NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

Virtual Office Hours – Questions and Answers

Question	Answer
I'm wondering what reviews will look like if Medicaid patients are staying with the LME/MCO (in my case Vaya)?	The reviews will be conducted in the same manor.
What period of time from DOS service should claim documentation and supporting documentation be maintained?	In accordance with NC Medicaid's participation agreement, the required amount of time would be a minimum of 6 years from the date of service (DOS) or longer if required specifically by Controlling Authority.
Will PHPs be trained in how to audit or will they be using PCG as a subcontractor to do the audits for them?	The Managed Care Organizations will do their own audit and review - it is under the PHPs discretion to use a contractor for this work.
Will PHPs be required to do provider post payment reviews a minimum of every 2 years and via desk review the same as LME/MCOs?	PHPs will conduct audits and investigations as a result of complaints, referrals and /or data analysis.
Will we be able to check same/similar on NCTracks?	Providers will continue to have access to NCTracks.
Will there be a standardized review tool for PHPs to audit services under standard plans?	There will not be a standardized tool for PHP Reviews. PHPs will develop tools according to their own Policies and in accordance with agreement between the Department.
Will standard plans providers have their own SIU's and LME MCO's will continue SIU's for tailored plan providers? What happens if a provider has both standard and tailored plan members?	Standard plans will have their own SIUs, LME/MCOs will continue to have PI/SIUs and in the future, Tailored plans will have SIUs. Both Standard and Tailored Plan SIUs will have the responsibility of conducting audits, reviews and investigations of their own members.
Will the HMO's follow Medicaid guidelines?	Plans have some NC Medicaid required policies to follow and may also be able to select other NC Medicaid policies or create their own.
Will the standard plans MCOs be conducting post-payment reviews like the MCO/LMEs? will it be the same questions as the LME?	The standard plans will be conducting reviews, audits, and investigations according to agreement with the State.
Will the authorization process change?	For specific authorization rules, providers will need to check with the PHP.
What are some of the red flags you look for in billing and/or documentation?	Documentation needs to support the billing.
Will retro authorizations be allowed?	For specific authorization rules, providers will need to check with the PHP.
Will LME/MCO SIU's use only NCTracks claims data or will they also use claims data from ex Alpha?	LME/MCO will continue to use ALPHA in conjunction with NC TRACKS

Will FAMS continue to be used by all entities to identify trends in f/w/a?	Currently FAMS is used by LME/MCOs and OCPI. FAMS is not required by the PHPs.
Will billing go through the PHPs' billing system or Alpha or NCTracks?	Billing will go through the designated LME/MCO, PHP claims processing system
Will you allow for retro authorizations for DME?	For specific authorization rules, providers will need to check with the PHP.
Are there two different sites we must check for the exclusion list, state and federal OIG?	Yes, there are two different sites.
What is a process when a provider is investigated? Would they be contacted by phone first? Would they have a chance to pull together their own audit before having an onsite audit from consultants?	This will be handled on a case by case basis - PHPs are able to conduct announced and unannounced audits.
If an investigation includes both standard and tailored plans members for a particular provider, which SIU will be responsible?	Both Standard and Tailored Plan SIUs will have the responsibility of conducting audits, reviews and investigations for their own members
What is the most common thing providers do that leads to inadvertent frauds?	Most common: billing for services not provided, providing services that are not medically necessary, upcoding, unbundling of services., and falsification of documents.
Will the standard plan MCO be doing post-payment reviews with the same frequency as the LME? will each MCO be doing their own audit?	Each PHP will do their audit and reviews.
What type of collaboration will occur among the various SIU's regarding particular providers of concern that are in more than for example one coverage area? Are their confidentiality constraints?	Yes, the plans will collaborate to prevent fraud, waste and abuse.
Will new guidelines be issued to all SIU's in all PHP's regarding what is considered for overpayment and what is only a Plan of Correction?	PHPs will develop and implement guidelines for overpayments and corrective action plans.
I love the idea of a standard format for providers to use as a self-audit	We encourage each provider to do their own quality assurance within their own organization and submit self audits when needed. If a provider identifies an issue that needs to be reported, that is when they submit the self audit.
Is there a requirement of how often the exclusion list must be checked? only upon hire?	The exclusion list should be routinely checked.
Where can i find the list of your audit companies that have tasked to conduct the audit?	The PHPs will conduct their own audit and review - it is under the PHPs discretion to use a contractor for this work.
We base our internal self-auditing tool on what is required from our clinical coverage policy. Will each PHP have their own Clinical Coverage Policy for us to follow? Or will they all, for instance, follow Clinical Coverage Policy 10A for documentation requirements?	Plans have some NC Medicaid required policies to follow and may also select some NC Medicaid policies or create their own.