NC Medicaid Managed Care
Provider Playbook

NC Medicaid

Fact Sheet
Managed Care Claims Submission – What Providers Need to Know – Part 1

Claims Submission Guidelines and Resources

With NC Medicaid Managed Care, it is critical to ensure providers are well-informed about changes to claims submission to be reimbursed in a timely manner.

This fact sheet contains general information to inform providers about managed care claim submission processes and billing guidelines.

WHERE SHOULD A PROVIDER SUBMIT CLAIMS

Claims routing depends on a beneficiary's enrollment at time of service and the service provided. Claims for beneficiaries enrolled in NC Medicaid Managed Care (e.g., a Standard Plan or Tailored Plan) should be submitted to the assigned health plan as shown on their beneficiary ID card.

Some Tailored Plans partner with Standard Plans for claims processing. Refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, for details on where to submit claims for Tailored Plans and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for where to submit claims for Standard Plans. For Tailored Care Management claims see the Managed Care Billing Guidance to Health Plans.

For beneficiaries in NC Medicaid Direct, providers should submit claims as they do today. Physical health claims for beneficiaries enrolled in NC Medicaid Direct should be submitted to NCTracks.

For beneficiaries of the Eastern Band of Cherokee Indians (EBCI) Tribal Option, providers should bill services as they do with NC Medicaid Direct beneficiaries. Behavioral health claims for beneficiaries enrolled in NC Medicaid Direct and dates of service on or after April 1, 2023, should be submitted to the assigned health plan as shown on their beneficiary ID card.

BENEFICIARY ELIGIBILITY

Providers must check eligibility in NCTracks prior to the beneficiary visit, even if the beneficiary presents with a Medicaid ID or NC Medicaid Managed Care health plan card, to determine which health plan the beneficiary is enrolled in and if their eligibility is current for the beneficiary's service visit date. While each health plan will have its own internal eligibility system, NCTracks is recognized as the real-time eligibility system for providers contracting with NC Medicaid.

Eligibility can be validated through the NCTracks Recipient Eligibility Verification methods outlined below.

Three methods of Recipient Eligibility Verification are available:

- Via the NCTracks Secure Provider Portal
- Real Time Eligibility Verification
- Batch Eligibility Verification using automatic voice verification. Call 800-723-4337 and reference Automated Voice Response System for voice verification.

As a reminder, these methods can be used for ***current*** eligibility information – future eligibility information is not available at this time.

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

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

OTHER INSURANCE VERIFICATION

Other insurance information should be verified through the health plan portal or through Real-Time Eligibility Electronic Data Interchange (EDI) transactions 270/271. Medicaid providers should use NCTracks to verify other found insurance for NC Medicaid Direct beneficiaries.

CARVED OUT SERVICES

NC Medicaid has defined services that are carved out of NC Medicaid Managed Care and should continue to be billed through NCTracks for beneficiaries in managed care. The services are defined below.

First Revised Section Services Carved Out of NC Medicaid Managed Care

- Services provided through the Program of All-Inclusive Care for the Elderly (PACE).
- Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), an Individual Health Plan (IHP) or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs).
- Services provided and billed by Children's Developmental Services Agency (CDSA) that are included in the child's ISFP.
- Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes except for the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.

- Services for Medicaid applicants provided prior to the first day of the month where eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the contract.
- Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses and ophthalmic frames.

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

- For physical health claims, out-of-network providers will file services covered under NC Medicaid Managed Care directly with the health plan. Out-of-network claims for emergency and post-stabilization services do not require prior approval (PA) and health plans will reimburse providers at 100% of the applicable Medicaid fee-for-service rate. For services other than emergency and post-stabilization, out-of-network providers are required to get a PA from the assigned health plan before providing services and may need to complete a single case agreement to receive payment.
- If a good faith contracting effort has been attempted by the health plan but the contract or negotiations have stalled, the health plan may deem the provider as an out-of-network provider in accordance with the health plan's Good Faith Contracting policy and pay the provider accordingly. A health plan is prohibited from paying an out-of-network provider more than 90% of the applicable Medicaid fee-for-service rate for services other than emergency and post-stabilization.
- Note: Tailored Plans and NC Medicaid Direct have the authority to maintain a closed network for behavioral health services and may require an out-of-net network agreement to receive payment.
- Please refer to the appropriate health plan provider manuals and websites in the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for additional details on out of network claim submission processes.

HOW DO PRIOR APPROVALS WORK?

- Providers can identify services requiring PAs through the health plan lookup tool. Refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for details on the location of the PA lookup tool for each health plan.
- For standard authorization decisions, the health plan will provide notice as expeditiously as the beneficiary's condition requires and no later than 14 calendar days after the receipt of the request of services. However, the health plan may receive a possible extension of up to 14 days if the beneficiary requests the extension or if the health plan justifies a need for additional information and how the extension is in the beneficiary's interest.
- If the health plan extends the timeframe beyond 14 days, the health plan will provide the beneficiary and provider with a written notice of the reason for the decision to extend the timeline and inform the beneficiary of the right to file a grievance if they disagree with the decision.
- Providers should be aware of PA policy flexibilities for out-of-network providers and in-network providers related to PAat Standard Plan transition.

- Health plans have the flexibility in managed care to set plan-specific PA requirements when they do not conflict with a required policy. Providers should check PA requirements for each health plan through the health plan lookup tool prior to patient visits.

HOW DO EXPEDITED AUTHORIZATION REVIEWS WORK?

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

WHERE CAN PROVIDERS FIND DETAILS OF CLAIM SUBMISSION REQUIREMENTS BY PLAN?

- For plan-specific claim submission requirements for Standard Plans, refer to the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2.
- For plan-specific claim submission requirements for Tailored Plans, refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2.

WHAT IF A PROVIDER EXPERIENCES CLAIM PAYMENT ISSUES?

- Providers experiencing claim payment issues should initially work with health plans to address the issues. Refer to the What Providers Need to Know: Part 1 Tailored Plan Fact Sheet and Day One Provider Quick Reference Guide for contact information for the health plans.
- If a provider is unable to resolve claim payment issues by contacting the health plan they should contact the Provider Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 866-304-7062 and provide a detailed description of the issue at hand, the health plan involved and claim examples.
- Providers at risk of not meeting financial obligations because of health plan claim processing issues may request a hardship advance to offset the business cost due to pended or denied claims. To request a hardship advance, send an email to the Provider Ombudsman. Refer to the Managed Care Hardship Advance bulletin for more information.

HOW ARE MEDICARE CROSSOVER CLAIMS SUBMITTED FOR NC MEDICAID DIRECT AND TAILORED PLAN DUAL ELIGIBLE BENEFICIARIES?

- Beneficiaries eligible for both Medicare and Medicaid (dual eligible beneficiaries) are excluded from Standard Plan, but are eligible for the Tailored Plans if they are on the Traumatic Brain Injury or Innovations Waiver.
- Effective April 17, 2025, for dual-eligible beneficiaries in a Tailored Plan, NCTracks will automatically route the claims processed by CMS Medicare Administrative Contractor (MAC) to NC Medicaid Direct or Tailored Plan to allow them to process the claim as the secondary payor. Providers will no longer have to wait for the CMS MAC to complete processing of the Medicare claim and then submit a secondary claim with the Explanation of Medicare Benefits (EOMB) to NC Medicaid Direct or Tailored Plan for determination of the NC Medicaid benefit.

- There are some situations in which the billing format used by the primary payor differs from Medicaid. For example, with Federally Qualified Health Centers and Rural Health Centers (FQHC/RHC) claims, Medicare requires a UB/837I format and Medicaid requires a CMS1500/837P format. In those cases, the claim will not crossover from Medicare and the provider will need to bill a secondary claim to the NC Medicaid designated coverage (NC Medicaid Direct).
- Providers will continue to receive their EOMB and now the respective Explanation of Benefit (EOB) from the designated health plan.
- If providers have questions or experience issues regarding the adjudication of the secondary claim, refer to the above section for the health plan contact information.

HOW ARE CLAIMS SUBMITTED FOR INPATIENT STAYS THAT INCLUDE PHYSICAL HEALTH AND BEHAVIORAL SERVICES?

Effective with the Tailored Plan launch , providers are 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 separate behavioral health and physical health claims and submit each claim 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 DPU should submit a single claim with both physical and behavioral health services to the Tailored Plan. Behavioral and physical health services will be covered using the appropriate DRG methodology.
- Reimbursement guidance follows an internal review of the 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.*

WHAT ARE SOME COMMON BILLING ERRORS?

Failure to follow Health Plan Billing Guidance:

- Under NC Medicaid Managed Care, providers should use the health plan's Billing Guidance. Though most services have not changed with the transition to managed care, the billing processes may be slightly different and may vary across health plans. The health plans are required to follow State and Federal requirements for claims processing but may have plan-specific requirements.
- For health plans billing guidance refer below:

Tailored Plan – NC Medicaid Direct	**Standard Plan**
Alliance Health alliancehealthplan.org/document-library/79431	AmeriHealth Caritas amerihealthcaritasnc.com/assets/pdf/provider/claims-billing/claims-and-billing-manual.pdf

Vaya Health providers.vayahealth.com/learning-lab/provider-manual/	Carolina Complete Health network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Current-Provider-Billing-Manual.pdf
Trillium Health Resources trilliumhealthresources.org/for-providers/provider-documents-forms	Healthy Blue provider.healthybluenc.com/docs/gpp/NCNC_CAID_ProviderManual.pdf
Partners Health Management partnersbhm.org/tailoredplan/providers/manuals-forms-and-policies/	UnitedHealthcare uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/NC-UHCCP-Care-Provider-Manual.pdf
WellCare wellcarenc.com/providers/medicaid.html	

Taxonomy Errors

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 for which the provider is enrolling.

- For information on how to view the taxonomies you are enrolled in, read the Taxonomy Enrollment Requirement Reminders for Claim Payment bulletin
- Clearinghouses may be updating taxonomy information submitted by providers, so it is important for providers to work with their clearinghouse to ensure valid taxonomy data is submitted on claims to the health plans. If a clearinghouse does not submit a taxonomy or if the taxonomy is incorrect, this may increase the provider's claim denials with the health plans. For more information on including taxonomies in submissions, read the Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive bulletin
- For how to view and update taxonomies on the provider profiles, refer to the View and Update Taxonomy on the Provider Profile in NCTracks User Guide
- For guidance on where the taxonomy information should be included on the claim, see Adding Billing, Rendering and Attending Provider Taxonomy to Professional and Institutional EDI Claims

Modifier Errors

Providers shall follow modifier guidelines outlined in clinical policies and health plan billing guidance and bill according to the services rendered based on clinical appropriateness.

Prior Approval

Providers should check prior approval (PA) requirements for each health plan outlined in the lookup tools in Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 prior to patient visits to avoid unnecessary claim denials.

Coordination of Benefits (COB)

Prior to submitting a claim, providers should identify if a beneficiary has other insurance. If a beneficiary has other insurance coverage, the provider should include all primary payor COB details on the Medicaid secondary claim when submitting to health plans. This will alleviate and reduce unnecessary claim denials. For more information, refer to the Third-party Liability (TPL) section of each plan's Billing Guide.

WHAT SERVICES ARE COVERED IN NC MEDICAID MANAGED CARE?

Visit the Covered Revenue Code webpage for a list of covered revenue codes and the Covered Procedure Code webpage for a list of covered procedure codes. Users can search for covered procedure code and modifier combinations for specified plans in the lookup tool or by downloading the Covered Procedure Code documents. The Covered Procedure Code documents are updated as needed.

The presence of a code on the Covered Code Combinations document does not guarantee inclusion on a published NC Medicaid fee schedule. In addition, payment is not guaranteed as coverage could be restricted. Refer to the appropriate Clinical Coverage Policy to confirm code coverage. There are instances where a covered code may not align with Clinical Coverage policy. Health plans are required to include all covered codes listed in the document however each health plan is subject to cover additional services. Please note the codes listed are not an all-inclusive list; and may be subject to ongoing updates for accuracy.

PAYMENT BY ELECTRONIC FUNDS TRANSFER

Each health plan has specific guidance for enrollment in electronic fund transfers for payments. Banking information from NCTracks will **not** be transferred to the health plans. Refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, and the Frequently Asked Questions – Part 2 for details on electronic fund transfers for each health plan.

WHAT IF I HAVE QUESTIONS?

For general inquiries and complaints regarding health plans, contact the NC Medicaid **Provider Ombudsman**. The Provider Ombudsman will:

- Provide resources and assist providers with issues through resolution.
- Assist providers with Health Information Exchange (HIE) inquires related to NC HealthConnex connectivity compliance and the HIE Hardship Extension process.
- Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov or through the Provider Ombudsman line at 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.
- For questions related to your NCTracks provider information, contact the NCTracks Call Center at 800-688-6696. To update your information, log into NCTracks Secure Provider Portal and use the Managed Change Request (MCR) to review and submit changes.
- For questions related to beneficiary eligibility, call the NCTracks Call Center for more information, 800-688-6696.
- For all other questions, call the NC Medicaid Contact Center at 888-245-0179.