NC Medicaid Managed Care
Provider Playbook

Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

Question	WellCare (WCHP) Response	AmeriHealth Caritas (AMHC) Response	Healthy Blue Response	Carolina Complete Health (CCH) Response	United Healthcare (UNHC) Response
How to file a claim with the PHP – what are the options (virtual, fax, paper, etc.)?	WellCare (WCHP) accepts both electronic and paper claims (no faxes). Paper claims must be received on original red/white CMS claim forms, so faxes are not considered compliant. See the provider manual, provider resource guide and Quick reference guide at this link for detailed information regarding clean claims and step by step filing instructions. wellcare.com/en/North-Carolina/Providers/Medicaid **Electronic Claim Submission** Via Wellcare provider portal at provider.wellcare.com **Paper Claim Submission** All paper claims should be submitted to: WellCare Health Plans	The claims submission process applies to providers who wish to submit out-of-network claims. This process can be found on page 4 of the AmeriHealth Caritas North Carolina (AMHC) Provider Claims and Billing Manual, found at amerihealthcaritasnc.com: "In accordance with 42 C.F.R. §438.602(b), health care providers (including ordering, prescribing, or referring only providers) interested in participating in the AMHC network must be screened and enrolled as a Medicaid provider by the North Carolina Department of Health and Human Services (NCDHHS) and shall be reenrolled every three years, except as otherwise specifically permitted by DHHS in the Revised and Restated RFP 30-190029-DHB, Section V. This applies to non-	Providers have the option of submitting claims electronically or by mail. Providers participating and those not participating with Healthy Blue may enroll with our trading partner, Availity at availity.com. Additional Claims information can be received by calling 844-594-5072, select the **Claims** prompt. **Paper Claim Submission** All paper claims should be submitted to: Blue Cross NC | Healthy Blue Claims P.O. Box 61010 Virginia Beach, VA 23466	Electronic Claims Submission CCH can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). Providers that bill electronically have the same timely filing requirements as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters. CCH's Payor ID is 68069. Our Clearinghouse vendors include Availity and Change. Visit our website for our	Both in-network and out-of-network providers may submit claims via EDI submission, under Payer ID 87726. Prior to doing so, they need to enroll with our clearinghouse OptumInsight to establish a secure connection, and they (or their claims processing service) may do so by calling 866-367-9778 and selecting option 3. UNHC uses this clearinghouse for both in-network and out-of-network providers. An out-of-network provider can submit a paper claim by mail to: UnitedHealthcare Community Plan P.O. Box 5280 Kingston, NY 12402-5240

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	Attn: Claims Department P.O. Box 31224 Tampa, FL 33631-3224	participating in and/or out of the State providers as well. Claims for all services provided to Plan members must be submitted by the provider who performed the services. **Submitting Claims** Providers may submit claim via electronic or paper methods: *Electronic/EDI* Use the payer ID for AmeriHealth Caritas North Carolina: 81671. *Paper/Mail* AmeriHealth Caritas North Carolina Attn: Claims Processing Department P.O. Box 7380 London KY 40742-7380 Additional details regarding the billing and the claims submission process is available in the Provider Claims and Billing Guide at ameriheathcaritasnc.com		electronic Companion Guide which offers more instructions. For questions or more information on electronic filing please contact: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT 800-225-2573, ext. 25525 Or by e-mail at EDIBA@centene.com **Paper Claim Submission** All paper claims and encounters should be submitted to: Carolina Complete Health Attn: Claims PO Box 8040 Farmington MO 63640-8040	
How does the health plan determine if the provider made a "good faith" effort in contracting to determine reimbursement?	Per our Good Faith contracting policy NC35-ND-001) if within 30 calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, WellCare may consider the request for inclusion in the NC Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing or the contract is under legal review, WellCare shall not consider the request rejected. The 30-day period begins when the provider	The Good Faith Contracting Policy must be developed in and submitted for approval to fulfill a PHP/DHB contract requirement. If NC Medicaid determines appropriate, AMHC is willing to share the policy in redacted form to remove information that is considered proprietary and/or confidential. AmeriHealth Caritas North Carolina will share a redacted version with NC Medicaid upon request. • AMHC offers to contract with a provider using a NCDHHS	Healthy Blue maintains a Good Faith Contracting policy and requires three unsuccessful attempts at completing a contract before the determination is made.	The Good Faith Effort starts from when the provider receives a version of the contract which is consistent with the version approved by the Department and include the standard provisions for provider contracts found in Attachment G. Required Standard Provisions of PHP and Provider Contracts, including the prescribed provisions located therein. The initial contract offering will serve as the first effort. If the provider does not execute the first effort, CCH will make a second effort at least 10	UNHC developed a "Good Faith Provider Contracting Policy" which was submitted for Department review and approval 90 days post contract award. Per those requirements, UNHC included a definition of "good faith" contracting effort and defined it as "United engaged in a good faith effort to contract with a provider of healthcare services but the provider refused or failed to meet United's objective quality standards." The policy expands on the process for documenting contracting outreach

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	has received a copy of the contract that is consistent with the version of the contract approved by the department.	approved provider agreement in writing via letter, email, or fax; an AMHC Account Executive will follow up the initial outreach within 10 business days and negotiations will continue until both parties agree on contract terms or decide not to move forward • If within 30 calendar days of receiving an agreement, the potential network provider rejects the agreement or fails to respond verbally or in writing, AMHC may consider the request for inclusion in the AMHC network rejected; if discussions are ongoing or the contract is under legal review, AMHC shall not consider the request rejected. • AMHC will consider all facts and circumstances surrounding a provider's willingness to contract, including reviews of non-standard requests, prior to determining that AMHC made a good faith effort which was not accepted.		calendar days after the first effort taking into consideration any feedback from the provider. If the provider does not execute the agreement from the second effort, CCH will make a third and final effort at least 10 calendar days after the second effort taking into consideration any feedback from the provider from the previous efforts. CCH will have exhausted all good faith contracting efforts after the third and final effort. The good faith contracting effort period must be at least 30 calendar days, but CCH may allow additional time if discussions are ongoing, contract revisions are being made or negotiated, the contract is under legal review by the provider or if in the opinion of CCH such additional time could lead to an executed contract. If after at least 30 days and the three good faith attempts, the provider fails to respond to the efforts verbally or in writing, the request to join the network will be considered rejected.	attempts and objective further elaborates on what it means to meet objective quality standards. In summary, Good Faith negotiation and contracting efforts are tracked in our database. We will not reimburse the out-of-network provider more than 90% of the Medicaid fee-for-service rate if the provider refuses to contract or fails to meet objective quality standards.
What information is needed from the provider to file a claim?	Paper claims must be received on original and complete red/white CMS claim forms. Please see the provider manual, provider resource guide, and quick reference guide. All these resources including detailed information regarding clean claims and step-by-step are available on the public Provider Portal, which does not require a username and password, by going to: th-	AMHC is required by applicable contract requirements with the Department and by applicable North Carolina and federal regulations to capture specific data regarding services rendered to its members. A detailed list of data elements, as listed here, are needed for a claim to be paid. This information is found in the AMHC Provider Claims and Billing Manual at amerihealthcaritasnc.com.	Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP levels 1 to 4: • Professional claims that meet standardized X12 EDI Transaction Standard: 837P - • Professional Claims • Institutional claims that meet	CCH follows Centers for Medicare & Medicaid Services (CMS) rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR §447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable. Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their	In terms of data elements needed for a provider to file a claim - this information is available in our provider administrative guide and located on UNHC's provider website: uhcprovider.com/en/ad min-guides/administrative-guides-manuals-2021/ch10-our-claims-process-2021/claims-enc-data-sub-ch10-guide.html • Billing provider name, address, telephone number (F1)

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	Carolina/Providers/Medicaid/Forms All claims must have complete and compliant data including: • Current CPT and ICD-10 (or its successor) codes • TIN • NPI number(s) Provider and/or practice name(s) matching the W-9 initially submitted to WellCare	The following mandatory information is required on all claims, both institutional and professional: • Member's (patient's) name • Member's Plan ID number • Member's date of birth and address • Other insurance information: company name, address, policy and/or group number • Amounts paid by other insurance (with copies of matching EOBs) • Information advising if member's condition is related to employment, auto accident or liability suit • Date(s) of service, admission, discharge • Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits. • Name of referring physician, if appropriate • HCPCS procedures, services or supplies codes • CPT procedure codes with appropriate modifiers • CMS place of service code • Charges (per line and total) • Days and units • Physician/supplier Federal Tax Identification Number or Social Security Number • National Practitioner Identifier (NPI) and Taxonomy • Physician/supplier billing name, address, zip code, and telephone	standardized X12 EDI Transaction Standard: 837I - • Institutional Claims Claim submissions, whether electronic or paper, must include the following information: • Member's ID number including alpha prefix • Member's name • Member's date of birth • ICD-10-CM diagnosis code • Date of service • Place of service • Procedures, services or supplies rendered with CPT-4 codes/HCPCS codes/ • disease-related groups • Itemized charges • Days or units • Provider tax ID number • Provider name according to contract • Billing provider information, and rendering provider information when different than billing or when billing a group taxonomy • NPI of billing and rendering provider when applicable, or API when NPI isn't appropriate • Taxonomy of billing provider, attending and rendering provider when submitted • Coordination of benefits/other insurance information • Precertification number or copy of precertification • NDC, unit of measure and quantity for medical injectables	taxonomy code in box 24Ja and the Member's Medicaid number in box 1a to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; Such claims are not considered "clean" and therefore cannot be accepted into our system. Claims eligible for payment must meet the following requirements: • The enrollee must be effective on the date of service (see information below on • identifying the enroll(lee), • The service provided must be a covered benefit under the enrollee's contract on the date of service, and Referral and prior authorization processes must be followed, if applicable. • Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual. When submitting your claim, you need to identify the enrollee. There are two ways to identify the enrollee: • The CCH enrollee number found on the enrollee ID card or the provider portal. • The Medicaid Number provided by the State and found on the enrollee ID card or the provider portal	• Type of bill (F4) • Statement Covers Period (F6) • Patient Name (F8b) • Patient Birth Date (F10) • Patient Sex (F11) • Admission date (F12) • Admission Hour (F13) • Admission Type/Visit (F14) • Source of Referral for admission (F15) • Discharge Status (F17) • Condition Codes (F18-28) if applicable • Occurrence Codes and Dates (F31-34) if applicable • Value Codes and Amounts (F39-41) if applicable • Revenue Code (F42) • Revenue Code Description (F43) • HCPCs, CPT Codes (F44) • Service Date (F45) • Service Units (F46) • Total Charges (F47) • Payer Name (F50A-C) • NPI (F56) • Insured Name (F58A-C) • Patients Relationship to Insured (F59A-C) • Insured's Unique Identifier (F60A-C) • Principal Diagnosis Code (F67) • Other Diagnosis Code (F67A-Q) • Admitting Diagnosis Code (F69) • Principal procedure code and date (F74) • Other procedure codes and dates (F74a-e) • Attending provider and Identifiers (F76)

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		number • Name and address of the facility where services were rendered • NDC's required for physician administered injectables that are eligible for rebate • Invoice date • Provider Signature			• Other providers (F77-79) if applicable Like an in-network claim, an out-of-network claim will require certain data fields to be completed accurately and the claim that is submitted to UNHC must pass basic NC Provider Validation rules. However, there is no rule validation surrounding the address or provider names so the rules will not deny based on abbreviations for address or name alone.
In what instances would a provider/health plan need to agree to a single case agreement?	Single case agreements are usually reserved for services provided by an out of network provider when no in-network provider is available. This would only likely occur for a delivery out of state or mother/baby requires highly specialized care at out-of-network facility. These are handled on a case-by-case basis and are not a normal occurrence.	If a non-participating provider offers needed services that a participating provider cannot offer in the member's service area, a single case agreement would be needed.	For provider/PHP to develop a Single case agreement, several criteria must be present: • A member is enrolled with NC Medicaid and Healthy Blue • The provider is not in-network • The member cannot be redirected to an in-network provider The out-of-network request has been approved as medically necessary	Most Single case agreements (SCAs) will be initiated internally by Medical Management, Appeals & Grievances (A&G) or Behavioral Health. On occasion, we may get a direct request from a provider, particularly if they are waiting for a contract to be effective. There are two common origins for SCAs: 1. Internal requests mainly from Medical Management, Appeals & Grievances (A&G) or Behavioral Health and 2. The much rarer request directly from a provider with an existing relationship with a member and/or the negotiator This accounts for the two common reasons where an SCA might be requested; 1) to cover services rendered out-of-network and 2) to	Single Case Agreements (SCAs) are negotiated on a case-by-case basis, and there is no default process to a SCA if a provider decides not to enter a contractual agreement with UNHC through a good faith contracting effort. With that said, at times (SCAs) are created to ensure the member's needs are met. In such instances, UNHC would typically expect a referral from in-network to an out-of-network provider to meet medical needs, review the network to ensure there is no in-network provider that can render that same service in the proximity.

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				cover services when the existing network providers are at capacity	
What is the payment cycle for medical and pharmacy claims?	Pharmacy payments are issued at the point of sale. Both medical and pharmacy claims will be paid daily. Check runs take place daily except for Sundays, last day of the month and national holidays.	Medical payment cycles will be every Monday and Wednesday, while pharmacy cycles will run every four days.	Payment disbursements for both medical and pharmacy claims are sent on Wednesdays.	CCH runs checks each Tuesday and Friday.	Check cycles take two days to complete. One day for ERA (electronic remittance advice)/PRA (paper remittance advice) generation and one day for check payment either through paper or electronic EFT. Payment cycle for both medical and pharmacy claims will be a daily check cycle.
What message will providers see in the Provider Portal regarding individual claim status prior to first payments being released?	WCHP's provider portal will display a banner with the date they intend on executing their first check run (July 6, 2021, for medical claims and July 1, 2021, for pharmacy claims).	There will be no provider messaging prior to first payments being released.	The claims status in our secure Provider Portal (Availity) will return the status at the time of the inquiry. Claim status will show as Pending/Paid or Denied.	CCH portal returns an EMS message queue, which includes the claim number, rejection code/message etc. The providers will see a message displaying the claim has been accepted.	The claim will show as **Acknowledged** until the claim is processed. It will show **Pending** if: • We are waiting on additional information from the provider or • The claim is still being worked on It will show **Payable** if it is processed but waiting for the payment to be posted.
How can I determine which services require prior authorization for a health plan?	WCHP provides a Prior Authorization Look-up Tool to determine if a PA is required prior to rendering services. WCHP's Provider Look-up Tool can be found at: wellcare.com/North-Carolina/Providers/Authorization-Lookup	AMHC provides a Prior Authorization Look-up Tool to determine if a PA is required prior to rendering services. AMHC's Provider Look-up Tool can be found at: amerihealthcaritasnc.com	Healthy Blue provides a Prior Authorization Look-up Tool to determine if a PA is required prior to rendering services. Healthy Blue's Provider Look-up Tool can be found at: provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup	CCH provides a Prior Authorization Look-up Tool to determine if a PA is required prior to rendering services. Pre-Auth Tool can be found at: network.carolinacompletehealth.com/resources/prior-authorization.html	UNHC provides a Prior Authorization Look-up Tool to determine if a PA is required prior to rendering services. UNHC's Provider Look-up Tool can be found at: UHCprovider.com/priorauth
How can I submit a prior authorization to a health plan?	WCHP submission methods: **Standard**: Online via Provider Portal: provider.wellcare.com/	AMHC submission methods: **Standard**: Online via Provider Portal: navinet.navimedix.com	Healthy Blue submission methods: **Standard**: Online via Provider Portal: provider.healthybluenc.com/ north-carolina-provider/prior- authorization	CCH submission methods: **Standard**: Online via Secure Provider Portal: carolinacompletehealth.com/	UNHC submission methods: **Standard**: Online via Prior Authorization and Notification Tool on Link:

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	Via fax to the numbers listed on the associated forms: wellcare.com/North-Carolina/Providers/Medicaid/Forms **Urgent**: Call 866-799-5318 and follow the prompts. **Pharmacy**: Via fax to 800-678-3189 Online via Surescripts portal: providerportal.surescripts.net/providerportal/	Via fax to 833-893-2262 Call: 833-900-2262 **After hours and holidays:** Call 855-375-8811 **Pharmacy**: Via fax to 877-234-4274 Call 866-885-1406 Prior authorization is not required for emergency services when a member seeks emergency care.	Via fax to: 800-964-3627 (inpatient) 844-445-6649 (Outpatient) **Urgent**: Call 844-594-5072 **Pharmacy**: Via fax to 844-376-2318 Call 844-594-5072	Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization. This tool will go live later this summer, before the launch of NC Medicaid Managed care. Call 833-552-3876 Via fax to 833-238-7694 **Urgent**: Call 919-719-4161. **Pharmacy:** Call 833-585-4309	UHCprovider.com/priorauth If you're unable to use the link, call Provider Services at 877-842-3210. **Urgent**: Call Provider Services at 877-842-3210 and follow the prompts. **Pharmacy**: Online via CoverMyMeds portal: covermymeds.com/main/prior-authorization-forms/optumrx/ Online via SureScripts portal: providerportal.surescripts.net/ProviderPortal/optum/login