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

As the NC Medicaid program transitioned to NC Medicaid Managed Care, it remains critical that providers are well-informed about the 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 SEND CLAIMS?

Claims routing depends on a beneficiary's enrollment at time of service and the service provided. Claims for members enrolled in NC Medicaid Managed Care (Standard Plan, Tailored Plan, Prepaid Inpatient Health Plans (PIHPs) and Children and Family Specialty Plan (CFSP)) should be submitted to the assigned health plan as shown on their member ID card.

Some Tailored Plans partner with Prepaid Health Plans (PHPs) for claims processing. Please 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 details on where to submit claims for Standard Plans. For Tailored Care Management claims please refer to the Health Plan Billing Guide.

For details on where to submit claims for CFSP please refer to the: Children and Family Specialty Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

For members that remain in NC Medicaid Direct, providers will continue to submit claims as they do today. Physical health claims for beneficiaries enrolled in NC Medicaid Direct should continue to be submitted to NCTracks. For members of the Eastern Band of Cherokee Indians (EBCI) Tribal Option,

providers will continue to bill services as they do with NC Medicaid Direct members. Behavioral health claims for members enrolled in NC Medicaid Direct should be submitted to the assigned PIHP as shown on their member ID card.

MEMBER ELIGIBILITY

Providers must check eligibility in NCTracks prior to the beneficiary visit, even if the beneficiary presents with a Medicaid ID or Medicaid Managed Care health plan card to determine which health benefit the beneficiary is enrolled in and whether their eligibility remains current. 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.

There are three methods of Recipient Eligibility Verification available: via the NCTracks Secure Provider Portal: Real Time Eligibility Verification and Batch Eligibility Verification and via automatic voice verification. Please 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 shall continue to use NCTracks to verify other found insurance for the NC Medicaid Direct enrollees.

CARVED OUT SERVICES

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

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 on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes with the exception of 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 in which 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 authorization 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 prior authorization 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 Prepaid Inpatient Health Plans have the authority to maintain a closed network for behavioral health services and may require an out of network agreement to receive payment.

Standard and Tailored Plan flexibilities were released prior to their launch. CFSP will follow that same process and will announce any policy flexibilities prior to launch. Please visit Flexibilities to Ensure Continuity of Care and Ease Provider Administrative Burden at Children and Families Specialty Plan Launch | NC Medicaid for informaiton on CFSP flexibilities. Health systems and providers are strongly encouraged to continue contract negotiations with health plans and finalize contracts to avoid reduced reimbursements.

Please refer to the appropriate health plan provider manuals and health plan websites in the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 and Children and Family Speciality Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2.

for additional details on out of network claim submission processes.

HOW WILL PRIOR AUTHORIZATIONS WORK?

Providers can identify services requiring prior authorizations through health plan lookup tools. Refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 and the Children and Family Speciality Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for details on the location of the prior authorization lookup tool for each health plan.

For standard authorization decisions, the health plans will provide notice as expeditiously as the member's condition requires and no later than 14 calendar days after the receipt of the request of services. However, the health plans may receive a possible extension of up to 14 days if the member requests the extension or if the health plans justify a need for additional information and how the extension is in the member's interest.

If the health plans extend the timeframe beyond 14 days, the health plans will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that decision.

Providers should be aware of prior authorization policy flexibilities for out-of-network providers and in-network providers related to prior authorizations at Standard Plan transition. Policy flexibilities for Tailored Plan will be communicated in the coming months.

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

HOW DO EXPEDITED AUTHORIZATION REVIEWS WORK?

For expedited authorization decisions, the health plans will provide notice no later than 72 hours after receipt of the request for service. The health plans may extend the 72-hour time period by up to 14 days if the member requests the extension or if the health plans justify a need for additional information and how the extension is in the member's interest. If the health plans extend the timeframe beyond 72 hours, the health plans will provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a grievance if he or she disagrees with that 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.
- For plan-specific claim submission requirements for CFSP, refer to the Children and Family Specialty Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2.

IF A PROVIDER EXPERIENCES CLAIM PAYMENT ISSUES?

Providers experiencing claim payment issues should initially work with the health plans to address claim issues. Refer to the What Providers Need to Know: Part 1 Tailored Plan Fact Sheet, Day One Provider Quick Reference Guide and Children and Family Speciality Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for contact information for the health plans. for contact information.

If a provider is unable to resolve claim payment issues through 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(s) involved and claim examples.

Providers who are 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. Please refer to the Managed Care Hardship Advance bulletin for more information.

HOW ARE MEDICARE CROSSOVER CLAIMS SUBMITTED FOR TAILORED PLAN DUAL ELIGIBLE MEMBERS?

Please note that the Standard Plan and Child and Family Specialty Plan (CFSP) does not apply to Medicare crossover claims. The guidance below pertains only to Tailored Plan members who are dually eligible for Medicare and Medicaid.

Members eligible for both Medicare and Medicaid (dual eligible members) are not part of Standard Plan, but they can be included in the Tailored Plan population. Since Tailored Plan launch, recipients with dual coverage (Medicare and NC Medicaid), the Centers for Medicare & Medicaid Services (CMS) are not transmitting crossover claims directly to the Tailored Plans. Providers must wait for the CMS Medicare Administrative Contractor (MAC) to complete processing of the Medicare claim, and then submit a secondary claim with the Explanation of Medicare Benefits (EOMB) to the appropriate Tailored Plan for determination of the NC Medicaid benefit.

The Department is evaluating an alternative solution with NCTracks that would eliminate the need for provider secondary payer resubmissions.

For Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plan or PIHP/NC Medicaid Direct members that are covered by both Medicare and Medicaid please follow these below steps starting on July 1, 2024.

- File the claim to Medicare for primary payer processing.
- Receive the remittance advice (R/A) (EOMB) from Medicare, (ACSX12 835 or paper).
- Update the claim in your system with the adjudication information from Medicare.
- Submit a secondary claim to your applicable Tailored Plan.
- This secondary claim must include the results of the Medicare adjudication recorded as other insurance information.
- Once the secondary claim inclusive of the Medicare payment information is received from the provider, the Tailored Plan will adjudicate the claim accordingly

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 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.*

WHAT ARE SOME COMMON BILLING ERRORS?

Failure to Follow Health Plan Billing Guidance:

As North Carolina Medicaid transitioned to the managed care model, providers must continue to follow the Billing Guidance of the health plan(s). Even though most services have not and will not change with the transition, the billing processes may be slightly different than previously done and may vary across individual health plans. The health plans are required to follow State and Federal requirements for claims processing but may also have plan-specific requirements.

For health plan(s) billing guidance refer below:

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

trilliumhealthresources.org/for-providers/provider-documents-forms	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 (-ies) for which the provider is enrolling.

- For information on how to view the taxonomies you are enrolled in, please check the Taxonomy Enrollment Requirement Reminders for Claim Payment bulletin.
- Clearinghouses may be updating taxonomy information submitted by providers, so it is important that providers work with their clearinghouse to ensure valid taxonomy data is submitted to the health plans on their claims. If a clearinghouse does not submit a taxonomy or if the taxonomy is incorrect, these errors may increase the provider's claim denials with the health plans they submit claims to. For more information on including taxonomies in submissions, please check the Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive bulletin.
- For how to view and update taxonomies on the provider profiles, please check 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, please check 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. Providers should bill according to the services that are rendered based on clinical appropriateness.

Prior Authorization:

Providers should check prior authorization (PA) requirements for each health plan outlined in the lookup tools in Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, Managed Care Claims and Prior Authorizations Submission: Frequently Asked

Questions – Part 2 and the Children and Family Speciality Plan (CFSP) Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 prior to patient visits to avoid unnecessary claim denials.

Coordination of Benefits:

Prior to submitting a claim, providers should identify if a member has other insurance. If a member has other insurance coverage, the provider should include the coordination of benefits (COB) when submitting secondary claims to the health plans. This will alleviate and reduce unnecessary claim denials. Refer to the TPL Billing Guide for more information.

WHAT SERVICES ARE COVERED IN MANAGED CARE?

Please 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 will be updated as needed.

The presence of a code on this Covered Code Combinations document does not guarantee inclusion on a published NCDHHS 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 a Clinical Coverage policy. Health plans are required to include all covered codes listed in document however each health plan is subject to cover additional services. Please note the codes listed are not an all-inclusive list; may be subject to ongoing updates for accuracy.

PAYMENT BY ELECTRONIC FUNDS TRANSFER

Each health plan has specific guidance to follow for enrollment in electronic funds transfers for payments. Your banking information from NCTracks will **not** transfer to the health plan(s). Refer to the Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2, Children and Family Speciality Plan (CFSP) Managed Care 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, NC Medicaid has created a **Provider Ombudsman** to represent the interests of the provider community. The 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 received 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, please contact the NCTracks Call Center at 800-688-6696. To update your information, please log into NCTracks Secure Provider Portal and utilize the Managed Change Request (MCR) to review and submit changes.

For questions related to member eligibility, please call the NCTracks Call Center for more information: 800-688-6696

For all other questions, please contact the NC Medicaid Contact Center at 888-245-0179.