NC Medicaid Managed Care
Provider Playbook

Fact Sheet
Prompt Payment

Understanding prompt payment requirements for Standard Plans, NC Medicaid Direct and Tailored Plans

NC Medicaid established provider payment requirements for health plans that:

- Encourage continued provider participation in the Medicaid program.
- Ensure beneficiary access and support safety net providers.
- Ensure continuation of current reimbursement levels using mechanisms that mitigate the risk of health plan steerage to other providers. Final capitation rates will reflect required reimbursement levels.

Health plans are required to act on additional information submitted by a provider within the required timeframe as defined below.

TIMELY FILING

Timely Filing for Medical Claims

For Standard Plans, the new timely filing time frame (365 calendar days) is effective July 1, 2023. This applies to the original claim submission and any subsequent corrected claims.

For NC Medicaid Direct, LME/MCOs may require claims be submitted within 90 days of the service until Tailored Plan launch. The new 365 day time frame goes into effect upon Tailored Plan launch. This applies to the original claim submission and any subsequent corrected claims.

For Tailored Plans, the new time frame goes into effect upon Tailored Plan launch. This applies to the original claim submission and any subsequent corrected claims.

For State funded services, the Tailored Plan shall require claims to be submitted within 90 calendar days from the date of service.

Unless otherwise agreed to by the health plan 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.

Timely Filing for Pharmacy Claims

Pharmacy point of sale claims shall be submitted within 365 calendar days of the date of the provision of care. For retroactive enrollees, timely filling limits starts from the date their enrollment is approved.

PROMPT PAYMENT

Health plans must, within 18 calendar days of receiving the medical claim, notify the provider whether the claim is clean* or pend the claim and request all additional information needed to timely process the claim.

If the claim is clean upon submission, or when it becomes clean with additional information submitted, the health plan must pay or deny within 30 days. If after 90 days, the provider has not provided the additional information needed, the health plan will deny the claim.

Prompt Pay for Pharmacy Claims:

1. Health plans 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.
2. A pharmacy pended claim shall be paid or denied within 14 calendar days of receipt of the requested additional information.

Prompt Pay for Additional Directed Payments:

Health plans shall make additional directed payments as prescribed by the Department and approved by the Centers for Medicare & Medicaid Services to certain in-network providers including, but not limited to, local health departments, faculty physicians affiliated with the Teaching Hospitals for each North Carolina medical school and hospitals owned by UNC Health Care or Vidant Medical Center and for inpatient and outpatient services of UNC Health Care System hospitals and Vidant Medical Center.

Health plans shall be financially obligated to pay the additional directed payments to the applicable providers within five business days of receiving the payment from the State.

* Please reference section below for clean claims.

CLEAN CLAIMS

A claim submitted to a health plan by a participating provider which can be processed without obtaining additional information from the participating provider or their authorized representative in order to adjudicate the claim.

Pursuant to 42 CFR § 447.45(b), a clean claim does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity. A claim is not clean when pended for a suspended health plan or taxonomy status.

The health plan shall pay clean claims, regardless of provider contracting status. The health plan shall reimburse providers according to the prompt pay timeframes included in this fact sheet when a clean medical or pharmacy claim is received.

INTEREST AND PENALTIES

Health plans that do not pay claims within the required timeframe according to prompt pay requirements will bear interest at the annual rate of 18 percent beginning on the date following the day on which the claim should have been paid or was underpaid.

In addition to interest, a health plan shall pay the provider a penalty equal to one percent of the claim per each calendar day following the date that the claim should have been paid.

Health plans that do not pay separate directed payments to providers within five business days receipt of funds shall pay interest on late directed payments at the annual rate of 18 percent beginning on the first date that the directed payment should have been paid as specified in the contract.

In addition to the interest on the late directed payments, the health plan shall pay the provider a penalty equal to one percent of the directed payment per each calendar day following the date that the directed payment should have been paid as specified in the contract.

Interest and penalties also apply when health plans take more than 45 days to implement rate changes and reprocess claims for rate floor services. Each plan should outline, for providers, the amount of interest and penalties that should be paid based on the guidance provided by DHHS.

Providers do not have to make separate requests to the health plan for interest or penalty payments and are not required to submit another claim to collect the interest and penalty. For additional guidance on health plans interest and penalties, refer to the Prepaid Health Plan Interest and Penalties for Provider Claims bulletin for reference and for guidance scenarios.

REPROCESSING

Health plans shall implement fee schedule changes within 45 calendar days of notification and reprocess all impacted claims within 75 calendar days of notification for all NC Medicaid rate floor programs. Health plans are expected to notify providers of any overpayment within the 75 calendar day period to reprocess impacted claims. Health plans have 60 calendar days to recoup payments after the provider has been notified of the overpayment.

PROMPT PAY QUICK REFERENCE SUMMARY

For a quick refence, please see below.

Section	Medical Claims	Pharmacy Claims
Timely Filing	LME/MCOs may require claims be submitted within 90 days of the service until Tailored Plan launch. For the LME/MCOs contract, the new timeframe (365 calendar days) goes into effect upon Tailored Plan launch, this applies to the original claim submission and any subsequent corrected claims.	Within 365 calendar days of date of provision of care.

Section	Medical Claims	Pharmacy Claims
	For Standard Plans, the new timely filing timeframe (365 calendar days) went into effect 7/1/2023, this applies to the original claim submission and any subsequent corrected claims. For Tailored Plans, the new timeframe (365 calendar days) goes into effect upon Tailored Plan launch, this applies to the original claim submission and any subsequent corrected claims.	
Timely Filing for Retroactive Enrollees	For Standard Plans, the new timely filing timeframe (365 calendar days) went into effect 7/1/2023, this applies to the original claim submission and any subsequent corrected claims. For the LME/MCOs, 180 calendar days of the approved enrollment. For Tailored Plans, the new timeframe (365 calendar days) goes into effect upon Tailored Plan launch, this applies to the original claim submission and any subsequent corrected claims.	365 calendar days of the approved retroactive enrollment.
Notify providers of Clean/Pend Claim	Within 18 calendar days of receiving claims.	Within 14 calendar days of receiving claims.
Pay/Deny claims upon clean submission/or becomes clean	Within 30 calendar days of clean submission / becoming clean.	Within 14 calendar days of clean submission / becoming clean.
Deny claims if no additional information provided from the provider	Within 90 calendar days of the date the additional information was requested.	Within 90 calendar days of the date the additional information was requested.
Implement rate floor rate changes	Within 45 calendar days of DHHS publishing the rate floor update.	Within 45 calendar days of DHHS publishing the rate floor update.
Reprocess claims after implementation of rate floor	Within 75 calendar days of DHHS publishing the rate floor update.	Within 75 calendar days of DHHS publishing the rate floor update.

Section	Medical Claims	Pharmacy Claims
Rate floor rate change recoupment	Within 60 calendar days after claim recoupment is identified and the provider has been notified.	Within 60 calendar days after claim recoupment is identified and the provider has been notified.

WHAT IF I HAVE QUESTIONS?

For general inquiries and complaints regarding health plans, please refer below.

Tailored Plan - Medicaid Direct	Standard Plan
Alliance Health • 919-651-8500	AmeriHealth Caritas • 844-388-0474
Vaya Health • 866-990-9712	Carolina Complete Health • 833-552-3876
Trillium Health Resources • 855-250-1539	Healthy Blue • 844-594-5072
Partners Health Management • 877-398-4145	United Health Care • 800-638-3302
	WellCare • 833-552-3876

NC Medicaid has created a Provider Ombudsman to represent the interests of the provider community, provide resources and assist providers with issues through resolution.

Provider Ombudsman inquiries, concerns or complaints can be submitted to Medicaid.ProviderOmbudsman@dhhs.nc.gov, or received through the Provider Ombudsman line at 866-304-7062. 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 the NCTracks Secure Provider Portal and use the Managed Change Request (MCR) to review and submit changes.

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

For all other questions, please contact the NC Medicaid Help Center at 888-245-0179 or email at Medicaid.HelpCenter@dhhs.nc.gov.