan shall pay each AMH a medical home fee on a PMPM basis without requiring the AMH to bill for the medical home fee.

3.15 Newborns

The health plan shall direct providers to bill a newborn's claims to their assigned Medicaid ID. Providers shall not be allowed to bill newborn claims to the mother's ID following delivery. The delivery is charged to the Mother's ID, but all services provided to the newborn are charged to the newborn's ID.

3.15.1 Newborn Clinical Information

For newborns the plans must ensure eligibility is established and the information is appropriately communicated to the Department. Health plans should allow additional time, up to 30 days after birth, for hospitals to batch and send additional requested clinical data to the health plans or allow the health plans to access this information through integration with the hospital's electronic medical record.

For additional information on Newborns please refer to the Playbook:

3.16 Pregnancy Global Bundle

The health plan shall allow providers to bill the global obstetrics bundle as defined in Section V.C.1.c.viii. of the Revised and Restated Health Plan Contract.

NC Medicaid wants to improve data collection to ensure a complete and more accurate picture of prenatal and postpartum care delivery. Two new, non-paid, F codes have been added to NC Medicaid's clinical policy 1E-5, Obstetrical Services. The two F codes include 0500F for Initial Prenatal Visits and 0503F for Postpartum Care Visits. Both codes are defined in the NCQA HEDIS® value sets and are meant to support more accurate and complete data collection around prenatal and postpartum care delivery in North Carolina.

Effective for dates of service on or after July 1, 2025, delivery claims will deny if 0500F is not in claims history. This includes individual delivery and global or package claims. 0503F is to be billed with the comprehensive postpartum examination. Global obstetric claims should not be submitted until the postpartum examination has been completed.

3.17 Pregnancy Management Program Payments

The health plan shall direct Pregnancy Management Program providers to bill the appropriate codes.

NC Medicaid is establishing a complete list of procedure codes under the Pregnancy Management Program, which will be posted to the NC Medicaid's website. All providers of OB services will be considered Pregnancy Management Program Providers.

[Please refer to 1E-6 of the clinical coverage policy.](#)

3.18 Procedure Codes

3.18.1 Covered Procedure Codes

For the list of covered procedure codes, please reference the [Fee Schedule and Covered Codes Portal](#). Health plans should contact NC Medicaid if they intend to remove covered codes from their system or are notified of any code related issues from providers.

3.19 Revenue Codes

3.19.1 Revenue Codes and NDC Codes

The health plan shall submit a National Drug Code (NDC) on claims where drug procedure codes are reported separately. All institutional and professional claims must include a valid 11-digit NDC code for each claim detail line that includes a drug procedure code. All pharmacy related revenue codes are required to also have a HCPCS/CPT code reported.

- This requirement applies to revenue codes in the 250-259 and 631 – 639 range.
- Revenue codes 251, 252, 254, and 257 should include an edit indicating that a HCPCS/CPT code must be reported. Both revenue code ranges indicate that a HCPCS/CPT code must be submitted on outpatient claims.

The following drug codes require the NDC on professional and institutional claims:

- J codes, including miscellaneous and unlisted drug codes
- Drug related C codes, including miscellaneous and unlisted drug codes
- Drug related Q codes, including miscellaneous and unlisted drug codes
- Drug related S codes, including miscellaneous and unlisted drug codes
- Drug related A codes, including miscellaneous and unlisted drug codes, radiopharmaceuticals
- Drug related CPT codes, including miscellaneous and unlisted drug codes (e.g. immunizations, Synagis, immune globulins)

A valid HCPCS/CPT code along with units of service must be entered on claims along with the NDC and NDC quantity (based on assigned unit of measure). NDC codes are not required for vaccines or immunizations. Administration codes should not be billed with an NDC code and shall result in a denial of the administration code.

All claims must be converted to an 11- digit 5-4-2 format (e.g., 99999-9999-99) for billing purposes.

- 10-digit NDC code formats can be converted into the 11-digit format by adding leading zeros
 - 4-4-2 (09999-9999-99)
 - 5-3-2 (99999-0999-99)
 - 5-4-1 (99999-9999-09)
- NDC codes that are not billed in the 11-digit format should be rejected as a provider billing error

Billing NDC codes in addition to drug CPT/HCPCS codes eliminate the need to request additional documentation/ information in order to identify a specific drug service.

3.19.2 Covered Revenue Codes

For the list of covered revenue codes, please reference the covered revenue codes page on the [Fee Schedule and Covered Codes Portal](#).

3.19.3 Institutional Hospital Outpatient Claims

The health plan shall not use Hospital Outpatient Prospective Payment System (OPPS) protocols to reimburse institutional hospital outpatient claims.

When a HCPCS is not required to be billed with a Revenue Code, then the claim line is reimbursed through Ratio of Cost to Charge (RCC) pricing. The reimbursement methodology calculation for RCC Pricing = Billed Amount x Outpatient Hospital RCC Rate x 100% (managed care only).

When reimbursement of an outpatient claim line is based on the procedure code then the claim line is reimbursed through fee schedule pricing.

3.19.4 Institutional Claims and Revenue Codes

Consistent with NC Medicaid Direct institutional claims processing, when reimbursement of a claim line is based only on the revenue code, the health plan shall not require submitted procedure codes to be checked for coverage or validity; unless the procedure code requires an NDC (refer to section 3.9).

Outpatient hospital claims with revenue codes that require a submitted procedure code must validate the submitted codes are valid and covered; including revenue codes, procedure codes (HCPCS or CPT) and, when applicable, National Drug Code (NDC, see Section 3.19.3).

Claim lines submitted with the following revenue codes do not require a procedure code and should not be denied as non-covered/ invalid procedure code:

| Revenue Code Group | Revenue Code |
|--|--------------|
| 010X - All-inclusive Rate | 0100 |
| | 0101 |
| 011X - Room and Board Private (one bed) | 0110 |
| | 0111 |
| | 0112 |
| | 0113 |
| | 0114 |
| | 0116 |
| | 0117 |
| | 0118 |
| | 0119 |
| | |
| 012X - Room and Board Semiprivate (two beds) | 0120 |
| | 0121 |
| | 0122 |
| | 0123 |
| | 0124 |
| | 0126 |
| | 0127 |
| | 0128 |
| | 0129 |
| | |
| 013X - Room and Board (3 & 4 beds) | 0130 |
| | 0131 |
| | 0132 |
| | 0133 |
| | 0134 |
| | 0136 |
| | 0137 |
| | 0138 |
| | 0139 |
| | |
| Revenue Code Group | Revenue Code |
| 019X - Subacute Care | 0190 |
| | 0191 |
| | 0192 |
| | 0193 |
| | 0194 |
| | 0199 |

| Revenue Code Group | Revenue Code |
|--------------------------------------|--------------|
| 014X - Room and Board Deluxe Private | 0140 |
| | 0141 |
| | 0142 |
| | 0143 |
| | 0144 |
| | 0146 |
| | 0147 |
| | 0149 |
| 015X - Room and Board Ward | 0150 |
| | 0151 |
| | 0152 |
| | 0153 |
| | 0154 |
| | 0156 |
| | 0157 |
| | 0158 |
| 016X - Other Room and Board | 0159 |
| | 0160 |
| | 0164 |
| | 0167 |
| 017X - Nursery | 0169 |
| | 0170 |
| | 0171 |
| | 0172 |
| | 0173 |
| | 0174 |
| | 0179 |
| 018X - Leave of Absence | 0183** |
| | |
| Revenue Code Group | Revenue Code |
| 026X - IV Therapy | 0260 |
| | 0261 |
| | 0262 |
| | 0263 |
| | 0264 |
| | 0269 |

| | | | |
|-----------------------------------|------|---|-------|
| 020X - Intensive Care Unit | 0200 | 027X - Medical/Surgical Supplies and Devices | 0270* |
| | 0201 | | 0271 |
| | 0202 | | 0272 |
| | 0203 | | 0273 |
| | 0204 | | 0275 |
| | 0206 | | 0276 |
| | 0207 | | 0278 |
| | 0208 | | 0279 |
| | 0209 | | |
| | | 028X - Oncology | 0280 |
| 021X - Coronary Care Unit | 0210 | | 0289 |
| | 0211 | 029X - Durable Medical Equipment (Other than Renal) | 0290 |
| | 0212 | | 0299 |
| | 0213 | 032X - Radiology Diagnostic | 0320 |
| | 0214 | | 0321 |
| | 0219 | | 0322 |
| 022X - Special Charges | 0220 | | 0323 |
| | 0221 | | 0324 |
| | 0222 | | 0329 |
| | 0223 | 033X - Radiology Therapeutic and/of Chemotherapy Administration | 0330 |
| | 0224 | | 0331 |
| | 0229 | | 0332 |
| 023X - Incremental Nursing Charge | 0230 | | 0333 |
| | 0231 | | 0335 |
| | 0232 | | 0339 |
| | 0233 | 034X - Nuclear Medicine | 0340 |
| | 0234 | | 0341 |
| | 0239 | | 0342 |
| 024X - All-inclusive Ancillary | 0240 | | 0343 |
| | 0241 | | 0344 |
| | 0242 | | 0349 |
| | 0243 | | |
| | 0249 | | |
| Revenue Code Group | | Revenue Code | |
| 036X - Operating Room Services | 0360 | 044X - Speech Therapy Language Pathology | 0440 |
| | 0361 | | 0441 |
| | 0362 | | 0442 |
| | 0367 | | 0443 |
| | 0369 | | 0444 |

| | |
|---|---------------------|
| 037X - Anesthesia | 0370 |
| | 0371 |
| | 0372 |
| | 0379 |
| 038X - Blood and Blood Products | 0380 |
| | 0381 |
| | 0382 |
| | 0383 |
| | 0384 |
| | 0385 |
| | 0386 |
| | 0387 |
| | 0389 |
| 039X - Administration, Processing and Storage for Blood and Blood Components | 0390 |
| | 0392 |
| | 0399 |
| 040X - Other Imaging Services | 0400 |
| | 0401 |
| | 0403 |
| 041X - Respiratory Services | 0410 |
| | 0412 |
| | 0413 |
| | 0419 |
| 042X - Physical Therapy | 0420 |
| | 0421 |
| | 0422 |
| | 0423 |
| | 0424 |
| | 0429 |
| 043X - Occupational Therapy | 0430 |
| | 0431 |
| | 0432 |
| | 0433 |
| | 0434 |
| | 0439 |
| Revenue Code Group | Revenue Code |
| 054X - Ambulance | 0542 |
| | 0543 |
| | 0544 |
| | 0545 |

| | |
|--|---------------------|
| | 0449 |
| 045X - Emergency Room | 0450 |
| | 0451 |
| | 0452 |
| | 0456 |
| | 0459 |
| 046X - Pulmonary Function | 0460 |
| | 0469 |
| 047X - Audiology | 0470 |
| | 0471 |
| | 0472 |
| | 0479 |
| 048X - Cardiology | 0480 |
| | 0481 |
| | 0482 |
| | 0483 |
| | 0489 |
| 049X - Ambulatory Surgical Care | 0490 |
| | 0499 |
| 050X - Outpatient Services | 0500 |
| | 0509 |
| 051X - Clinic | 0510 |
| | 0511 |
| | 0512 |
| | 0513 |
| | 0514 |
| | 0515 |
| | 0516 |
| | 0517 |
| | 0519 |
| Revenue Code Group | Revenue Code |
| 072X - Labor Room/Delivery | 0720 |
| | 0721 |
| | 0722 |
| | 0723 |

| | |
|---|--------------|
| | 0546 |
| | 0549 |
| 055X - Skilled Nursing | 0550 |
| | 0551 |
| | 0559 |
| 057X - Home Health Aide | 0570 |
| 058X - Home Health Other Visits | 0580 |
| | 0581 |
| | 0589 |
| 062X - Medical/Surgical Supplies - Extension of 027X | 0621 |
| | 0622 |
| | 0623 |
| 065X - Hospice Service | 0651 |
| | 0652 |
| | 0655 |
| | 0656 |
| 065X - Hospice Service 067X - Outpatient Special Residence Charges 068X - Trauma Response | 0658 |
| | 0659 |
| | 0679 |
| | 0681 |
| | 0682 |
| | 0683 |
| 067X - Outpatient Special Residence Charges | 0684 |
| 068X - Trauma Response 070X - Cast Room 071X - Recovery Room Revenue Code Group | 0689 |
| | 0700 |
| | 0710 |
| | 0719 |
| | Revenue Code |
| 082X - Hemodialysis - Outpatient or Home | 0821 |
| 071X - Recovery Room 083X - Peritoneal Dialysis - Outpatient or Home | 0829 |
| | 0831 |
| Revenue Code Group | 0839 |
| 084X - Continuous Ambulatory Peritoneal Dialysis (CAPD)- Outpatient or Home | 0841 |
| | 0851 |

| | |
|--|------|
| | 0724 |
| | 0729 |
| 073X - EKG/ECG Electrocardiogram | 0730 |
| | 0731 |
| | 0732 |
| | 0739 |
| 074X - EEG Electroencephalogram | 0740 |
| | 0749 |
| 075X - Gastrointestinal Services | 0750 |
| | 0759 |
| 076X - Specialty Services | 0760 |
| | 0761 |
| | 0762 |
| | 0769 |
| 077X - Preventive Services | 0770 |
| 078X - Telemedicine | 0780 |
| 079X - Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) | 0790 |
| | 0799 |
| 080X - Inpatient Renal Dialysis | 0800 |
| | 0801 |
| | 0802 |
| | 0803 |
| | 0804 |
| | 0809 |
| 081X - Acquisition of Body Components | 0810 |
| | 0811 |
| | 0812 |
| | 0813 |
| | 0819 |

| | |
|---|------|
| 085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home | |
| 088X - Miscellaneous Dialysis | 0880 |
| | 0881 |
| 084X - Continuous Ambulatory Peritoneal Dialysis (CAPD)- Outpatient or Home | 0889 |
| 090X - Behavioral Health Treatments/Services (also see 091X, and extension of 090X) | 0900 |
| 088X - Miscellaneous Dialysis | 0901 |
| | 0905 |
| | 0906 |
| 090X - Behavioral Health Treatments/Services (also see 091X, and extension of 090X) 091X - Behavioral Health Treatments/Services - Extension of 090X | 0907 |
| | 0911 |
| | 0914 |
| | 0915 |
| | 0916 |
| 091X - Behavioral Health Treatments/Services - Extension of 090X 092X - Other Diagnostic Services | 0917 |
| | 0918 |
| | 0919 |
| | 0920 |
| | 0921 |
| | 0922 |
| | 0923 |
| 092X - Other Diagnostic Services 094X - Other Therapeutic Services - See also 095X | 0924 |
| | 0925 |
| | 0929 |
| | 0940 |
| | 0942 |
| | 0943 |
| | 0944 |
| 094X - Other Therapeutic Services - See also 095X | 0945 |
| | 0946 |
| | 0947 |
| | 0948 |
| | 0949 |
| | |
| | |
| | |
| | |

**270: A HCPCS is required for Home Health claims*

***0183: A HCPCS is required when billed by Behavioral Health residential facilities.*

3.20 Sterilizations

The health plan shall require providers to complete and submit the Sterilization Consent Form outlined in [Clinical Coverage Policy 1E-3](#) Attachment C and maintain completed consent forms consistent with the health plan contract and federal statute. The health plan shall not pay claims for this service without (1) receipt of the form from the provider, and (2) review and validation of the form by the health plan.

3.21 Skilled Nursing Facilities

As stated in [Clinical Coverage Policy 2B-1](#), Skilled Nursing Facility (SNF) providers should bill the most appropriate codes that accurately describe the service provided. Room and board is not restricted to Revenue Codes 100 and 183. Health plans can refer to the covered code list for covered room and board revenue codes. As a reminder, SNF room and board is reimbursed per diem at the Medicaid provider specific established fee schedule rate, regardless of the revenue code billed.

Members must be determined to meet long term care financial eligibility when this determination has been made the Patient's Monthly Liability (PML) will be added to the 834-file. Plans cannot pay nursing facility claims until the plan receives the 834-file confirming the PML. Once received, the health plan then pays the nursing facility for the member's stay minus the PML.

3.21.1 Short Term Skilled Nursing Facilities

Effective Jan. 1, 2023, NC Medicaid requires health plans to pay nursing facilities no less than 95% of the facilities' adjusted Medicare rate for the first 20 days of the nursing facility stay, and then pay no less than 80% of the facilities' adjusted Medicare rate for the remainder of the nursing facility stay covered under managed care.

If the nursing facility stay exceeds 90 days and the member is discharged back to NC Medicaid Direct, the 80% rate should remain in place until the member is discharged to NC Medicaid Direct.

3.22 Taxonomy Claims Guidance:

Providers must select a taxonomy as listed in the Provider Permission Matrix based on their license and scope of practice. The Department will perform credentialing based on the taxonomy (-ies) for which the provider is enrolling. The enrolled taxonomy will be reported on the PEF in the Taxonomy Code field. Additional taxonomy level information is provided on the PEF for informational purposes only.

When claims are processed:

- The health plan shall validate the taxonomy code submitted on the claim against the Taxonomy Code field(s) sent for the provider on the PEF. The additional taxonomy level information provided for information purposes only on the PEF should NOT be used during the claim submission process.
- The health plan shall validate the claim's date of service against the enrolled taxonomy effective dates. In the case of inpatient stays, if a provider's taxonomy status changes during a

beneficiary's stay, taxonomy effective date validation should be based on the date of discharge for DRG based claims and should be based on the date of service for per diem claims.

- Once validated, the health plan shall price claims based on the taxonomy code submitted on the claim.

Example 1:

1649418971 has the following active taxonomy codes.

| Enrolled Taxonomy Code | Taxonomy Level 2 | Taxonomy Level 3 |
|------------------------|------------------|------------------|
| 101YM0800 | 101Y00000X | 101YM0800 |
| 363LA2200X | 363L00000X | 363LA2200X |
| 363LC1500X | 363L00000X | 363LC1500X |
| 363LF0000X | 363L00000X | 363LF0000X |
| 363LP0808X | 363L00000X | 363LP0808X |
| 363LP2300X | 363L00000X | 363LP2300X |
| 363L00000X | 363L00000X | |

- Claims submitted for the enrolled taxonomy code should price using that submitted taxonomy code
- Claims submitted with 101Y00000X should deny for invalid taxonomy since it is not an enrolled taxonomy code
- Claims previously paid for 101Y00000X should be adjusted to deny since it is not an enrolled taxonomy code

Example 2:

The provider below has the listed taxonomy codes with the following effective dates:

| Enrolled Taxonomy Code | Status Code | Begin Date | End Date | Taxonomy Level 2 | Taxonomy Level 3 | Disposition for DOS |
|------------------------|-------------|------------|------------|------------------|------------------|---------------------|
| 101YM0800X | Active | 05/20/2021 | 12/31/9999 | 101Y00000X | 101YM0800X | Pay |
| 101YM0800X | Term | 02/05/2021 | 05/19/2021 | 101Y00000X | 101YM0800X | Deny |
| 101YM0800X | Active | 02/19/2019 | 02/04/2021 | 101Y00000X | 101YM0800X | Pay |
| | | | | | | |
| 363LA2200X | Suspend | 08/02/2020 | 12/31/9999 | 363L00000X | 363LA2200X | Pend |
| 363LA2200X | Active | 02/01/2020 | 08/01/2020 | 363L00000X | 363LA2200X | Pay |
| | | | | | | |
| 363L00000X | Active | 08/31/2021 | 12/31/9999 | 363L00000X | | Pay |
| 363L00000X | Active | 10/01/2021 | 08/30/2021 | 363L00000X | | Pay |

- Claims with a date of service of May 17, 2021 submitted with 101YM0800X should deny as the enrolled taxonomy code was in a Term status.
- Claims with a date of service of Sept. 9, 2021 submitted with 363LA2200X should pend as the enrolled taxonomy code was in Suspend status.
- Claims with a date of service of Oct. 17, 2021 submitted with 363L00000X should pay as the enrolled taxonomy code was in Active status.

3.22.1 Professional Claims Pricing

The general rule for professional claims pricing is if the Billing Provider Taxonomy is 193200000X (multi-specialty) or 193400000X (single specialty), the health plan shall use the Rendering Provider Taxonomy to determine pricing; otherwise, the Billing Provider Taxonomy shall be used to determine pricing.

3.23 Tribal Payment Policy

This Tribal Payment Policy outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by a health plan.

IHCP refers to a “health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Providers operated by state recognized tribes are not considered IHCPs.

In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a “Tribal Provider Attestation.” This “Tribal Provider Attestation” letter from the EBCI Chief’s office shall be submitted to NC DHHS as part of the NC DHHS centralized credentialing process. The information about tribal providers will be shared with health plans through DHB’s existing process

This Policy applies to health plans and covers payment for covered services provided by IHCPs and other Tribal providers. This Policy shall apply to all IHCPs/Tribal providers regardless of the provider’s contracting status. The health plan shall implement:

Claim Submission

- Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.

Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NCTracks in fee for service.

Payment:

- Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the Office of Management and Budget (OMB) rate, for services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The health plan shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with health plan shall continue to follow those arrangements. OMB tribal rates for hospital IP and OP services are included and identified on the hospital fee schedule available on the [Fee Schedule and Covered Codes Portal](#).
- If a member seeks care at an Indian health provider out of state, the services to the member should be reimbursed by the OMB rate if applicable.
- To promote same day access and reduce barriers or burdens to a member such as transportation or taking time off from work, providers receiving the AIR rate may receive

multiple different service encounters per day (single day of service) such as but not limited to follows:

- Medical
 - Dental;
 - Behavioral; and,
 - One other, such as optical
 - The health plan shall reimburse I/T/U pharmacies for pharmacy claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan. (A maximum of two pharmacy AIR per patient per day).
 - High-cost drugs are excluded and are paid based on NC Medicaid's outpatient pharmacy "lessor of logic".
 - If more than two drugs are filled, additional drugs beyond the two will be paid at \$0 and should be used by the health plan for medication reconciliation.
 - The Pharmacy Point of Sale OMB encounter rate (ER) fee schedule is found on the fee schedule and covered codes portal. The fee schedule name is Indian Tribal (I/T/U) Pharmacy fee schedule.
 - There is no Tribal OMB rate for Ambulatory Surgical Center Fee Schedule; the health plan should follow the fee schedule on the fee schedule and covered codes portal.
- **Ambulatory Surgical:**
 - All procedures billed that fall under \$1,000 will be billed at the Outpatient OMB Rate.
 - All procedures that are \$1,000 and above will be billed at the Medicaid Fee Schedule rate.
 - Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.
 - All non-OMB rates for Tribal payment follows the regular NC Medicaid Direct methodology and fee schedules for health plans, unless otherwise defined in the Tribal Payment Policy.
 - Health plan shall comply with Health Plan Contract Section V.D.4.h., Indian Health Care Provider (IHCP) Payments
 - In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the health plan shall reimburse IHCPs as follows:
 - Those that are not enrolled as an FQHC, regardless of whether they participate in the health plan's network:
 - The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - The NC Medicaid Direct rate for services that do not have an applicable encounter rate.
 - Those that are enrolled as FQHCs, but do not participate in the health plan's network, an amount equal to the amount the health plan would pay a network FQHC that is not an IHCP.
 - The health plan shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

- The Indian Tribal (I/T/U) Home Health Fee schedule is posted on the [fee schedule and covered codes portal](#) and specific to just the Tribe codes and rates.
- The Skilled Nursing Facility Fee schedule is posted on the [fee schedule and covered codes portal](#) and specific to just the Tribe codes and rates.
- Health plan shall comply with Health Plan Contract Section V.F.1., Engagement with Federally Recognized Tribes with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.

The health plan shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

Prompt Pay

Health plan shall comply with Health Plan Contract Section V.H.1.d., Prompt Payment Standards.

- The health plan shall promptly pay Clean Claims, regardless of provider contracting status. The health plan shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.
 - Medical Claims
 - The health plan shall, within 18 calendar days of receiving a Medical claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.
 - The health plan shall pay or deny a Clean Medical Claim at lesser of 30 calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
 - A Medical Pended Claim shall be paid or denied within 30 calendar days of receipt of the requested additional information.
 - Pharmacy Claims
 - The health plan shall within 14 calendar days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.
 - A Pharmacy Pended Claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.
 - A Medical Pended Claim shall be paid or denied within 30 calendar days of receipt of the requested additional information.
 - If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within 90 calendar days of the notice requesting the required additional information, the health plan may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).
- The health plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest if applicable).
- Timely filing for Standard Plans
 - Dates of Service Prior to July 1, 2023*
 - Providers must submit claims (excluding Pharmacy point of sale claims) to the health plans within 180 calendar days from the covered date of service or discharge.

- When a member is retroactively enrolled with a health plan providers must submit claims to the health plans within 180 days from the member's enrollment date, excluding Pharmacy point of sale claims.
- Pharmacy point of sale claims must be submitted to the health plans within 365 calendar days from the date of the provision of care.

Dates of Service on or After July 1, 2023

- For dates of service on or after July 1, 2023, providers must submit claims to the health plans within 365 calendar days from the covered date of service, discharge or provision of care. This applies to the original claim submission and any subsequent corrected claims.
- When a member is retroactively enrolled with a health plan providers must submit claims to the health plans within 365 days from the member's enrollment date.

Exceptions

Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one year from the time submittal of the claim is otherwise required.

- Interest
 - The health plan shall pay interest on late payments to the Provider at the annual percentage rate of 18% beginning on the first day following the date that the claim should have been paid as specified in the Contract.
 - The health plan shall not be subject to interest payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).
- The health plan shall maintain written or electronic records of its activities under this Section in accordance with N.C. Gen. Stat. § 58-3-225(i).
- For purposes of actions which must be taken by a health plan as found in Health Plan Contract Section V.H.1.d., Prompt Pay Standards, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

Other Payment Sources

- Due to the change in payer hierarchy, the health plan will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.
- Tribal self-funded insurance is not a billable source for the EBCI, and therefore, health plan shall not attempt to coordinate benefits with that plan.

Sovereignty

No contractual relationship shall deny or alter tribal sovereignty.

3.24 Value-Based Payments/Alternative Payment Models

The health plan shall direct providers how to bill or receive payment for any value-based payment/alternative payment model arrangement included in the health plan provider contract as described in Section V.E.2 of the Revised and Restated Health Plan Contract.

3.25 Well Child Visit

The preventative health services/periodic screening portion of Medicaid's package of healthcare benefits for children is known as Early and Periodic Screening Diagnostic and Treatment (also referred to as *Health Check*). The health plan shall provide all EPSDT services without copay or other beneficiary expense, to Medicaid eligible children. The health plan shall pay these services as primary and chase any recoveries from the liable third-party insurance carriers. Furthermore, the health plan shall require all providers to bill well child visits for Medicaid children as defined in the NC Medicaid Health Check Program Guide, including the use of modifier EP respectively. You can find the NC Medicaid Health Check Program Guide linked in the *More Information* section of the [Wellness Visits, and Diagnostic and Treatment Services page](#).

3.25.1 Vaccines for Children

Vaccine for Children (VFC) coverage should be determined by individual vaccine name and NDC code. Health plans should NOT place VFC edits on CPT codes however VFC edits may be placed on NDCs. A complete list of vaccines and NDCs that qualify for VFC is available on the [CDC Vaccines for Children Program's Current CDC Vaccine Price List webpage](#).

3.26 340B Drugs

The health plan shall require providers to follow the 340B drugs billing requirements as defined in Section V.C.3.h.v. of the Revised and Restated Health Plan Contract.

Consistent with the [NC Medicaid: Pharmacy Services Clinical Coverage Policies](#), all 340B providers must submit the actual purchased drug price in the usual and customary charge field when dispensing 340B drugs. Additionally, providers submitting professional claims with 340B Drug information shall include a "UD" modifier on the applicable claim lines.

Providers may not dispense a 340B-purchased drug and bill Medicaid the calculated Medicaid price for non-340B drugs. For hemophilia drugs, 340B providers may submit the state upper limit established for a 340B purchased hemophilia drug, as defined by the state. 340B providers, when dispensing 340B drugs, must submit POS claims with an '8' in the basis of cost determination field (NCPDP D.0 field 423-DN) and a '20' in the submission clarification code field (NCPDP D.0 field 420-DK) to indicate they are dispensing a 340B product. This is necessary to eliminate duplicate discounts as all 340B claims will be pulled from rebate collections.

3.26.1 Long-Acting Reversible Contraception (LARCs)

Reimbursement methodology for LARCs acquired through the 340B program and utilized in the PADP are reimbursed at a different rate than other 340B acquired drugs. Effective Dec. 1, 2022, LARCs acquired and dispensed under the 340B program, reimbursement is paid at the lesser of actual acquisition cost submitted plus 6% or 340B ceiling price plus 6%.

3.27 Other Insurance

3.27.1 Explanation of Benefits (EOB)

The Council on Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules requires health plans to use standard and consistent Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to communicate claim adjudication outcomes to providers on EDI 835 transactions. To adhere to these rules, health plans are required to use the CAGC and CARC entered on the 837 and apply the CAQH CORE business rule associated with the code combination during the adjudicating process of secondary claims rather than requiring a separate Explanation of Benefits (EOB) from the primary insurance.

3.27.2 Pay and Chase

The health plan shall pay and then chase for the following services per the federal mandate:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Diagnostic and Treatment (Medical Necessity) after Early and Periodic Screening
- Child Support Enforcement

Early & Periodic Screening

Wellness visits are an essential part of children's health. Medicaid's Early and Periodic Screening benefit covers a program of regular wellness visits called Health Check.

Wellness visits allow health care providers to carefully monitor a child's overall health and development, so that health concerns are identified and addressed early. These visits include services recommended by the American Academy of Pediatrics.

Health plans should identify these services by Modifier EP for Medicaid members.

The required components of Early and Periodic Screening and Child Wellness visit are:

- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders
- Comprehensive, unclothed physical examination
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for both the child and caregiver

Diagnostic and Treatment (Medical Necessity) after Early and Periodic Screening

- EPSDT Medical Necessity Claims Process
 1. Health plans should determine if a prior authorization is approved for EPSDT medical necessity, based on the Health Plan's EPSDT policy.
 2. Health plans shall communicate to the provider whether the prior authorization is approved or denied for EPSDT medical necessity per the plan's EPSDT policy.
 3. If a prior authorization is approved as EPSDT medical necessity, health plans should pay and chase for all claims related to this prior authorization.

Child Support Enforcement

Health plans should pay and chase if the claim is for a service provided to a member on whose behalf the child support enforcement is being carried out:

- The third-party coverage is through an absent parent; and
- The provider certifies that, if the provider has billed a third party, the provider has waited 100 calendar days from the date of service without receiving payment before billing the health plan.
- The child support enforcement population may be identified on the 834 COB loop.

3.27.3 Program and Service Exceptions for TPL and Coordination of Benefits

In addition to medical support enforcement and preventative pediatric services, *Section V. J. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits* lists programs and services that are an exception to the general rule that NC Medicaid is the payer of last resort. As applicable, when a Member of the health plan is entitled to one or more of the following programs or services covered by the health plan, the health plan shall pay and chase the claim

There are several state and federal programs that health plans are required to process claims as the primary payer. The claims for the state and federal programs are exempt for normal coordination of benefits. Providers would identify these programs and members during the initial patient intake. The providers should inquire if the member is enrolled into one of the state or federal programs. The health plans would not be able to identify these populations on the 834.

| Section V.J. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits | | |
|---|---------|-------|
| Program or Service | Federal | State |
| 1. Crime Victims Compensation Fund | X | |
| 2. Part B and C of Individuals with Disabilities Education Act (IDEA) | X | |
| 3. Ryan White Program | X | |
| 4. Indian Health Services | X | |
| 5. Veteran's Benefits for state nursing home per diem payments | X | |
| 6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility | X | |
| 7. Older American Act Programs | X | |
| 8. World Trade Center Health Program | X | |

| | | |
|--|---|---|
| 9. Grantees under the Title V of the Social Security Act | X | |
| 10. Division of Service for the Blind | | X |
| 11. Division of Public Health “Purchase of Care” Program | | X |
| 12. Vocational Rehabilitation Services | | X |
| 13. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) | | X |

3.27.4 Third Party Liability (TPL) Bypass Rules

Federal regulations require Medicaid to be the “payer of last resort,” meaning that Medicaid claims must be filed through all existing third-party insurance carriers before Medicaid processes the claim. Third-party insurance includes Medicare and any commercial health insurance carriers. Historically Medicaid has several exception situations in which Medicaid will not treat claims as “payer of last resort” and instead Medicaid will pay claim as primary payer.

The following tables provides guidance to recognize those exception situations in which Medicaid will pay claims as primary payer without checking for Third Party Liability.

Commercial Insurance

Health plans shall bypass Third-Party Liability edits and pay claims as the primary payer. Health Plans are not required to pursue recovery from the commercial insurance carrier because NC Medicaid recognizes that commercial insurance carriers typically do not cover the claims.

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|---|---|---------------|---------------|------|
| 1 | Health plan shall pay as primary payer for Non-Emergency Transportation (NEMT) except when the member is a resident at a Nursing Facility (NF)* if the following rules apply: a. Billing Provider Taxonomy Code is 347E00000X *when a member is a resident at a NF the NEMT services are included in the NF per diem rate and NEMT should not be billed separately. | Y | Y | N/A |
| 2 | Health plan shall pay as primary payer for Nursing Facility if the following rules apply: a. Nursing Facility Claim b. And member does not have Long Term Care insurance c. And Billing Provider taxonomy is one of the following: 314000000X, 315P00000X, or 275N00000X | Y | Y | N/A |
| 3 | Health plan shall pay as primary payer for Personal Care Services (PCS) if the following rules apply: a. Billing Provider Taxonomy Code is 253Z00000X or 311ZA0620X | Y | Y | N/A |

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|---|---|---------------|---------------|------|
| 4 | <p>Health plan shall pay as primary for pharmacy claims if the following rules apply:</p> <p>a. Member has drug coverage from a third-party</p> <p>b. And other Coverage code is one of the following:</p> <ul style="list-style-type: none"> i. 01 – No other coverage ii. 02 – Other iii. 03 - Other coverage exists (This claims Not Covered: Claim not covered under primary Third-Party Plan. If primary denied the claim as Refill Too Soon, the claim would be submitted to the secondary payor with the Other Coverage Code-3.) iv. 04 - Other coverage exists (Payment Not Collected: Used when the member has other coverage, and that payor has accepted the claim but did not return any payment. This would be an example in which the member had a deductible amount to meet under the primary payor. The member is responsible for 100% of the payment, and the payor returns \$0) | Y | Y | N/A |
| 5 | <p>Health plan shall pay as primary payer for Case Management (regardless of provider) if the following rules apply:</p> <p>a. Procedure code is one of the following: G9012, T1016 with Modifier HI, T1017 or T1017 with Modifier HE</p> | Y | Y | Y |
| 6 | <p>Health plan shall pay as primary payer for Pregnancy Management Program (PMP) if the following rules apply:</p> <p>a. Procedure code is one of the following S0280 or S0281</p> <p>b. No other procedure codes on claim</p> | Y | Y | N/A |
| 7 | <p>Health plan shall pay as primary payer for only Behavioral Health if the following rules apply:</p> <p>a. Procedure code is one of the following: H0036 or H0046</p> | N | Y | Y |
| 8 | <p>Health plan shall pay as primary for Community Based Residential Treatment Facility if the following rules apply:</p> <p>a. Billing Provider Taxonomy code is 320800000X</p> <p>b. And procedure code is one of the following: H0019 or H2020</p> | N | Y | Y |
| 9 | <p>Health plan shall pay as primary for Community Behavioral Health Agency if the following rules apply:</p> <p>a. Billing and Rendering Provider Taxonomy Code is 251S00000X</p> <p>b. And procedure code is one of the following: H0010*, H0012, H0013, H0014*, H0015*, H0019, H0020*, H0036, H0038*, H0040, H0046, H2011*, H2012, H2015, H2017, H2020, H2022, H2033, T1023*, S5145 or S9484*, An asterisk (*) denotes that these codes are covered by Standard Plans.</p> | N* | Y | Y |

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|----|---|---------------|---------------|------|
| 10 | Health plan shall pay as primary payer for Home and Community Based Services (1915i/B3) if the following rules apply: a. Procedure code is one of the following: H0043, H0045, H2023, H2026, T1019, or T2013 | N | Y | Y |
| 11 | Health plan shall pay as primary payer for Traumatic Brain Injury (TBI) Waiver [ALLIANCE PLAN ONLY] if the following rules apply: a. Procedure code is one of the following: 97129, 97130, H2011, 97130, H2015 with modifier HQ or UI, H2016, H2025 with modifier HQ, S5102, S5110, S5111, S5125, S5150 with modifier HQ or US, S5165, T1005 with modifier TD and TE, T1015, T1999, T2012 with no modifier or modifier HQ, T2013 with modifier HQ, T2014, T2020, T2021 with modifier HQ, U1 or U2, T2025 with modifier HO, U1 and U2 or U3, T2029, T2033 no modifier, modifier HI or TF, T2034, T2038, T2039, or T2041 with modifier U1 | N | Y | N |

Medicare Part A, B, or C

Health plans shall bypass Third-Party Liability edits and pay claims as the primary payer. Health plans are not required to pursue recovery from the Medicare carrier because NC Medicaid recognizes that Medicare carriers typically do not cover the claims.

Medicare Part A

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|---|---|---------------|---------------|------|
| 1 | Health plan shall pay as primary payer if member is living in one of the following: a. State Incarceration b. County/ Local Incarceration c. Federal Incarceration | Y | Y | Y |

Medicare Part B or C

~~“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”~~

The below table may not be all-inclusive, and health plans are encouraged to include any known non-covered Medicare codes in their own internal bypass list.

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|---|--|---------------|---------------|------|
| 1 | Health plan shall pay as primary payer for Refugees if the following rules apply: a. Member eligibility is refugee | Y | Y | Y |
| 2 | Health plan shall pay as primary payer for Emergency services if the following rules apply: a. Member category of eligibility class codes is F, H, O, R, U or V | Y | Y | Y |
| 3 | Health plan shall pay as primary payer for Audiology if the following rules apply: a. Procedure code is one of the following: 92590 through 92595 | Y | Y | Y |
| 4 | Health plan shall pay as primary payer for Optical services if the following rules apply: a. Procedure code is 92015, 92310, 92326, 92340, 92341, 92342, 92353, 92370, S0620, S0621 and V2020 through V2799 | Y | Y | Y |
| 5 | Health plan shall pay as primary payer for Vision Services if the following rules apply: a. Procedure code is one of the following: 92002 through 92499 | Y | Y | Y |

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|----|--|---------------|---------------|------|
| 6 | Health plan shall pay as primary payer for various services if the following rules apply: a. Procedure code is one of the following: 11976, 92015, S0580, 58300, 65760, 65765, 65767, 75556, 78351, ,78608 – 78610, 78630, 78635, 78645, 78645, 78650, 78660, 78699 -78701, 78707 - 78709, 78725, 78730, 78740, 78761, 78799 – 78804, 78808, 80050, 86910, 88099, 92015, 92560, 92590, 92591 through 92595, 99383, 99384, 99385, 99386,99387, 99404, 99412, A4215, A4244, A4260, A4554, A4627, A4927, E0244, E0265, E1300, J1055, J7300, K0005, T4533, V5050, V5090, V5110, V5130, or V5160 | Y | Y | Y |
| 7 | Health plan shall pay as primary payer for dental procedures if the following rules apply: a. If the provider is a physician rendering the Fluoride Varnish procedure codes D0145 or D1206 on children under age 3.5 usually in conjunction with their well child visit. b. If the provider is Ambulatory Surgery Center (ASC) and bills with procedure code G0330 for facility charges and 41899 for Hospital. | Y | Y | Y |
| 8 | Health plan shall pay as primary payer for Crisis Intervention if the following rules apply: a. Procedure code is one of the following: S9484 or H2011 | Y | Y | Y |
| 9 | Health plan shall pay as primary payer for Alcohol and Drug Abuse Treatment if the following rules apply: a. Procedure code is one of the following: H0001, H0004, H0005 , H2035* or H0032 An asterisk (*) denotes that these codes are covered by Standard Plans. | N* | Y | Y |
| 10 | Health plan shall pay as primary payer for Tailored Case Management (TCM) if the following rules apply: a. Procedure code is T1017, and Modifier is HT | N | Y | Y |

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|----|--|---------------|---------------|----------------|
| 11 | <p>Health plan shall pay as primary payer for Treatment procedures if the following rules apply:</p> <p>a. Procedure code is one of the following: H0019, H0032, H2020*, H0046, or S5145</p> <p>An asterisk (*) denotes that these codes are covered by Standard Plans.</p> | N* | Y | Y |
| 12 | <p>Health plan shall pay as primary payer for Community Behavioral Health with Treatment for Substance Abuse Disorder (SUD) if the following rules apply:</p> <p>a. Rendering Taxonomy is 251S00000X</p> <p>b. Procedure code is one of the following: H0010*, H0012, H0013, H0014*, H0015*, H0020*, H0036, H0040, H2011*, H2012, H2015, H2017, H2022, H2033, or S9484*</p> <p>An asterisk (*) denotes that these codes are covered by Standard Plans.</p> | N* | Y | Y |
| 13 | <p>Health plan shall pay as primary payer for Pregnancy Management Program (PMP) is one of the following:</p> <p>a. Procedure code is one of the following S0280 or S0281 and no other procedure codes are billed on the claim</p> | Y | Y | N/A |
| 14 | <p>Health plan shall pay as primary for Community Behavioral Health Agency if the following rules apply:</p> <p>a. Billing and Rendering Provider Taxonomy Code is 251S00000X</p> <p>b. And procedure code is one of the following: T1023 or H0038</p> | N | Y | N |
| 14 | <p>Health plan shall pay as primary payer for Health Departments is one of the following:</p> <p>a. Billing provider taxonomy code is one of the following: 261QC1500X, 261QH0100X, 261QP0905X and 261QP2300X</p> | Y | Y | N/A |
| 15 | <p>Health plan shall pay as primary payer for Private Duty Nursing is one of the following:</p> <p>a. Billing provider taxonomy code is 251J00000X</p> | Y | Y | Y |

| # | Bypass Rules | Standard Plan | Tailored Plan | PIHP |
|----|--|---------------|---------------|------|
| 16 | Health plan shall pay as primary payer for Hearing Aid Services if the following rules apply: a. V5014, V5030-V5299 | ✗ | ✗ | ✗ |

3.28 Electronic Attachments

To help reduce claim denials, ensure prompt payment, and reduce administrative burden on providers, the Department expects the Standard Plans and Tailored Plans to allow for electronic submission of consent forms and all other claim attachments including but not limited to Certificates of Medical Necessity (CMNs), invoices, discharge summaries, operative reports, sterilization consent forms and child medical exam checklists.

3.29 Transaction Fees

Health plans are required to have a no cost option for any provider to elect payments by EFT and to transmit claims to their clearinghouses. Requiring transaction fees including but not limited to clearinghouse fees and EFT fees are in violation of rate floors. Health plans must provide a no-cost option for processing all claim types.

3.30 Line Service Unit and NDC Fields on Claims and Encounters

- a) On medical encounters/claims for IV fluids, plans should require providers to include the HCPCS unit (i.e., number of bags) in the Line Service Unit Count field. For example, your plan should not send 14000 in the Line Service Unit Count field to represent 14 bags of fluid (1000 mL each), but instead should send a unit of 14.
 - i) Please Note: For IV fluid NDCs the Line Service Unit or Basis for Measurement Code field should always be “UN”, which is why the Line Service Unit Count would be 14 (to represent the number of bags).
 - ii) Additionally, the Line NDC Unit Count and the Line NDC Unit or Basis for Measurement Code field need to be consistent with the NDC units.
 - (1) For a 1,000 mL bag, in which 14 bags were administered, the following should be submitted:
 - (a) Option 1:
 - (i) Line Service Unit or Basis for Measurement Code: UN
 - (ii) Line Service Unit Count: 14
 - (iii) Line NDC Unit or Basis for Measurement Code: UN
 - (iv) Line NDC Unit Count: 14
 - (b) Option 2:
 - (i) Line Service Unit or Basis for Measurement Code: UN

- (ii) Line Service Unit Count: 14
- (iii) Line NDC Unit or Basis for Measurement Code: ML
- (iv) Line NDC Unit Count: 14000

3.31 Claims Guidance for Provider Enrollment File

3.31.1 Provider Location Matching Guidance:

For the processing of claims:

- Health plans should not consider the rendering or attending provider's service location when adjudicating claims; validation should be based on the provider's taxonomy information.
- Health plans shall select an in-network location when both in-network and out of network matches are found using the below matching criteria.
- If the Individual Provider Rendering Only Indicator is True, then the plan should not render payment to the individual NPI, whether the agency independently bills for services or uses an individual provider as a Billing provider on claims.
- Health plans shall match the claim to the billing provider using the NPI, taxonomy code, and billing provider's zip plus four (nine digits).
 - If there are multiple matches found, the health plans shall select one of the matches found.
 - If no matches are found, the health plans shall match the claim to the billing provider using the NPI, taxonomy code, and billing provider's zip code (five digits).
- Health plans shall validate the affiliation between a rendering provider and a billing provider for the billing provider's NPI. Affiliated organizations are found on the PEF under the Affiliated Organization Section.
- After matching the claim to a provider, health plans shall use the provider's taxonomy information to determine what services the provider is eligible to perform.

3.31.2 Out of Network Provider Affiliation Guidance

Health plans should ensure that all affiliated individual providers contracted with the health plan are reported on the Provider Network File (PNF) as contracted providers, each on a separate row. When health plans contract with a provider group, all individual providers affiliated and contracted under the provider group tax identification (TIN) should be validated against the Provider Enrollment File (PEF) as active participants with NC Medicaid. The PEF is a file health plans receive daily with the latest provider information from NC Medicaid. The PEF is a segmented file and is not intended as a full replacement file so historical data must be maintained by the health plans. To ensure that providers do not receive

inaccurate out-of-network denials, the PEF should be the source of truth when loading all affiliated individual providers under a contracted TIN.

3.31.3 NPI Attending Provider Field for Prepaid Inpatient Health Plan (PIHP) ONLY

Per X12 HIPAA guidelines, providers (such as ICF IID and PRTF) should be entering an individual NPI in the attending provider field on institutional claim forms. The attending provider does not need to be employed by the facility but is the individual who has responsibility for the medical care/treatment on this beneficiary.

3.32 Psych/Rehab Hospital Reimbursement Guidelines for Inpatient Hospital Claims

1. If the billing provider taxonomy is one of the following, health plans should reimburse at least 100% of the per diem rates for Rehab Services as they are included in the designation of hospital rate floor services outlined in the hospital fee schedules. Health plans are allowed to negotiate rates for Psych services per diem rates with managed care providers:
 - a. Psych/Rehab is identified by the provider type (taxonomy)
 - i. If the billing provider taxonomy is 283Q00000X or 273R00000X claim should price as psych per diem at the health plan/Provider negotiated rate, regardless of the diagnosis codes which drive to the DRG code.
 - ii. If the billing provider taxonomy is 284300000X or 273Y00000X claim should price as rehab per diem at the Medicaid established Fee schedule rate, regardless of the diagnosis codes which drive to the DRG code.
2. Health plans should align to the most current grouper version the State is utilizing as the diagnosis/DRG mapping happens within the grouper software. Diagnosis list could potentially change annually. **NCTracks does not house a mapping/crosswalk.**
 - a. Diagnosis codes are a key component to determining which DRG is selected. The most current grouper version can be found at the following CMS link: [MS-DRG Classifications and Software | CMS](#)
 - i. If the billing provider taxonomy is 282N00000X or 27640000X, 283Q00000X, or 284300000X (General Acute Care Hospital, Psychiatric Hospital, Special Hospital) and any of the DRG listed below are used, price as psych and rehab per diem
 - ii. MDC 19 and 20 for Psych DRGs and MDC 23 for Rehab DRGs:
 1. PSYCH - '0880' THRU '0887', '0894' THRU '0897', '0876'
 2. REHAB - '0945' '0946'
 - iii. Otherwise, for other DRGs, claim should price using the DRG Payment methodology

3.33 High Dollar Review and Itemized Bills Guidance

~~“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”~~

If a health plan performs pre and post payment reviews, it may only be based on the codes submitted by the provider and the health plans may not downcode or otherwise manipulate claims submitted by providers as a result of the reviews.

High Dollar Pre-Payment – High dollar pre-payment reviews requiring itemized bills shall meet the following criteria:

- Health plans shall clearly define the high dollar threshold for pre-payment reviews and communicate it to providers in writing 30 days prior to requiring itemized bills so that they can submit the itemized bill proactively to avoid payment delays.

High Dollar Pre-Payment – High dollar pre-payment reviews requiring itemized bills must meet the following criteria:

- Health plans must clearly define the high dollar threshold for pre-payment reviews and communicate it to providers in writing 30 days prior to requiring itemized bills so that they can submit the itemized bill proactively to avoid payment delays.
- Health plans must have the capability to accept electronic attachments for itemized bills through portal and EDI submission.
- Health plans can define high dollar pre-payment review requirements for hospital inpatient claims with a header or total billed amount greater than \$250k. Health plans high dollar review thresholds for hospital inpatient claims may be set above \$250k.
- Health plans can define high dollar pre-payment review requirements for hospital outpatient claims with a header or total billed amount greater than \$75k. Health plans high dollar review thresholds for hospital outpatient claims may be set above \$75k.
- Health plans can define high dollar pre-payment review requirements for professional claims with a header or total billed amount greater than \$25k. Health plans high dollar review thresholds for professional claims may be set above \$25k.
- To minimize provider administrative burden, health plans defining different high dollar thresholds must base it on billed amount so that providers know when the itemized bill needs to be included with the claim.

High Dollar Post-Payment – High dollar post-payment reviews requiring itemized bills must meet the following criteria:

- Health plans have the capability to electronically receive itemized bills for post-payment reviews
- Health plans cannot request itemized bills for high dollar post-payment reviews if the claim did not meet the DHHS-defined pre-payment review thresholds

3.34 Independent Lab Reimbursement

Health plans shall follow the independent lab reimbursement methodology as currently outlined in the State Plan.

However, when clinical laboratories services are provided on behalf of a hospital inpatient or critical access hospital inpatient, payment will be made to the hospital and not to the clinical laboratory (see

attachment 4.18 B, section 3, of the State Plan). The independent lab shall bill the hospital to receive reimbursement for these services.

The hospital shall then bill the services, including any independent laboratory services, to the health plans. It is the expectation that health plans reimburse the hospital for the clinical laboratory services billed and not the clinical laboratory. Health plans shall reimburse all Hospital Outpatient Laboratory providers under Managed care based on the [Health Plan Managed Care Hospital Outpatient Laboratory Fee schedule](#) provided by NC Medicaid.

3.35 Known System Issues

- I. The health plan shall develop, maintain, and share a Known System Issues Tracker with providers through newsletters, provider portal, and/or health plan website on a weekly basis to keep providers informed on all known health plan system issues with provider impact.
- II. The Known System Issues tracker shall include the following information, at a minimum:
 - a. Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);
 - b. Number of Impacted Providers: number of known providers impacted by the system issue;
 - c. Category: type of system issue (e.g., claims, eligibility, provider, prior approval);
 - d. Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;
 - e. Date Issue Found: month, day, and year the health plan identified the system issue;
 - f. Number of Days Outstanding: number of days this issue has been open;
 - g. Estimated Fix Date: month, day, and year the health plan plans to have this system issue resolved;
 - h. Status: status of the issue (open, ongoing, or closed);
 - i. Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;
 - j. Interest Owed: whether interest will be applied (Yes or No); and
 - k. Date Resolved: month, day, and year the health plan resolved this system issue.
- III. The health plan shall maintain each item on the Known Issues Tracker for at least ninety (90) Calendar Days after resolution of the issue.-
- IV. The health plan shall include the link to the Known Issues Tracker in the Provider Manual.

3.36 Payments for Non-Rate Floor Permanent Rates

Rate differentials do not apply to non-rate floor permanent rates established after the end date of the temporary Covid-19 rates for the specific program service. Health plans are obligated to pay rate differentials on non-rate floor permanent rates established during the Public Health Emergency that include a temporary COVID-19 add-on amount for claims billed with dates of service falling within the Public Health Emergency period.

3.36.1 Lesser of Payment Methodology

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. Please refer to the Third-Party Liability Medicaid Billing manual for guidance. Please refer to the secondary claims page on NCTracks to see an example of the calculation.

Link: [Provider Policies, Manuals, Guidelines and Forms - Provider Policies, Manuals, Guidelines and Forms \(nc.gov\)](#)

Link: [Secondary Claims - Secondary Claims \(nc.gov\)](#)

3.37 Rate Floors

For any provider subject to a rate floor as outlined in Section V.B.4.iv. Provider Payments, except DME providers, a Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan may include a provision in the provider’s contract that the Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a “lesser than” provision. Health plans shall not include a “lesser than” provision for services that are reimbursed through the non-risk-based payments. A Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider’s refusal to agree to a “lesser than” provision.

An alternative reimbursement agreement is not required for health plans to pay more than 100% of the rate floor rate.

3.38 Rate Differentials

When a rate differential is identified for non-rate floor services, health plans are required to pay the rate in addition to contracted rates. The rate differential is already included in the posted fee schedules on the [Fee Schedule and Covered Codes Portal](#). Therefore, health plans paying the rate from the DHHS fee schedule do not need to pay the rate differential.

3.39 Telehealth Codes and Modifiers

Telehealth, virtual communication, and remote patient monitoring claims should be filed with the provider’s usual place of service code(s) and not place of service 02.

- Providers should use the GT modifier when the policy says that telehealth is allowed. Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via two-way real-time interactive audio-visual communication. This modifier should not be used for virtual patient communications (including telephonic evaluation and management services) or remote patient monitoring.

- Providers should use the CR modifier for telehealth that is only available to use during a State of Emergency (SOE) or Public Health Emergency (PHE)

3.40 Pended Claims

~~“Implementation of these updates will be delayed for Tailored Plans until the fall publish of the quarterly billing guide”~~

A Medical Pended Claim shall be paid or denied within 30 calendar days of receipt of the requested additional information. If the health plan holds a Pended claim longer than 30 calendar days from the receipt of the requested additional information, the health plans shall pay interest beginning the first day following the date on which the claim should have been paid. If the requested additional information on a Medical Pended Claim is not submitted within 90 calendar days of the notice requesting the required additional information, the health plan may deny the claim.

Health plans are required to process claims in accordance with N.C.G.S. 58-3-225 and as follows:

Pursuant to NCGS 58-3-225(g), if a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider 30 days after the previous report was sent.

- The health plan shall, within 18 calendar days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.
- Every insurer shall maintain written or electronic records of its activities as stated in the health plan Contract in accordance with NCGS 58-3-225(i) to include “records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.”
- Pursuant to NCGS 58-3-225(j), a violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

Examples in which a claim must pend versus deny for additional information includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists.

3.41 Clean Claim Date Guidance

1. For claims submitted with all information that is necessary to process the claim the clean claim date should be the date received (Including Value Based Purchasing (VBP), Non-Emergency Medical Transportation (NEMT) and Vision claims).
2. For claims from providers under investigation for fraud and abuse, the clean claim date should be the date the investigation is closed (Including VBP, NEMT and Vision claims).
3. For claims submitted without all information that is necessary to process the claim the clean claim date should be the date the additional information is received (Including VBP, NEMT and Vision claims).
4. For claims submitted with provider taxonomies or health plans that are suspended, the clean claim date should be the date the taxonomy or health plan status changes to active or terminated.
5. For NCPDP transactions the clean claim date should be the adjudicated date.
6. For claims submitted prior to PML determination, the clean claim date can be no earlier than the date the PML has been received on the X12 834.

~~3.42~~ Adjustments

3.43 DPU vs. Non-DPU Inpatient Stays with Both Behavioral Health and Physical Health Services

Effective with the launch of Tailored Plans, providers will be reimbursed according to the following methodologies for inpatient stays with behavioral and physical health services:

- Hospital providers with a Distinct Part Unit (DPU) will split the inpatient stays into behavioral health and physical health claims and submit the claims with the appropriate diagnosis code since there will be a separate Acute Care NPI and sub-Acute Care NPI that requires a discharge and an admit.
- Hospital providers without a Distinct Part Unit will submit a single claim with both physical health and behavioral health services to the Tailored Plan. Behavioral health and physical health services will be covered using the appropriate DRG methodology.

This reimbursement guidance follows an internal review of our State Plan Authority related to the hospital inpatient reimbursement plan (Attachment 4.19-A, page 7)

As stated in Attachment 4.19-A, page 7, of the State Plan Amendment, *Transfers occurring within general hospitals from acute care services to non-DPU psychiatric or rehabilitation services are not eligible for reimbursement under this Section. The entire hospital stay in these instances shall be reimbursed under the DRG methodology.*

3.44 Inpatient Stays with Enrollment or Eligibility Changes

DRG and Outlier Claims

Changes in Enrollment:

In instances where a member's enrollment changes (member changes between health plans or between NC Medicaid Direct full coverage and a health plan) and there is no lapse in Medicaid coverage during a DRG-based inpatient stay, the payer assigned to the member on the "from" date of service is responsible for the DRG base payment. This payer is also responsible for the entire Cost or Day Outlier payment, if applicable according to the State Plan. DRG and outlier payment calculations cannot be split and must consider the total number of days during the entire length of stay based on the DRG and the Outlier payment methodology rules respectively for determining actual days to be paid.

Example Scenarios:

1. Change from NC Medicaid Direct full coverage to health plan: Member goes to the ER on 12/31/22 and then has an inpatient stay from 1/1/23 - 2/6/23. The member moves from NC Medicaid Direct to health plan A on 2/1/23.
 - a. From date of service = 12/31/22
 - b. Admit date = 1/1/23
 - c. Discharge date = 2/6/23

NC Medicaid Direct is responsible on the from date of service; therefore, NC Medicaid Direct is responsible for the full inpatient stay and the outlier payment. The DRG and outlier calculations should consider the full stay from 12/31/22 - 2/6/23.

2. Change between health plans: Member goes to the ER on 1/15/23 and then has an inpatient stay from 1/16/23 - 2/3/23. The member moves from health plan A to health plan B on 2/1/23.
 - a. From date of service = 1/15/23
 - b. Admit date = 1/16/23
 - c. Discharge date = 2/3/23

Health plan A is responsible on the from date of service therefore health plan A is responsible for the full inpatient stay and the outlier payment. The DRG and outlier calculations should consider the full stay from 1/15/23 - 2/3/23.

3. Change from health plan to NC Medicaid Direct : Member goes to the ER on 1/20/23 and then has an inpatient stay from 1/21/23 - 2/7/23. The member moves from health plan C to NC Medicaid Direct on 2/1/23.
 - a. From date of service = 1/20/23
 - b. Admit date = 1/21/23
 - c. Discharge date = 2/7/23

Health plan C is responsible on the from date of service therefore health plan C is responsible for the full inpatient stay and the outlier payment. The DRG and outlier calculations should consider the full stay from 1/20/23 - 2/7/23.

Changes in Medicaid Eligibility:

In instances where a member's Medicaid eligibility changes (ex. Medicaid eligibility starts or ends) and there is no immediately prior period of Medicaid managed care or NC Medicaid Direct enrollment with inpatient coverage, the first eligible payer of record during a DRG-based inpatient stay, (NC Medicaid Direct /health plan) is responsible for the DRG base payment. This payer is also responsible for the Cost or Day Outlier payment, if applicable. Day Outlier payments are based on Medicaid eligible days only. Cost outlier payments are based on established Cost Thresholds.

When a patient is admitted in a hospital, that hospital assigns a DRG when the patient is discharged, based on the diagnosis the patient received and the treatment that patient needed during their hospital stay. The number of Medicaid eligible days are not relevant to the assignment of the DRG.

Per Diem Claims

In instances where a member's enrollment changes during a per-diem-based stay, NC Medicaid Direct /the health plan is responsible only for the dates of service in which the member is enrolled with their plan. The provider should split the claim and bill the respective dates of service to the respective Plans responsible for the dates of service in which the member was enrolled with their plan.

Example Scenarios:

1. Change from NC Medicaid Direct to health plan: Member goes to the ER on 12/31/22 and then has a per-diem-based inpatient stay from 1/1/23 - 2/14/23. The member moves from NC Medicaid Direct to health plan A on 2/1/23.
 - a. From date of service = 12/31/22
 - b. Admit date = 1/1/23
 - c. Change in Plan = 2/1/23
 - d. Discharge date = 2/14/23

NC Medicaid Direct is responsible only for the dates of service in which the member is enrolled; therefore, NC Medicaid Direct is responsible for the payment from 12/31/22 - 1/31/23. health plan A is responsible only for the dates of service in which the member is enrolled with their plan therefore health plan A is responsible for payment from 2/1/23 - 2/14/23. The provider submits separate claims to NCTracks and health plan A for the applicable dates of service.

2. Change between health plans: Member goes to the ER on 1/15/23 and then has a per-diem-based inpatient stay from 1/16/23 - 3/31/23. The member moves from health plan A to health plan B on 3/1/23.
 - a. From date of service = 1/15/23
 - b. Admit date = 1/16/23
 - c. Change in Plan = 3/1/23
 - d. Discharge date = 3/31/23

Health plan A is responsible only for the dates of service in which the member is enrolled with their plan therefore health plan A is responsible for payment from 1/15/23 - 2/28/2023. Health plan B is responsible only for the dates of service in which the member is enrolled with their plan therefore health plan B is responsible for payment from 3/1/23 - 3/31/23. The provider submits separate claims to health plan A and health plan B for the applicable dates of service.

3. Change from health plan to NC Medicaid Direct: Member goes to the ER on 1/20/23 and then has a per-diem-based inpatient stay from 1/21/23 - 2/7/23. The member moves from health plan C to NC Medicaid Direct on 2/1/23.
 - a. From date of service = 1/20/23
 - b. Admit date = 1/21/23
 - c. Change in Plan = 2/1/23
 - d. Discharge date = 2/7/23

Health plan C is responsible only for the dates of service in which the member is enrolled with their plan therefore health plan C is responsible for payment from 1/20/23 - 1/31/23. NC Medicaid Direct is responsible only for the dates of service in which the member is enrolled, therefore NC Medicaid Direct is responsible for payment from 2/1/23 - 2/7/23. The provider submits separate claims to NCTracks and health plan C for the applicable dates of service.

3.45 Remittance Advice Guidance

Health plans are required to clearly communicate claim outcomes to providers through the remittance advice. The remittance advice shall include the following:

- Itemized information for each claim and/or service line enabling the provider to associate the adjudication decisions with those submitted claims/lines.
- The reason and the value of each adjustment
- For each line that is denied, all applicable denial reasons shall be notated.
- The Council on Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules requires health plans to use standard and consistent Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to communicate claim adjudication outcomes to providers on EDI 835 transactions. The combination of these codes shall align with the CAQH CORE Operating Rules
- Interest amount (identified on the encounter with CARC code 225 - Penalty or Interest Payment by Payer)

3.46 Professional Dispensing Fee

The Professional Dispensing Fee (PDF) is currently established at a flat fee of \$10.24 per prescription, as determined by the Cost of Dispensing Study conducted on behalf of NCDHHS, Division of Health Benefits every five years.

The PDF is paid every time a drug is dispensed, including emergency dispensations (including the one emergency fill allowed through the lock-in program per year). Effective Dec. 1, 2022, the policy requiring only one PDF per drug, per member, per pharmacy, per month was removed.

3.47 Endoscopy Codes and Pricing

A value of '3' in the Multiple Procedure field on the 2023 National Physician Fee Schedule Relative Value File January Release indicates special rules for multiple endoscopic procedures are to be applied if the procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field.

Multiple endoscopy pricing rules will be applied to a family before it is ranked with other procedures performed on the same day (i.e., when multiple endoscopies in the same family are reported on the same day as endoscopies from another family, or on the same day as a non-endoscopic procedure).

If an endoscopic procedure and its base procedure code are billed on the same day, no separate payment will be made for the base code. Payment for the base code is included in the payment for the other endoscopy.

If an endoscopic **BASE** procedure is billed with a 51 modifier with other procedures that are not endoscopies (i.e., surgical procedures), the standard multiple surgery guidelines apply.

Examples of Medicaid Pricing

Single endoscopy code and its base code

- The health plan denies the base code because the allowance for the base code is included in the allowance for the single endoscopy code.

Multiple endoscopies in the same family

- The health plan determines the highest-paying procedure and allows payment at 100%.
- For the other endoscopies, the health plan subtracts the allowance for the family's base code from the allowance for the related endoscopy and allows the difference.

Multiple endoscopic procedures in different families

For the first

- The health plan determines the allowance for the highest paying procedure and pays at 100%.
- The health plan determines the allowance for the other related endoscopic procedures by subtracting the allowance for the family's base code from the allowance for the related endoscopy and pays the difference.

For second or subsequent family on the same date of service family

- The health plan follows the same method of determining the allowance for each procedure reported within a family.
- The health plan determines the total allowance for each "family" and pays the family with the highest allowance at 100% and the remaining family at 50%.

Multiple endoscopies in one family reported with one endoscopy from a different family.

For the first family

- The health plan determines the allowance for the highest paying procedure and pays at 100%.
- The health plan determines the allowance for the other related endoscopic procedures by subtracting the allowance for the family's base code from the allowance for the related endoscopy and pays the difference.

For the endoscopy in a different family

- The health plan considers that code to be a separate family and obtains the allowance for this code.
- The health plan determines the total allowance for each “family” and pays the family with the highest allowance at 100% and the remaining family at 50%.

One endoscopy in one family reported with one endoscopy from a different family

- The health plan pays the highest paying procedure at 100% of the allowance.
- The health plan pays the other endoscopy at 50% of its allowance.

Multiple endoscopies in one family and one is that family’s base code reported with multiple endoscopies in a different family

For the family that includes the base code

- The health plan determines the allowance for the highest paying related procedure and pays at 100%.
- The health plan denies the base code because the allowance for the base code is included in the allowance for the highest paying procedure.
- The health plan determines the allowance of any subsequent related procedure(s) and subtracts the allowance of the base code

For the endoscopies in the other family(s)

- The health plan determines the allowance for the highest paying related procedure and pays at 100%.
- The health plan determines the allowance of any subsequent related procedure(s) and subtracts the allowance of the base code
- The health plan determines the total allowance for each “family” and pays the family with the highest allowance at 100% and the remaining family at 50%.

3.48 Behavioral Health vs Physical Health Claims Guidance

The objective of this guidance is to differentiate behavioral health and physical health claims for Tailored Plans. This behavioral health – physical health guidance is used for claims processing for closed network logic and consistent claim routing logic for Tailored Plans that use a Standard Plan partner to process physical health claims. This logic is not intended to be used for reimbursement methodology. Health plans are required to use rate floor fee schedules as described in their contract regardless of whether a claim is classified as behavioral health or physical health. While this document will be maintained with regular updates, health plans are responsible for incorporating policy changes and covered code changes within required timelines.

Behavioral Health claims, for purposes of claims processing, shall be identified using a hierarchy system encompassing the following levels. If any claim line meets the criteria within a level, the entire claim should be categorized according to that level. **Since it is not possible to account for every potential scenario in the BH/PH Claims Guidance, Plans have the flexibility to add configurations to their systems to address additional scenarios as needed. This guidance should be used in conjunction with all other**

relevant documents and member information (i.e. Health Check Program Guide, Clinical Policy, Member's benefit, etc.).

| <u>Level</u> | <u>Logic by Level</u> |
|---|---|
| <p>Level 1: Emergency Department Claims</p> <p><i>Only applicable for claim routing logic for Behavioral Health and Physical Health Claims</i></p> | <p>Institutional Claims: Claims submitted with an emergency department (ED) revenue or procedure code and a primary/ principal diagnosis code listed below will be considered as Behavioral Health claim.</p> <p>Primary/Principal Diagnosis Codes</p> <ul style="list-style-type: none"> Behavioral Health Diagnoses (between F01xx-F99xx) Suicide Attempt (beginning with T14.91) Emotional State Symptoms and Signs (beginning with R45) <p>And</p> <p>Either a revenue code or procedure code listed below:</p> <ul style="list-style-type: none"> Rev Codes: 450-452, 456, 459 Procedure Codes: 99281-99285, 99288 |
| | <p>Professional Claims: Claims submitted with Emergency Room procedure codes and a Behavioral Health Primary Diagnosis code included below will be considered a professional Behavioral Health Emergency Department claim.</p> <p>Behavioral Health Primary/Principal Diagnosis Codes</p> <ul style="list-style-type: none"> Behavioral Health Diagnoses (between F01xx-F99xx) Suicide Attempt (beginning with T14.91) Emotional State Symptoms and Signs (beginning with R45) <p>And</p> <ul style="list-style-type: none"> Procedure Codes: 99281-99285, 99288 |

| <u>Level</u> | <u>Logic by Level</u> |
|---|--|
| <p>Level 2: Institutional Outpatient Claims</p> <p><i>Only applicable for claim routing logic for Behavioral Health and Physical Health Claims</i></p> | <p>Claims must satisfy one of the following criteria:</p> <ul style="list-style-type: none"> Claims submitted with a revenue code included in the <u>Behavioral Health Exclusive Institutional Revenue Codes</u> table will be considered a Behavioral Health Institutional claim. <p>OR</p> <ul style="list-style-type: none"> Claims which have a procedure code included in the <u>Procedure Codes Exclusive to Behavioral Health</u> table below will be considered a Behavioral Health claim <p>OR</p> <ul style="list-style-type: none"> Claims submitted with a revenue code in the <u>Institutional Codes Identified By Diagnosis</u> table below <p>AND not a Nursing Home (without a billing provider taxonomy of 314000000X)</p> <p>AND without type of bill 66X (Intermediate Care Level II)</p> <p>AND a Behavioral health primary/principal diagnosis code included below will be considered a Behavioral Health Institutional claim.</p> <p>Behavioral Health Primary/Principal Diagnosis Codes</p> <ul style="list-style-type: none"> Behavioral Health Diagnoses (between F01xx-F99xx) Suicide Attempt (beginning with T14.91) Emotional State Symptoms and Signs (beginning with R45) |

| | |
|---|---|
| <p>Level 3: Institutional Inpatient Claims</p> | <p>Claims must satisfy one of the following criteria:</p> <ul style="list-style-type: none"> • Claims submitted with a BH DRG as noted on the DRG Weight Table Fee Schedule <p>OR</p> <ul style="list-style-type: none"> • Claims submitted with one of the following Behavioral Health Revenue Codes: 0114, 0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, and 0204 <p>AND not a Nursing Home (without a billing provider taxonomy of 314000000X)</p> <p>AND without with type of bill 66x (Intermediate Care Level II) will be considered a Behavioral Health Institutional Inpatient claim.</p> <p>OR</p> <ul style="list-style-type: none"> • Claims submitted using a Behavioral Health primary/principal diagnosis code included below <p>Behavioral Health Primary/Principal Diagnosis Codes</p> <ul style="list-style-type: none"> • Behavioral Health Diagnoses (between F01xx-F99xx) • Suicide Attempt (beginning with T14.91) • Emotional State Symptoms and Signs (beginning with R45) <p>AND a Revenue Code included from the following range: 101–182, 184–219</p> <p>AND not a Nursing Home (without a billing provider taxonomy of 314000000X)</p> <p>AND without with type of bill 66x (Intermediate Care Level II) will be considered a Behavioral Health Institutional Inpatient claim.</p> <p>All other Institutional claims will be considered a Physical Health claim.</p> <p>Note: <i>Diagnosis codes mapped to a DRG included in the CMS Crosswalk must remain aligned with CMS expectations and cannot be added or removed. Claim BH/PH identification may not align with DRG assignment during claim adjudication. Health Plans are expected to use the DRG grouper for claim payment, not the BH/PH definition.</i></p> |
|---|---|

| <u>Level</u> | <u>Logic by Level</u> |
|--|--|
| Level 4: Procedure Codes Exclusive to Behavioral Health | Claims which have a procedure code included in the Procedure Codes Exclusive to Behavioral Health table below will be considered a Behavioral Health claim |
| Level 5 Primary Care Physicians – Physical Health | <p>Claims with a primary care billing or rendering provider taxonomy will be considered Physical Health:</p> <ul style="list-style-type: none"> 207Q00000X, 207QA0000X, 207QA0505X, 207QG0300X, 207R00000X, 207RA0000X, 207RG0300X, 207V00000X, 207VG0400X, 207VX0000X, 208000000X, 2080A0000X, 208D00000X, 363A00000X, 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LP0200X, 363LP1700X, 363LP2300X, 363LW0102X, 363LX0001X, 364S00000X, 364SG0600X, 364SF0001X and 367A00000X |
| Level 6: Shared Procedure Codes | <ul style="list-style-type: none"> Claims with the rendering provider taxonomy is included in the Behavioral Health Provider Taxonomy Codes table below and procedure code on claim lines is included in the Procedure Codes Shared by Physical and Behavioral Health table below <p>OR</p> <ul style="list-style-type: none"> Claims with the procedure code on claim lines included in the Procedure Codes Shared by Physical and Behavioral Health table below and a Behavioral Health primary diagnosis below: <p>Behavioral Health Primary Diagnosis Codes</p> <ul style="list-style-type: none"> Behavioral Health Diagnoses (between F01xx-F99xx) Suicide Attempt (beginning with T14.91) Emotional State Symptoms and Signs (beginning with R45) |
| Level 7: Behavioral Health Taxonomies | Any claims not assigned in previous levels will be considered Behavioral Health if it has one of the Provider Taxonomy Codes in the Behavioral Health Provider Taxonomy Codes table. |
| Level 8: All Other Claims | Claims that have not been identified in any of the above levels will be considered a Physical Health claim. |

Appendix A – Behavioral Health vs Physical Health Claims

Procedure Codes Exclusive to Behavioral Health

| Procedure Codes Exclusive to Behavioral Health | |
|--|---|
| Procedure Code | Description |
| 0364T—0371T | BEHAVIORAL ID ASSESSMENT/ADAPTIVE BEHAVIOR TREATMENT |
| 90785 | PSYTX COMPLEX INTERACTIVE |
| 90791 | PSYCH DIAGNOSTIC EVALUATION |
| 90792 | PSYCH DIAG EVAL W/MED SRVCS |
| 90801—90899 | PSYCH PROCEDURE CODES FOR E/M |
| 90828- | INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, U- |
| 90832 | PSYTX W PT 30 MINUTES |
| 90833 | PSYTX W PT W E/M 30 MIN |
| 90834 | PSYTX W PT 45 MINUTES |
| 90836 | PSYTX W PT W E/M 45 MIN |
| 90837 | PSYTX W PT 60 MINUTES ` |
| 90838 | PSYTX W PT W E/M 60 MIN |
| 90839 | PSYTX CRISIS INITIAL 60 MIN |
| 90840 | PSYTX CRISIS EA ADDL 30 MIN |
| 90845 | PSYCHOANALYSIS |
| 90846 | FAMILY PSYTX W/O PT 50 MIN |
| 90847 | FAMILY PSYTX W/PT 50 MIN |
| 90849 | MULTIPLE FAMILY GROUP PSYTX |
| 90853 | GROUP PSYCHOTHERAPY |
| 90857- | INTERACTIVE GROUP PSYCHOTHERAPY- |
| 90862- | PHARMACOLOGIC MANAGEMENT, INCLUDING PRES- |
| 90865- | NARCOSYNTHESIS- |
| 90870- | ELECTROCONVULSIVE THERAPY- |
| 90899 | UNLISTED PSYC SVC/THERAPY |
| 96110- | DEVELOPMENTAL SCREEN W/SCORE- |
| 96115—96118 | NUBHVL XM PHYS/QHP |
| 96116 | NUBHVL XM PHYS/QHP 1ST HR |
| 96130 | PSYCL TST EVAL PHYS/QHP 1ST |
| 96131 | PSYCL TST EVAL PHYS/QHP EA |
| 96132 | NRPSYC TST EVAL PHYS/QHP 1ST |
| 96133 | NRPSYC TST EVAL PHYS/QHP EA |
| 96136 | PSYCL/NRPSYC TST PHY/QHP 1ST |
| 96137 | PSYCL/NRPSYC TST PHY/QHP EA |
| 96138 | PSYCL/NRPSYC TECH 1ST |
| 96139 | PSYCL/NRPSYC TST TECH EA |
| 97152 | BHV ID SUPRT ASSMT BY 1 TECH |
| 97153 | ADAPTIVE BEHAVIOR TX BY TECH |
| 97154 | GRP ADAPT BHV TX BY TECH |

| Procedure Codes Exclusive to Behavioral Health | |
|--|---|
| Procedure Code | Description |
| 97157 | MULT FAM ADAPT BHV TX GDN |
| 97532 | DEVELOPMENT OF COGNITIVE SKILLS |
| H0001 | ALCOHOL AND/OR DRUG ASSESS |
| H0004 | ALCOHOL AND/OR DRUG SERVICES |
| H0005 | ALCOHOL AND/OR DRUG SERVICES |
| H0010 | ALCOHOL AND/OR DRUG SERVICES |
| H0012 | ALCOHOL AND/OR DRUG SERVICES |
| H0013 | ALCOHOL AND/OR DRUG SERVICES |
| H0014 | ALCOHOL AND/OR DRUG SERVICES |
| H0015 | ALCOHOL AND/OR DRUG SERVICES |
| H0019 | ALCOHOL AND/OR DRUG SERVICES |
| H0020 | ALCOHOL AND/OR DRUG SERVICES |
| H2023 | SUPPORTED EMPLOY, PER 15 MIN |
| H0031 | MH HEALTH ASSESS BY NON-MD |
| H0032 | MH SVC PLAN DEV BY NON-MD |
| H0035 | MH PARTIAL HOSP TX UNDER 24H |
| H0038 | PEER SUPPORT SERVICES |
| H0040 | ASSERT COMM TX PGM PER DIEM |
| H0043 | SUPPORTED HOUSING, PER DIEM |
| H0045 | RESPIRE NOT-IN-HOME PER DIEM |
| H0046 | MENTAL HEALTH SERVICE, NOS |
| H2011 | CRISIS INTERVEN SVC, 15 MIN |
| H2012 | BEHAV HLTH DAY TREAT, PER HR |
| H2015 | COMP COMM SUPP SVC, 15 MIN |
| H2016 | COMP COMM SUPP SVC, PER DIEM |
| H2017 | PSYSOC REHAB SVC, PER 15 MIN |
| H2020 | THER BEHAV SVC, PER DIEM |
| H2022 | COM WRAP-AROUND SV, PER DIEM |
| H2023 | SUPPORTED EMPLOY, PER 15 MIN |
| H2025 | SUPP MAINT EMPLOY, 15 MIN |
| H2033 | MULTISYS THER/JUVENILE 15MIN |
| H2034 | A/D HALFWAY HOUSE, PER DIEM |
| H2035 | A/D TX PROGRAM, PER HOUR |
| S5102 | CRISIS INTERVENTION PER HOUR |
| S5110 | CRISIS INTERVEN WAIVER/DIEM |
| S5111 | HOME CARE TRAINING, FAMILY: PER SESSIO |
| S5125 | ATTENDANT CARE SERVICES; PER 15 MINUTES |
| S5145 | FOSTER CARE, THERAPEUTIC, CHILD; PER DIEM |
| S5150 | UNSKILLED RESPIRE CARE, NOT HOSPICE: PER 15 MINUTES |

| Procedure Codes Exclusive to Behavioral Health | |
|--|---|
| Procedure Code | Description |
| S5165 | HOME MODIFICATIONS: PER SERVICE |
| S9484 | CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER HOUR |
| S9485 | CRISIS INTERVENTION MENTAL HEALTH SERVICES, PER DIEM |
| T1005 | RESPIRE CARE SERVICES, UP TO 15 MINUTES |
| T2012 | HABIL ED WAIVER, PER DIEM |
| T2013 | HABILITATION, EDUCATIONAL, WAIVER; PER HOUR |
| T2014 | HABILITATION, PREVOCATIONAL, WAIVER: PER DIEM |
| T2016 | ALTERNATIVE SERV. BHUC |
| T2020 | DAY HABILITATION, WAIVER: PER DIEM |
| T2021 | DAY HABILITATION, WAIVER: PER 15 MINUTES |
| T2027 | SPECIALIZED CHILDCARE, WAIVER; PER 15 MINUTES |
| T2029 | SPECIALIZED MEDICAL EQUIPMENT, NOT OTHERWISE SPECIFIED, WAIVER |
| T2033 | RESIDENTIAL CARE, NOT OTHERWISE SPECIFIED (NOS), WAIVER: PER DIEM |
| T2034 | CRISIS INTERVENTION, WAIVER; PER DIEM |
| T2038 | COMMUNITY TRANSITION, WAIVER: PER SERVICE |
| T2039 | VEHICLE MOD WAIVER/SERVICE |
| T2041 | SUPPORTS BROKERAGE, SELF-DIRECTED, WAIVER: PER 15 MINUTES |

Revenue Codes Exclusive to Behavioral Health

| Revenue Codes Exclusive to Behavioral Health | |
|--|---|
| Revenue Code | Description |
| 114 | 0114 Room and Board/Private Psychiatric |
| 116 | 0116 Room and Board/Private Detoxification |
| 124 | 0124 Room & Board /Semi-private Two Bed/Psychiatric |
| 126 | 0126 Room & Board/Semi-private Two Bed/Detoxification |
| 134 | 0134 Semi-Private/ Three and Four Bed/Psychiatric |
| 136 | 0136 Semi-Private /Three and Four Bed/Detoxification |
| 144 | 0144 Private (Deluxe)/Psychiatric |
| 146 | 0146 Private (Deluxe)/Detoxification |
| 154 | 0154 Room & Board Ward/Psychiatric |
| 156 | 0156 Room & Board Ward/Detoxification |
| 204 | 0204 Intensive Care/Psychiatric |
| 919 | 0919 PRTF Crisis Assessment Program |
| 900 | 0900 General - Psych Treatment |
| 901 | 901 - Psychiatric/Psychological Trt: Electroshock treatment |
| 902 | 902 - Psychiatric/Psychological Trt: Milieu therapy |
| 903 | 0903 Play therapy |

| Revenue Codes Exclusive to Behavioral Health | |
|--|---|
| Revenue Code | Description |
| 904 | 0904 Activity therapy |
| 905 | 905 - Psychiatric/Psychological Trt: Intensive Outpatient serv-psyc |
| 906 | 906 - Psychiatric/Psychological Trt: Intensive out serv - chem dep |
| 907 | 0907 Community behavioral health program (day treatment) |
| 908 | 0908 Reserved for national use |
| 909 | 0909 Reserved for national use |
| 910 | 0910 Reserved for national use |
| 912 | 912 - Psychiatric/Psychological Svcs: Partial Hosp - less intensive |
| 913 | 0913 Partial hospitalization-Intensive |
| 914 | 914 - Psychiatric/Psychological Svcs: Individual therapy |
| 915 | 915 - Psychiatric/Psychological Svcs: Group therapy |
| 916 | 916 - Psychiatric/Psychological Svcs: Family therapy |
| 917 | 0917 Biofeedback |
| 918 | 918 - Psychiatric/Psychological Svcs: Testing |
| 911 | RC911 - PRTF |

Revenue Codes with Behavioral Health Primary Diagnosis

| Revenue Codes with Behavioral Health Primary Diagnosis | |
|--|---|
| Revenue Code | Description |
| 100 | 100 HI - ICF/MR Hospital Admission & General Hospital |
| 101 | 0101 All-inclusive room and board |
| 101 | 0101 HT-Holly Hill IMD |
| 110 | 0110 General |
| 111 | 0111 Medical/surgical/GYN |
| 112 | 0112 Obstetrics (OB) |
| 113 | 0113 Pediatric |
| 115 | 0115 Hospice |
| 117 | 0117 Oncology |
| 118 | 0118 Rehabilitation |
| 119 | 0119 Other |
| 120 | 0120 General |
| 121 | 0121 Medical/surgical/GYN |
| 122 | 0122 OB |
| 123 | 0123 Pediatric |
| 125 | 0125 Hospice |
| 127 | 0127 Oncology |
| 128 | 0128 Rehabilitation |
| 129 | 0129 Other |

| Revenue Codes with Behavioral Health Primary Diagnosis | |
|--|---|
| Revenue Code | Description |
| 130 | 0130 General |
| 131 | 0131 Medical/surgical/GYN |
| 132 | 0132 OB |
| 133 | 0133 Pediatric |
| 135 | 0135 Hospice |
| 137 | 0137 Oncology |
| 138 | 0138 Rehabilitation |
| 139 | 0139 Other |
| 140 | 0140 General |
| 141 | 0141 Medical/surgical/GYN |
| 142 | 0142 OB |
| 143 | 0143 Pediatric |
| 145 | 0145 Hospice |
| 147 | 0147 Oncology |
| 148 | 0148 Rehabilitation |
| 149 | 0149 Other |
| 150 | 0150 General |
| 151 | 0151 Medical/surgical/GYN |
| 152 | 0152 OB |
| 153 | 0153 Pediatric |
| 155 | 0155 Hospice |
| 157 | 0157 Oncology |
| 158 | 0158 Rehabilitation |
| 159 | 0159 Other |
| 160 | 0160 IMD Inpatient Hospital |
| 164 | 0164 Sterile environment |
| 167 | 0167 Self-care |
| 169 | 0169 Other |
| 170 | 0170 General |
| 171 | 0171 Newborn-Level I |
| 172 | 0172 Newborn-Level II |
| 173 | 0173 Newborn-Level III |
| 174 | 0174 Newborn-Level IV |
| 179 | 0179 Other |
| 180 | 0180 General LOA |
| 181 | 0181 Reserved |
| 182 | 0182 Patient convenience-Charges billable |

| Revenue Codes with Behavioral Health Primary Diagnosis | |
|--|---|
| Revenue Code | Description |
| 183 | 0183 - THERAPEUTIC LEAVE |
| 183 | 0183 - Therapeutic Leave - Residential Not State |
| 184 | 0184 Reserved |
| 185 | 0185 Hospitalization |
| 189 | 0189 Other LOA |
| 190 | 0190 General |
| 191 | 0191 Sub acute care-Level I (skilled care) |
| 192 | 0192 Sub acute care-Level II (comprehensive care) |
| 193 | 0193 Sub acute care-Level III (complex care) |
| 194 | 0194 Sub acute care-Level IV (intensive care) |
| 199 | 0199 Other sub acute care |
| 200 | 0200 General |
| 201 | 0201 Surgical |
| 202 | 0202 Medical |
| 203 | 0203 Pediatric |
| 206 | 0206 Intermediate intensive care unit (ICU) |
| 207 | 0207 Burn care |
| 208 | 0208 Trauma |
| 209 | 0209 Other intensive care |
| 210 | 0210 General |
| 211 | 0211 Myocardial infarction |
| 212 | 0212 Pulmonary care |
| 213 | 0213 Heart transplant |
| 214 | 0214 Intermediate coronary care unit (CCU) |
| 219 | 0219 Other coronary care |
| 656 | 0656 General inpatient care (nonrespite) |
| 656 | 0219 Other coronary care |

Procedure Codes Shared by Physical and Behavioral Health

| Procedure Codes Shared by Physical and Behavioral Health | |
|--|------------------------------|
| Code | Description |
| 90865 | NARCOSYNTHESIS |
| 90870 | ELECTROCONVULSIVE THERAPY |
| 96105 | ASSESSMENT OF APHASIA |
| 96110 | DEVELOPMENTAL SCREEN W/SCORE |
| 96112 | DEVEL TST PHYS/QHP 1ST HR |
| 96113 | DEVEL TST PHYS/QHP EA ADDL |
| 96121 | NUBHVL XM PHY/QHP EA ADDL HR |
| 96127 | BRIEF EMOTIONAL/BEHAV ASSMT |
| 96146 | PSYCL/NRPSYC TST AUTO RESULT |
| 96372 | THER/PROPH/DIAG INJ SC/IM |
| 97129 | THER IVNTJ 1ST 15 MIN |
| 97151 | BHV ID ASSMT BY PHYS/QHP |
| 97155 | ADAPT BEHAVIOR TX PHYS/QHP |
| 97156 | FAM ADAPT BHV TX GDN PHY/QHP |
| 98966 | HC PRO PHONE CALL 5-10 MIN |
| 98967 | HC PRO PHONE CALL 11-20 MIN |
| 98968 | HC PRO PHONE CALL 21-30 MIN |
| 99202 | OFFICE O/P NEW SF 15-29 MIN |
| 99203 | OFFICE O/P NEW LOW 30-44 MIN |
| 99204 | OFFICE O/P NEW MOD 45-59 MIN |
| 99205 | OFFICE O/P NEW HI 60-74 MIN |
| 99211 | OFF/OP EST MAY X REQ PHY/QHP |
| 99212 | OFFICE O/P EST SF 10-19 MIN |
| 99213 | OFFICE O/P EST LOW 20-29 MIN |
| 99214 | OFFICE O/P EST MOD 30-39 MIN |
| 99215 | OFFICE O/P EST HI 40-54 MIN |
| 99221 | 1ST HOSP IP/OBS SF/LOW 40 |
| 99222 | 1ST HOSP IP/OBS MODERATE 55 |
| 99223 | 1ST HOSP IP/OBS HIGH 75 |
| 99231 | SBSQ HOSP IP/OBS SF/LOW 25 |
| 99232 | SBSQ HOSP IP/OBS MODERATE 35 |
| 99233 | SBSQ HOSP IP/OBS HIGH 50 |
| 99234 | HOSP IP/OBS SM DT SF/LOW 45 |
| 99235 | HOSP IP/OBS SAME DATE MOD 70 |
| 99236 | HOSP IP/OBS SAME DATE HI 85 |
| 99238 | HOSP IP/OBS DSCHRG MGMT 30/< |
| 99239 | HOSP IP/OBS DSCHRG MGMT >30 |

| Procedure Codes Shared by Physical and Behavioral Health | |
|--|------------------------------|
| Code | Description |
| 99242 | OFF/OP CONSLTJ NEW/EST SF 20 |
| 99243 | OFF/OP CNSLTJ NEW/EST LOW 30 |
| 99244 | OFF/OP CNSLTJ NEW/EST MOD 40 |

Behavioral Health Provider Taxonomy Codes

| Behavioral Health Provider Taxonomy Codes | | | |
|---|-------------------------------|--|------------|
| Category | Classification | Specialization | Code |
| Behavioral Health and Social Service Providers (begins with 10) | Counselor | Addiction (Substance Use Disorder) | 101YA0400X |
| Behavioral Health and Social Service Providers (begins with 10) | Counselor | Mental Health | 101YM0800X |
| Behavioral Health and Social Service Providers (begins with 10) | Behavior Analyst | | 103K00000X |
| Behavioral Health and Social Service Providers (begins with 10) | Psychologist | | 103T00000X |
| Behavioral Health and Social Service Providers (begins with 10) | Social Worker | Clinical | 1041C0700X |
| Behavioral Health and Social Service Providers (begins with 10) | Marriage and Family Therapist | | 106H00000X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Addiction Medicine | 2084A0401X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Diagnostic Neuroimaging | 2084D0003X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Forensic Psychiatry | 2084F0202X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Neuromuscular Medicine | 2084N0008X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Neurology | 2084N0400X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Neurology with Special Qualifications in Child Neurology | 2084N0402X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Clinical Neurophysiology | 2084N0600X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Neurodevelopmental Disabilities | 2084P0005X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS (begins with 20) | Pediatrics | Developmental – Behavioral Pediatrics | 2080P0006X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Psychosomatic Medicine | 2084P0015X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Psychiatry | 2084P0800X |

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|---|--|--|------------|
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Addiction Psychiatry | 2084P0802X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Child & Adolescent Psychiatry | 2084P0804X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Geriatric Psychiatry | 2084P0805X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Sleep Medicine | 2084S0012X |
| ALLOPATHIC & OSTEOPATHIC PHYSICIANS | Psychiatry & Neurology | Vascular Neurology | 2084V0102X |
| Agencies (begins with 25) | Day Training; Developmentally Disabled Services | | 251C00000X |
| Agencies (begins with 25) | Community/ Behavioral Health | | 251S00000X |
| Ambulatory Health Care Facilities (begins with 26) | Clinic/Center | Developmental Disabilities | 261QD1600X |
| Ambulatory Health Care Facilities (begins with 26) | Clinic/Center | Rehabilitation; Substance Use Disorder | 261QR0405X |
| Hospital Unit (begins with 27) | Psychiatric Unit | | 273R00000X |
| Hospital (begins with 28) | Psychiatric Hospital | | 283Q00000X |
| Nursing & Custodial Care Facilities | Intermediate Care Facility, Intellectual Disabilities | | 315P00000X |
| Residential Treatment Facility (begins with 32) | Community-based Residential Treatment Facility, Mental Illness | | 320800000X |
| Residential Treatment Facility (begins with 32) | Psychiatric Residential Treatment Facility | | 323P00000X |
| Residential Treatment Facility (begins with 32) | Substance Abuse Disorder Rehabilitation Facility | | 324500000X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Nurse Practitioner | Psychiatric/Mental Health | 363LP0808X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; child & adolescent | 364SP0807X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health | 364SP0808X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; adult | 364SP0809X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; child & family | 364SP0810X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; chronically ill | 364SP0811X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; community | 364SP0812X |
| PHYSICIAN ASSISTANTS & ADVANCED PRACTICE NURSING PROVIDERS (begins with 36) | Clinical Nurse Specialist | Psychiatric/ Mental Health; geropsychiatric | 364SP0813X |

3.49 Personal Care Services (PCS) Reimbursement Methodology

Effective 4/1/2025, the health plans shall reimburse members receiving Personal Care Services (PCS) according to the rate methodology for the daily per diem rate as described below:

- Only procedure code 99509 and modifiers SC, HC, HQ, HH, HI or TT are impacted.
- Providers will be reimbursed a daily rate based on the approved daily units, not the actual time spent delivering the service on a specific day.
- The PCS authorization period will contain the prior approval effective and end date.

3.50 Tailored Care Management (TCM)

3.50.1 General Guidance for Health Plans

The intent of the TCM Program is to provide whole-person care management for eligible NC Medicaid members through a single, designated care manager supported by a multidisciplinary care team. The guidance provided below is applicable for those NC Medicaid health plans that are contractually obligated to provide TCM to eligible members within their populations.

- A. Health plans will assign eligible TCM Beneficiaries to certified TCM entities, (Advanced Medical Homes, (AMH+), Care Management Agencies (CMAs) for TCM services.
- B. Health plans will submit adjudicated AMH+ and CMA claims for the first monthly TCM contact per member to NCTracks, along with all corresponding encounters to the State Encounters Processing System (EPS).
- C. Health plans providing TCM services will submit TCM claims for the first monthly TCM qualifying contact per member to NCTracks, along with all corresponding encounters to the EPS.
- D. Health plans, AMH+, and CMAs will receive payment based on the TCM blended rate. Care Management providers with members assigned and eligible for Innovations/TBI, and/or 1915i and/or enrolled in Healthy Opportunities will receive add-on payments.
- E. All TCM interactions/contacts should be documented by the respective TCM entity performing the service(s). TCM Providers should submit that data to their respective health plans through the Patient Risk List (PRL).
- F. Health plans should submit all TCM interactions/contacts for their eligible TCM population to the Department through the BCM051 operational report. Health plans should include their TCM contacts as well as providers' contact for their members.
- G. Health plans should have processes to archive historical TCM claims data submitted to the State for Federal and/or State audit purposes. Health plans should reference their respective contracts for detailed information.
- H. Health plans should identify a beneficiary's first TCM interaction of a given month based on the date of service.
- I. Health plans should use the appropriate Plan ID when submitting TCM claims to NCTracks based on the contract type and population served. TCM Claims for members enrolled in a PIHP should be billed using the PIHP Plan ID. TCM Claims for members enrolled in a Tailored Plan (TP) should be billed using the TP Plan ID.

- J. Health plans should not bill for or perform TCM services if a member is concurrently receiving a duplicative service or if a member is in a population excluded from TCM.
- a. Duplicative services include:
 - i. Members receiving Assertive Community Treatment (ACT)
 - ii. Members obtaining care management from the Department's Primary Care Case Management (PCCM) vendor (including members participating in Eastern Band of Cherokee Indians (EBCI) Tribal Option)
 - iii. Members participating in the High-Fidelity Wraparound program as described in Section IV.G.7. Other Care Management Programs
 - iv. Members obtaining Child Assertive Community Treatment (Child ACT)
 - v. Members obtaining Critical Time Intervention
 - vi. Members receiving services through Skilled Nursing Facilities (SNFs) for more than 90 calendar days
 - vii. Members participating in Care Management for At-Risk Children; and
 - viii. Members receiving any approved In Lieu Of Services (ILOS) that are deemed duplicative through the Department's ILOS approval process.
 - b. Excluded populations include:
 - i. Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs)
 - ii. Members receiving case management through the Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA) programs
 - c. The Department will communicate any additional services or populations identified as duplicative to, or excluded from, TCM as appropriate.

3.50.2 Procedure Codes and Claims Submissions

- A. Health plans and TCM Providers shall use the below procedure code and modifier combinations when submitting TCM Claims:
- a. T1017 HT – applies to all TCM service claims.
 - b. T1017 HA – applies to TCM service claims with the Healthy Opportunities (HOP) Add-on
 - i. The HOP Add-on can be billed monthly whenever TCM activities are rendered by Delegated Pilot Care Management Entities (AMH+/CMA) to HOP-enrolled members.
 - ii. Members are considered HOP enrolled when they have a completed Pilot Eligibility Service Assessment (PESA) and have been referred to an HSO through NCCARE360 for at least one HOP service, either Provisional or non-Provisional. Note that completion of HOP enrollment tasks is a billable TCM activity.
 - iii. HOP enrollment should be completed and/or confirmed through NCCARE360 prior to billing the HOP add-on. To verify HOP enrollment, care managers should complete the following steps in NCCARE360:

1. Navigate to the member's Facesheet by utilizing the search bar or Clients tab
 2. From the Facesheet, click on the Profile tab and scroll to the Social Care Coverage section to verify the member has active Provisional or non-Provisional Social Care Coverage
 - iv. Effective Nov. 1, 2024, the T1017 HA code can be billed on (1) a separate claim from the T1017 HT code or (2) on the same claim but separate claim lines with different Dates of Service, or (3) on the same claim but separate claim lines with the same Dates of Service as appropriate.
 - c. T1017 HTCG – applies TCM service claims with the Innovations/TBI add-on.
 - i. Health plans should receive the Innovations Add-On when the individual is given an Innovations slot. TCM claims with the innovations add-on will not be paid until a member is deemed eligible and the IN indicator added to the member's eligibility record. The service can be backdated if the service occurred after the initial Level of Care.
 - d. T1017 U4 -- TCM service claims with the 1915i add-on
 - i. T1017 U4 code must be billed on the same claim as the T1017 HT on separate claim lines
 - e. No further procedure code and modifier combinations are permitted for TCM. AMH+ and CMAs should work with contracted health plans for accurate claims submissions.
- B. Additional Notes:
- a. Health plans should submit their NC Medicaid Direct ID as the billing and rendering provider for TCM claims.
 - b. Health plans should submit the appropriate taxonomy for which they are enrolled with NC Medicaid.
 - c. Health plans should submit the location where the service was rendered such as in a School, Home, Place of employment, etc. per Centers for Medicare & Medicaid Services (CMS) approved codes.
 - d. All claims submissions require diagnosis codes for processing. TCM claims need to have at least one Medicaid Recognized diagnosis code to process. There shall be no edits specific to Diagnosis code for TCM claims other than verification of the presence of a Diagnosis code.
 - i. Telehealth is not a valid billable service or Place of Service code if the service was performed in-person, but may be used for telephonic or video services.

Others

As defined in the Contract (Section V.C.1.Table 4: Required Clinical Coverage Policies), the health plan shall instruct providers to follow these policies as stated below. The health plans shall not modify these policies and should ensure publications aligned with the list below:

- 1E-7: Family Planning Services

- 1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment [included above in 3.3)
- 1A-23: Physician Fluoride Varnish Services
- 1A-36: Implantable Bone Conduction Hearing Aids (BAHA)
- 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
- 13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair
- 13B: Soft Band and Implant

4 PROVIDER EDUCATION

4.1 Provider Training

The health plan shall include training for providers on these billing requirements in the Provider Training Plan as defined in Section V.D.3.c. of the Revised and Restated Health Plan Contract.

4.2 Inclusion in Provider Contract/Manual

The health plan shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the health plans and Medicaid Managed Care as defined in Section V.D.3.d. of the Revised and Restated Health Plan Contract.

5 VERSIONS

| Version Number | Description of changes | Date |
|---------------------|---|------------|
| Version 9.0 | Added section 3.5 Dental Ambulatory Surgical Center Services; Added FQHC/RHCs exemption from copayments (Section 3.7); Included a reference to the Health Choice Guidance (Section 3.8), Section 3.1: Abortion language changes, Section 10: Hysterectomy language changes, Section 16: Sterilizations language changes | 6/22/2021 |
| Version 10.0 | Added the following sections: 3.17 - Revenue Code with Non-Covered Procedure Code; 3.20 - Taxonomy Claims Guidance | 11/3/2021 |
| Version 11.0 | Added the following sections: 3.4 - Child Medical Evaluation and Medical Team Conference for Child Maltreatment (CMEP) 3.5.2 – Pricing Manual Rules 3.6 – Updated Dental ASC guidance | 01/07/2022 |

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| | 3.7 – Downcoding Emergency Department Visits; 3.8 – Emergency Department Copay; 3.12 – Labs 3.17 – Procedure Codes 3.18 – Revenue Codes 3.21.1 - Professional Claims Pricing | |
| Version 12.0 | Added the following sections: 3.17.1 – Covered Procedure Codes 3.18.2 – Covered Revenue Codes Updated the following sections: 3.12 – Update guidance for Institutional Hospital Outpatient Claims 3.18 – Removed revenue code 063X from the list | 01/27/2022 |
| Version 13.0 | Added the following sections: 3.9 HCPCS/NDC Crosswalk Guidance By Claim Type 3.13 Lab Test Codes 3.15.1 Newborn Clinical Information 3.18.1 Covered Procedure Codes 3.19.2 Covered Revenue Codes | 03/11/2022 |
| Version 14.0 | Added the following section: 3.27 Other Insurance Updated the following sections: 3.6 Adjudicating Claims Based on Codes Submitted (formerly downcoding) 3.18.1 Covered Procedure Codes 3.19.2 Covered Revenue Codes | 5/12/2022 |

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| Version 15.0 | <p>Added the following sections: 3.28 Electronic Attachments, 3.29 Transaction Fees, 3.30 Line Service Unit/NDC Fields on Claims and Encounters</p> <p>Updated the following sections: 3.7 Copayment Rules (formerly Emergency Department Copay), 3.7.2 Copayment Rules and Exemptions (formerly System Configuration), 3.18 Procedure Codes</p> | 6/03/2022 |
| Version 16.0 | <p>Added the following sections: 3.12.2 Inpatient Hospital Billing 3.33 Psych/Rehab Reimbursement Guidelines 3.32 Tribal Payment Policy 3.31 Claims Guidance for Derived Service Location</p> <p>Updated the following sections: 3.1 Autism Screening 3.22 Taxonomy Claim Guidance 3.7.2 Copayment Rules and Exemptions</p> | 6/30/2022 |
| Version 17.0 | <p>Added the following section: 3.34 High Dollar Review and Itemized Bills Guidance</p> <p>Updated the following section: 3.27 Other Insurance</p> | 7/7/2022 |

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| Version 18.0 | <p>Added the following section: 3.35 Independent Lab Reimbursement</p> <p>Updated the following sections: 3.30 Abortions, 3.3 Child Medical Evaluation and Medical Team Conference for Child Maltreatment (CMEP), and 3.18 Procedure Codes</p> | 7/28/2022 |
| Version 19.0 | <p>Added the following sections: 3.5.1 Claims Submission for Hospital Dental Treatment, 3.36 Known System Issues, and 3.37 Payments for Non-Rate Floor Permanent Rates</p> <p>Updated the following sections: 3.2 Care Management Payments, 3.4.1 DME/POS Miscellaneous Codes, 3.4.2 DME/POS Manual Pricing Rules, 3.4.4 Multiple Procedure Code Reductions, 3.5 Dental Ambulatory Surgical Center Services, 3.7.2 Copayment Rules and Exemptions, 3.8.1 Core Services, 3.11 Hysterectomy, 3.12 Hospital Claims, 3.19.1 Revenue Codes and NDC Codes, 3.19.2 Covered Revenue Codes, 3.27 Other Insurance, 3.31 Claims Guidance for Derived Service Locations, and 3.33 Psych/Rehab Hospital Reimbursement Guidelines for Inpatient Hospital Claims</p> | 10/7/2022 |

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| <p>Version 20.0</p> | <p>Added the Following Sections: 3.5.2 Billing for Anesthesia Services in an Ambulatory Surgical Center for Dental Surgeries, 3.25.1 Vaccines for Children, 3.36.1 Lesser of Payment Methodology, 3.37 Rate Floors, 3.38 Rate Differentials, 3.39 Telehealth Codes and Modifiers, and 3.40 Pended Claims</p> <p>Updated the following sections: 2 Medicaid Managed Care Billing Guidance, 3.4.2 DME/POS Manual Pricing Rules, 3.4.3 Unlisted CPT Codes, 3.5 Dental Operating Room Facility Time Billed by an Ambulatory Surgical Center (ASC), 3.6.1 Federal Guidance on Emergency Conditions, 3.9 HCPCS/NDC Crosswalk Guidance by Claim Type, 3.13 Lab Test Codes, 3.14 Medical Home Fees, 3.15 Newborns, 3.15.1 Newborn Clinical Information, 3.16 Pregnancy Global Bundle, 3.17 Pregnancy Management Program Payments, 3.18 Procedure Codes, 3.19.2 Covered Revenue Codes, 3.19.3 Institutional Hospital Outpatient Claims, 3.19.4 Institutional Claims and Revenue Codes, 3.20 Sterilizations, 3.21 Skilled Nursing Facilities, 3.22.1 Professional Claims Pricing, 3.23 Tribal Payment Policy, 3.24 Value-Based Payments/Alternative Payment Models, 3.25 Well Child Visit, 3.26 340B Drugs, 3.27.2 Pay and Chase, 3.27.3 Program and Service Exceptions for TPL and Coordination of Benefits, Others, 4.1 Provider Training,</p> | <p>1/20/2023</p> |
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| | 4.2 Inclusion in Provider Contract/Manual | |
| Version 21.0 | <p>Added the following sections: 3.41 Clean Claim Date Guidance, 3.42 DPU vs. Non-DPU Inpatient Stays with Both Behavioral Health and Physical Health Services, and 3.43 Inpatient Stays with Enrollment or Eligibility Changes</p> <p>Updated the following sections: 3.4.2 DME Manual Pricing Rules, 3.7.2 Copayment Rules and Exemptions, 3.32 Psych/Rehab Hospital Reimbursement Guidelines for Inpatient Hospital Claims, 3.27.2 Pay and Chase, 3.33 High Dollar Review and Itemized Bills Guidance, and 3.31 Claims Guidance for Provider Location Matching</p> | 4/27/2023 |
| Version 22.0 | Updated the following sections: 3.27.2 Pay and Chase | 5/02/2023 |

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| Version 23.0 | <p>Added the following sections: 3.12.2 DRG Payment Methodology, 3.27.4 Third Party Liability (TPL) Bypass Rules, 3.31.2 Out of Network Provider Affiliation Guidance, and 3.44 Remittance Advice Guidance</p> <p>Updated the following sections: 3.7.1 Emergency Department Copay, 3.26 340B Drugs, and 3.33 High Dollar Review and Itemized Bills Guidance</p> | 8/4/2023 |
| Version 24.0 | <p>Added the following sections: 3.21.1 Short Term Skilled Nursing Facilities, 3.26.1 Long-Acting Reversible Contraception (LARCs), 3.42 Adjustments, and 3.46 Professional Dispensing Fee</p> <p>Updated the following sections: 3.18.1 Covered Procedure Codes, 3.7.2 Copayment Rules and Exemptions, 3.41 Clean Claim Guidance, 3.23 Tribal Payment Policy, 3.28 Electronic Attachments, and 3.43 DPU vs. Non-DPU Inpatient Stays with Both Behavioral Health and Physical Health Services</p> | 10/27/2023 |
| Version 25.0 | <p>Added the following sections: 3.31.3 NPI Attending Provider Field for Prepaid Inpatient Health Plan (PIHP) ONLY, and 3.47 Endoscopy Codes and Pricing</p> <p>Updated the following sections: 3.5 Dental Operating Room Facility Services, 3.5.1 Claims Submission for Ambulatory Surgical Centers (ASC), 3.5.2 Claims Submission for Hospital Dental Treatment, 3.7.1</p> | 1/5/2024 |

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| | Emergency Department Copay, 3.7.2 Copayment Rules and Exemptions, 3.19.3 Institutional Hospital Outpatient Claims, 3.27.1 Explanation of Benefits (EOB), and 3.42 Adjustments | |
| Version 26.0 | <p>Added the following sections: 3.6.2 NCCI and MUE Edits, 3.8.2 FQHC/RHC Wrap Payments, and 3.12.3 High-Cost Gene Therapy Medications and Clinical Services Reimbursement Guidance</p> <p>Updated the following sections: 3.6.1 Federal Guidance on Emergency Conditions, 3.8.1 FQHC/RHC Core Service Payments, and 3.27.3 Program and Service Exemptions for TPL and Coordination of Benefits</p> | 4/5/2024 |
| Version 27.0 | Updates for PHP Billing Guide version 27 include the revision of the existing sections: 3.12 Hospital Claims, 3.27.4 Third Party Liability (TPL) Bypass Rules, 3.12.2 DRG Payment Methodology , 3.33 High Dollar Review and Itemized Bills Guidance, 3.6 Adjudicating Claims Based on Codes Submitted, 3.6.1 Federal Guidance on Emergency Conditions , 3.31.1 Provider Location Matching Guidance, 3.8.2 FQHC/RHC Wrap Payment, 3.40 Pended Claims, 3.5.1 Claims Submission for Ambulatory Surgical Centers | 7/17/24 |

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| | (ASC) , 3.8.1 FQHC/RHC Core Service Payments | |
| Version 28.0 | <p>Added the following sections: 3.48 Behavioral Health vs Physical Health Claims Guidance & 3.49 Personal Care Services (PCS) Reimbursement Methodology</p> <p>Updated the following sections: 3.7.2 Copayment Rules and Exemptions, 3.8.1 FQHC/RHC Wrap Payments, 3.8.1 FQHC/RHC Core Service Payments, 3.8.2 FQHC/RHC Wraparound (Wrap) Payments, 3.12.2 DRG Payment Methodology, 3.23 Tribal Payment Policy, 3.27.4 Third Party Liability Bypass Rules, 3.35 Known System Issues, 3.36 Payments for Non-Rate Floor Permanent Rates, 3.39 Telehealth Codes and Modifiers, 3.40 Pended Claims, 3.44 Inpatient Stays with Enrollment or Eligibility Changes, 3.45 Remittance Advice Guidance</p> | 11/22/24 |

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| Version 29.0 | <p>Added the following sections: 3.50 Tailored Care Management TCM</p> <p>Updated the following sections: 2. Medicaid Managed Care Billing Guidance, 3.8.1 FQHC/RHC Core Service Payments, 3.8.2 FQHC/RHC Wraparound (Wrap) Payments, 3.12.3 NC Select Drugs (including Cell & Gene Therapies) and Clinical Services Billing and Reimbursement Guidance, 3.25 Well Child Visit, 3.26 340B Drugs, 3.27.2 Pay and Chase, 3.36.1 Lesser of Payment Methodology, 3.49 Personal Care Services (PCS) Reimbursement Methodology</p> | 1/10/2025 |
| Version 30.0 | <p>Added the following sections: 3.27.4 Third Party Liability Bypass Rules</p> <p>Updated the following sections: 3.5.1 Claims Submission for Ambulatory Surgical Centers (ASC), 3.6 Adjudicating Claims Based on Codes Submitted, 3.8.1 FQHC/RHC Core Service Payments, 3.8.2 FQHC/RHC Wraparound (Wrap) Payments, 3.12 Hospital Claims, 3.12.3 High Cost Drugs (NC Select Drug List), 3.12.4 Lower Level of Care, 3.16 Pregnancy Global Bundle, 3.19.4 Institutional Claims and Revenue Codes, 3.33 High Dollar Review and Itemized Bills Guidance, 3.40 Pended Claims, 3.48 Behavioral Health vs Physical Health Claims Guidance</p> | 4/29/25 |