NC Medicaid Managed Care
Provider Playbook

Fact Sheet
What Providers Need to Know When a Member Retroactive Enrollment Occurs

Claim Submission & Prior Approved Authorization Resources

RETROACTIVE ENROLLMENT BACKGROUND

Retroactive Enrollments are defined as an action that changes a previously enrolled member's coverage plan or disenrollment from a Managed Care health plan to NC Medicaid Direct.

Retroactive Enrollments may occur in the following situations, but this is not an exhaustive list:

- A change in a beneficiary's circumstance occurs resulting in a change in Managed Care enrollment. An example of this is when a child enters foster care, they would be disenrolled from the Managed Care health plan and enrolled in NC Medicaid Direct.
- A beneficiary's becomes dually eligible for Medicare and Medicaid
    - If an individual is enrolled in a health plan and Medicare data is delayed, submission of Medicare evidence will trigger an automatic retroactive disenrollment of the member back to the first day of the month of the Medicare effective date.
    - More information on this process is located in bulletin Update: Retroactive Disenrollment from NC Medicaid Managed Care
- An approved Request to Move to NC Medicaid Direct – Service Associated Request.
    - This process is used for members currently enrolled in a health plan with NC Medicaid Managed Care who need intellectual/developmental disability (I/DD), mental illness, traumatic brain injury (TBI) or substance use disorders related services that are only available in NC Medicaid Direct or a health plan.
    - More information on this process is located in the Request to Move to NC Medicaid Direct Process Fact Sheet

Providers can verify eligibility and managed care enrollment through the NCTracks Recipient Eligibility Verification function available in the secure Provider Portal.

- Real Time Eligibility Verification Method
    a. Log into the NCTracks Provider Portal
    b. Follow the Eligibility > Inquiry navigation

c. Populate the requested provider, recipient and time period information

- NCTracks Call Center: 800-688-6696

PRIOR APPROVED AUTHORIZATION TRANSITION PROCESS

Health Plans

If a member is retroactively enrolled to a new health plan, the previous plan will facilitate the transfer of a Member's claims/encounters history and prior authorization data to the newly responsible party. If providers are seeking additional information relating to prior authorization requirements please refer to the Managed Care Claims and Prior Authorizations Submission FAQ or the Health Plan contacts and resources

Medicaid Direct

If a member is retroactively enrolled into NC Medicaid Direct, most previously approved prior authorizations are transitioned back to NCTracks. Some prior authorizations such as nursing facility, NEMT, hospice, etc. are not transitioned back will need to be resubmitted to NCTracks. The provider should check the enrollment date for the member and confirm the prior authorization in NCTracks if applicable. For outpatient specialized therapies, a new prior authorization request needs to be submitted to Constellation Quality Health, https://www.medicaidprograms.org/NC/ChoicePA.

If the prior authorization is not expected to return to NCTracks the provider should follow the standard process to request prior approval. If the authorization should have returned to NCTracks and did not, the provider should refer to the Retroactive Disenrollment from NC Medicaid Managed Care bulletin and contact the Ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov, or call the Provider Ombudsman line at 919-527-6666.

CLAIM RECOUPMENT FROM A HEALTH PLAN OR NCTRACKS

When a member is retroactively enrolled into a new health plan or NC Medicaid Direct, the previous payor will recoup previously paid claims, and providers will need to resubmit claims to the new payor. Health plans have two years after the date of original claim payment to recoup the payment unless the payor has reason to believe fraud or an overpayment may have occurred.

What should a provider do if a previously paid claim is recouped?

Providers should resubmit the claim to the appropriate entity (e.g., health plan or NC Medicaid Direct) in the event that a previously paid claim is recouped by a health plan due to the member no longer being enrolled in the plan for the date of service.

Providers should confirm member eligibility by logging into the NCTracks Provider Portal. For more information on claims submission and member eligibility please refer to the Managed Care Claims Submission fact sheet.

When experiencing retro enrollments, providers shall not bill a NC Medicaid beneficiary for services furnished to a beneficiary who the provider has accepted as a Medicaid patient. Please refer to the Provider Requirements related to Billing Medicaid Beneficiaries bulletin.

CLAIM TIMELY FILING RULES – MEMBER RETROACTIVE ENROLLMENT

When a member is retroactively enrolled, below are the minimum standards for claim timely filing rules.

Health Plans
Claim date of service on or before June 30, 2023

- 180 calendar days from the date of enrollment for medical claims
- 365 calendar days from the date of enrollment for pharmacy claims

Claim date of service on or after July 1, 2023

- 365 calendar days from the date of enrollment for medical and pharmacy claims

Please note, the date of enrollment is the date in which the member enrollment update occurred in the NCTracks system.

Medicaid Direct

- 365 calendar days from the date of enrollment for medical and pharmacy claims

Refer to the table below for further supporting information on how to submit claims and timely filing claim denials or refer to the following section if a provider requires additional support. If the service provided is subject to Electronic Visit Verification (EVV) please check with the health plan for billing instructions.

Entity	Link to Guidance
AmeriHealth	Provider Manual
Healthy Blue	Provider Manual
Carolina Complete Health	Provider Manual
United Healthcare	Provider Manual Claim Reconsideration Guide
WellCare	Provider Manual
NC Medicaid Direct	Provider Adjustment, Time Limit & Medicare Override

WHAT IF I HAVE QUESTIONS?

For questions about claim submissions, contact the health plan.

Additional resources for providers can be found in the Provider Playbook and on the Medicaid Transformation website.

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

For general inquiries and complaints regarding health plans, 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 919-527-6666. The Provider Ombudsman contact information is also published in each health plan's provider manual.