

***Basic Medicaid***

***Billing Guide***

***August 2005***



*Table of Contents*

---

**SECTION 1 – WHO’S WHO IN THE MEDICAID PROGRAM**

<b>Who’s Who in the Medicaid Program.....</b>	<b>1</b>
<b>What is Medicaid .....</b>	<b>1</b>
<b>Centers for Medicare and Medicaid Services .....</b>	<b>1</b>
<b>Department of Health and Human Services.....</b>	<b>1</b>
<b>Division of Medical Assistance.....</b>	<b>1</b>
<b>Department of Social Services .....</b>	<b>2</b>
<b>Electronic Data Systems .....</b>	<b>2</b>
<b>Division of Medical Assistance Organization Roles .....</b>	<b>3</b>
<b>Recipient and Provider Services.....</b>	<b>3</b>
<b>Clinical Policy and Programs .....</b>	<b>3</b>
Clinical Policy Development and Technical Support.....	3
<b>Managed Care .....</b>	<b>3</b>
Program Operations and Development.....	4
Quality Management.....	4
Early Periodic Screening, Diagnostic and Treatment (EPSDT) and Health Check.....	5
Piedmont Cardinal Health Pan.....	5
<b>Information Services.....</b>	<b>5</b>
<b>Financial Operations .....</b>	<b>5</b>
<b>Program Integrity .....</b>	<b>6</b>

**SECTION 2 – RECIPIENT ELIGIBILITY**

<b>Recipient Eligibility.....</b>	<b>1</b>
<b>Eligibility Determination.....</b>	<b>1</b>
<b>Eligibility Categories .....</b>	<b>1</b>
<b>When Does Eligibility Begin .....</b>	<b>2</b>
<b>Retroactive Eligibility .....</b>	<b>2</b>
<b>Eligibility Reversals .....</b>	<b>2</b>
<b>Medicaid Identification Cards.....</b>	<b>3</b>
Blue and Pink Medicaid Card Information .....	4
Blue Medicaid Identification Card.....	6
Piedmont Cardinal Health Plan Information .....	7
Piedmont Cardinal Health Plan Card .....	7
Pink Medicaid Identification Card.....	8
Buff MEDICARE-AID ID Card Information.....	9
Buff MEDICARE-AID ID Card .....	10
County-Issued Medicaid Identification Cards .....	11
<b>Verifying Eligibility .....</b>	<b>11</b>
Verification Methods .....	11
Automated Voice Response System.....	11
Electronic Data Interchange .....	11
DMA Claims Analysis .....	11
<b>Eligibility Denials .....</b>	<b>12</b>
EOBs for Eligibility Denials.....	13
<b>24-Visit Limitation .....</b>	<b>14</b>

*Table of Contents*

---

24-Visit Limit Exemption Requests.....14  
**Copayments .....15**  
Copayment Exemptions .....16

**SECTION 3 – MEDICAID PROVIDER INFORMATION**

**Medicaid Provider Information..... 1**  
**Qualifications for Enrollment.....1**  
    General Requirements.....1  
        Licensure .....1  
        Service Location.....1  
        Provider Agreements.....1  
    Enrollment Procedure .....1  
    Tax Information .....1  
**Conditions of Participation .....2**  
    Civil Rights Act .....2  
    Rehabilitation and Disabilities Acts.....2  
    Disclosure of Medicaid Information .....2  
    Medical Record Documentation .....3  
    Payment in Full.....3  
    Fee Schedule Requests.....3  
**Provider Responsibilities.....4**  
    Verifying Recipient Eligibility .....4  
    Billing the Recipient .....4  
    Third Party Liability .....5  
    Overpayments .....5  
**Reporting Provider Changes .....5**  
    What Changes Must be Reported .....5  
    How to Report a Change.....5  
    Voluntary Termination.....5  
    Termination of Inactive Providers .....6  
    Payment Suspension .....6  
    Licensure Revocation or Suspension .....6  
    Sanctions .....6  
**Program Integrity Reviews .....6**  
    Determining Areas for Review .....6  
    Provider Responsibilities with a Program Integrity Review.....7  
        Personal Hearings.....7  
        Paper Reviews .....7  
        Miscellaneous.....8  
    Self-Referral Federal Regulation .....8  
**Advance Directives.....8**  
**Provider Information – Commonly Asked Questions .....9**  
**Attachments**  
    Sample of Fee Schedule Request Form .....14  
    Sample of Medicaid Provider Change Form.....16  
    Sample of Carolina ACCESS Change in Provider Information Form.....18  
    Sample of Advance Directives Brochure.....20

*Table of Contents*

**SECTION 4 – MANAGED CARE PROVIDER INFORMATION**

**Managed Care Provider Information ..... 1**

**Community Care of North Carolina .....1**

Community Care of North Carolina – Carolina ACCESS .....1

Community Care of North Carolina – ACCESS II/III.....1

**Managed Care Recipient Enrollment .....2**

Recipient Education .....2

**Carolina ACCESS Provider Participation .....3**

Requirements of Participation.....3

Conditions of Participation.....5

Exceptions.....5

Sanctions .....6

Sanction Appeals .....6

Terminations .....6

**Carolina ACCESS Provider Reports .....6**

Enrollment Report.....7

Emergency Room Management Report.....7

Referral Report .....7

Quarterly Utilization Report .....7

**Carolina ACCESS Provider Requirements .....7**

Health Check Services .....7

Adult Preventive Annual Health Assessments.....7

24-Hour Coverage Requirement .....8

Standards of Appointment Availability .....8

Emergency Conditions .....8

Urgent Conditions .....9

Standards for Office Wait Times .....9

Hospital Admitting Privileges Requirements .....9

Women, Infant, and Children (WIC) Special Supplemental  
Nutrition Program Referrals .....9

Transfer of Medical Records .....10

Carolina ACCESS Medical Records Guidelines .....10

**Carolina ACCESS Referrals and Authorizations.....11**

Referrals for a Second Opinions .....11

Referral Documentation.....11

Exempt Services .....12

Carolina ACCESS Override Requests .....12

**Medical Exemption Requests.....13**

**Patient Disenrollment .....13**

**Carolina ACCESS – Commonly Asked Questions .....14**

**Attachments**

Modified Example of CA Provider Enrollment Report .....17

Section 1: New Enrollees .....17

Section 2: Current Enrollees.....18

Section 3: Terminated Enrollees .....19

List of Regional Managed Care Consultants .....20

Example of Emergency Room Management Report .....21

Example of Referral Report .....22

Instructions for Using the Quarterly Utilization Report .....23

## *Table of Contents*

---

Example of Quarterly Utilization Report.....	24
Sample of Health Department Health Check Agreement .....	26
Sample of Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form .....	28
Instructions for Completing the WIC Exchange of Information Forms .....	30
Sample of WIC Exchange of Information Form for Women .....	31
Sample of WIC Exchange of Information Form for Infants and Children .....	32
Sample of Medical Record Release Form.....	33
Sample of Carolina ACCESS Override Request Form.....	34
Sample of Carolina ACCESS Medical Exemption Request Form .....	35
<b>HMO Risk Contracting .....</b>	<b>36</b>
<b>In-Plan Benefits.....</b>	<b>36</b>
<b>Out-of-Plan Benefits .....</b>	<b>37</b>

<b>SECTION 5 – SUBMITTING CLAIMS TO MEDICAID</b>
--

<b>Submitting Claims to Medicaid .....</b>	<b>1</b>
<b>Time Limits for Filing Claims .....</b>	<b>1</b>
<b>Submitting Claims on Paper .....</b>	<b>1</b>
<b>Processing Paper Claims without a Signature .....</b>	<b>1</b>
<b>Submitting Claims Electronically.....</b>	<b>1</b>
<b>Billing on the CMS-1500 Claim Form .....</b>	<b>2</b>
CMS-1500 Claim Form Instructions .....	2
Place of Service Code Index .....	6
Type of Treatment/Type of Service Index .....	8
Example of CMS-1500 Claim Form.....	9
Sample of the Back of the CMS-1500 Claim Form.....	10
<b>Billing on the UB-92 Claim Form .....</b>	<b>11</b>
UB-92 Claim Form Instructions .....	11
Example of UB-92 Claim Form.....	25
Sample of the Back of the UB-92 Claim Form.....	26
<b>Billing on the ADA Claim Form.....</b>	<b>27</b>
<b>Attachments</b>	
Sample of Provider Certification for Signature on File Form.....	28
Sample of Medicare Crossover Reference Request.....	29

*Table of Contents*

**SECTION 6 – PRIOR APPROVAL**

**Prior Approval ..... 1**

**Services Requiring Prior Approval.....1**

    General Requests for Prior Approval.....3

    Requests for Prior Approval of Out-of-state or State-to-state Ambulance Services.....4

    Requests for Prior Approval of Long-Term Care Services.....4

    Requests for Prior Approval of Services Provided to the Mentally Retarded .....4

    Requests for Approval of Optical Services.....4

        Requests for Routine Eye Exams and Refractions .....4

        Requests for Prior Approval for Visual Aids .....4

    Requests for Prior Approval of Hearing Aids, FM Systems, and Accessories .....5

    Requests for Prior Approval of Dental Services .....5

    Requests for PA of Durable Medical Equipment/ Orthotic and Prosthetic Devices.....5

    Enhanced Care (Adult Care Home Recipients) Approval Process .....5

    Hospice Participation Notification Process.....5

    Utilization Review for Psychiatric Services .....6

    Prior Approval for Outpatient Specialized Therapies.....6

    Requesting Prior Approval for Prescription Drugs.....6

**Six-Prescription Override Requests.....7**

**Procedures for Approval and Reimbursement of Transplants .....8**

**Attachments**

    Sample of Six-Prescription Limit Override Form.....9

*Table of Contents*

**SECTION 7 – THIRD PARTY INSURANCE**

**Third Party Insurance ..... 1**  
    **Medicaid Payment Guidelines for Third Party Coverage .....1**  
    **Services Provided to Medicare-Eligible Medicaid Recipients .....1**  
    **Capitated Payments .....1**  
    **Discounted Fee-for-Service Payments.....1**  
    **Noncompliance Denials .....2**  
    **Third Party Liability .....2**  
        Determining Third Party Liability .....2  
        Time Limit Override on Third Party Insurance .....3  
        Refunds to Medicaid .....3  
    **Personal Injury Cases.....3**  
        Tort (Personal Injury Liability).....3  
        Provider’s Rights in a Personal Injury Case .....3  
        Billing for Personal Injury Cases .....4  
        Payment for Personal Injury Cases .....4  
        Refunds and Recoupments for Personal Injury Cases .....4  
    **Third Party Liability – Commonly Asked Questions.....5**  
    **Health Insurance Premium Payments .....9**  
        Payment of Health Insurance Premiums .....9  
        Eligibility Determination .....9  
        Eligibility Process .....9  
        Where to Obtain Information.....9  
    **Medicaid Credit Balance Reporting.....10**  
        Completing and Submitting the Medicaid Credit Balance Report.....10  
    **Attachments**  
        Sample of Health Insurance Information Referral Form .....11  
        Sample of Third Party Recovery “Accident” Information Report.....12  
        Sample of Health Insurance Premium Payment (HIPP) Application Form.....13  
        Sample of Medicaid Credit Balance Report Form.....14

*Table of Contents*

---

**SECTION 8 – RESOLVING DENIED CLAIMS**

**Resolving Denied Claims..... 1**

**Claim Adjustments .....1**

        Resubmission of a Denied Claim.....1

        Instructions for Completing the Medicaid Claim Adjustment Request Form .....1

        Tips for Filing Adjustments .....3

        Submitting an Adjustment Electronically .....4

**Pharmacy Claim Adjustments.....4**

        Instructions for Completing the Pharmacy Claim Adjustment Request Form.....5

        EOB Denials that Do Not Require Filing Adjustments .....6

**Resolution Inquiries .....8**

        Time Limit Overrides .....8

        Instructions for Completing the Medicaid Resolution Inquiry Form.....9

**Recoupments .....10**

        Automatic Recoupments .....10

**Provider Refunds .....10**

**Attachments**

        Sample of Medicaid Claim Adjustment Request Form .....12

        Sample of Pharmacy Adjustment Request Form .....13

        Sample of Medicaid Resolution Inquiry Form .....14

**SECTION 9 – REMITTANCE AND STATUS REPORT**

**Remittance and Status Report..... 1**

**What is the Remittance and Status Report .....1**

**Remittance and Status Report Sections and Subsections .....1**

        Paid Claims .....1

        Adjusted Claims.....1

        Informational Adjustment Claims.....1

        Denied Claims.....2

        Claims in Process .....2

        Financial Items.....2

        Claims Summary.....2

        Claims Payment Summary.....2

        Financial Payer Code .....2

        Population Group Payer Code .....3

        New Totals Following the Current Claim Total Line .....3

        Summary Page .....3

**Remittance and Status Report Field Descriptions.....4**

**Explanation of Internal Claim Number.....6**

*Table of Contents*

**SECTION 10 – ELECTRONIC COMMERCE SERVICES**

**Electronic Commerce Services ..... 1**  
    **What Services are Available .....1**  
    **Electronic Claims Submission .....1**  
        Billing Claims Electronically.....1  
        Billing with the North Carolina Electronic Claims Submission Web-based Tool .....2  
        Billing with Software Obtained from a Vendor .....2  
        Billing with Software Written by your Office or Company .....2  
        Billing through a Clearinghouse.....2  
        Helpful Hints for Testing .....3  
    **Electronic Data Interchange Services .....3**  
        Value Added Networks.....3  
        Interactive Recipient Eligibility Verification.....3  
        Approved EDI Vendors .....4  
    **Important Telephone Numbers for Electronic Commerce Services.....5**  
    **Sample of Electronic Funds Transfer Form Authorization.....5**  
    **Electronic Commerce Services – Commonly Asked Questions.....5**  
    **Attachments**  
        Sample of Electronic Funds Transfer Form.....8

**Appendices**  
    **Appendix A: N.C. Medicaid Program Automated Voice Response System..... A-1**  
    **Appendix B: Automated Attendant Telephone Instructions .....B-1**  
    **Appendix C: Contacting Medicaid..... C-1**  
        Telephone Contact List .....C-1  
        EDS Address List.....C-4  
        DMA Address List.....C-5  
    **Appendix D: EDS Provider Services Representatives..... D-1**  
    **Appendix E: Requesting Forms.....E-1**  
    **Appendix F: Table of Acronyms .....F-1**

**Index .....I-1**

## WHO'S WHO IN THE MEDICAID PROGRAM

### What is Medicaid?

Title XIX of the Social Security Act (Medicaid) is a medical assistance program administered by the Division of Medical Assistance for certain low-income individuals and families. DMA contracts with EDS to process Medicaid claims for payment and to perform administrative tasks.

Eligible recipients receive medical care from providers enrolled in the program who then bill Medicaid for services. Updated coverage information and changes are issued in monthly Medicaid bulletins and through provider visits and seminars. Medical coverage information and Medicaid bulletins are available on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>.

### Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that regulates and oversees all state Medicaid programs. In addition, CMS is responsible for enforcing the transaction and code set standards that are part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### Department of Health and Human Services

The N.C. Department of Health and Human Services (DHHS) oversees the administration of numerous health care programs in the State of North Carolina including Medicaid.

### Division of Medical Assistance

The N.C. Division of Medical Assistance (DMA) is the state agency that administers the N.C. Medicaid program by:

- interpreting federal laws and regulations as they relate to the Medicaid program
- establishing clinical policy
- establishing all fees and rates
- establishing provider enrollment requirements
- maintaining provider files
- maintaining third party insurance files
- maintaining the Eligibility Information System
- enrolling all qualified North Carolina Medicaid providers
- administering Medicaid Managed Care programs
- publishing clinical policy
- publishing Medicaid bulletins

**Department of Social Services**

Each county department of social services (DSS) is responsible for:

- determining recipient eligibility for Medicaid
- enrolling recipients in Managed Care programs
- educating recipients about Managed Care programs
- processing primary care provider (PCP) changes for Managed Care enrollees
- maintaining all recipient eligibility files, including Managed Care recipient enrollment
- providing adult care home (ACH) enhanced care prior approval and case management services

**Electronic Data Systems**

Electronic Data Systems (EDS) is the fiscal agent contracted by DMA to:

- process claims for approved Medicaid providers according to DMA's policies and guidelines
- establish and maintain a presence with the Medicaid provider community through:
  - ◆ provider seminars
  - ◆ onsite visits to providers for assistance with billing issues

**DIVISION OF MEDICAL ASSISTANCE ORGANIZATION ROLES**

DMA is the state agency responsible for the administration of the N.C. Medicaid program. DMA is organized into six administrative sections with responsibilities as outlined below.

**Recipient and Provider Services**

The Recipient and Provider Services section is responsible for establishing recipient eligibility policy and maintaining the Eligibility Information System (EIS). This section is also responsible for provider enrollment, claims analysis, time limit overrides and provider education. This unit works closely with EDS provider services and monitors activities such as seminar planning, provider visits, and Medicaid bulletins. DMA Field Staff provides management consultation and technical assistance to county DSS staff and are responsible for training DSS staff on eligibility and EIS issues. This section is also responsible for provider enrollment, claims analysis, time limit overrides, and provider services such as Medicaid bulletins and other publications.

**Clinical Policy and Programs**

The Clinical Policy and Programs section is responsible for the overall administration of programs and clinical services covered by the N.C. Medicaid Program. The Clinical Policy and Programs section established policies and procedures for the provision of all Medicaid covered services. This includes institutional care services, community-based care services, practitioner and clinic services, behavioral health services, pharmacy, durable medical equipment, orthotics and prosthetics, optical services, hearing aids, local education agency services, independent practitioners, and specialized therapies.

***Clinical Policy Development and Technical Support***

The Clinical Policy Development and Technical Support unit is responsible for:

- assuring compliance with Session Law 2004-124 to develop clinical coverage policies according to national or evidence-based standards
- obtaining the advice of the N.C. Physician's Advisory Group
- following a prescribed process for provider/public comment on proposed policies
- routinely reviewing and updating clinical coverage policies based on changes in medical practice and literature
- policy evaluations of efficacy, fiscal impact, utilization, and population analyses

**Managed Care**

The Managed Care section is responsible for the administration of the Community Care of North Carolina (CCNC) program (Carolina ACCESS (CA) and ACCESS II/III) and HMO Risk Contracting. (Refer to **Managed Care Provider Information** on page 4-1 for additional information on Managed Care providers.)

The Managed Care section is divided into three administrative sections with specific program roles.

***Program Operations and Development***

Program Operations and Development (POD) is responsible for the day-to-day operation of Medicaid's Managed Care programs. Staff includes six regional Managed Care Consultants who provide program support to Managed Care providers. (Refer to page 4-20 for a list of the consultants and the areas they serve.) POD responsibilities include:

- the development and implementation of Managed Care policy
- recruiting and educating providers to participate as primary care providers (PCPs)
- furnishing technical assistance to providers
- assisting the medical community to understand Managed Care programs
- the development of ACCESS II/III in conjunction with the Office of Research, Demonstration, and Rural Health Development
- staffing a recipient hotline
- monitoring contractual compliance

***Quality Management***

Quality Management is responsible for ensuring that the care provided within each of the Medicaid Managed Care programs is of acceptable quality, accessibility, continuity, and efficiency. Activities include utilization monitoring, assessment of patient satisfaction, complaint monitoring, focused care studies, physician collaborations, report development, and quality improvement projects. Following is a list of Quality Management Initiatives:

- Anti-Microbial Resistance Project – July 2002
- North Carolina Asthma Collaborative – June 2002
- Managed Care Diabetes Project
- Managed Care Heart Failure Project
- Consumer Assessment of Health Plans Survey (CAHPS)
- Health Plan Employer Data Information Set (HEDIS) – annual results
- After-Hours Accessibility Audit Summary
- Treatment of Persistent Asthma in the Pediatric Medicaid Population

Additional information on these and other Quality Management Initiatives can be obtained on DMA's website at <http://www.dhhs.state.nc.us/dma/ca/qm.htm>.

**Early Periodic Screening, Diagnostic and Treatment (EPSDT) and Health Check**

Health Check is important because it provides early and regular medical and dental screenings for all Medicaid recipients under the age of 21. Services must be prescribed by the recipient's doctor or another licensed clinician. The treatment cannot be experimental/investigational, unsafe or ineffective. Health Check examinations and other Medicaid covered services are free of charge. Medicaid for recipients under age 21 may also cover some services that are not provided to recipients over 21. Services must be prescribed by the recipient's doctor or another licensed clinician. Health care services will be provided in a frequency and amount consistent with the recipient's medical needs. The treatment cannot be experimental/investigational, unsafe, or ineffective. Prior approval from the Division of Medical Assistance (DMA) may be required for some services or procedures before they can be provided. If approval is denied or services reduced or terminated, the recipient or his/her representative can appeal this decision.

For further information about Health Check and EPSDT covered services, refer to the:

Health Check Billing Guide at [www.dhhs.state.nc.us/dma/healthcheck.htm](http://www.dhhs.state.nc.us/dma/healthcheck.htm);

EPSDT Policy Instructions on the DMA website at <http://www.dhhs.state.nc.us/dma>;

"A Consumer's Guide to North Carolina Medicaid Programs for the Aged, Blind, and Disabled"; and

"A Medicaid Consumer's Guide to North Carolina Medicaid Health Insurance for Families and Children".

**Piedmont Cardinal Health Plan**

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

**Information Services**

The Information Services section is responsible for the automation resources/functionality of DMA, which is maintained either in-house or by contract. This section is divided into the Contract Monitoring unit, the Medicaid Management Information Services (MMIS) unit, the Information Center unit, and Decision Support unit.

**Financial Operations**

DMA's Financial Operations section is responsible for establishing and maintaining Medicaid's reimbursement policy, including rate setting (fee schedules) and cost settlements.

***Program Integrity***

Program Integrity (PI) ensures that:

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse or fraud.
- Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions.
- Recipients' rights are protected and recipients receive quality care.
- Problems are communicated to appropriate staff, providers or recipients and corrected through education and changes to the policy, procedure or process, and are monitored for corrective action.

PI achieves this by:

- conducting post-payment reviews of:
  - ◆ provider billing practices and cost reports
  - ◆ payment of claims by the fiscal agent
  - ◆ recipient eligibility determinations
- identifying overpayments for recoupment
- identifying medical, administrative, and reimbursement policies or procedures that need to be changed
- educating providers on their errors
- assessing the quality of care for Medicaid recipients
- assuring Medicaid pays for only medically necessary services
- identifying and referring suspected Medicaid fraud cases to the Attorney General's Office, Medicaid Investigation Unit, other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.) or to federal agencies for investigations (e.g., Drug Enforcement Agency)
- overseeing recipient fraud and abuse activities by the local county department of social services (DSS) to assure that recipient overpayments are recouped

PI operates under federal and state laws and regulations that are both stringent and comprehensive. The state rules are found in the N.C. Administrative Code Title 10A, Section 22F, and the federal rules are found in 42 CFR 455. Information regarding requirements resulting from these laws and rules are conveyed to all providers through general Medicaid bulletins. Refer to **Program Integrity Reviews** on page 3-7 for additional information.

## **RECIPIENT ELIGIBILITY**

### **Eligibility Determination**

For most recipients, Medicaid eligibility is determined by the local department of social services (DSS) in the county in which the individual resides. Applicants for programs that serve families and children may enroll in person, or in some cases, by mail. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards such as age and disability. Families receiving Work First Family Assistance and individuals receiving Special Assistance benefits also receive Medicaid.

If a family's income exceeds the allowable level but is not adequate to meet all medical expenses, the family may be eligible for Medicaid if sufficient medical expenses are incurred that would reduce the income to the allowable level. This is known as "meeting a deductible."

Aged, blind, and disabled individuals (including children) who receive Supplemental Security Income (SSI) are automatically entitled to N.C. Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration. If an SSI recipient needs Medicaid coverage prior to the effective date of the SSI coverage, the recipient may apply for this coverage at the county DSS office. The recipient must apply for retroactive SSI Medicaid within 60 days (90 days with good cause) from the date of the SSI Medicaid approval or denial notice in order to protect the SSI retroactive period.

### **Eligibility Categories**

North Carolina Medicaid recipients receive benefits in the following assistance categories:

- Medicaid - Work First Family Assistance (AAF)
- Medicaid - Aid to the Aged (MAA)
- Medicaid - Aid to the Blind (MAB)
- Medicaid - Aid to the Disabled (MAD)
- Medicaid – Families and Children (MAF)
- Medicaid - Infants and Children (MIC)
- Medicaid - Pregnant Women (MPW)
- Medicaid - Special Assistance to the Blind (MSB)
- Foster Care; Adoption Subsidy (HSF; IAS)
- Special Assistance - Aid to the Aged (SAA)
- Special Assistance - Aid to the Disabled (SAD)
- Medicaid - Medicare-Qualified Beneficiaries (MQB)
- Medicaid - Refugees (MRF)
- Medicaid - Refugee Assistance (RRF)

Providers who have general eligibility questions should call their local county DSS.

### **When Does Eligibility Begin**

An individual is eligible for Medicaid the **month** in which all categorical and financial conditions of eligibility are met. If all requirements are met on the first day of the month, eligibility begins that day.

If the individual has a deductible or excess resources and all other conditions are met, eligibility begins on the **day** of the month the deductible is met or the resource is reduced to the allowable limit. The Medicaid deductible is met by incurring medical expenses, which the individual is responsible for paying from personal funds, during the certification period in which assistance is requested. The Medicaid certification period (the period for which the deductible is computed) is typically six months.

Eligibility for nonqualified alien residents is approved for emergency service only and is limited to only the services required to treat the emergency condition. To be eligible for emergency services, the individual must still meet all other eligibility requirements, such as income, resources, age, and/or disability criteria.

Eligibility for most recipients ends on the last day of the month. Exceptions to this are a presumptively eligible pregnant woman whom the county DSS has determined to be ineligible and a nonqualified alien eligible to receive emergency service only.

### **Retroactive Eligibility**

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period and has unpaid medical bills for any one of the three months prior to application. Medicaid will pay for covered services received during the retroactive period provided that all other Medicaid guidelines are met. Providers may choose to accept or decline retroactive eligibility. However, the provider's office policy should be consistently enforced. If a provider accepts retroactive eligibility, all payments made by the recipient must be reimbursed to the recipient when the provider files the claim to Medicaid.

### **Eligibility Reversals**

In some cases an application for Medicaid benefits is initially denied and then later approved due to a reversal of a disability denial, a state appeal or a court decision. Because some of these appeals and reversals are not final for many months, the county DSS can request an override of the claims filing time limit from DMA. Written notice is provided to the recipient and to the county DSS when the time limit override is approved. Recipients are instructed to immediately notify the provider of retroactive approval. Failure to do so will result in the recipient being financially liable for the services provided. Refer to **Eligibility Denials** on page 2-12 for additional information.

### **Medicaid Identification Cards**

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The MID card indicates eligibility coverage and restrictions that apply to the recipient. The MID card shows information necessary for filing claims, including the recipient's MID number, date of birth, insurance information, Medicaid Managed Care information, and recipient eligibility dates for which the card is valid.

A recipient's eligibility and managed care provider may change from month to month. Therefore, new MID cards are issued at the beginning of each month. The new card shows valid eligible dates through the current calendar month. The "From" date may show eligibility for prior months in addition to the current calendar month.

Providers must request that recipients present their current MID card as proof of eligibility for the dates of services rendered. Recipients must present a valid MID card at each provider visit. Failure to provide proof of eligibility may result in the recipient being financially liable for the service provided as the provider can refuse to accept the recipient as a Medicaid client.

Field	Description
Case ID Casehead	The address for the county DSS office is listed above the Case ID, which is an 8-digit number assigned to the recipient. (Refer to this number when requesting assistance from the recipient's county DSS office.) Casehead refers to the head of the household. <b>Note:</b> The casehead is not necessarily eligible for Medicaid benefits.
Eligible Members	The card lists all of the eligible members and their unique MID number. <b>Note:</b> Each member enrolled with CA receives a separate MID card.
CAP	A 2-character code in the CAP field indicates that the recipient is authorized for home- and community-based services in lieu of nursing facility care. <b>Note:</b> CAP participants are exempt from Medicaid copayment requirements.
County Case No.	A 6-digit County Case number is assigned to the case.
Issuance	The 5-digit Julian date and letter (R or S) indicates the date that the card was prepared and when the card was mailed.
Program	The 3-character code indicates the recipient's coverage category.
Class	The letter in this field indicates the case classification.
Valid From - Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of eligibility in the current month or prior month for retroactive eligibility.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Eligibles for Medicaid	The first name, middle initial, and last name of each eligible family member is listed in this field.
Eligibles for Medicaid – Carolina ACCESS (CCNC) Enrollees	If the recipient is enrolled in CA (CCNC), the name and address of the PCP for that recipient is listed below the recipient's name. The daytime and after-hours telephone numbers for the practice are also listed below the recipient's name.
Insurance Number	If a recipient is covered by one of the insurance resources shown in the Insurance Data field, the corresponding number is listed here.
Birth Date	The recipient's date of birth is listed by the month, day, and year.
Sex	The recipient's gender is listed in this field.
<p>The following message is printed on pink MID cards issued to MPW recipients:</p> <p><i>This recipient is only entitled to receive pregnancy-related services which include prenatal, delivery and postpartum care as well as services required for conditions which may complicate pregnancy.</i></p> <p>A second message limiting coverage to ambulatory care for pregnancy-related services may appear if the pink MID card was issued to a presumptively eligible MPW recipient.</p> <p>The blue MID card may contain messages informing recipients about new Medicaid programs that are implemented or changes to existing programs.</p>	

**Blue and Pink Medicaid Identification Card Information, continued**

Field	Description
Insurance Number	A number in this field indicates that the recipient has specific third party insurance.
Name Code	A 3-digit code identifies the name of the third party insurance carrier. <b>Note:</b> The <b>Third Party Insurance Code book</b> is available on DMA's website at <a href="http://www.dhhs.state.nc.us/dma/tpr.html">http://www.dhhs.state.nc.us/dma/tpr.html</a> and provides a key to the insurance codes listed in this field.
Policy Number	If the recipient has coverage with a third party insurance carrier, the recipient's insurance policy number is listed in this field.
Type	A 2-digit code indicates the type of coverage provided in the policy. The type of coverage codes are listed below: 00 - Major Medical Coverage 01 - Basic Hospital with Surgical Coverage 03 - Dental Coverage Only 02 - Basic Hospital Only Coverage 04 - Cancer Only Coverage 05 - Accident Only Coverage 06 - Indemnity Only Coverage 07 - Nursing Home Only Coverage 08 - Basic Medicare Supplement 10 - Major Medical and Dental Coverage 11 - Major Medical and Nursing Home Coverage 12 - Intensive Care Only Coverage 13 - Hospital Outpatient Only Coverage 14 - Physician Only Coverage 15 - Heart Attack Only Coverage 16 - Prescription Drugs Only Coverage 17 - Vision Care Only Coverage
Recipient Name and Address	The name and address of the head of the household is listed to the right of the Insurance Data.
Recipient Name and Address – Carolina ACCESS (CCNC) Enrollees	If the recipient is enrolled with CA (CCNC) or a Medicaid HMO, the words "Carolina ACCESS Enrollee" or "Prepaid Health Plan Enrollee" appear on the card.
Date	The month and the year that the card was issued for are listed here.
Signature	The recipient must sign the MID card where indicated.

**Blue Medicaid Identification Card**

The card lists the casehead of the family and other eligible persons. Each eligible recipient has a specific recipient MID number. A recipient is only eligible for Medicaid if his/her name and MID number appear on the card.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

HMO enrollees are identified by the phrase "Prepaid Health Plan Enrollee" on the MID card. The name of the health plan, the address, and the member services phone number are also listed on the card. Providers must contact the health plan listed on the recipient's MID card to obtain referral authorization before providing treatment. (HMO enrollees also receive a membership card from the health plan.)

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-11 for additional information on Managed Care referrals.

**THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER**

**MEDICAID IDENTIFICATION CARD**

**01-01-05**    **01-31-05**    **VALID FROM 01-01-05 THRU 01-31-05**

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

CAP	COUNTY CASE NO.	ISSUANCE	PROGRAM	CLASS
	123456	99364R	AAF	N

CASE I.D. 10847667  
 CASEHEAD Jane Recipient  
 P.O. Box 111  
 Any City, NC  
 Zip=12345

RECIPIENT I.D.	ELIGIBLES FOR MEDICAID	INS.NO.	BIRTHDATE	SEX
900-00-0000K	Jane Recipient Carolina ACCESS Provider 123 Any Street Any City, NC 12345 555-5555	1	12-17-73	F

ELIGIBLE MEMBERS

INS. NO.	NAME CODE	POLICY NUMBER	TYPE
1		Medicare-B	
2	091	123456789	

Jane Recipient  
900-00-0000K

Carolina ACCESS Enrollee  
**Jan 2005 AAF11**    10847667 101  
 123 Any Street  
 Any City, NC 12345

SAMPLE

RECIPIENT (Signature) Jane Recipient (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

5005 DMS300S (REV 8/99)

**Piedmont Cardinal Health Plan Card**

Effective April 1, 2005, Piedmont Behavioral Healthcare began operating under a managed care plan which applies to Medicaid recipients who get their Medicaid cards from Rowan, Stanly, Union, Davidson, and Cabarrus counties. The new managed care plan is known as Piedmont Cardinal Health Plan (PCHP). All Medicaid mental health, development disabilities and substance abuse (MH/DD/SA) services for individuals receiving Medicaid from one of the five counties listed above are provided through PCHP. This includes services in the Innovations wavier, which replaces CAP-MR/DD in the five-county Piedmont area.

PCHP is paid a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the catchment area. DMA does not authorize, prior approve or reimburse individual providers for these services.

All Medicaid recipients in the catchment area are covered by the PCHP with the exception of the following groups:

- Medicare Qualified Beneficiaries
- Refugees
- Non-qualified aliens or qualified aliens during the five year ban
- Individuals receiving Family Planning Medicaid (yet to be implemented)

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

**THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER**

04-01-05 to 04-30-05

P.O. Box 111  
Any City, NC  
Zip=12345

CASE ID 10847667  
CASEHEAD Jane Recipient

---

Eligible Members

Jane Recipient

123-45-6789K

**MEDICAID IDENTIFICATION CARD** \* = PCHP  
**VALID**

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

CAP	COUNTY CASE NO 123456	ISSUANCE 05090 R	PROGRAM AAF	CLASS N	FROM 04-01-05	THRU 04-30-05
RECIPIENT ID 123-45-6789K		ELIGIBLE# FOR MEDICAID * Jane Recipient			INS NO 1	BRTHDATE 12-17-73
INS NO 1	NAME CODE 091	POLICY NUMBER Y23684219	TYPE 00			

APR.2005 AAF11 10847667 101  
456 That Street  
That City, NC 45678

RECIPIENT (Signature) *Jane Recipient* (Not valid unless signed)

MISUSE MAY RESULT IN FRAUD PROSECUTION

Providers who are interested in applying to participate in the PCHP network should call Piedmont Provider Relations at 1-800-958-5596.

**Pink Medicaid Identification Card**

The pink MID card indicates the recipient is eligible for pregnancy-related services only. Only the name of the eligible pregnant woman is listed on the card. No other recipients are listed on the card. A message is printed on the card stating that eligibility is limited to services relating to pregnancy and conditions that may complicate the pregnancy. If a second message appears on the MID card stating the recipient is presumptively eligible only, coverage is limited to ambulatory care.

CA (CCNC) enrollees are identified by the phrase "Carolina ACCESS Enrollee" on the MID card. The name of the CA (CCNC) PCP, the PCP's address, and the daytime and after-hours telephone numbers for the practice are also listed on the card. The date listed under the phrase "Carolina ACCESS Enrollee" indicates that the recipient is enrolled with the PCP listed on the card for that month. Providers must contact the PCP listed on the recipient's MID card to obtain referral and authorization before providing treatment.

HMO enrollees are identified by the phrase "Prepaid Health Plan Enrollee" on the MID card. The name of the health plan, the address, and the member services phone number are also listed on the card. Providers must contact the health plan listed on the recipient's MID card to obtain referral authorization before providing treatment. (HMO enrollees also receive a membership card from the health plan.)

Refer to **Carolina ACCESS Referrals and Authorization** on page 4-11 for additional information on Managed Care referrals.

If the recipient is enrolled in the Piedmont Cardinal Health Plan, the letters "PCHP" are printed on the card. If the recipient is enrolled in the Innovations plan, both "PCHP" and "CM" or simply "CM" are printed on the card. All behavioral health services for recipients participating in PCHP or CM or both must be approved by PCHP in order for the provider to be reimbursed.

**THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER**

**01-01-05 01-31-05**      **MEDICAID IDENTIFICATION CARD**

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

<small>CAP</small>	<small>COUNTY CASE NO.</small>	<small>ISSUANCE</small>	<small>PROGRAM</small>	<small>CLASS</small>	<b>VALID</b>
	098766	99364S	MPW	N	FROM <b>01-01-05</b> THRU <b>01-31-05</b>

<small>RECIPIENT I.D.</small>	<small>ELIGIBLES FOR MEDICAID</small>	<small>INS.NO.</small>	<small>BIRTHDATE</small>	<small>SEX</small>
123-45-6789K	Jane Recipient	1	11-16-73	F

P.O. Box 123  
Anytown, NC  
Zip=12345

CASE I.D. 12345678  
CASEHEAD Jane Recipient

---

ELIGIBLE MEMBERS

Jane Recipient  
123-45-6789K

<small>INS. NO.</small>	<small>NAME CODE</small>	<small>POLICY NUMBER</small>	<small>TYPE</small>
1	091	876543210	00

This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions which may complicate pregnancy.

MISUSE MAY RESULT IN FRAUD PROSECUTION

**January 2005** MPW 11 12345678 101

Jane Recipient  
123 Any Street  
Anytown, NC 12345

RECIPIENT (Not valid unless signed)  
(Signature) Jane Recipient

DM2A001 (REV 11 01)

**Buff MEDICARE-AID ID Card Information**

<b>Field</b>	<b>Description</b>
Program	The 3-character code indicates the recipient's coverage category.
Issuance	The 5-digit Julian date and letter (R or S) indicates the date that the card was prepared and when the card was mailed.
Valid From - Thru	The From and Thru dates indicate the eligibility period. The From date may show eligibility for prior months in addition to the current calendar month. The Thru date is the last day of eligibility in the current month.
Recipient ID	This refers to the unique MID number assigned to the recipient. The MID number is a 9-digit number followed by an alpha character.
Insurance Name Code	A 3-digit code identifies the name of the third party insurance carrier. <b>Note:</b> The <b>Third Party Insurance Code book</b> is available on DMA's website at <a href="http://www.dhhs.state.nc.us/dma/tpr.html">http://www.dhhs.state.nc.us/dma/tpr.html</a> and provides a key to the insurance codes listed in this field.
Birth Date	The recipient's date of birth is listed by the month, day, and year.
Sex	The recipient's gender is listed in this field.
County Number	A 2-digit code indicates the county that issued the card to the recipient.
Case Identification Number	An 8-digit number is assigned to the head of the household. (Refer to this number when requesting assistance from the recipient's county DSS office.)
County District Number	A 3-digit number indicates the district. This information is only used by the county.
Recipient Name and Address	The name and address of the head of the household is listed in this area.
Signature	The recipient must sign the MID card where indicated.

**Buff MEDICARE-AID ID Card**

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID program. If both Medicare and Medicaid allow the service, Medicaid will pay the difference between the Medicare cost-sharing amounts and the Medicaid maximum allowable for the service. Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in Medicaid Managed Care programs.

**THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER**

**NOTICE TO RECIPIENT**

**USE OF CARD** - This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

**RIGHT TO RECONSIDERATION REVIEW** - You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

**FRAUD** - Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

**DO YOU HAVE QUESTIONS?** - If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department social services.

CUT ALONG DOTTED LINES

MEDICARE-AID ID CARD				
N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE				
PROGRAM	ISSUANCE	<b>VALID</b>		
MQB	99364	<b>FROM 01-01-5 THRU 01-31-05</b>		
RECIPIENT I.D.	INS. NAME CDE	BIRTHDATE	SEX	
222-00-1010-L	091	05-29-CCYY	F	
Jan CCYY MQB 61 76543210 004				
Jane Recipient 123 Any Street Any City, NC 12345				
(Signature) <u>Jane Recipient</u>				
(Not valid unless signed)				

DMA/ASDH (REV 09/02)

**NOTICE TO PROVIDERS**

**ENROLLMENT** - To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-855-4050 for information and forms.

**BENEFITS** - Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services for this recipient.

**USE OF CARD** - Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

**BILLING** - Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

58388 (rev. 01/03)

***County-Issued Medicaid Identification Cards***

The county DSS office has the authority to issue MID cards to recipients in an emergency (when the original card is incorrect or has been lost or destroyed), for new applicants or for retroactive eligibility dates. County-issued MID cards are identified by the word “EMERGENCY” stamped on the top margin of the MID card.

**Verifying Eligibility**

A recipient's eligibility (PCP or HMO) status may change from month to month if financial and household circumstances change. For this reason, providers should request that Medicaid recipients provide proof of eligibility each time a service is rendered. A MID card with valid from and through dates covering the date(s) of service is proof of eligibility.

If a recipient no longer meets eligibility requirements, a written notice is mailed to the recipient at least ten working days before the eligibility period ends. Should a recipient state that the MID card has not been received by mail, the provider should ask the recipient if a notice regarding a change in their eligibility status has been received. If the recipient has received a status change notice, the provider should inquire as to the nature of the change.

Recipients requesting services without proof of insurance or Medicaid coverage can be asked to pay for the services received. However, since individuals and families who are Medicaid-eligible have incomes ranging from as low as 34 percent of poverty up to 185 percent of poverty, most do not have the financial means to pay for care. Therefore, DMA provides additional methods for recipient eligibility verification.

***Verification Methods***

Although the recipient's MID card is the most expedient method for eligibility verification, eligibility can also be verified using the following methods:

Automated Voice Response System – Medicaid eligibility can be verified using the Automated Voice Response (AVR) system. Eligibility verification is available for services provided on the date of the inquiry as well as for services provided within the past 12 months. Refer to **Appendix A** for information on using the AVR system.

Electronic Data Interchange – Interactive eligibility verification programs are available from approved Electronic Data Interchange (EDI) vendors. These vendors interface directly with the Medicaid recipient database maintained by EDS. Refer to **Electronic Data Interchange Services** on page 10-3 for additional information.

DMA Claims Analysis – To verify eligibility for dates for service over 12 months old, contact DMA Claims Analysis at 919-855-4045.

## Eligibility Denials

If claims deny for eligibility reasons, the following steps should help resolve the denial and obtain reimbursement for covered dates of service for eligible recipients.

<b>Step 1 Check for Errors on the Claim</b>	<b>Step 2 Check for Data Entry Errors</b>	<b>Step 3 When All Information Matches</b>
<p>Compare the recipient's MID card to the information entered on the claim.</p> <p>If the information on the claim and the MID card does not match:</p> <ul style="list-style-type: none"> <li>• Correct the claim and resubmit on paper or electronically as a new day claim.</li> </ul> <p>If the claim is over the 365-day claim filing time limit:</p> <ul style="list-style-type: none"> <li>• Request a time limit override by submitting the claim and a completed Medicaid Resolution Inquiry form to EDS Provider Services at the address listed on the form. Include a copy of the RA or other documentation of timely filing.</li> </ul> <p>If the claim was originally received and processed within the 365-day claim filing time limit:</p> <ul style="list-style-type: none"> <li>• Resubmit the claim on paper or electronically as a new day claim ensuring that the recipient's MID number, provider number, from date of service, and total billed match the original claim exactly.</li> </ul>	<p>Compare the RA to the information entered on the claim.</p> <p>If the RA indicates the recipient's name, MID number or the date of service have been keyed incorrectly:</p> <ul style="list-style-type: none"> <li>• Correct the claim and resubmit on paper or electronically as a new day claim.</li> </ul> <p>If the claim is over the 365-day claim filing time limit, follow the instructions in Step 1 for requesting a time limit override.</p> <p>If the claim was originally received and processed within the 365-day claim filing time limit, follow the instructions in Step 1 for resubmitting the claim.</p>	<p>Verify that the recipient's eligibility information has been updated in the state eligibility file by calling the AVR system.</p> <p>If the AVR system indicates that the recipient is ineligible:</p> <ul style="list-style-type: none"> <li>• Submit a Medicaid Resolution Inquiry form to DMA Claims Analysis. Include a copy of the recipient's MID card, the claim, and the RA. Mail to:</li> </ul> <p>*DMA Claims Analysis Unit 2501 Mail Service Center Raleigh, NC 27699-2501</p> <p>The Claims Analysis unit will review/update the information in EIS and resubmit the claim. <b>Do not mail eligibility denials to EDS as this will delay the processing of your claim.</b></p>

Refer to **Resolving Denied Claims** on page 8-1 for additional information. Refer to **Appendix A** for information on using the AVR system.

**EOBs for Eligibility Denials**

<b>Article I. EOB</b>	<b>Message</b>	<b>Explanation</b>
10	<b>Diagnosis or service invalid for recipient age.</b>	Verify the recipient's MID number, the date of birth, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to DMA Claims Analysis*.
11	<b>Recipient not eligible on service date.</b>	Follow the instructions outlined in Steps 1, 2, and 3 on page 2-10
12	<b>Diagnosis or service invalid for recipient sex.</b>	Verify the recipient's MID number, the diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. Or, if all information on the claim is correct, send the claim and the RA to DMA Claims Analysis*.
84	<b>Recipient is partially ineligible for service dates. Resubmit a new claim billing only eligible dates of service.</b>	Verify eligibility and coverage dates using the AVR system. Resubmit the claim for eligible dates of service only.
93	<b>Patient deceased per state eligibility file.</b>	Verify the recipient's MID number and the date of service. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID number and the date of service are correct, send the claim and the RA to DMA Claims Analysis*.
120	<b>Recipient MID number missing. Enter MID and submit as a new claim.</b>	Verify the recipient's MID number and enter it in the correct block or form locator. Resubmit to EDS as a new claim.
139	<b>Services limited to presumptive eligibility.</b>	Verify from the recipient's MID card that the recipient was eligible for all prenatal services, delivery, and postpartum care as well as for services required for conditions that may complicate pregnancy on the date of service. If a second "presumptive eligibility" message does not appear on the MID card, send the claim and a copy of the RA to DMA Claims Analysis*.
143	<b>MID number not on state eligibility file.</b>	Follow the instructions in Steps 1 and 2 on page 2-10. Make corrections, if necessary, and resubmit to EDS as a new claim. If the MID card is not available, obtain the recipient's correct MID number through the AVR system by using the social security number and date of birth. If the recipient's social security number is unknown, call DMA Claims Analysis* to obtain the correct MID number.
191	<b>MID number does not match patient name.</b>	Verify the recipient's name and MID number with the MID card. If all information is correct, the denial may have occurred because the recipient's name has been changed on Medicaid records since the MID card was issued. Call EDS to verify the patient's name. Correct and resubmit to EDS as a new claim.
292	<b>Qualified Medicare Beneficiary-MQB Recipient.</b>	If services billed are covered by Medicare, file charges to Medicare. <b>For dates of service prior to October 1, 2002</b> , attach the Medicare voucher to the Medicaid claim. <b>For dates of service after October 1, 2002</b> , enter the Medicare payment on the Medicaid claim. If services are not covered by Medicare, verify eligibility benefits using the AVR system to see if the recipient's eligibility has been changed to full benefits. If so, resubmit the claim to EDS. If the recipient's status is still MQB, no payment can be made by Medicaid for services not paid by Medicare. <b>For dates of service September 6, 2004</b> , attach the Medicare voucher to the Medicaid claim. Professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule.

\* Refer to pg. 2-12 for address.

## 24-Visit Limitation

Ambulatory medical visits are limited to 24 visits per year beginning July 1 of each year through June 30 of the next year. These include any one or a combination of visits to the following: physicians, clinics, optometrists, chiropractors, and podiatrists. Once this limit has been reached, claims will deny with EOB 525, "Exceeds legislative limits for provider visits for fiscal year." Providers should notify the recipient when a denial is received for exceeding the visit limits. Providers may bill the patient the usual and customary charge for the office visit.

Exemptions to the 24-visit limit include:

1. End stage renal disease.
2. Chemotherapy and/or radiation therapy for malignancy.
3. Acute sickle cell disease, hemophilia or other blood clotting disorders.
4. Services rendered to recipients under age 21.
5. Prenatal services.
6. Dental services.
7. Physician inpatient visits to patients in intermediate care facilities or skilled nursing facilities.
8. Mental health services that are subject to independent utilization review.
9. Recipients receiving Community Alternatives Program (CAP) services.
10. Recipients receiving services that are **covered by both** Medicare and Medicaid.

### *24-Visit Limit Exemption Requests*

A provider may request an exemption from the 24-visit limit if a recipient is being treated for an illness that is eminently life threatening. The process to request an exemption usually begins when the provider receives the EOB 525 denial. However, the provider may request an exemption in advance if it is anticipated that the recipient will exceed 24 visits.

Providers must submit the request in letter form, stating the recipient's name and MID card number, and the recipient's primary diagnosis. Medical documentation supporting the exemption should be included with the request. The letter and denied claim, if applicable, must be sent to:

Medical Director  
EDS  
P.O. Box 300001  
Raleigh, NC 27622

The Medical Director reviews each request and responds in writing with either an approval or denial of the exemption. Providers who have obtained an approval will be instructed on how to code claims for processing.

**Note:** Under the requirements for Early Periodic Screening, Diagnostic and Treatment (ESPDT) and for recipients under the age of 21, established limits on services do not apply as long as medical necessity can be validated. Health care services will be provided in a frequency and amount consistent with the recipient's medical needs.

Therefore, should a recipient under the age of 21 require continued care over the 24-visit limit "to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening", whether or not the service is covered under the State Plan, a request for continued service must be submitted. It will be

reviewed and approved, provided medical necessity exists and established criteria are met. Providers should consider obtaining authorization after the eighth visit. If approval is denied or services reduced or terminated, the recipient or his/her representative can appeal this decision.

For a more detailed explanation of ESPDT, see the general discussion regarding ESPDT found on page 1-5 of the Billing Guide and the DMA EPSDT Policy Instructions located on the DMA and DMH web sites.

## Copayments

The following copayments apply to all Medicaid recipients except those specifically exempted by law from copayment:

Service	Copayment
Chiropractic	\$1.00 per visit
Dental	\$3.00 per visit
Prescription Drugs and Insulin	
Generic	\$1.00 per prescription
Brand Name	\$3.00 per prescription
Ophthalmologist	\$3.00 per visit
Optical Supplies and Services	\$2.00 per visit
Optometrist	\$2.00 per visit
Outpatient	\$3.00 per visit
Physician	\$3.00 per visit
Podiatrist	\$1.00 per visit

Providers may bill the patient for applicable copayment amounts, but may not refuse services for inability to pay the copayment. **DO NOT ENTER COPAYMENT AS A PRIOR PAYMENT ON THE CLAIM FORM.** The copayment is deducted automatically when the claim is processed.

## Copayment Exemptions

Providers may not charge copayments for the following services:

- hospital emergency department services including physician services delivered in the emergency department
- family planning services
- services in state-owned psychiatric hospitals
- services **covered by both** Medicare and Medicaid
- services to individuals under the age of 21
- services related to pregnancy
- services provided to residents of nursing facilities, intermediate care facilities for mental retardation (ICF-MR), and psychiatric hospitals
- Health Check-related services
- services provided to participants in the Community Alternatives Programs (CAP)
- services to enrollees of prepaid plans (HMOs) except services not covered under the HMO's plan such as prescriptions and dental services
- Rural Health Clinic (RHC) core services
- Federally Qualified Health Center (FQHC) core services
- nonhospital dialysis facility services
- hospital inpatient services (inpatient physician services **are not** exempt)
- home health services
- hearing aid services
- ambulance services

***Copayment Exemptions (continued)***

- mental health clinic services
- hospice services
- durable medical equipment (DME)
- private duty nursing (PDN) services
- home infusion therapy (HIT)
- dental services provided in a health department
- HIV Case Management

## MEDICAID PROVIDER INFORMATION

### Qualifications for Enrollment

#### *General Requirements*

Licensure – Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Enrollment requirements vary, but most providers must complete an application, provide verification of licensure, if applicable, and complete a N.C. Medicaid participation agreement. All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. For additional information, refer to DMA's website at <http://www.dhhs.state.nc.us/dma/provenroll.htm> or call DMA Provider Services at 1-919-855-4050.

Service Location – Services must be provided at a site location in North Carolina or within 40 miles of the North Carolina border. Out-of-state providers beyond 40 miles of the North Carolina border may enroll in the N.C. Medicaid program to provide emergency or prior approved services only.

Provider Agreements – Most providers sign formal participation agreements with DMA. These agreements contain general requirements for all providers as well as specific requirements for each service type. Physicians, dentists, and other practitioners signify their compliance with the conditions of participation when they submit a claim for payment. Each claim constitutes an agreement for services provided under the claim.

All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to **Reporting Changes in Provider Status** on page 3-5 for information on reporting changes in provider status to the Medicaid program.

#### *Enrollment Procedure*

The enrollment process takes approximately 4 to 6 weeks. However, the process can take longer if supporting documentation from other entities is required. Enrollment periods vary according to provider types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 1-919-855-4050.

Providers are assigned a provider number and are notified by mail once the enrollment process has been completed. Providers are referred to DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm> for Medicaid service information.

#### *Tax Information*

To ensure that 1099 MISC forms are issued to providers correctly, proper tax information must be on file with EDS for all providers. This will also ensure that the correct tax information is provided to the IRS.

The last page of the Remittance and Status Report (RA) indicates the provider tax name and number (FEIN) that Medicaid has on file. Review the RA throughout the year to ensure that the correct provider number information is on file with EDS. The tax information needed for a group practice is as follows:

1. group tax name and group tax number
2. attending Medicaid provider numbers in group

Providers may also verify the tax information by calling EDS Provider Services at 1-800-688-6696 or 919-851-8888.

The procedure for submitting corrected tax information to the Medicaid program is as follows:

- All providers must submit completed and signed W-9 forms along with a completed and signed **Medicaid Provider Change Form** to Medicaid at the address listed below:

Division of Medical Assistance  
Provider Services  
2501 Mail Services Center  
Raleigh, NC 27699-2501

Providers must also report changes of ownership and group practice changes. For more information, refer to **Reporting Changes in Provider Status** on page 3-5.

## **Conditions of Participation**

### *Civil Rights Act*

Providers must comply with Title VI of the Civil Rights Act of 1964, which states “No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance.”

### *Rehabilitation and Disabilities Acts*

Providers must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states “No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from the participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance.”
- **The Age Discrimination Act of 1975**, as amended, which states, “No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.”
- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in or denial of services because the agency’s facilities are not accessible to individuals with a disability.

### *Disclosure of Medicaid Information*

The provider must comply with the requirements of the Social Security Act and federal regulations concerning:

1. Disclosure by providers (other than an individual practitioner or group of practitioners) of ownership and control information; and
2. Disclosure of information on a provider’s owners and other persons convicted of criminal offences against Medicare, Medicaid or the Title XIX services program.

***Medical Record Documentation***

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program. Records must be retained for a period of not less than five years from the date of service unless a longer retention period is required by applicable federal or state law, regulations or agreements. Copies of records must be furnished upon request. Record documentation is used by DMA to determine medical necessity and verify services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

***Payment in Full***

The provider must agree to accept the amount paid for Medicaid covered services as payment in full in accordance with the rules and regulations for reimbursement, promulgated by the Secretary of DHHS and by the State of North Carolina, and established under the Medicaid program, with the exception of authorized copayments by recipients.

***Fee Schedule Requests***

There is no charge for fee schedules or reimbursement plans requested from DMA. The information that is provided is to be used only for internal analysis. Providers must bill their usual and customary rate. Requests for fee schedules and reimbursement plans must be made on the **Fee Schedule Request form** (see page 3-14) and mailed to the address listed on the form. The Fee Schedule Request form may also be faxed to DMA's Financial Operations section at 919-715-0896. Requests by phone are not accepted.

The following fee schedules are also available on DMA's website at <http://www.dhhs.state.nc.us/dma/fee/fee.htm>:

- Community Alternative Program Services
- DEC-CDSA
- Dental Services
- DRG Weight Table
- Durable Medical Equipment
- Federally Qualified Health Center
- Home Health
- Home Infusion Therapy
- Local Health Department
- Medicare Crossover Percentage Payment
- Orthotic and Prosthetic Devices
- Physician
- Rural Health Clinic

## **Provider Responsibilities**

### ***Verifying Recipient Eligibility***

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. Refer to **Verifying Eligibility** on page 2-9 for additional information

### ***Billing the Recipient***

When a noncovered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay **only** if the provider informs the recipient, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

A provider may also bill a Medicaid recipient for:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare.
- The recipient has MEDICARE-AID (MQB-Q) coverage and the service is non-covered by Medicare. (MQB-Q recipients receive a buff MEDICARE-AID card.)
- The provider may bill a patient accepted as a Medicaid patient for allowable Medicaid deductibles or copayments.
- Prescriptions in excess of the six-per-month limit.
- The recipient exceeds the 24-visit limit for provider visits for the state fiscal year (July 1 through June 30).
- The recipient's failure to provide proof of eligibility by presenting a current MID card.
- The patient is no longer eligible for Medicaid as defined in 10 A NCAC 21B.
- The Medicare eligible recipient is receiving psychiatric services that have been designated non-covered by Medicare due to the 37.5 percent psychiatric reduction.

### ***Third Party Liability***

State and federal laws, rules, and regulations for Third Party Liability (TPL) require responsible third party insurance carriers to pay for medical services prior to a provider submitting a claim to Medicaid. Providers are required to seek payment from third party insurance carriers when they know of their existence. A third party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, auto or other liability carriers. DMA's Third Party Recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Refer to **Third Party Liability – Commonly Asked Questions** on page 7-5 for additional information.

### ***Overpayments***

The Program Integrity (PI) section of DMA conducts regular postpayment reviews in an ongoing effort to:

1. Determine a statistical payment accuracy rate for claims submitted by providers and paid by Medicaid.
2. Assure that Medicaid payments are made only for services that are covered under Medicaid policy.
3. Verify that coding on Medicaid claims correctly reflects the services that were provided.
4. Assure that third party carriers are billed before Medicaid was billed and that providers reported any such payments from third parties on claims filed for Medicaid payment.

**When overpayments are identified, providers are given written information about the errors and are required to refund the overpayment amount.**

## **Reporting Changes in Provider Status**

### ***What Changes Must be Reported***

All providers are required to report all changes in status to Medicaid. This includes changes of ownership (within 30 days), name, address, tax identification number, licensure status, and the addition or deletion of group members. Managed Care providers (Carolina ACCESS [CCNC], ACCESS II/III, HMOs, and PCHP) must also report changes in daytime or after-hours phone numbers, counties served, enrollment restrictions, etc.

Failure to report changes in provider status results in incorrect information in the provider's file. This may prevent or delay payments to the provider or providers may be liable for taxes on income not received by their business. CCNC providers must report Medicaid provider number changes immediately to ensure that CCNC management fees are paid correctly.

### ***How to Report a Change***

The process for reporting a change to Medicaid is determined by the provider type. Refer to the back of the **Medicaid Provider Change Form** on page 3-16 to determine the appropriate process for reporting changes in provider status. CCNC providers and ACCESS II/III providers must also report changes using the **Carolina ACCESS Provider Information Change Form** (refer to page 3-18). Both forms are also available on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### ***Voluntary Termination***

All providers must notify DMA in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Managed Care providers (CCNC, ACCESS II/III, HMOs, and PCHP) must also notify DMA's Managed Care section of their decision to terminate. Refer to page 4-6 for additional information.

### ***Termination of Inactive Providers***

Medicaid provider numbers that do not reflect any billing activity within the previous 12 months will be terminated. Providers are notified by mail of DMA's intent to terminate their inactive number and will have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

### ***Payment Suspension***

If RAs and checks cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RA and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, claims in suspension deny and the provider number is terminated.

### ***Licensure Revocation or Suspension***

Any provider or facility whose license(s) is revoked or suspended is not eligible for participation in the N.C. Medicaid program. In the event that a provider who is licensed by the Division of Facility Services (DFS) should have their license/certification revoked or suspended, either DFS or the Centers for Medicare and Medicaid Services (CMS) will notify DMA. All other providers should notify DMA immediately. Managed Care providers must also notify DMA's Managed Care section of any licensure revocation or suspension.

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested in writing by the provider or the facility. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

### ***Sanctions***

Providers who receive sanction(s) from CMS may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under a CMS sanction(s). CMS will notify DMA of providers who are sanctioned. Individual practitioners who are sanctioned should notify DMA immediately.

## **Program Integrity Reviews**

### ***Determining Areas for Review***

PI reviews are initiated for a variety of reasons. The following are some common examples (list not all-inclusive):

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies or other DMA sections.

- PI uses a sophisticated Fraud and Abuse Detection System (FADS), which consists of two software products called HealthSPOTLIGHT™ and OmniAlert™.
  1. HealthSPOTLIGHT™ uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.
  2. OmniAlert™ is PI's new client server Surveillance and Utilization Review System (SURS). OmniAlert™ is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
  3. Additional features such as claims imaging, the claims data warehouse, and ad hoc query tools along with FADS software also make detection and investigation faster.
- Special ad-hoc DRIVE computer reports that target specific issues, procedure codes or duplications of services, etc.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.
- PI staff also conducts a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.
- EDS refers questionable services identified during claims processing to PI.

#### ***Provider Responsibilities with a Program Integrity Review***

If you are notified that PI has initiated a review, you can ensure that the review will be both positive and educational by adhering to the following steps:

- PI will request medical or financial records either by mail or in person. EDS, as the fiscal agent for DMA, may also request records. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
  1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. (Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in a duplication of your refund.)
  2. If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DMA Hearing Unit (at the address on the letter) and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Personal Hearings – These are held in Raleigh and the Hearing Unit will assign the date, time and place. You will be notified in writing of the Hearing Officer's final decision after the personal hearing.

Paper Reviews – You may instead send any additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Miscellaneous

- For assistance or education, please call EDS at 919-851-8888 or 1-800-688-6696 and request a provider education visit.
- When calling EDS or DMA to get clarification of a policy, it is helpful if you record the date, name of staff person talked with, the policy issue discussed, and a summary of the guidance given.
- It is the provider's responsibility to maintain the medical coverage policies and Medicaid bulletins and ensure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to and follow these Medicaid guidelines.

***Self-Referral Federal Regulation***

For Medicaid payments, OBRA 1993 prohibits self-referral by a physician to designated health services in which the physician has certain ownership or compensation arrangements. Designated health services include the following:

- |   |   |
|---|---|
| • clinical laboratory services                              | • eyeglasses  |
| • outpatient drugs  | • radiation therapy services  |
| • durable medical equipment                                 | • inpatient and outpatient hospital services  |
| • parenteral and enteral nutrition equipment and supplies   | • radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services) |
| • comprehensive outpatient rehabilitation facility services | • hearing aids  |
| • contact lenses  | • home dialysis   |
| • physical and occupational therapy services                | • home health services  |
| • home infusion therapy services                            | • ambulance services  |
| • prosthetic and orthotic devices                           |   |

If postpayment review determines that inappropriate payments were made due to the provider's failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in section 1877 of the Social Security Act.

**Advance Directives**

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (e.g., living will or health care power of attorney).

Effective January 1, 1998, a new law entitled "An Act to Establish Advance Instruction for Mental Health Treatment" (NCGS §122C-71–§122C-77) became effective. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (i.e., lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record.

DMA, in conjunction with an advisory panel, has developed the required summary of state law concerning patients' rights that must be distributed by providers. This brochure is entitled *Medical Care Decisions and Advance Directives: What You Should Know*. A print-ready copy is available on page 3-20.

The two-page brochure can be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Indicate in the box on the last page a contact for the patient to obtain more information. The brochure should be copied as is. If providers choose to alter the document graphically, they may not change or delete text, or the order of paragraphs. A provider-published pamphlet must include the N.C. DHHS logo and production statement on page four of the folded brochure.

### Provider Information – Commonly Asked Questions

#### 1. What are the requirements for enrollment in the N.C. Medicaid program?

Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application, provide verification of licensure, if applicable, and complete a Medicaid participation agreement.

#### 2. How long does it take to complete the enrollment process?

The enrollment process takes approximately 4 to 6 weeks if all supporting documentation has been included with the application. Providers receive written notification once the enrollment process has been completed.

#### 3. Where can I get an enrollment application?

- Applications for enrollment as a **Medicaid provider** are available from DMA Provider Services at the address listed below and also on the website at the following address: <http://www.dhhs.state.nc.us/dma/provenroll.htm>.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

- Applications for participation as a **CCNC provider** are also available on DMA's website at <http://www.dhhs.state.nc.us/dma/provenroll.htm>.

#### 4. How do I enroll as a Medicaid Managed Care provider?

- Applications for participation as a **CCNC provider** are available from DMA's website at <http://www.dhhs.state.nc.us/dma/provenroll.htm>.
- To enroll as an ACCESS II/III provider, contact the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.
- To enroll as an HMO provider in Mecklenburg County, contact the HMO directly.
- To enroll as a Piedmont Cardinal Health Plan (PCHP) provider, contact Piedmont Provider Relations at 1-800-958-5596.

For additional information, contact DMA Provider Services at 919-855-4050 or the regional Managed Care Consultant for your county.

**5. How are group provider numbers assigned?**

Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. If a group practice has 10 sites, each site has to have a separate provider number. Individual providers do not have to have separate numbers if they practice at more than one site; their individual numbers can be “floated” from one group to another. Groups must notify DMA when an individual practitioner is added to or deleted from their group practice.

**6. What is the enrollment process for physician assistants?**

The Medicaid program does not enroll physician assistants. Services rendered by physician assistants employed by a physician or physician’s group are billed under the supervising physician’s provider number.

**7. When can I begin billing for services I have rendered to Medicaid recipients?**

Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, assigned a provider number, and agree to certain conditions of participation before payment can be made for services rendered to Medicaid recipients. The effective date on the participation agreement or EDS enrollment letter (to physicians) is the date a provider can begin billing for services.

**8. How often do I have to re-enroll as a Medicaid provider?**

Enrollment periods vary according to service types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 919-855-4050.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider.

All providers are responsible for ensuring that information on file with N.C. Medicaid for their service or facility remains up to date.

**9. Is it necessary for a physician who already has a Medicaid provider number to re-enroll with the Medicaid program if he/she transfers to a new practice?**

No. A physician will usually keep the same provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician’s individual provider number is active.

**10. Are we required to apply for a new provider number if our group merges with another group and our group tax ID number changes?**

Yes. A provider must apply for a new group provider number but the provider’s individual provider numbers will remain the same. If you are merging groups but will still have separate locations, each office site must apply for a new group provider number.

**11. Are individual providers required to apply for a new provider number if there is a change to the tax ID number?**

No. But, providers must notify the Medicaid program of the tax ID number changes.

**12. How do I contact the Medicaid program to report changes to my provider status?**

The process for reporting changes to provider status is determined by service type. Refer to **How to Report a Change** on page 3-5 for information on reporting changes in your provider status to the Medicaid program.

**13. I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. Who do I report this change to?**

Changes must be reported to DMA Provider Services using the **Carolina ACCESS Provider Information Change form** (see page 3-18).

If the Medicaid provider number that is changing is also your CCNC provider number, DMA's Provider Services must be alerted as soon as possible to ensure that the CCNC management fee is paid properly and to prevent claim denials. Until you receive notification that your CCNC number has been changed, claims filed using your new Medicaid provider number must also include your old Medicaid provider number (current CCNC number) in block 19 of the CMS-1500 claim form. It is imperative that you use your active CCNC number when you refer patients.

**14. If our practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, who do I contact when there is a change in our practice's provider number?**

CCNC providers must report all changes to DMA Provider Services using the **Carolina ACCESS Provider Information Change form** (see page 3-18). When reporting a change in ownership, CCNC providers must submit a new Carolina ACCESS enrollment application package.

All providers must report changes to DMA using the **Medicaid Provider Change Form** (see page 3-16).

**15. If our practice is participating in an HMO with the Medicaid program, who do I contact when there is a change in our practice's provider information?**

HMO providers must report all changes to their HMO(s).

**16. My organization participates with the Medicaid program as an administrative entity for ACCESS II/III. Who do I contact when there is a change in our provider status?**

Report changes to the Office of Research, Demonstrations, and Rural Health Development at 919-715-7625.

**17. My organization contracts with Medicaid as an HMO Risk Contracting Managed Care plan. Who do I contact when there is a change in our provider status?**

Report changes to DMA Provider Services using the **Medicaid Provider Change Form** (see page 3-16).

**18. I am currently enrolled as a Community Alternatives Program (CAP) provider. How do I amend my enrollment to include additional services?**

CAP providers who are currently enrolled in the Medicaid program must send a completed enrollment application and verification of appropriate licensure and certification to DMA Provider Services at the address listed below. However, it is not necessary to complete a new agreement. Applications may be obtained from DMA Provider Services at the address listed below or on DMA's website at <http://www.dhhs.state.nc.us/dma/provenroll.htm>.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**19. Can the effective date of a provider number be changed?**

Requests to change the effective date of a group provider number must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the group provider number and the effective date that you are requesting. Requests will be reviewed and providers will be notified of the decision.

Requests to change the effective date of an individual provider number must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the individual provider number, the effective date that you are requesting, and a copy of the provider's license covering the effective date. Requests will be reviewed and providers will be notified of the decision.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**20. My specialty is listed incorrectly. How do I correct it?**

Requests to change a provider's specialty must be submitted in writing to DMA Provider Services at the address listed below. Requests must be written on letterhead and include the provider number and correct specialty.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**21. How do I terminate my enrollment as a Medicaid provider?**

Providers must notify DMA Provider Services in writing at the address listed below of their decision to terminate their participation in the Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager or administrator.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**22. How do I terminate my enrollment as a Managed Care provider?**

Managed Care providers (Carolina ACCESS [CCNC], ACCESS II/III) must notify DMA Provider Services at least 30 days in advance in writing of their decision to terminate their participation in the Managed Care program. Notification must be sent by registered mail with return receipt request to the address listed below.

Division of Medical Assistance  
Provider Services  
2501 Mail Service Center  
Raleigh, NC 27699-2501

Sample of Fee Schedule Request Form

Fee Schedule Request Form

There is no charge for fee schedules or reimbursement plans requested from the Division of Medical Assistance (DMA). DMA stipulates that the information provided is to be used only for internal analysis. Providers are expected to bill their usual and customary rate. All requests for fee schedules and reimbursement plans must be made on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Financial Operations - Fee Schedules
2501 Mail Service Center
Raleigh, N. C. 27699-2501

Or fax your request to DMA's Financial Operations section at 919-715-0896.

NOTE: PHONE REQUESTS ARE NOT ACCEPTED

- Advanced Practice Psychiatric Clinical Nurse Specialist
Advanced Practice Psychiatric Nurse Practitioner
After Care Surgery Period
Ambulatory Surgery Center
Anesthesia Base Units
Community Alternatives Program
Dental
Durable Medical Equipment
Health Department
Home Health
Home Infusion Therapy
Hospital Reimbursement Plan
ICF/MR Reimbursement Plan
Laboratory
Licensed Clinical Social Worker
Licensed Psychologist
Nurse Midwife
Nurse Practitioner
Nursing Facility Reimbursement Plan
Optical and Visual Aids
Orthotics and Prosthetics
Physician Fees (includes x-ray and laboratory)
Portable X-ray

Name of Provider/Facility Provider Type:

Address: Provider #:

Contact Person: Phone:

**Sample of Fee Schedule Request Form, continued**

Request for Diskettes – Provider fee schedules, the after-care surgery schedule, and the anesthesia base units schedule are also available on **diskette** or by **e-mail**.

**NOTE:** To reduce costs, where available, schedules will be sent by e-mail.

DMA stipulates that the information provided is to be used only for internal analysis. **Providers are expected to bill their usual and customary rate.**

Please complete the information below with each request:

Name of Provider/Facility: \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of File (circle one):

Format (circle one):

Text File    Excel Spreadsheet

e-mail            diskette

Type of Schedule on Diskette (check):

- Advanced Practice Psychiatric Clinical Nurse Specialist
- Advanced Practice Psychiatric Nurse Practitioner
- After Care Surgery Period
- Ambulatory Surgery Center
- Anesthesia Base Units
- Dental
- Health Department
- Laboratory
- Licensed Clinical Social Worker
- Licensed Psychologist
- Nurse Midwife
- Optical and Visual Aids
- Physician Fees (includes x-ray)
- Portable X-ray

Mail the request to:

Division of Medical Assistance  
Financial Operations – Fee Schedules  
2501 Mail Service Center  
Raleigh, North Carolina 27699-2501

Or **fax** your request to DMA’s Financial Operations section at **919-715-0896**.

Sample of Medicaid Provider Change Form, continued

**MEDICAID PROVIDER CHANGE FORM**

Date: \_\_\_\_\_

Medicaid Provider Number (Required): \_\_\_\_\_

Medicaid Provider Name: \_\_\_\_\_

Type of Provider: (select one)

<input type="checkbox"/> Group Provider	<input type="checkbox"/> Individual Provider	<input type="checkbox"/> Other _____
---	--	--------------------------------------

Type of Change: (select all that apply)

<input type="checkbox"/> Change of Business Name (attach completed W-9)	<input type="checkbox"/> Change of Ownership (attach completed W-9)	<input type="checkbox"/> Change of Tax ID Number (attach completed W-9)	<input type="checkbox"/> Address Change and Termination
--	--	--	--

Terminate Medicaid Participation Effective date): \_\_\_\_\_

Reason: \_\_\_\_\_

Change Medicaid Provider Physical Address to: \_\_\_\_\_  
(If applicable, attach a copy of facility license) \_\_\_\_\_

Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Change Medicaid Provider Payment Address to: \_\_\_\_\_

Add or Delete Participating Individual Provider(s) to/from Medicaid Group:

	Individual Provider Name	Individual Medicaid Provider Number (Required)	Social Security Number	License Number
<input type="checkbox"/> add <input type="checkbox"/> delete				
<input type="checkbox"/> add <input type="checkbox"/> delete				
<input type="checkbox"/> add <input type="checkbox"/> delete				
<input type="checkbox"/> add <input type="checkbox"/> delete				

**Note:** If you are a Carolina ACCESS provider, please complete the Carolina ACCESS Provider Change Form on our website at <http://www.dhhs.state.nc.us/dma/Forms/capicf>.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Typed or Printed Name and Title of Authorized Signature Above

Mail this form to: DMA Provider Services, 2501 Mail Service Center Raleigh, NC 27699-2501 or fax to 919-715-8548.

(Revised 11/30/04)

## Sample of Medicaid Provider Change Form, continued

**All Carolina ACCESS and ACCESS II Providers must, also, complete the [Carolina ACCESS Provider Change Form](#) or obtain a copy of the form by calling Provider Services @ 919-855-4050.**

**These Medicaid providers must report all changes to the Division of Medical Assistance using this form.**

**ACCESS II Providers & Administrative Entities – Also, report changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-715-7625).**

Ambulance Services

Certified Registered Nurse Anesthetists

Chiropractors

Community Alternative Program Services - DMA Provider Services contacts you to obtain additional information as needed to complete your change request.

Dentists

Developmental Evaluation Centers

DSS Case Management

Durable Medical Equipment Services - **Include a copy of your new license.**

Federal Qualified Health Centers

Head Start Programs

Health Departments

Hearing Aid Dealers

HIV Case Management

Home Infusion Therapy Services - **Include a copy of your new license.**

HMO Risk Contracting Managed Care Plans

Independent Diagnostic Treatment Facilities

Freestanding Birthing Centers - Include a copy of your new accreditation from the Commission of Free-Standing Birthing Center

Independent Freestanding Laboratories - Include a copy of your new CLIA certificate.

Independent Practitioners (Audiologists, Occupational Therapists, Physical Therapists, Respiratory Therapists, Speech Therapists)

Licensed Clinical Social Workers

Licensed Psychologists

Mental Health Centers

Nurse Midwives

Nurse Practitioners

Optical Services

Optometrists

Osteopaths

Out-of-State Hospitals

Personal Care Services - **Include a copy of your new license.**

Physicians

Planned Parenthood Programs

Pharmacies - Include a copy of your new license.

Private Duty Nurses - Include a copy of your new license.

Psychiatric Clinical Nurse Specialist

Psychiatric Nurse Practitioners

Public School Health Programs

Residential Evaluation Centers

School Based Health Centers

**The providers listed here must also report changes to the Division of Facility Services by calling (919) 733-1610.**

Adult Care Homes

Ambulatory Surgical Centers

Critical Access Hospitals

Dialysis Centers

Home Health Agencies

Hospice

Intermediate Care/Mental Retardation Facilities

In-State Hospitals

Nursing Facilities

Portable X-Ray Suppliers

Psychiatric Residential Treatment Facilities

Residential Child Care Facility (Level II – IV)

Rural Health Clinics

Sample of Carolina ACCESS Provider Information Change Form

**CAROLINA ACCESS PROVIDER INFORMATION CHANGE FORM**

For DMA Office Use Only			
EIS _____	EDS _____	ACCESS _____	COUNTY _____

Date: \_\_\_\_\_

CA Practice Name: \_\_\_\_\_

CA Practice Provider Number: \_\_\_\_\_ County: \_\_\_\_\_

**This CA practice requests the following change(s) be made to their CA application and information contained in CA databases:**

Change **CA practice name** to: \_\_\_\_\_  
Please make change effective for CA (date): \_\_\_\_\_

Change **CA practice provider number** to: \_\_\_\_\_ Make change effective for CA (date): \_\_\_\_\_  
Reason for number change: \_\_\_\_\_

**Terminate** CA practice provider number effective (date): \_\_\_\_\_ Reason: \_\_\_\_\_

Change **enrollment restriction information (i.e., ages 15 and up only)**: \_\_\_\_\_  
New enrollment restriction code(s): \_\_\_\_\_

**Delete provider(s)** from practice: \_\_\_\_\_

**Add participating provider(s)** to practice: (Note: Medical license number of all new provider(s) and individual Medicaid provider number of new physician(s) **must** be included.)

Provider Name	Title	License Number	Individual Medicaid Provider Number (MDs Only)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Change **CA practice site address** to: \_\_\_\_\_

Change **CA practice mailing address** (if different from site address) to: \_\_\_\_\_

Change **telephone** number to: \_\_\_\_\_ Change **after-hours** telephone number to: \_\_\_\_\_

Change **enrollment limit** from: \_\_\_\_\_ to: \_\_\_\_\_ (Note: maximum 2000 per participating provider in this practice.)

Change **contact person** to: \_\_\_\_\_ Title: \_\_\_\_\_

**Add county(ies) served:** \_\_\_\_\_ **Delete county(ies) served:** \_\_\_\_\_

**Comments/Other:** \_\_\_\_\_

**Form Completed By:** \_\_\_\_\_ **Title:** \_\_\_\_\_

Note: Please fax form to the **DMA Provider Services** at **(919) 715-8548** Changes will be entered in the database(s) and changes made to the CA application on file.

(Revised 10/01)

## Sample of Carolina ACCESS Provider Information Change Form, continued

This form is intended for use when making a change in the information originally provided on the Carolina ACCESS (CA) PCP application. Providers are also responsible for ensuring that information on file with the **Medicaid** program for their practice or facility remains up-to-date. (Please refer to the January 2001 Special Bulletin I, *Provider Enrollment Guidelines* for information on notifying Medicaid of a change within your practice.) Medicaid bulletins and other valuable information are available on the Division of Medical Assistance's Internet web site at <http://www.dhhs.state.nc.us/dma>.

Multiple changes may be indicated on the same change form. The following information **must** be included for each change request:

- CA practice name
- CA practice provider number
- Name and title of the person at the practice requesting the change

Fax the completed form to DMA Provider Services at (919) 715-8548. **Note:** It is not necessary to fax the back of the form (instructions) with the change form.

When changing a CA practice provider number, the reason for the number change **must** be provided. When terminating a CA practice provider number, DMA will disenroll all enrollees from your practice effective on the first day of the next calendar month provided that the request is received prior to the 12<sup>th</sup> working day before the last day of the month. Requests received after that day will be made effective on the first day of the month following the next calendar month. Therefore, enrollees **may** remain enrolled **through the end of the month** following the notification of changes. Providers will be notified of the effective date of the termination.

When adding a participating provider to a practice, the provider's title (e.g., M.D., N.P., Midwife, P.A.) and the medical license number must be included for **all** new providers. The physician's individual Medicaid provider number **must** also be included on the form. For nurse practitioners, midwives, or physician assistants only the license number is required. If any of the required information is missing from the change form, the provider(s) cannot be listed as a CA provider with the practice.

A new CA application is required when **any** of the following occurs:

- The provider or representative who signed the CA Agreement is no longer with the practice.
- The practice has had a change in ownership.
- All the providers in the practice have changed since the original application and Agreement were signed.
- Multiple change forms have been submitted and the original application is no longer valid.

If a change form is submitted, but it is deemed appropriate to request a new CA application, the provider will be contacted by DMA

**Note: When a new CA application and Agreement are sent to replace an existing application on file and the provider ID number is changing with the new application, a change form requesting the termination or cross referencing of the old number should be submitted together with the new application. This will prevent problems with management fee(s) and claim(s) payment(s). A new CA application can be obtained by calling DMA Provider Services at 919-857-4017.**

**Enrollment Restriction Codes**

- 01** No restriction
- 02** Established patients only
- 06** MPW only (pink card)
- 07** Dialysis patients-including nephrology-only (in same or contiguous counties)
- 08** Chronic infectious disease patients only (in same or contiguous counties)
- 09** Oncology patients only (in same or contiguous counties)
- 10** Established patients and siblings
- 11** Newborns only
- 14** Two track clinics: facilities serving two distinct populations
- 15** Age restriction

**Please call DMA Provider Services at 919-857-4017 if there are questions about the change form or the Carolina ACCESS application process.**

## Sample of Advance Directives Brochure

## Medical Care Decisions and Advance Directives What You Should Know

doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

### Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

### Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

### What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

### Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

### What are My Rights?

#### Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

#### What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

#### Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.



the Department of Health and Human Services

*This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.*

## Sample of Advance Directives Brochure, continued

**Living Will****What is a living will?**

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

**Health Care Power of Attorney****What is a health care power of attorney?**

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

**How should I choose a health care agent?**

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

**Advance Instruction for Mental Health Treatment****What is an advance instruction for mental health treatment?**

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

**Other Questions****How do I make an advance directive?**

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

**Are there forms I can use to make an advance directive?**

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

**When does an advance directive go into effect?**

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

**What happens if I change my mind?**

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

**MANAGED CARE PROVIDER INFORMATION****Community Care of North Carolina**

Community Care of North Carolina (CCNC) is comprised of the two programs formerly known as Carolina ACCESS (CA) and ACCESS II/III. The majority of Medicaid recipients in all 100 counties in North Carolina are enrolled in the CCNC program. Primary care physicians (PCPs) enroll as CCNC providers to provide service and bill on a fee-for-service basis. PCPs are reimbursed according to the Medicaid rate schedule. All of the guidelines and policies documented in this section apply to all PCPs participating in the CCNC programs.

***CCNC - Carolina ACCESS***

Carolina ACCESS (CCNC) was initiated in 1991 as Medicaid's primary care case management (PCCM) program. CCNC allows Medicaid recipients easier access to the private provider community and reduces the necessity for recipients to seek care from hospital emergency departments for non-emergent conditions. PCPs coordinate care for enrollees by providing and arranging for the recipient's health care needs.

Participating PCPs receive a monthly management fee of \$1.00 per member per month for coordinating the care of Medicaid recipients enrolled with their practices. They also receive fee for service when treating their patients.

***CCNC - ACCESS II/III***

ACCESS II/III (CCNC) is a community-based enhanced PCCM program designed to bring PCPs, hospitals, health departments, county departments of social services (DSS), and other community providers together to manage the health care needs of Medicaid recipients. ACCESS II/III (CCNC) enrollees also have care managers who assist in developing, implementing, and evaluating the care management strategies at each site. These care management strategies include:

- Risk assessment process – utilizing an “at-risk” screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees.
- Implementing disease management processes – including, but not limited to, pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those enrollees at risk.
- Identifying high costs and high users – developing and implementing activities that impact utilization and cost.
- Developing pharmacy initiatives to alleviate the high cost of medications.

Currently, there are 14 ACCESS II/III (CCNC) plans, which are expanding to include CA (CCNC) practices throughout the state. Participating ACCESS II/III PCPs receive \$2.50 per enrollee per month. Each plan is directed by a local administrative entity and is paid an additional \$2.50 per enrollee per month to develop and implement care management strategies. ACCESS II/III (CCNC) is jointly administered by the Office of Research, Demonstration, and Rural Health Development and the Division of Medical Assistance (DMA).

The following table lists the administrative entities for ACCESS II/III (CCNC).

ACCESS Care II of Western N.C.	Community Care Plan of Eastern N.C.
ACCESS III of Lower Cape Fear	Community Health Partners
ACCESSCare, Inc.	Partnership for Health Management
Cabarrus Community Care Plan	Sandhills Community Care Network
Carolina Community Health Partnership	Wake County ACCESS II
Central Piedmont ACCESS II	Northern Piedmont Community Care
Community Care Partners of Greater Mecklenburg	Carolina Cooperative Community Care

### Managed Care Recipient Enrollment

The county DSS is responsible for recipient enrollment in Managed Care programs. CA enrollment (CCNC) is mandatory for most Medicaid recipients. For some Medicaid recipients, enrollment with CA (CCNC) is optional. [For example, recipients are eligible for both Medicare and Medicaid not required to enroll with CA (CCNC).]

Medicaid recipients who are required to enroll with CA (CCNC) (mandatory enrollees) must select a PCP from the list of participating PCPs in their county of residence. If they do not choose a PCP, the county DSS will assign enrollees to an appropriate PCP. Each family member can select their own PCP.

Enrollees may request to change their PCP at any time. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Enrollment is limited to 2,000 recipients per physician or physician extender, unless otherwise approved by the Division of Medical Assistance (DMA).

Enrollees are responsible for all copayments required by Medicaid. Refer to **Copayments** on page 2-16 for additional information.

CA (CCNC) enrollees are identified by the information on their Medicaid identification (MID) card. "Carolina ACCESS Enrollee" appears on the card along with the PCP's name, address, and daytime and after-hours telephone numbers.

Refer to **Verifying Eligibility** on page 2-11 for information on verifying recipient eligibility.

### Recipient Education

The county DSS is responsible for recipient education. Enrollees are provided with a recipient handbook (available in English and Spanish) that informs them of their rights and responsibilities. However, as the coordinator of care, it is also important for PCPs to be actively involved in patient education. CA (CCNC) PCPs are strongly encouraged to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly **Carolina ACCESS Provider Enrollment Report**. Refer to page 4-17 for an example of the report.

Providers should address the following subjects with each new enrollee:

- The PCP's provides medical advice 24 hours per day, 7 days per week and the preferred method for contacting the PCP.
- The enrollee's responsibility to bring his/her **current** month's Medicaid card to each appointment.
- The enrollee must contact the PCP for a referral before going to any other doctor.
- The enrollee must contact the PCP before going to the emergency department unless the enrollee feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as Health Check screenings for children, immunizations, checkups, mammographs, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the county DSS.
- Copayment requirements.

## **Carolina Access Provider Participation**

### ***Requirements for Participation***

DMA Provider Services and DMA Managed Care work closely together to administer the Carolina ACCESS (CCNC) program. DMA Provider Services is responsible for the CA (CCNC) application process and enrollment of providers into the program. DMA Managed Care is responsible for establishing PCP participation requirements, working with providers to answer CA (CCNC) policy questions and to assist providers with the program. Questions about the CA (CCNC) program or requirements for participation can be answered by the Regional Managed Care Consultants or by contacting DMA Managed Care at 919-647-8170.

Carolina ACCESS requires providers to complete and submit a signed application and agreement indicating their compliance with all participation requirements. The **CA Provider Enrollment Packet** is available on DMA's website at <http://www.dhhs.state.nc.us/dma/caenroll>. The application and the agreement must each contain the original signature of the authorized representative (or a participating provider.) Applications may be pended for a maximum of ninety (90) days from the date of receipt of the application by DMA Provider Services. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time unless a sanction has been imposed upon the provider's participation by the Managed Care Section.

Every County Department of Social Services is notified weekly of new CA (CCNC) providers and changes in current CA (CCNC) provider information. Providers are required to report any changes regarding their practice's status to DMA Provider Services. To report changes to the Medicaid program (see page 3-5), CA (CCNC) providers must submit a signed **Carolina ACCESS Provider Information Change Form** (see page 3-18.)

The following requirements must be met for a provider to be approved as a CA (CCNC) Primary Care Provider (PCP):

1. Accept North Carolina Medicaid payment as payment in full, practice in the state of North Carolina (NC) or within forty (40) miles of the borders of NC and have an active NC Medicaid provider number for use as the CA (CCNC) provider number.
2. Must have an active license for each provider in the practice. Each physician and doctor of osteopathy must also have an active individual Medicaid provider number. Each participating nurse practitioner and certified nurse midwife who has been issued an individual Medicaid provider number must also disclose their individual provider number on the CA (CCNC) provider application. The information on file for each individual Medicaid provider number must be consistent with the information provided in the CA (CCNC) application for participation.
3. Be enrolled as one of the following Medicaid provider types to participate as CA (CCNC) PCPs:

• family medicine	• gynecologists
• general practitioners	• internists
• nurse practitioners	• Federally Qualified Health Centers
• osteopaths	• health departments
• pediatricians	• rural health clinics
• obstetricians	

**Note:** Physician Assistants do not directly enrolled in Medicaid at this time, but may participate in Carolina ACCESS through their supervising physician and enroll with Carolina ACCESS using the supervising physician Medicaid number.

4. Enroll each CA (CCNC) location with a separate provider number which is site specific. Practices operating as a group should enroll with a site specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the NC Medicaid Program, and, therefore, must be site specific. The CA (CCNC) PCPs practice name, address, daytime and after-hours telephone numbers are printed on the enrollees' Medicaid identification (MID) card.
5. Should enroll with CA (CCNC) using a group number, if applicable, for ease of claims filing, referrals, management of reports, and accurate financial reporting to the IRS.  
**Note:** All CA (CCNC) management fees are generated under the CA (CCNC) provider number and this number is also the authorization given to other providers of service when appropriate.
6. Indicate the maximum number of enrollees that will be accepted for the site and also any specific enrollment restrictions such as age or gender on the initial application. Enrollment of Medicaid recipients is capped at 2000 per participating provider (MD, DO, PA, NP or CNM).  
**Note:** Providers who do not accept Medicare shall not have CA (CCNC) enrollees who have Medicare coverage assigned to their practice.
7. List all contiguous counties from which the practice will accept CA (CCNC) enrollees on the application. These counties must only include the county in which the practice is located and the bordering counties, since the provider must be accessible for primary care.

8. Disclose information regarding sanctions or termination by the Medicaid Program or the Carolina ACCESS Program on the CA (CCNC) application. Refer to *Sanctions* for complete information on page 4-6.
9. Establish and maintain hospital admitting privileges or enter into a formal agreement with another physician or group practice for the management of inpatient hospital admissions of CA (CCNC) enrollees. If the CA (CCNC) practice does not admit patients and provide age appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the **Carolina ACCESS Hospital Admitting Agreement** form must be submitted to DMA Provider Services to address this requirement for participation.
10. Must have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week.
11. Provide access to medical advice and care for enrolled recipients 24 hours per day, 7 days per week. Refer to *24-Hour Coverage Requirements* on page 4-8.
12. Must make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.
13. The medical components listed below must be indicated on the application and must encompass all requirements for the specified ages of recipients to be enrolled in the practice. For example, if a provider wishes to enrollee recipients ages 2 through 20 they must agree to provide all components for each age category, 2 through 20.

**Note:** PCPs who request CA (CCNC) participation for Medicaid for Pregnant Women (MPW) enrollees only are exempt from the preventive and ancillary services requirements.

### ***Conditions of Participation***

When a provider agrees to participate with CA (CCNC), he/she agrees to:

1. Develop patient/physician relationships
2. Manage the health care needs of recipients
3. Provider mandatory preventive services
4. Authorize and arrange referrals, when necessary, for health services that the primary care practice does not provide
5. Review and use recipient utilization, emergency room enrollment, and referral reports
6. Follow standards of appointment availability

In addition to the conditions of participation for Medicaid providers listed on page 3-2, CA (CCNC) providers must comply with section 1932 (b)(7) of the Social Security Act, which states “the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider’s license or certification under applicable State law solely on the basis of provider’s license or certification.”

### ***Exceptions***

Exceptions to a requirement for participation may be granted in cases where it is determined the benefits of a provider’s participation outweigh the provider’s inability to comply with this requirement. The provider shall submit a written request to the Division of Medical Assistance for consideration for exception for a specific agreement requirement. The request shall include the reasons for the Contractor’s

inability to comply with this agreement. The request shall be submitted at the time this agreement is submitted to DMA for consideration. Approval of the application constitutes acceptance of the request for exception.

***Sanctions***

Failure to meet the terms outlined in the CA (CCNC) provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly management/coordination fee may be withheld.
- The PCP may be referred to DMA Program Integrity (PI) for investigation of potential fraud or for quality of care issues.
- The PCP may be referred to the North Carolina Medical Board.
- The PCP may be terminated from the CA (CCNC) program.

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

***Sanction Appeals***

The PCP is notified by certified mail of the sanction and the right to appeal the sanction.

DMA must receive the PCP's request for a formal evidentiary hearing by the DMA Hearing Unit no later than 15 calendar days after the receipt of the sanction notice. The hearing provides an opportunity for all sides to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself or may enlist the services of an attorney or designate a representative. The findings are documented by the DMA hearing office and presented to the DMA Director who makes the final determination to uphold or rescind the sanction. The PCP is notified by certified mail of the Director's decision.

PCPs that are terminated from the CA (CCNC) program – or voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year with a maximum time period to be determined by the Managed Care section. The decision is predicated on the extent or severity of the contract violation necessitating the termination.

***Terminations***

The PCP's agreement to participate in the CA (CCNC) program may be terminated by either the PCP or DMA, with cause, or by mutual consent, upon at least 30 days written notice delivered by registered mail with return receipt requested and will be effective on the first day of the month, pursuant to processing deadlines.

**Carolina ACCESS Provider Reports**

The goals of the CA (CCNC) program are to improve access to primary care and to provide a more cost efficient health care system. It is the responsibility of the PCP to manage effectively the care of their enrollees. DMA provides four reports to assist PCPs with this goal.

***Enrollment Report***

DMA's Managed Care section provides PCPs with a monthly **CA Provider Enrollment Report**. The report consists of three sections: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the Managed Care Consultant or the county DSS. PCPs must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported until the change or error has been resolved and reported correctly. Refer to page 4-17 for an example of the report.

***Emergency Room Management Report***

The **Emergency Room Management Report** lists the PCP's enrollees for whom emergency department visits were paid for the month listed on the report. It is very important to review this report to determine enrollees who are using the emergency department inappropriately and to develop strategies to redirect these enrollees to the appropriate setting. PCPs may need to evaluate their after-hours message or procedures or collaborate with an urgent care center to provide the most cost-effective after-hours care. Refer to page 4-21 for an example of the report.

***Referral Report***

DMA provides CA (CCNC) PCPs with a monthly Referral Report providing information on where and when enrollees obtained services during the month. The report is available to PCPs on paper or diskette. Refer to page 4-22 for an example of the report.

***Quarterly Utilization Report***

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost effective primary care. An example of the report and instructions for using the report are available beginning on page 4-24.

**Carolina ACCESS Provider Requirements*****Health Check Services***

CA (CCNC) PCPs are required to provide Health Check preventive care screenings to Medicaid-eligible children age birth through 20. PCPs serving this population who do not provide Health Check services are required to sign an agreement with the local health department to provide Health Check services. PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer to page 4-26 or to DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html> for a copy of the **Health Department Health Check Agreement**.

Refer to the **Health Check Billing Guide** which is printed every year as a special bulletin for screening requirements. The special bulletin will be located on DMA's website at [www.dhhs.state.nc.us/dma/bulletin.htm](http://www.dhhs.state.nc.us/dma/bulletin.htm).

***Adult Preventive Annual Health Assessments***

CA (CCNC) PCPs are required to provide all of the components of an initial preventive annual health assessment and periodic assessments to adult enrollees age 21 and over. For more information, please refer to "Clinical Preventive Services for Normal Risk Adults Recommended by the U.S. Preventive Services Task Force" at [www.ahcpr.gov/ppip/adulttm.pdf](http://www.ahcpr.gov/ppip/adulttm.pdf).

**24-Hour Coverage Requirement**

CA (CCNC) requires PCPs to provide access to medical advice and care for enrolled recipients 24 hours per day, 7 days per week. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by the office staff during regular office hours.

PCPs must provide enrollees with an after-hours telephone number. The after-hours number may be the PCP's home telephone number. The after-hours telephone line must be listed on the enrollee's MID card. The after-hours telephone number must connect the enrollee to:

- an answering service that promptly contacts the PCP or the PCP-authorized medical practitioner
- a recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner
- a system that automatically transfers the call to another telephone line that is answered by a person who will promptly contact the PCP or PCP-authorized medical practitioner
- a call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer enrollees to the PCP's home telephone if there is no system in place as outlined above to respond to calls. PCPs are encouraged to refer patients with urgent medical problems to an urgent care center.

**Standards of Appointment Availability**

PCPs must conform to the following standards for appointment availability:

- emergency care – immediately upon presentation or notification
- urgent care – within 24 hours of presentation or notification
- routine sick care – within 3 days of presentation or notification
- routine well care – within 90 days of presentation or notification (15 days if pregnant)

**Emergency Conditions** – An emergency medical condition is one in which the sudden onset of a medical condition, including emergency labor and delivery, manifests itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual or the health of a pregnant women or the unborn child in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any body organ or part

With regard to pregnant women having contractions, a situation is considered to be an emergency if:

- There is inadequate time to effect a safe transfer to another hospital before delivery.
- Transfer may pose a threat to the health or safety of the woman or the unborn child.

**Urgent Conditions** – An urgent medical condition is defined as a condition that could seriously compromise the patient’s condition and outcome for a full recovery without medical attention and intervention within 12 to 24 hours.

### ***Standards for Office Wait Times***

PCPs must conform to the following standards for office wait times:

- walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- scheduled appointment – within one hour
- life-threatening emergency – must be managed immediately

### ***Hospital Admitting Privileges Requirement***

CA (CCNC) PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CA (CCNC) enrollees. An appropriate arrangement must be made to ensure access to care for all enrollees regardless of age. The **Carolina ACCESS Patient Admission Agreement/Formal Arrangement form** fulfills this requirement for participation by serving as a voluntary written agreement between the CA (CCNC) PCP and a physician or group who agrees to admit CA (CCNC) enrollees for the PCP. By signing the agreement, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the enrollee throughout the enrollee’s inpatient stay. **This agreement must be completed by both parties.** The CA (CCNC) PCP must submit the original form with his/her application for participation or when a change occurs regarding the provider’s admitting agreement. A copy of the admission agreement is on page 4-28 or on DMA’s website at <http://www.dhhs.state.nc.us/dma/forms.html>.

The following arrangements are acceptable:

- A physician, a group practice, a hospital group, a physician call group (not necessarily a CA (CCNC) provider).
- The physician, group practice or hospital group must be enrolled with the N.C. Medicaid program.
- Admitting privileges or formal arrangements must be maintained at a hospital that is within 30 miles or 45 minutes drive time from the PCP’s office. If there is no hospital that meets this geographic criteria, the closest hospital to the CA (CCNC) PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases where it is determined the benefits of a PCP’s participation outweighs the PCP’s inability to comply with the admitting privileges requirement.

### ***Women, Infants, and Children (WIC) Special Supplemental Nutrition Program Referrals***

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. CA (CCNC) PCPs are required to refer potentially eligible enrollees to the WIC program. Copies of the **WIC Exchange of Information Form for Women**, the **WIC Exchange of Information Form for Infants and Children**, and the **Medical Record Release form** are available beginning on page 4-31 or on DMA’s website at <http://www.dhhs.state.nc.us/dma/forms.html>.

For more information, contact the local WIC agency at the county health department or the Division of Maternal and Child Health at 1-800-FOR-BABY (1-800-367-2229).

***Transfer of Medical Records***

CA (CCNC) PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request.

***Carolina ACCESS Medical Records Guidelines***

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the CA (CCNC) program and approved by the Physician Advisory Group. All CA (CCNC) PCPs must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CA (CCNC) PCPs. Refer to page 3-3 for medical records standards that apply to all providers.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page, or electronic file in the record, contains the patient's name or patients Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (ages 12 and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present for patients age 12 and over at the routine visit.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with CA.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

## Carolina ACCESS Referrals and Authorizations

Coordination of care is an important component of CA (CCNC). PCPs are contractually required to either provide services or authorize another provider to treat the enrollee. This applies even when an enrollee has failed to establish a medical record with the PCP. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of exempt services on page 4-11.) All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring an enrollee to a specialist can be made by telephone or in writing. The referral must include:

- the number of visits being authorized
- the extent of the diagnostic evaluation

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP must be contacted for authorization. The same authorization referral number must be used by both specialists.

Authorization is not required for services provided in an urgent care center billing with a hospital provider number. Specialist referrals for follow-up care after discharge from an urgent care center **do** require PCP authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization**. Specialist referrals for follow-up care after discharge from a hospital **also** require PCP authorization.

In addition to CA (CCNC) authorization, prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. Refer to **Prior Approval** on page 6-1 for additional information about services requiring PA.

Claims submitted for reimbursement must include the PCP's authorization number in block 19 on the CMS-1500 claim form or form locator 11 on the electronic UB-92 claim form. When filing a paper UB-92 claim form, the authorization number is entered in form locator 83b.

### ***Referrals for a Second Opinion***

CA (CCNC) PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

### ***Referral Documentation***

All referrals must be documented in the enrollee's medical record. PCPs should review the monthly **Referral Report** to ensure that services rendered to their enrollees were authorized and have been documented and recorded accurately in the enrollee's medical record. It is the PCPs responsibility to review the Referral Report for validity and accuracy and to report inappropriate referrals to the Managed Care Consultant. Refer to page 4-22 for an example of the report.

**Exempt Services**

Enrollees can obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- ambulance services
- anesthesiology
- at-risk case management
- Community Alternatives Program services
- certified nurse anesthetist
- child care coordination
- dental\*
- developmental evaluation centers
- eye care services (limited to CPT codes 92002, 92004, 92012, 92014 and diagnosis codes related to conjunctivitis 370.3, 370.4, 372.0, 372.1, 372.2, 372.3)
- family planning (including Norplant)
- health department services
- hearing aids (under age 21)
- HIV case management
- hospice
- independent and hospital lab services
- maternity care coordination
- optical supplies/visual aids
- pathology services
- pharmacy
- psychiatric/mental health (psychiatrists; psychiatric hospitals; area mental health programs; psychiatric facilities; inpatient and outpatient services billed with a primary or secondary diagnosis of 290 - 319)
- radiology (only services billed under a radiologist provider number)
- services provided by schools and Head Start programs

**Note:** CA (CCNC) enrollees are instructed to contact their PCP for assistance in locating a dental provider enrolled with the Medicaid program. A list of dental providers is available on DMA's website at <http://www.dhhs.state.nc.us/dma/dental/dentalprov.htm>. Recipients can also be referred to the Office of Citizen Services, CARE-LINE Information and Referral at 1-800-662-7030 or 919-855-4400 (English and Spanish).

**Note:** Although enrollees are not required to obtain an authorization from their PCP for the services listed above, PA may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the AVR system at 1-800-723-4337. Refer to **Prior Approval** on page 6-1 for information on services requiring PA.

**Carolina ACCESS Override Requests**

It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CA (CCNC) enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers must request an override using the **Carolina ACCESS Override Request form** to obtain payment. However, override requests will only be considered if the PCP was contacted and refused to authorize treatment or if extenuating circumstances beyond the control of the responsible parties affected access to medical care.

Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, override requests will not be approved if the enrollee failed to establish a medical record with the PCP. Overrides will not be approved for well visits.

Override requests must be submitted to EDS within six months of the date of service. Requests will be evaluated within 30 days of receipt.

A copy of the **Carolina ACCESS Override Request form** is on page 4-34 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### Medical Exemption Requests

CA (CCNC) was established on the premise that patient care is best served by coordinated care through a PCP. However, enrollees may request a medical exemption from participation in CA (CCNC) for the following medical conditions:

- Terminal illness – the enrollee has a life expectancy of six months or less or is currently a hospice patient.
- Mental illness, developmental delay or impaired mental/cognitive status – the enrollee does not possess the ability to comprehend and participate in CA (CCNC).  
**Note:** This statement is not a determination of the patient's legal mental competence.
- Chemotherapy or radiation treatment – the enrollee is currently undergoing treatment.  
**Note:** This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than six months, the exemption must be requested after the initial six-month time period during reapplication for Medicaid coverage.
- Continuity of care issues.  
**Note:** A temporary exemption may be granted to allow a CA (CCNC) enrollee to continue to see a non-participating physician while the physician is in the process of applying for participation in CA (CCNC).
- Diagnosis/other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PCP.
- End-Stage Renal Disease

The **Carolina ACCESS Medical Exemption Request form** must be completed by the enrollee's physician and mailed to DMA Managed Care section at the address listed on the form. Recipients may also obtain the Medical Exemption Request form at their county DSS. A copy of the form is also available on page 4-34 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### Patient Disenrollment

On occasion, it may become necessary to disenroll a CA (CCNC) enrollee from a practice due to good cause\*. To disenroll a patient, PCPs must follow these procedures:

- Notify the CA (CCNC) enrollee in writing of his/her disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days notice. Advise the enrollee to contact his/her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.
- Fax a copy of the disenrollment letter to the Managed Care Consultant.

**Note:** Until a DSS worker deletes the PCP's name, address, and telephone number from the recipient's MID card, the PCP must continue to provide services to the enrollee or authorize another provider to treat the enrollee.

\*Good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired;
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a CA (CCNC) enrollee may be disenrolled for nonpayment of copayments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

### **Carolina ACCESS – Commonly Asked Questions**

#### **1. Is there a limit to the number of Carolina ACCESS patients I can enroll for my practice?**

PCPs can enroll up to a maximum of 2,000 CA (CCNC) enrollees per physician or physician extender, unless otherwise approved by DMA.

#### **2. Can I change my enrollment limit?**

PCPs can change enrollment limits or restrictions by completing and submitting a **Carolina ACCESS Provider Information Change Form** (see page 3-18).

#### **3. How can I verify that a patient is enrolled with Carolina ACCESS?**

It is important to check the enrollee's current monthly MID card at each visit because the enrollee's eligibility status or PCP may have changed. If the patient is enrolled in CA (CCNC), the MID card will list the name of the PCP. If there is no PCP listed on the MID card, the patient is not currently enrolled in CA (CCNC).

In addition to the verification methods listed on page 2-11, enrollment can also be verified by:

- Automated Voice Response (AVR) system
- Checking the current Carolina ACCESS Enrollment Report

#### **4. What should I do if the patient does not bring their MID card to an appointment?**

In addition to the verification methods listed on page 2-11, enrollment can also be verified by:

- Automated Voice Response (AVR) system
- Checking the current Carolina ACCESS Enrollment Report

Or

Prior to rendering the service, the provider must inform the patient either orally or in writing that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

**Carolina ACCESS – Commonly Asked Questions (cont.)**

**5. What if the primary care provider listed on the patient’s MID card is incorrect?**

Advise the patient to contact his/her caseworker or the Medicaid supervisor at the county DSS to request a change of PCP. In most circumstances, the change takes a minimum of 30 days. Changes are always effective the first day of the month following the change.

**6. Are Carolina ACCESS enrollees responsible for copayments?**

CA (CCNC) enrollees are subject to the same copayment requirements as fee-for-service Medicaid recipients. Refer to **Copayments** on page 2-16 for additional information.

**7. Do all Medicaid covered services require authorization from the primary care provider?**

No. Some Medicaid covered services are exempt from PCP authorization. Refer to page 4-12 for a list of exempt services.

**8. What if a Carolina ACCESS enrollee assigned to my practice needs health care that my office cannot provide?**

PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-11 for additional information on coordination of care.

**9. What is the process for referring a patient to a specialist or to other health services?**

The Medicaid number on your approved CA (CCNC) application is the authorization number to be given to providers when referring an enrollee to a specialist or to other health services. The CA (CCNC) enrollee may be referred to any specialist or to other health services enrolled with Medicaid.

Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

**10. What if my practice receives a request for an authorization for a patient we have not yet seen?**

Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, PCPs are not required to authorize a specialist or another health service provider to treat an enrollee that has not yet been seen in their practice. However, if the PCP does not authorize treatment, an appointment must be made available to the enrollee according to the standards of appointment availability (see page 4-8). All referrals must be documented in the enrollee’s medical record.

## **Carolina ACCESS – Commonly Asked Questions (cont.)**

### **11. What if a Carolina ACCESS enrollee “self refers” to our practice?**

PCP authorization must be obtained before a CA (CCNC) enrollee may see a specialist or another health service provider, unless the service is exempt from authorization. You may contact the PCP listed on the enrollee’s MID card and request authorization but the PCP is not obligated to authorize the service.

If you do not receive authorization to treat the patient, you may refer the patient back to the PCP or inform the patient either orally or in writing prior to rendering the service that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

### **12. Do Carolina ACCESS enrollees admitted through the emergency department require authorization from their primary care provider?**

Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization**. Specialist referrals for follow-up care after discharge from a hospital **do** require PCP authorization.

### **13. How should claims be filed when a primary care provider refers a Carolina ACCESS enrollee to our office?**

Claims submitted for reimbursement must include the PCP’s authorization referral number in block 19 on the CMS-1500 claim form or form locator 11 on the UB-92 claim form. For UB-92 paper claims, the authorization referral number must be entered in form locator 83b.

### **14. Who do I contact if I have questions or require additional information?**

DMA has established regional Managed Care Consultants to assist managed care providers. Refer to page 4-20 for a list of consultants. If you are unable to reach the consultant, you may contact the DMA Managed Care program at 919-647-8170.

Modified Example of the CA Provider Enrollment Report of New Enrollees

**CA PROVIDER ENROLLMENT REPORT**  
**SECTION 1**  
**“New Enrollees”**

NC DEPT. OF HUMAN RESOURCES				PAGE NUMBER		
PROVIDER NUMBER: 1234567		CAROLINA ACCESS		DATE RUN:		
PROVIDER NAME: DR. JOE PROVIDER		PROVIDER ENROLLMENT REPORT				
FOR THE MONTH OF: SEPTEMBER						
ENROLLMENT STATUS: (NEW ENROLLEE)						
					<b>ELIGIBILITY DATES</b>	
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX	BIRTHDAY	FROM	TO	
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M	08/08/98	<b>09/01/03</b>	<b>11/30/03</b>	
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F	10/26/56	<b>09/01/03</b>	<b>02/28/03</b>	
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M	11/02/73	<b>09/01/03</b>	<b>12/31/03</b>	

**Note:** This section of the report lists all “New” Carolina ACCESS enrollees linked to your practice for the report month. Some of the clients listed in this section may be previous clients who were listed in the “Terminated” section of a previous report.

Carolina ACCESS primary care physicians are encouraged to use this section of the report to identify and contact all new enrollees by telephone or through a “welcome” letter as a way of establishing a medical record with your practice.

**Modified Example of the CA Provider Enrollment Report of Current Enrollees**

**CA PROVIDER ENROLLMENT REPORT**  
**SECTION 2**  
**“Current Enrollees”**

NC DEPT. OF HUMAN RESOURCES		PAGE NUMBER			
PROVIDER NUMBER: 1234567		CAROLINA ACCESS			
PROVIDER NAME: DR. JOE PROVIDER		DATE RUN:			
PROVIDER ENROLLMENT REPORT					
FOR THE MONTH OF: SEPTEMBER					
ENROLLMENT STATUS: (CURRENT)					
<b>ELIGIBILITY DATES</b>					
<b>INDIVIDUAL I.D.</b>	<b>CLIENT NAME / ADDRESS</b>	<b>SEX</b>	<b>BIRTHDAY</b>	<b>FROM</b>	<b>TO</b>
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M	08/08/98	09/01/03	12/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F	10/26/56	09/01/03	10/31/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M	11/02/73	09/01/03	09/30/03

**Note:** This section of the report lists all Carolina ACCESS enrollees linked to your practice for the report month.

The eligibility “**FROM**” date listed for the client is always the current report month. The “**TO**” date will vary depending on each client’s Medicaid certification period.

This section of the report can be used to verify **current month** eligibility if a client has not received their MID card for the current month or fails to bring the MID card to an appointment.

## Modified Example of the CA Provider Enrollment Report of Terminated Enrollees

**CA PROVIDER ENROLLMENT REPORT**  
**SECTION 3**  
**“Terminated Enrollees”**

NC DEPT. OF HUMAN RESOURCES		PAGE NUMBER			
PROVIDER NUMBER: 1234567		CAROLINA ACCESS			
PROVIDER NAME: DR. JOE PROVIDER		PROVIDER ENROLLMENT REPORT			
		FOR THE MONTH OF: SEPTEMBER			
		ENROLLMENT STATUS: ( <b>TERMINATED</b> )			
				ELIGIBILITY DATES	
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX	BIRTHDAY	FROM	TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M	08/08/98	09/01/00	08/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F	10/26/56	04/01/03	09/30/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M	11/02/73	06/01/03	09/30/03

**Note:** This section of the report lists all of the Carolina ACCESS enrollees “**Terminated**” from your practice for the report month.

The eligibility “**FROM**” date and “**TO**” date listed for the client will vary indicating that:

- The client is no longer eligible for Medicaid; or
- The client is eligible for Medicaid but has selected another CA PCP, or has been granted an exemption for this report month; or
- A change was made to the client’s file but was not entered into the system in time to generate a link to the “**New Enrollee**” section of the report for this month.

**List of Regional Managed Care Consultants**

<b>Jerry Law</b> <b>PH: 252-321-1806</b> Jerry.Law@ncmail.net	<b>Rosemary Long</b> <b>PH: 910-738-7399</b> Rosemary.Long@ncmail.net	<b>Lisa Gibson</b> <b>PH: 919-319-0301</b> Lisa.Gibson@ncmail.net	<b>Christopher Lucas</b> <b>PH: 919-647-8176</b> Christopher.Lucas@ncmail.net	<b>LaRhonda Cain</b> <b>PH: 919-647-8190</b> LaRhonda.Cain@ncmail.net	<b>Lisa Catron</b> <b>PH: 828-683-8812</b> Lisa.Catron@ncmail.net
Beaufort Bertie Camden Chowan Currituck Dare Edgecombe Gates Greene Halifax Hertford Hyde Martin Nash Northampton Pasquotank Perquimans Pitt Tyrrell Washington	Bladen Brunswick Carteret Columbus Craven Cumberland Duplin Jones Lenoir New Hanover Onslow Pamlico Pender Robeson Sampson Wayne	Davidson Davie Forsyth Guilford Hoke Montgomery Moore Randolph Richmond Rockingham Scotland Stokes Surry Wilkes Yadkin	Alamance Caswell Chatham Durham Franklin Granville Harnett Johnston Lee Orange Person Vance Wake Warren Wilson	Alexander Alleghany Anson Ashe Cabarrus Caldwell Catawba Gaston Iredell Lincoln Mecklenburg Rowan Stanly Union Watauga	Avery Buncombe Burke Cherokee Clay Cleveland Graham Haywood Henderson Jackson Macon Madison McDowell Mitchell Polk Rutherford Swain Transylvania Yancey

**Example of Emergency Room Management Report**

REPORT: HMSR300N

DIVISION OF MEDICAL ASSISTANCE

PAGE: 1

PRIMARY CARE PROVIDER

DATE: 11/27/2003

EMERGENCY ROOM MANAGEMENT REPORT

FIN PAYER: NCXIX

AS OF DATE: 11/27/2003

CLAIMS PAID DURING THE MONTH OF NOVEMBER 2003

COUNTY: ALAMANCE

PCP: FUN FAMILY PRACTICE

PCP NUMBER: 1234567

ENROLLEE NAME	MEDICAID NUMBER	PRIMARY DIAG.	REASON FOR VISIT	BILLING PROVIDER	DOS	TOS	PAID AMOUNT
---------------	-----------------	---------------	------------------	------------------	-----	-----	-------------

IDENTIFIED EMERGENCIES

COOL	JOE	F.	123456789M 7806	PYREXIA UNKNOWN ORIGIN	FUN HOSPITAL	10/26/03 11	\$27.22
SMALL	SALLY	A.	987654321P 92310	CONTUSION OF FOREARM	CITY COUNTYHOSPITAL	10/18/03 14	\$99.73
TOTAL PAID AMT							\$126.95
TOTAL VISITS							2

OTHER ER CLAIMS

DOE	JANE	R.	123456798W 6929	DERMATITIS NOS	LOCAL URGENT CARE	10/28/03 08	\$28.52
TOTAL PAID AMT							\$28.52
TOTAL VISITS							1
AVERAGE PER VISIT							\$28.52
TOTAL ER PAID AMT							\$155.47
TOTAL ER VISITS							3



## **Instructions for Using the Quarterly Utilization Report**

### **INSTRUCTIONS FOR QUARTERLY UTILIZATION REPORT**

This report gives the PCP a detailed representation of the utilization of services by recipients linked with the PCP's practice. These reports are based on claims that were paid during the quarter prior to the report date. This report can be a useful tool in assisting the provider with their internal utilization and quality management programs.

There are 14 service categories listed on the top portion of the report, with an explanation of each listed on the second page of the report. The 14 service categories are divided into 4 subcategories as follows:

1. **Current Quarter PCP** – PMPM (per member per month) is the cost for that quarter for each of the 14 service categories. The rate = units (claims) divided by quarterly enrollment x 1000. Rates and cost are reported per 1000 members.
2. **Current Quarter PCP Peer Group** – Average rate and cost for all practices in your specialty for the quarter in respective category.
3. **Quarter Average for PCP Peer Group** – Average rate and cost for PCP Peer group practices in respective categories.
4. **Quarterly Average** – Totals for the last four quarters in respective categories.

**IF YOU HAVE ANY QUESTIONS REGARDING THE QUARTERLY UTILIZATION REPORT  
CONTACT YOUR REGIONAL MANAGED CARE CONSULTANT**

Example of Quarterly Utilization Report

REPORT: HMSR4051

NORTH CAROLINA MMIS  
 CAROLINA ACCESS QUARTERLY UTILIZATION REPORT  
 01/01/2004 - 03/31/2004

DATE: 04/20/2004

PRACTICE NAME: WE CURE WHAT AILS YOU MEDICAL OFFICE  
 PROVIDER NUMBER: 8888888  
 CA PCP TYPE: 001 - GP/FAMILY PRACTICE  
 COUNTY: 017 - CASWELL

\*\*\*\*  
 OFFICE MANAGER: PLEASE DISTRIBUTE THIS  
 REPORT TO ALL PHYSICIANS  
 IN THE PRACTICE.

SERVICE CATEGORY	CURRENT QTR		CURRENT QTR		QUARTERLY AVE.	
	PCP RATE	PCP PMPM	PCP RATE	PEER GROUP PMPM	LAST 4 RATE	PCP PMPM
(1) PCP OFFICE SERVICES	256	\$14.01	292	\$15.63	232	\$13.52
(2) TOTAL ER/URGENT CARE SERVICES	28	\$5.12	65	\$17.44	48	\$8.30
A. IDENTIFIED EMERGENCY	19	\$2.71	38	\$12.32	28	\$5.48
B. NON-EMERGENT	9	\$2.41	27	\$5.12	20	\$2.82
(3) PHARMACY	809	\$35.16	1504	\$81.72	758	\$32.14
(4) HOSPITAL INPATIENT	9	\$28.65	8	\$45.20	3	\$10.21
(5) INPATIENT MENTAL HEALTH	0	\$0.00	1	\$5.61	0	\$0.00
(6) SPECIALISTS/REFERRALS	88	\$13.95	169	\$20.66	65	\$8.07
(7) LABS	84	\$2.84	70	\$2.51	85	\$2.63
(8) X-RAYS	1	\$0.43	4	\$2.54	1	\$0.78
(9) MENTAL HEALTH OUTPATIENT	47	\$5.69	97	\$24.48	46	\$4.79
(10) OUTPATIENT/AMBULATORY	47	\$17.43	133	\$43.07	38	\$9.36

PMPM CALCULATIONS	CURRENT QUARTER		PCP LAST 4 QTRS	LAST 4 QUARTERS
	PCP	PCP PEER GROUP	PMPM	PCP PEER GROUP
(11) PRIMARY CARE PROVIDER	\$16.01	\$18.07	\$16.40	\$17.53
(12) ALL OTHER SERVICES	\$133.13	\$298.57	\$99.51	\$291.07
(13) TOTAL SERVICES	\$149.13	\$316.64	\$115.91	\$308.60

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: \_\_\_\_\_ 51 AGES > 21: \_\_\_\_\_ 20 AVERAGE TOTAL MONTHLY ENROLLMENT: \_\_\_\_\_ 71

**Example of Quarterly Utilization Report, continued**

- (1) NUMBER AND ASSOCIATED \$ OF PCP OFFICE VISITS, INCLUDING OFFICE LABS/XRAYS AND HEALTH CHECKS
- (2) ER/URGENT CARE VISITS AND ASSOCIATED \$. IDENTIFIED EMERGENCIES = DMA DEFINED EMERGENCY DIAGNOSES (10/99 BULLETIN)
- (3) PHARMACY SERVICES AND ASSOCIATED \$ FROM DRUG CLAIMS
- (4) HOSPITAL ADMISSIONS AND ASSOCIATED \$ (INCLUDING ANESTHESIA). MENTAL HEALTH AND INPATIENT PHYSICIAN CONSULTATIONS ARE NOT INCLUDED.
- (5) HOSPITAL ADMISSIONS AND ASSOCIATED \$ FOR MENTAL HEALTH
- (6) NUMBER AND ASSOCIATED \$ FOR REFERRAL SERVICES TO SPECIALISTS, OTHER OUTPATIENT PROVIDERS, AND INPATIENT PHYSICIAN CONSULTATIONS PCP REFERRAL # IS ON THE CLAIM. (THIS DOES NOT INCLUDE OT/PT/ST OR MENTAL HEALTH).
- (7) NUMBER AND ASSOCIATED \$ IDENTIFIED FOR LABORATORY PROCEDURE CODES, PATHOLOGY INCLUDED.
- (8) NUMBER AND ASSOCIATED \$ IDENTIFIED BY X-RAY PROCEDURE CODES. THERAPEUTIC RADIATION SERVICES NOT INCLUDED.
- (9) NUMBER AND ASSOCIATED \$ FOR OUTPATIENT SERVICES RELATED TO MENTAL HEALTH.
- (10) NUMBER AND ASSOCIATED \$ FOR HOSPITAL OUTPATIENT SERVICES. THIS INCLUDES AMBULATORY, ANESTHESIA IN AN OUTPATIENT SETTING, HOME HEALTH, AND PT/OT/ST. E/R AND MENTAL HEALTH SERVICES NOT INCLUDED.
- (11) QUARTERLY AND ANNUAL PMPM FOR PCP SERVICES INCLUDING MANAGEMENT FEES FOR PCP AND PCP PEER GROUP
- (12) QUARTERLY AND ANNUAL PMPM FOR LINES 2-10 AND ALL NON-PCP SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
- (13) QUARTERLY AND ANNUAL PMPM FOR ALL SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
- (14) AVERAGE MONTHLY NUMBER OF RECIPIENTS LINKED WITH THIS PCP.

NOTE: THESE FIGURES ARE BASED ON CLAIMS PROCESSED FOR SERVICES PROVIDED DURING THE QUARTER REPORTED

MEDICARE CROSSOVER CLAIMS AND ADJUSTMENTS NOT INCLUDED  
RATE = UNITS / QUARTERLY ENROLLMENT X 1000.

**Sample of Health Department Health Check Agreement**

**HEALTH CHECK AGREEMENT BETWEEN PRIMARY CARE PROVIDER (PCP) AND THE LOCAL HEALTH DEPARTMENT**

For recipients of Medicaid, birth to age 21, the Health Check Medical Screening Exam is required as a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the health check exam, all of which are required in the Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in the attached document "Health Check Screening Components."

**WHAT IS AN AGREEMENT FOR HEALTH CHECK?**

**If a Carolina ACCESS PCP cannot or chooses not to perform the comprehensive health check screenings, this agreement allows the PCP to contract with the Health Department serving the PCP's county to perform the screenings for enrollees in the birth to 21 year age group.**

The agreement requires the following:

- The Health Department must provide the results of the exam to the PCP within 30 days unless follow-up is necessary, in which case, the Health Department must communicate the results of the screening within 24 hours.
- The PCP is required to coordinate any necessary treatment or follow-up care as determined by the screening.
- Under this agreement, the health department must perform all health check components at the time of the appointment unless circumstances require an appointment be rescheduled.

If the PCP chooses to utilize this agreement in order to meet this Carolina ACCESS requirement for participation, the agreement containing the original signatures of the PCP or the authorized representative and the Director of the Health Department or an authorized representative must be submitted to the Division of Medical Assistance (DMA). The PCP must keep a copy of this agreement on file.

This agreement can be entered into or terminated at any time by the PCP or the Health Department. DMA must be notified immediately of any change in the status of the agreement.

Questions regarding this agreement or health check requirements can be made to DMA Managed Care at 919-647-8170 or by contacting the regional Managed Care Consultant.

Sample of Health Department Health Check Agreement, continued

AGREEMENT BETWEEN PRIMARY CARE PROVIDER AND HEALTH DEPARTMENT TO PROVIDE HEALTH CHECK SERVICES TO CAROLINA ACCESS PATIENTS

In order to provide coordinated care to those children who are enrolled in Carolina ACCESS and obtain primary care services from \_\_\_\_\_ and Health Check services and immunizations from \_\_\_\_\_ County Health Department (CHD), the undersigned agree to the following provisions.

Primary Care Provider agrees to:

- 1. Refer Carolina ACCESS patients to the CHD for Health Check appointments. If the patient is in the office, the physician/office staff will assist the patient in making a Health Check appointment with the CHD.
2. Maintain, in the office, a copy of the physical examination and immunization records as a part of the patient's permanent record.
3. Monitor the information provided by the CHD to assure that children in the Carolina ACCESS program are receiving immunizations as scheduled and counsel patients appropriately if they are noncompliant with well child visits or immunizations.
4. Review information provided by the CHD and follow up with patients when additional services are needed.
5. Provide the Division of Medical Assistance Managed Care Section at least thirty (30) days advance notice if the Primary Care Provider (PCP) and/or the CHD wishes to discontinue this Agreement.

The Health Department agrees to:

- 1. Provide age appropriate Health Check examinations and immunizations within ninety (90) days of the request for patients who are referred by the PCP or are self-referred.
2. Send Health Check physical examination and immunization records monthly to the Primary Care Provider.
3. Notify the Primary Care Provider of significant findings on the Health Check examination within twenty-four (24) hours. Allow the Primary Care Provider to direct further referrals for specialized testing or treatment.
4. Provide the Division of Medical Assistance Managed Care Section thirty (30) days advance notice if the Primary Care Provider and/or the CHD wishes to discontinue this Agreement.

Signature of Primary Care Provider or Authorized Official Date PCP Medicaid Provider #

Printed Name of Provider or Authorized Official Provider Group Name (if applicable)

Signature of Health Department Director/Designee Date

Printed Name of Health Department Director/Designee Health Dept. Provider Number

cc: DMA, Managed Care Section, Program Administrator

(7/98)

**Sample of Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form****CAROLINA ACCESS HOSPITAL ADMITTING REQUIREMENT**

The establishment of a continuous and comprehensive patient/provider relationship is an essential component of Carolina ACCESS. Therefore, Carolina ACCESS (CA) primary care providers (PCPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addresses the needs all enrollees or potential enrollees. If the CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the North Carolina Medicaid program, then the ***Carolina ACCESS Hospital Admitting Agreement*** form must be submitted to DMA Provider Services to address this requirement for participation. To ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the ***Carolina ACCESS Hospital Admitting Agreement*** form, which serves as the written agreement between the two parties. **IF the Carolina ACCESS provider has entered into a formal arrangement for inpatient services, this form must be completed by both parties, and the applicant must submit the original form with the application for participation or when a change occurs regarding the provider's management of inpatient hospital admissions.**

**Note:** A *formal arrangement* is defined as a voluntary agreement between the Carolina ACCESS primary care provider and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Carolina ACCESS enrollee throughout the inpatient stay.

The following Carolina ACCESS requirements regarding inpatient hospital care must be met:

1. Under the conditions stated above, the CA PCP must provide inpatient hospital care, or have a signed ***Carolina ACCESS Hospital Admitting Agreement*** form on file at DMA.
2. All ages of the provider's CA enrollees or potential enrollees must be covered by the inpatient hospital care or formal arrangement for inpatient hospital care or a combination of the two.
3. If the ***Carolina ACCESS Hospital Admitting Agreement*** form is utilized, the Agreement(s) must be between the CA PCP and one or more of the following:
  - a physician
  - a group practice
  - a hospitalist group
  - a physician call group

**Note:** The above providers must be enrolled as NC Medicaid providers, but it is not necessary that they be enrolled as Carolina ACCESS providers. Admissions through unassigned hospital-based call groups do not meet this requirement.

4. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five (45) minutes drive time from the CA PCP's practice.

**Note:** If there is no hospital that meets the above geographical criteria, *the hospital geographically closest to the CA PCP's (Contractor's) practice will be accepted.*

5. Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

**Note:** For more information refer to the ***Agreement for Participation as a Primary Care Provider in North Carolina's Patient Access and Coordinated Care Program***, Section IV, 6.4.

Questions regarding hospital admitting privileges may be directed to DMA Managed Care by calling 919-647-8170.

Sample of Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form, continued

Division of Medical Assistance
Provider Services
801 Ruggles Drive – 2501 Mail Service Center – Raleigh, N.C. 27699-2501
919-855-4050
www.dhhs.state.nc.us/dma

Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement

This form is to be completed only if the Carolina ACCESS (CA) Primary Care Provider (PCP) does not provide inpatient hospital care that addresses the needs of the CA enrollees or potential enrollees.

Carolina ACCESS Primary Care Provider or Applicant:
(First Party Section)

CA PCP Applicant Name: CA Provider Number:

Mailing Address:

Contact Person: Telephone Number:

to ensure a complete understanding between both parties and continuity of coverage among providers, Carolina ACCESS has adopted the Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form. This form serves as a formal written agreement established between the two parties as follows:

- The Carolina ACCESS Primary Care Provider is privileged to refer Carolina ACCESS patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
The second party will arrange coverage for Carolina ACCESS enrollee admissions during their vacations.
Either party may terminate this agreement at any time by giving written 30 days advance notice to the other party or by mutual agreement.
The Carolina ACCESS Primary Care Provider will notify Carolina ACCESS in writing of any changes to or terminations of this agreement.
The Carolina ACCESS Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For
Above Carolina ACCESS Primary Care Provider Applicant:
(Second Party Section)

Physician/Group Name: Medicaid Provider Number:

Mailing Address:

Specialty: Ages Admitted:

Hospital Affiliation(s) and Location(s):

Contact Person: Telephone Number:

Authorized Signature: Date:

## Instructions for Completing the WIC Exchange of Information Forms

### WIC Program Exchange of Information (DHHS 3492)

**PURPOSE:** To facilitate transmittal of information necessary for WIC certification between a health care provider and the local WIC Program.

**GENERAL INSTRUCTIONS:** The appropriate side of the form (infants/children or women) should be initiated by the local WIC Program with the following information completed.

**WIC Agency/Address/Phone:** of local WIC Program where person receives program services.

**Patient name/DOB:** of person being referred.

**Client's Signature/Date:** authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

**DISTRIBUTION:** Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

**DISPOSITION:** This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

**REORDER INFORMATION:** Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch  
1914 Mail Services Section  
Raleigh, NC 27699-1914

Sample of WIC Exchange of Information Form for Women

1. Last Name First Name MI

2. Patient Number

3. Date of Birth  
 Month Day Year

4. Race  1. White  2. Black Ethnicity: Hispanic Origin?  
 3. Am. Ind.  4. Other  1. Yes  2. No

5. Sex  1. Male  2. Female

6. County of Residence

North Carolina Department of Health and Human Services  
 Division of Public Health  
 Women's and Children's Health Section  
 Nutrition Services Branch • WIC Program

**WIC PROGRAM EXCHANGE OF INFORMATION**  
**- WOMEN -**

*WIC is an Equal Opportunity Program.*

**RETURN COMPLETED FORM TO:**

Local WIC Agency / Address / Phone

**I authorize the exchange of the information below between the WIC Program and my Health Care Provider.**

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

↓ Information Below To Be Completed By The Health Care Provider ↓

1. Actual or Expected Date of Delivery: \_\_\_\_\_

2. Enter date & results of most recent measurements:

Date \_\_\_\_\_ Weight \_\_\_\_\_

Date \_\_\_\_\_ Height \_\_\_\_\_

Date \_\_\_\_\_ Hemoglobin \_\_\_\_\_ OR Hematocrit \_\_\_\_\_

3. Significant Obstetric History:

4. Findings / Diagnosis / Recommendations:

5. Would you like to receive a summary of nutrition services provided by the WIC Program staff?  Yes  No

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

*Signature/Title*

**SUMMARY OF NUTRITION SERVICES (to be completed by the WIC Program Staff)**

Date: \_\_\_\_\_ Signature/Title: \_\_\_\_\_ Phone No.: \_\_\_\_\_

DHHS 3492 (Revised 3/00)  
 DPHWCHS/Nutrition Services Branch/WIC Program /Review 3/03)



**Sample of Medical Record Release Form**

**MEDICAL RECORD RELEASE**

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

Signature \_\_\_\_\_

(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)

Date \_\_\_\_\_

Sample of Carolina ACCESS Override Request Form

Carolina ACCESS Override Request

Complete this form to request a Carolina ACCESS override when you have received a denial for EOB 270 or 286 or the Primary Care Provider (PCP) has refused to authorize treatment for past date(s) of service. The request must be submitted within six months of the date of service. Overrides will not be considered unless the PCP has been contacted and refused to authorize treatment. Attach any supporting documentation. Mail or fax completed form to EDS. EDS will telephone or fax your office within 30 days with a denial or, if approved, the override number to use for filing the claim. This form is also available in the Carolina ACCESS Primary Care Provider Manual and on DMA's website at http://www.dhhs.state.nc.us/dma.

Mail To: CA Override
EDS Provider Services
PO Box 300009
Raleigh, NC 27622

OR

Fax: CA Override
919/851-4014

Recipient MID No. Recipient Name

Date(s) of Service ICN No. RA Date

Is this claim due to?

- A well visit
An inpatient admission
An inpatient admission via the ER

PCP on recipient's Medicaid card

Name of person contacted at PCP's office Date contacted

Reason PCP stated he would not authorize treatment

Reason recipient stated he did not go to the PCP listed on his Medicaid card

I am requesting an override due to:

- Enrollee linked incorrectly to PCP. Please explain:
Who is the correct PCP?
This child has been placed in foster care in another area:
This enrollee has moved to another county:
The provider listed on the enrollee's Medicaid card is different from the PCP indicated by the AVR system (attach a copy of the Medicaid card with this form).
Unable to contact PCP. Please explain:
Other. Please explain:

Provider Name Provider Number

Provider Contact Telephone No. Fax No.

**Sample of Carolina ACCESS Medical Exemption Request Form**

**Carolina ACCESS Medical Exemption Request**

Carolina ACCESS PCCM model was established in 1991 based on the premise that patient care is best served by a medical home where a Primary Care Provider (PCP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

**Attention Recipient:** Please fill out this section of the form consisting of enrollee’s name, MID#, DOB and county of residence.

(Enrollee’s Name)	(MID#)	(DOB)	(County of Residence)

**Attention Physician:** This section is to be completed only by the physician. Please check all blocks that apply regarding the patient’s medical condition, and mail to the address below (with recipient’s medical record if indicated). Please note at least one block should be checked, and the physician information requested below completed.

- Terminal illness** (the enrollee has a six (6) month or less life expectancy and/or is currently a hospice patient.)
- Impaired mental/cognitive status** that makes it impossible for the adult recipient to comprehend and participate in Carolina ACCESS. (**Note:** This statement is not a determination of the patient’s legal mental competence.)
- Currently undergoing **Chemotherapy** or **Radiation treatments**. (**Note:** Exemptions for this purpose are temporary until the completion of the therapy. If the therapy will last longer than 6 months, exemption must be requested after the 6 month time period during reapplication for Medicaid coverage.)
- End-Stage Renal Disease**
- Diagnosis/Other information:** (Specify reasons why this recipient would not benefit from having a medical home with a local PCP who would coordinate his care)

---



---



---



---



---

Pursuant to federal regulations regarding utilization of Medicaid services, the Division of Medical Assistance is authorized by Section 1902 (a) (27) of the Social Security Act and Federal Regulation 42 CFR 431.107 to access information from the patient’s medical records for the purposes directly related to the administration of the Medicaid Program. Therefore, no special enrollee permission is necessary for the release of medical records. In addition, when applying for Medicaid benefits, each enrollee signs a release, which authorizes access to his/her Medicaid records by the appropriate authorities.

(Physician Signature)	(Medicaid Provider No.)	(Date)
(Print Physician Name)	(Telephone Number)	

If you have any questions or would like to apply to become a Carolina ACCESS provider, please contact DMA/Managed Care at (919) 647-8170.

Mail completed signed forms to: DMA/ Managed Care  
2501 Mail Service Center  
Raleigh, NC 27699-2501

## HMO RISK CONTRACTING

HMO Risk Contracting is a Medicaid Managed Care program whereby DMA contracts with Southcare/Coventry Health Care, a health maintenance organization (HMO) operating in Mecklenburg County, to provide and coordinate medical services for certain Medicaid eligibles on a full-risk capitated basis.

HMO enrollees are identified by the information on their MID card. "Prepaid Health Plan Enrollee" appears on the card along with the HMO's name, address, and telephone number. Enrolled recipients also receive a member identification card from the plan. Newborns of HMO members are automatically enrolled and services are covered by the mother's plan, effective the date of the child's birth.

### In-Plan Benefits

Because in-plan benefits are covered under the capitation rate paid to HMOs, authorization and reimbursement for these services must be sought from the HMO. There is no copayment for any in-plan benefits. Following is a list of in-plan benefits.

- adult health screening
- ambulance
- chiropractic services
- clinic services (except mental health and substance abuse)
- dialysis
- durable medical equipment
- emergency department
- health check
- family planning services and supplies
- hearing aids
- home health
- home infusion therapy
- hospice
- injectable drugs
- inpatient hospital (except mental health and substance abuse)
- laboratory services
- midwife services
- occupational therapy
- optical supplies
- outpatient hospital
- physical therapy
- physician services (including physician assistants and nurse practitioners – except mental health and substance abuse)
- private duty nursing
- prosthetics and orthotics
- radiology
- speech therapy
- sterilization
- total parenteral nutrition

### Out-of-Plan Benefits

The following services are not provided through the HMO benefit plan. These out-of-plan benefits are reimbursed by the Medicaid program on a fee-for-service basis. Recipients continue to use their MID card for these services and are responsible for applicable copayments. Prior approval is required for some services. Refer to **Prior Approval** on page 6-1 for information on services requiring prior approval.

- Community Alternative Program services
- mental health – inpatient and outpatient
- child service coordination
- DSS nonemergency transportation
- dental services
- intermediate care facilities for the mentally retarded
- prescription drugs
- specialized therapies provided by school-based agencies and Head Start programs
- mental health and substance abuse services
- at-risk case management
- developmental evaluation center services (occupational, speech, and physical therapy)
- HIV case management
- maternity care coordination
- nursing care – skilled and intermediate
- personal care services

Refer to the HMO Member Services Department to assist enrollees in accessing out-of-plan services.

## SUBMITTING CLAIMS TO MEDICAID

### Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim.

### Submitting Claims on Paper

When completing the paper claim form, use black ink only. Do not submit carbon copies or photocopies. EDS uses optical scanning technology to store an electronic image of the claim and the scanners cannot detect carbon copies, photocopies or any color of ink other than black. For auditing purposes, all claim information must be visible in an archive copy. Carbon copies, photocopies, and claims containing a color of ink other than black will not be processed and will be returned to the provider.

### Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File form**. Providers who file claims electronically are not required to complete this form. Refer below to **Submitting Claims Electronically**.

The form must contain the provider's original signature. Stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. For groups such as home health, hospitals, facilities (including adult care), etc. that do not require an attending provider number on the claim, the certification should be signed by an individual who has authority to sign contracts on behalf of the provider.

To avoid EOB 1350 denials (which indicate that a **Provider Certification for Signature on File form** has not been submitted), please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 prior to submitting claims to verify that the system has been updated.

A copy of the form is available on page 5-28 or on the DMA website at <http://www.dhhs.state.nc.us/dma/forms.html>. FAX or mail completed certifications two weeks in advance of submitting claims without a signature.

### Submitting Claims Electronically

Providers who plan to submit claims electronically must indicate their intention to do so by agreeing to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement.

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Commerce Services (ECS). EDS will process claims submitted through ftp and async dial-up.

Billing electronically requires software that complies with the transaction standards mandated by the Health Insurance Portability and Accountability Act (HIPAA). Refer to page 10-1 for additional information about electronic billing and ECS services.

### Billing on the CMS-1500 Claim Form

Listed below are some of the provider types who bill Medicaid using the CMS-1500 claim form:

ambulatory surgery center*	independent mental health provider
audiology or speech pathology, physical therapy, occupational therapy, respiratory therapy	independent practitioner
	local education agency
audiology or speech pathology, physical therapy, occupational therapy and psychological services, case management services (department of social services)	mental health center
certified registered nurse anesthetist*	nurse midwife*
chiropractor*	nurse practitioner*
community alternatives program	optical supply dealer
durable medical equipment*	optometrist*
federally qualified health center**	orthotics and prosthetics*
free standing birthing center*	personal care services
head start	physician*
health department	planned parenthood (non-medical doctor)*
hearing aid dealer	podiatrist*
HIV case management	portable x-ray
home infusion therapy	private duty nursing services
independent diagnostic testing facility*	residential evaluation services
independent laboratory*	rural health clinic**

\* The provider types listed on the preceding page are mandated to bill Medicaid using modifiers. Please refer to the **April 1999 Special Bulletin II, Modifiers**, for Medicaid modifier usage guidelines.

\*\* Modifier usage is subject to noncore services only.

Medicaid special bulletins are available on DMA's website at <http://www.dhhs.state.nc.us/dma.bulletin.htm>.

### CMS-1500 Claim Form Instructions

Instructions for completing the standard CMS-1500 claim form are listed below.

Block	Block Name	Explanation
<b>1.</b>	<b>Type of Coverage</b>	Place an (X) in the Medicaid block.
<b>1a.</b>	<b>Insured's ID Number</b>	Enter the recipient's ten-character identification number found on the MID card.
<b>2.</b>	<b>Patient's Name</b>	Enter the recipient's full name (last name, first name, middle initial) exactly as it appears on the MID card.
<b>3.</b>	<b>Patient's Birth Date</b>	Enter the recipient's date of birth using eight digits (e.g., July 19, 1960 would be entered as 07191960). <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
	<b>Sex</b>	Place an (X) in the appropriate block to indicate the recipient's sex (M = male; F = female).

Block	Block Name	Explanation
5.	Patient's Address	Enter the recipient's street address including city, state, and zip code.
	Telephone	Entering the recipient's telephone number is optional.
9.	Other Insured's Name	If applicable, enter private insurance information. For programs that use Medicare override statements, enter applicable statement.
10.	Is Patient's Condition Related To: a. Employment? b. Auto Accident? c. Other Accident?	If applicable, check the appropriate block.
15.	If Patient Has Had Same or Similar Illness, Give First Date	Leave blank <b>EXCEPT</b> when billing for:  <b>OB Antepartum Care Package Codes:</b> Enter the first date recipient care was rendered for current pregnancy.  <b>Health Check:</b> The next screening date (NSD) may be entered in block 15.
15.	If Patient Has Had Same or Similar Illness, Give First Date, continued	If the date the provider enters in block 15 is within the periodicity schedule, the system will keep this date. If the NSD entered by the provider is out-of-range with the periodicity schedule or the provider chooses one of the three options listed below, an appropriate NSD will be systematically entered during claims processing according to the Medicaid periodicity schedule.  <ul style="list-style-type: none"> <li>• Leave block 15 blank</li> <li>• Place zeros in block 15 (example – 00/00/0000)</li> <li>• Place all ones in block 15 (11/11/1111)</li> </ul> <b>Dialysis Treatment or Supervision:</b> Enter the dialysis start date.  <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
16.	Dates Patient Unable to Work in Current Occupation "From" and "To"	If billing for postoperative management only (designated by modifier 55 in block 24D), enter the "From" and "To" dates the provider was responsible for recipient's care. If the provider was responsible for care for nonconsecutive periods of time per follow-up period, multiple claims must be filed. Date spans cannot overlap with dates on another claim. Refer to the <b>April 1999 Special Bulletin II, Modifiers</b> , for billing guidelines.
19.	Reserved for Local Use	<b>For CA Enrollees:</b> Enter the PCP's referral authorization number.  <b>For Area Mental Health Providers ONLY:</b> Enter the area mental health program reference number when applicable.

Block	Block Name	Explanation
20.	Outside Lab?	Check "yes" or "no."  "No" indicates that the lab work was performed in the office.
21.	Diagnosis or Nature of Illness or Injury	The written description of the primary diagnosis is not required unless using diagnosis code V900. However, the claim must be ICD-9-CM coded to describe the primary diagnosis.
23.	Prior Authorization Number	Any provider billing for laboratory services must enter the CLIA number in this field.  It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
24A.	Date(s) of Service "From" and "To"	Enter the eight-digit date of service in the "From" block.  <b>Example:</b> Record the date of service January 31, 2003 as 01312003. If the service consecutively spans a period of time, enter the beginning service date in the "From" block and the ending service date in the "To" block.  <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
24B.	Place of Service	Enter the appropriate code from the <b>Place of Service Code Index</b> on page 5-7.
24C.	Type of Service	Enter the appropriate code from the <b>Type of Treatment/Type of Service Code Index</b> on page 5-9.  <b>Note:</b> Effective date of processing October 16, 2003, Type of Service will no longer be required.
24D.	Procedures, Services, or Supplies	Enter the appropriate five-digit CPT or HCPCS code.  <b>Note:</b> Providers mandated to bill modifiers can bill up to three modifiers per procedure code, if applicable. Refer to the <b>April 1999 Special Bulletin II, Modifiers</b> , for billing guidelines. Health Check claims may also contain modifiers. Refer to guidelines listed in the <b>April 2004 Special Bulletin I, Health Check Billing Guide 2004</b> .
24F.	Charges	Enter the usual and customary charge for each service rendered.
24G.	Days or Units	Enter the number of visits or units.
24H.	EPSDT Family Plan	If the service is the result of an EPSDT (Health Check) screening referral, enter "E." If the service is related to family planning, enter "F."

Block	Block Name	Explanation
26.	<b>Patient's Account No.</b>	A provider has the option of entering either the recipient control number or medical record number in this block. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
28.	<b>Total Charge</b>	Enter the total charges. (Medicaid is not responsible for any amount that the recipient is not responsible for if the recipient is private pay or has Third Party coverage.)
29.	<b>Amount Paid</b>	<p><b>For dates of service after October 1, 2002</b>, enter the total amount received from Medicare, including penalties and outpatient psychiatric reductions, and other third party payment source(s). Refer to the <b>September 2002 Draft Special Bulletin IV (Revised November 14, 2002) Medicare Part B Billing Guidelines</b> for detailed instructions on billing for Medicare Part B.</p> <p><b>Effective with dates of service September 6, 2004</b>, professional charges will be reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B Reimbursement schedule. Do not enter Medicare payments on the claim. Attach the Medicare voucher when the submitting the claim to Medicaid. Refer to the <b>August 2004 Special Bulletin V, Medicare Part B Billing</b> for detailed instructions.</p>
31.	<b>Signature of Physician or Supplier Including Degrees or Credentials</b>	<p>The physician, supplier or an authorized representative must either:</p> <ol style="list-style-type: none"> <li>1. Sign and date all claims, or</li> <li>2. Use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or</li> <li>3. If a <b>Provider Certification for Signature on File form</b> has been completed and submitted to EDS, leave the signature block blank and enter the date only.</li> </ol> <p>Printed initials and printed signatures are not acceptable and will result in a denied claim.</p>

Block	Block Name	Explanation
33.	<b>Physician's or Supplier's Billing Name, Address, Zip Code &amp; Phone #.</b>	<p>Enter the billing provider's name, street address including zip code, and phone number.</p> <p><b>PIN #:</b> Enter the attending physician's seven-character Medicaid provider number.</p> <p><b>GRP #:</b> Enter the seven-character group provider number used for Medicaid billing purposes. The provider number must correspond to the provider name above (i.e., if billing with a group number, use the group name entered in block 33).</p>

*Place of Service Code Index*

<b>POS Code</b>	<b>Description</b>	<b>Explanation</b>
<b>03</b>	<b>School</b>	A facility whose primary purpose is education.
<b>11</b>	<b>Office</b>	Location, other than a hospital or nursing facility, where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
<b>12</b>	<b>Home</b>	Home is considered the recipient's private residence, which also includes an adult care home facility.
<b>13</b>	<b>Assisted Living Facility</b>	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
<b>21</b>	<b>Inpatient Hospital</b>	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to recipients admitted for a variety of medical conditions.
<b>22</b>	<b>Outpatient Hospital</b>	A section of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
<b>23</b>	<b>Emergency Department - Hospital</b>	A section of a hospital where emergency diagnosis and treatment of illness or injury is provided.
<b>24</b>	<b>Ambulatory Surgical Center</b>	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
<b>25</b>	<b>Free-Standing Birthing Center</b>	A facility, other than a hospital's maternity facilities or a physician's office, that provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborns.
<b>26</b>	<b>Military Treatment Facility</b>	A medical facility operated by one or more of the Uniformed Services Military Treatment Facilities (MTF). Also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
<b>32</b>	<b>Nursing Facility</b>	A facility that provides nursing facility level of care of the elderly and physically disabled adults. This facility provides nursing and related services, and rehabilitation services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

*Place of Service Code Index*, continued

<b>POS Code</b>	<b>Description</b>	<b>Explanation</b>
33	<b>Custodial Care Facility</b>	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, which does not include a medical component.
34	<b>Hospice</b>	A facility, other than a recipient's home, in which palliative and supportive care for terminally ill recipients and families are provided.
51	<b>Inpatient Psychiatric Facility</b>	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
53	<b>Community Mental Health Center</b>	A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.
54	<b>Intermediate Care Facility/Mentally Retarded</b>	A facility that primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or nursing facility.
61	<b>Comprehensive Inpatient Rehabilitation Facility</b>	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include rehabilitative nursing, physical therapy, speech pathology, social or psychological services, and orthotic and prosthetic services.
62	<b>Comprehensive Outpatient Rehabilitation Facility</b>	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	<b>End Stage Renal Disease Treatment Facility</b>	A facility other than a hospital, that provides dialysis treatment, maintenance or training to recipients or caregivers on an ambulatory or home-care basis.
71	<b>State or Local Public Health Clinic</b>	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	<b>Rural Health Clinic</b>	A certified facility that is located in a medically underserved rural area that provides ambulatory primary medical care under the general direction of a physician.
81	<b>Independent Laboratory</b>	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.
99	<b>Other Unlisted Facility</b>	Other unlisted facilities not identified above, such as a school.

*Type of Service Index*

TOS	Description	Type of Service Conversion in Medicaid Claims Processing System
01	Medical	3
02	Surgical	3
03	Consultation	3
04	Diagnostic x-ray and lab, professional component	5
05	Diagnostic laboratory, complete procedure	3
06	Radiation therapy	5
07	Anesthesia	1
08	Assistant at surgery	2
09	Maternity	3
10	Eye exams	3
11	Dental	4
15	Independent practitioners, ambulatory surgery, visual aids, and hearing aids	9
31	Complete procedure (both professional and technical components)	3
E	Durable medical equipment - rental	B
N	Durable medical equipment - new purchase	6
T	Technical component	T
U	Durable medical equipment - used purchase	8

**Note:** Providers must utilize these TOS codes for the Automated Voice Response (AVR) system inquiries that ask for the type of treatment.

Sample CMS 1500 Claim Form

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	12. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 900000000K					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Joe				3. PATIENT'S BIRTH DATE MM DD YY 01 01 1946		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 123 Any Street				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			STATE			
CITY Any City		STATE NC	8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/>	Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	CITY		STATE	ZIP CODE				
ZIP CODE 12345		TELEPHONE (Include Area Code) (555) 555-5555			CITY		STATE	ZIP CODE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	b. EMPLOYER'S NAME OR SCHOOL NAME			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____						SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
19. RESERVED FOR LOCAL USE 1234567				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 786.50		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER 34D0000000				24. TABLE OF SERVICES								
A DATE(S) OF SERVICE To		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR Family Plan	H IPSOT	J EMG	K COB	L RESERVED FOR LOCAL USE
10 15 04 10 15 04		11	11	99214			80 00	1				
10 15 04 10 15 04		11	11	G0001			20 00	1				
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 100 00	29. AMOUNT PAID \$ 78 81	30. BALANCE DUE \$ 21 19				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on file				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Jane Provider 123 Any Street Any City, NC 12345 PIN# 81111111 GRP# 8000000						
SIGNED _____ DATE _____												

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM CWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

## Sample CMS 1500 Claim Form

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

**REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the *Federal Register*, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," *Federal Register* Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P. L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**Billing on the UB-92 Claim Form**

Listed below are some of the provider types who bill on the UB-92 claim form:

- ◆ adult care home
- ◆ ambulance
- ◆ area mental health
- ◆ dialysis facilities
- ◆ home health agency
- ◆ hospice
- ◆ hospital
- ◆ intermediate care facility/mental retardation
- ◆ nursing facility
- ◆ psychiatric residential treatment facilities
- ◆ residential child care facilities (level II, III, and IV)

**UB-92 Claim Form Instructions**

Instructions for completing the standard UB-92 standard claim are listed below.

Form Locator/Description	Requirements	Explanation
<b>1. Provider Name/Address</b>	Required	Enter the provider's name as it appears on the RA and up to three lines of the address. <b>Note:</b> Do not abbreviate the provider's name.
<b>3. Patient Control Number</b>	Optional	Enter either the recipient control number or medical record number, which the provider has selected to appear on their RA. This number will be keyed by EDS and reported back to the provider in the medical record field of the RA. This block will accommodate up to 20 characters (alpha or numeric) but only the first nine characters of this number will appear on the RA.
<b>4. Type of Bill</b>	Required Three Digits	<u>Type of Facility - 1<sup>st</sup> Digit</u> Hospital .....1 Skilled Nursing (SNF) .....2 Home Health .....3 Intermediate Care (ICF) .....6 Special Facility ..... 8*  * If Type of Facility code 8 (Special Facility) is used, then use a Bill Classification for Special Facilities.

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<p><b>4. Type of Bill, continued</b></p>	<p>Required Three Digits</p>	<p><u>Bill Classification - 2<sup>nd</sup> Digit</u>                      Inpatient (including Medicare Part A) .....1                      Outpatient.....3                      Other (for hospital referenced diagnostic services or home health not under a plan of treatment).....4                      Intermediate Care - Level I Medicaid swing-bed ICF .....5                      Intermediate Care - Level II Medicaid swing-bed SNF .....6                      Subacute Inpatient.....7                      Swing Beds Medicaid SNF inappropriate level of care.....8</p> <p><u>Bill Classification - 2<sup>nd</sup> Digit (Clinics Only)</u>                      Rural Health Clinic .....1                      Independent and Provider Based FQHC .....3                      Outpatient Rehab. Facility/Community Mental Health Center. ....4                      Comprehensive Outpatient Rehab. Facility .....5                      Community Mental Health .....6</p> <p><u>Bill Classification - 2<sup>nd</sup> Digit (Special Facilities Only)</u>                      Hospice (nonhospital-based).....1                      Hospice (hospital-based).....2                      Ambulatory Surgery Center .....3                      Free Standing Birthing Center .....4                      Rural Primary Care Hospital.....5</p>
		<p><u>Frequency - 3<sup>rd</sup> Digit</u>                      Admit Through Discharge .....1                      Interim - First Claim .....2                      Interim - Continuing Claim .....3                      Interim - Last claim.....4                      Late Charge(s) - Only Claim.....5                      Replacement of Prior Claim.....7                      Void/Cancel of Prior Claim .....8</p>
<p><b>5. Federal Tax Number</b></p>	<p>Required, where applicable</p>	

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>6. Statement Covers Period “From” and “Through”</b>	Required	Enter the eight-digit beginning service date in the "From" block. Enter the eight-digit ending service date in the “Through” block.  <b>Example:</b> Record the date of service January 31, 2004 as 01312004.  <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
<b>7. Covered Days</b>	Required (Hospital/ Nursing Home)	Indicate the total number of days the provider is billing on this claim form.
<b>9. Coinsurance Days</b>	Required, where applicable	Indicate any coinsurance days during the period the provider is billing on this claim form.
<b>10. Lifetime Reserve Days</b>	Required, where applicable	Indicate any lifetime reserve days used for this period.
<b>11.</b>	Required, where applicable	<b>For electronic claims for services provided to CA enrollees, enter the PCP’s referral authorization number here.</b>  <b>For paper claims, enter the PCP referral authorization number in form locator 83b.</b>
<b>12. Patient Name</b>	Required	Enter recipient's full name exactly as shown on the MID card (last name, first name, middle initial).
<b>13. Patient Address</b>	Required	Enter the recipient's street address including city, state, and zip code.
<b>14. Patient Birthdate</b>	Required	Enter the recipients date of birth using eight digits  <b>Example:</b> July 19, 1960 would be entered as 07191960.  <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
<b>15. Patient Sex</b>	Required	Enter one alpha character indicating the sex of the recipient. Valid characters are "M", "F", or "U."

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation			
17. Admission Date	Required	Enter the eight-digit date that the recipient was admitted. <b>Example:</b> Record the date January 31, 2004 as 01312004. <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.			
18. Admission Hour	Required (hospital/ambulance)	For multiple outpatient visits on the same day, indicate the admission hour and submit each visit on a separate claim.			
		<b>Time Code</b>  00 01 02 03 04 05 06 07 08 09 10 11	<b>AM</b>  12:00 – 12:59 midnight 01:00 – 01:59 02:00 – 02:59 03:00 – 03:59 04:00 – 04:59 05:00 – 05:59 06:00 – 06:59 07:00 – 07:59 08:00 – 08:59 09:00 – 09:59 10:00 – 10:59 11:00 – 11:59	<b>Time Code</b>  12 13 14 15 16 17 18 19 20 21 22 23	<b>PM</b>  12:00 – 12:59 noon 01:00 – 01:59 02:00 – 02:59 03:00 – 03:59 04:00 – 04:59 05:00 – 05:59 06:00 – 06:59 07:00 – 07:59 08:00 – 08:59 09:00 – 09:59 10:00 – 10:59 11:00 – 11:59

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>19. Admission Type</b>	Required (hospital)	<p>Indicate the applicable code for all inpatient visits. A "1" must be used to indicate an emergency department visit that meets emergency criteria to ensure that a copayment amount is not deducted during the claim processing.</p> <p>1     <b>Emergency:</b> The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency department.</p> <p>2     <b>Urgent:</b> The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.</p> <p>3     <b>Elective:</b> The patient's condition permits adequate time to schedule the availability of a suitable accommodation.</p> <p>4     <b>Newborn:</b> Any newborn infant admitted to the hospital within the first 24 hours of life.</p>
<b>20. Source of Admission</b>	Required (hospital)	<p>1     <b>Physician Referral:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of their personal physician.</p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by their personal physician or the patient independently requested outpatient services (self-referral).</p> <p>2     <b>Clinic Referral:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility upon recommendation of <b>this facility's clinic physician.</b></p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services <b>by this facility's clinic or other outpatient department physician.</b></p>

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
20. Source of Admission, continued	Required (hospital)	<p>3. <b>HMO Referral:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.</p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a health maintenance organization physician.</p> <p>4. <b>Transfer From a Hospital:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility as a transfer from an acute care facility where they were an inpatient.</p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.</p> <p>5. <b>Transfer From a Skilled Nursing Facility:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility as a transfer from a skilled nursing facility where they were an inpatient.</p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the skilled nursing facility they were an inpatient.</p> <p>6. <b>Transfer From Another Health Care Facility:</b></p> <p><u>Inpatient:</u> The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long-term care facilities, and skilled nursing facility patients that are at a nonskilled level of care.</p> <p><u>Outpatient:</u> The patient was referred to this facility for outpatient services or referenced diagnostic services by a physician of another health care facility where they are an inpatient.</p>

UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation																																																				
<p><b>20. Source of Admission,</b> continued</p>	<p>Required (hospital)</p>	<p>7     <b>Emergency Department:</b>   <u>Inpatient:</u> The patient was admitted to this facility upon the recommendation of this facility's emergency department physician.   <u>Outpatient:</u> The patient was referred to the facility for outpatient services or referenced diagnostic services by this facility's emergency department physician.   <b>For Newborns:</b>                      1     <b>Normal Delivery:</b> A baby delivered without complications.                      2     <b>Premature Delivery:</b> A baby delivered with time or weight factors qualifying it for premature status.                      3     <b>Sick Baby:</b> A baby delivered with medical complications, other than those relating to premature status.                      4     <b>Extramural Birth:</b> A baby born in a nonsterile environment.                      5 - 8   <b>Reserved For National Assignment</b>                      9     <b>Information Not Available</b></p>																																																				
<p><b>21. Discharge Hour</b></p>	<p>Required (hospital)</p>	<table border="1"> <thead> <tr> <th data-bbox="834 1203 927 1287">Time Code</th> <th data-bbox="927 1203 1149 1287">AM</th> <th data-bbox="1149 1203 1242 1287">Time Code</th> <th data-bbox="1242 1203 1453 1287">PM</th> </tr> </thead> <tbody> <tr> <td>00</td> <td>12:00 – 12:59 midnight</td> <td>12</td> <td>12:00 – 12:59 noon</td> </tr> <tr> <td>01</td> <td>01:00 – 01:59</td> <td>13</td> <td>01:00 – 01:59</td> </tr> <tr> <td>02</td> <td>02:00 – 02:59</td> <td>14</td> <td>02:00 – 02:59</td> </tr> <tr> <td>03</td> <td>03:00 – 03:59</td> <td>15</td> <td>03:00 – 03:59</td> </tr> <tr> <td>04</td> <td>04:00 – 04:59</td> <td>16</td> <td>04:00 – 04:59</td> </tr> <tr> <td>05</td> <td>05:00 – 05:59</td> <td>17</td> <td>05:00 – 05:59</td> </tr> <tr> <td>06</td> <td>06:00 – 06:59</td> <td>18</td> <td>06:00 – 06:59</td> </tr> <tr> <td>07</td> <td>07:00 – 07:59</td> <td>19</td> <td>07:00 – 07:59</td> </tr> <tr> <td>08</td> <td>08:00 – 08:59</td> <td>20</td> <td>08:00 – 08:59</td> </tr> <tr> <td>09</td> <td>09:00 – 09:59</td> <td>21</td> <td>09:00 – 09:59</td> </tr> <tr> <td>10</td> <td>10:00 – 10:59</td> <td>22</td> <td>10:00 – 10:59</td> </tr> <tr> <td>11</td> <td>11:00 – 11:59</td> <td>23</td> <td>11:00 – 11:59</td> </tr> </tbody> </table>	Time Code	AM	Time Code	PM	00	12:00 – 12:59 midnight	12	12:00 – 12:59 noon	01	01:00 – 01:59	13	01:00 – 01:59	02	02:00 – 02:59	14	02:00 – 02:59	03	03:00 – 03:59	15	03:00 – 03:59	04	04:00 – 04:59	16	04:00 – 04:59	05	05:00 – 05:59	17	05:00 – 05:59	06	06:00 – 06:59	18	06:00 – 06:59	07	07:00 – 07:59	19	07:00 – 07:59	08	08:00 – 08:59	20	08:00 – 08:59	09	09:00 – 09:59	21	09:00 – 09:59	10	10:00 – 10:59	22	10:00 – 10:59	11	11:00 – 11:59	23	11:00 – 11:59
Time Code	AM	Time Code	PM																																																			
00	12:00 – 12:59 midnight	12	12:00 – 12:59 noon																																																			
01	01:00 – 01:59	13	01:00 – 01:59																																																			
02	02:00 – 02:59	14	02:00 – 02:59																																																			
03	03:00 – 03:59	15	03:00 – 03:59																																																			
04	04:00 – 04:59	16	04:00 – 04:59																																																			
05	05:00 – 05:59	17	05:00 – 05:59																																																			
06	06:00 – 06:59	18	06:00 – 06:59																																																			
07	07:00 – 07:59	19	07:00 – 07:59																																																			
08	08:00 – 08:59	20	08:00 – 08:59																																																			
09	09:00 – 09:59	21	09:00 – 09:59																																																			
10	10:00 – 10:59	22	10:00 – 10:59																																																			
11	11:00 – 11:59	23	11:00 – 11:59																																																			

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>22. Patient Status</b>	Required (except for ambulance and personal care services)	01 Discharged to home or self care (routine discharge). 02 Discharged/transferred to another short-term general hospital. 03 Discharged/transferred to skilled nursing facility. 04 Discharged/transferred to an intermediate care facility. 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution. 06 Discharged/transferred to home under care of organized home health service organization. 07 Left against medical advice. 08 Discharged/transferred to home under care of a home IV provider. 20 Expired. 30 Still a patient or expected to return for outpatient services. 61 Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed. 62 Discharged/transferred to another rehabilitation facility including rehabilitation-distinct part units of a hospital. 63 Discharged/transferred to a long-term care hospital. 64 Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare.
<b>23. Medical Record Number</b>	Optional	If a number is entered, it will not appear on the RA.

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
24. - 30. Condition Codes	Required, where applicable	<p>D7 <b>Medicare Part A noncovered service or does not meet Medicare criteria for Part A.</b></p> <p>D9 <b>Medicare Part B noncovered service or does not meet Medicare criteria for Part B.</b></p> <p>Refer to the <b>July 1999 N.C. Medicaid Ambulance Services Manual</b> for applicable ambulance condition codes.</p> <p><b>Note:</b> Condition codes should not be entered for entitlement issues.</p>
32. - 35., a - b Occurrence Codes and Dates	Required, where applicable	<p><b>Accident Related Codes:</b></p> <p>24 <b>Date Insurance Denied:</b> This code should be used when a provider receives a denial from the recipient's third party insurance. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB.</p> <p>25 <b>Date Benefits Terminated By Primary Payer:</b> This code should be used when a recipient's third party insurance has been terminated. It allows the provider to file the claim to Medicaid without a voucher attached. This code allows the TPL indicator to override during claim processing. When using this code, enter the date from the third party insurance EOB.</p> <p><b>Note:</b> Medicare crossover claims require a paper insurance denial.</p>

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>32. - 35., a - b</b> <b>Occurrence Codes and Dates,</b> continued		<b>Special Codes:</b> A3 <b>Benefits Exhausted:</b> Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer A. B3 <b>Benefits Exhausted:</b> Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer B. C3 <b>Benefits Exhausted:</b> Providers should use this code to indicate the last date for which benefits are available and after which no payment can be made by payer C. 11 <b>Date of Initial Treatment:</b> Providers should use this code to indicate the first date of dialysis treatment
<b>39. - 41., a - d</b> <b>Value Codes and Amounts</b>	Required, where applicable	Values codes and amounts only pertain to a long-term care facility, hospital, psychiatric residential treatment facility or, if the recipient lives in a nursing facility, a hospice. Enter any value code pertinent to this claim. Applicable deductible/patient liability amounts should be indicated with a value code of 23.
		23 <b>Recurring Monthly Income:</b> This code indicates that the Medicaid eligibility requirements are determined at the state level. <b>Note:</b> Include code 23 and value (even if it is 0) for any inpatient stay extending beyond the first of the month following the 30 <sup>th</sup> consecutive day of admission.
<b>42. Revenue Code</b>	Required	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes. Revenue code 634 is required for dialysis treatment centers.
<b>43. Revenue Code Description</b>	Not required	
<b>44. HCPCS/Rates</b>	Required, where applicable	Enter the appropriate revenue code. Refer to program-specific Medicaid services information for applicable codes.

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>45. Service Date</b>	Required, where applicable	Enter an eight-digit service date for each line item billed. Required if multiple dates of services are billed on one outpatient claim. <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
<b>46. Unit of Service</b>	Required, where applicable	Enter the number of units for each detail line. Refer to program-specific Medicaid services information on how a unit is defined.
<b>47. Total Charges</b>	Required	Enter the total of the amounts in this column. Enter the revenue code 001 on the corresponding line in form locator 42.
<b>50. A, B, C Payer</b>	Required	Enter the Payer Classification Code and Specific Carrier Identification Code for each of up to three payers. List the payers in order of priority: A Primary payer B Secondary payer C Tertiary payer The information entered on lines A, B, and C must correspond with the information in form locators 37, and 52 through 66. <b>Note:</b> Effective with date of service October 1, 2002, Medicare Part B payer codes M0000 must be indicated. <b><u>Payer Classification Codes</u></b> Medicare M Medicaid D Blue Cross B Commercial Insurance I Tricare C NC DHHS-Purchase of Care N Worker's Compensation W State Employee Health Plan E Administered Plans S Health Maintenance Organization H Self-Pay/Indigent/Charity P Other O

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation																																													
50. A, B, C Payer, continued		<p><b><u>Specific Carrier Identification Codes</u></b></p> <table border="1"> <thead> <tr> <th data-bbox="846 338 1073 394">Carrier Payer Classification</th> <th data-bbox="1073 338 1187 394">Code</th> <th data-bbox="1187 338 1451 394">Explanatory Notes</th> </tr> </thead> <tbody> <tr> <td data-bbox="846 405 1073 441">Medicare (M)</td> <td data-bbox="1073 405 1187 441">0000</td> <td data-bbox="1187 405 1451 441">4 zeros</td> </tr> <tr> <td data-bbox="846 451 1073 535">Medicaid (D)</td> <td data-bbox="1073 451 1187 535">XX00</td> <td data-bbox="1187 451 1451 535">Where XX = postal state code (example: NC00)</td> </tr> <tr> <td data-bbox="846 546 1073 630">Blue Cross (B)</td> <td data-bbox="1073 546 1187 630">0XXX</td> <td data-bbox="1187 546 1451 630">Where XXX = Blue Cross Plan Code or FEP</td> </tr> <tr> <td data-bbox="846 640 1073 703">Commercial Insurer (I)</td> <td data-bbox="1073 640 1187 703">XXXX</td> <td data-bbox="1187 640 1451 703">Where XXXX = Docket Number</td> </tr> <tr> <td data-bbox="846 714 1073 777">Commercial Insurer (I)</td> <td data-bbox="1073 714 1187 777">9999</td> <td data-bbox="1187 714 1451 777">When Docket Number is unassigned</td> </tr> <tr> <td data-bbox="846 787 1073 823">Tricare (C)</td> <td data-bbox="1073 787 1187 823">0000</td> <td data-bbox="1187 787 1451 823">4 zeros</td> </tr> <tr> <td data-bbox="846 833 1073 896">NC DHHS – Purchase of Care</td> <td data-bbox="1073 833 1187 896">0000</td> <td data-bbox="1187 833 1451 896">4 zeros</td> </tr> <tr> <td data-bbox="846 907 1073 970">Worker's Compensation</td> <td data-bbox="1073 907 1187 970">XXXX</td> <td data-bbox="1187 907 1451 970">Where XXXX = Docket Number</td> </tr> <tr> <td data-bbox="846 980 1073 1043">Worker's Compensation</td> <td data-bbox="1073 980 1187 1043">9999</td> <td data-bbox="1187 980 1451 1043">When Docket Number is unassigned</td> </tr> <tr> <td data-bbox="846 1054 1073 1117">State Employees Health Plan</td> <td data-bbox="1073 1054 1187 1117">0000</td> <td data-bbox="1187 1054 1451 1117">4 zeros</td> </tr> <tr> <td data-bbox="846 1127 1073 1163">Administered Plan (S)</td> <td data-bbox="1073 1127 1187 1163">0000</td> <td data-bbox="1187 1127 1451 1163">4 zeros</td> </tr> <tr> <td data-bbox="846 1173 1073 1236">Health Maintenance Organization (H)</td> <td data-bbox="1073 1173 1187 1236">XXXX</td> <td data-bbox="1187 1173 1451 1236">Where XXXX = Docket Number</td> </tr> <tr> <td data-bbox="846 1247 1073 1310">Health Maintenance</td> <td data-bbox="1073 1247 1187 1310">9999</td> <td data-bbox="1187 1247 1451 1310">When Docket Number is unassigned</td> </tr> <tr> <td data-bbox="846 1320 1073 1383">Self-Pay/Indigent/Charity (P)</td> <td data-bbox="1073 1320 1187 1383">6666</td> <td data-bbox="1187 1320 1451 1383">Self-pay-hospital bills patient and expects payment</td> </tr> </tbody> </table>	Carrier Payer Classification	Code	Explanatory Notes	Medicare (M)	0000	4 zeros	Medicaid (D)	XX00	Where XX = postal state code (example: NC00)	Blue Cross (B)	0XXX	Where XXX = Blue Cross Plan Code or FEP	Commercial Insurer (I)	XXXX	Where XXXX = Docket Number	Commercial Insurer (I)	9999	When Docket Number is unassigned	Tricare (C)	0000	4 zeros	NC DHHS – Purchase of Care	0000	4 zeros	Worker's Compensation	XXXX	Where XXXX = Docket Number	Worker's Compensation	9999	When Docket Number is unassigned	State Employees Health Plan	0000	4 zeros	Administered Plan (S)	0000	4 zeros	Health Maintenance Organization (H)	XXXX	Where XXXX = Docket Number	Health Maintenance	9999	When Docket Number is unassigned	Self-Pay/Indigent/Charity (P)	6666	Self-pay-hospital bills patient and expects payment
Carrier Payer Classification	Code	Explanatory Notes																																													
Medicare (M)	0000	4 zeros																																													
Medicaid (D)	XX00	Where XX = postal state code (example: NC00)																																													
Blue Cross (B)	0XXX	Where XXX = Blue Cross Plan Code or FEP																																													
Commercial Insurer (I)	XXXX	Where XXXX = Docket Number																																													
Commercial Insurer (I)	9999	When Docket Number is unassigned																																													
Tricare (C)	0000	4 zeros																																													
NC DHHS – Purchase of Care	0000	4 zeros																																													
Worker's Compensation	XXXX	Where XXXX = Docket Number																																													
Worker's Compensation	9999	When Docket Number is unassigned																																													
State Employees Health Plan	0000	4 zeros																																													
Administered Plan (S)	0000	4 zeros																																													
Health Maintenance Organization (H)	XXXX	Where XXXX = Docket Number																																													
Health Maintenance	9999	When Docket Number is unassigned																																													
Self-Pay/Indigent/Charity (P)	6666	Self-pay-hospital bills patient and expects payment																																													
51. A, B, C Provider Number	Required	Enter the Medicaid number as shown on the RA. Do not use extra zeros or dashes.																																													

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
54. A, B, C Prior Payments (from Payers)	Required, where applicable	<p>For dates of service <b>before</b> October 1, 2002, enter any applicable third party amount. Enter the Medicare Part B payment amount in this block for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim.</p> <p>For dates of service <b>after</b> October 1, 2002:</p> <p>54A Enter any applicable Medicare payment or third party.</p> <p>54B If the Medicare payment is indicated in field locator 54A, enter any applicable third party payments in form locator 54B. The Medicare Part B payment amount should be entered for hospital inpatient claims when Part A benefits are exhausted or not applicable to the claim. Include penalties and outpatient psychiatric reductions with Medicare part B payments. Refer to the <b>September 2002 Draft Special Bulletin IV (Revised November 14, 2002) Medicare Part B Billing Guidelines</b> for detailed instructions on billing for Medicare Part B.</p> <p>Amounts entered in this block will be deducted from allowable payment.</p>
55. Estimated Amount Due	Required (hospital outpatient)	For claims filed to Medicaid for dates of service <b>after</b> October 1, 2002, where Medicare Part B has made a payment, enter the sum of both the coinsurance and the deductible.
60. A, B, C Certificate/Social Security/Health Insurance Claim/Identification Number	Required	Enter the ten-character MID number as indicated on the recipient's MID card.
63. A, B, C Treatment Authorization Code	Not Required	It is not necessary to enter the authorization code in this block. However, if prior approval is a service requirement, it is still necessary to obtain the approval and keep it on file.
67. Principal Diagnosis Code	Required	Enter the applicable ICD-9-CM diagnosis code.
68. - 75. Other Diagnosis Codes	Required, where applicable	Enter any additional diagnosis codes.

## UB-92 Claim Form Instructions, continued

Form Locator/Description	Requirements	Explanation
<b>76. Admitting Diagnosis</b>	Required, inpatient only	Enter the ICD-9-CM code for the admitting diagnosis.
<b>80. Principal Procedure Code and Date</b>	Required, where applicable	Enter the codes for any surgical or diagnostic procedures performed during this period. Use only ICD-9-CM procedure codes. Enter the eight-digit date of service. <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
<b>81. Other Procedure Codes and Dates</b>	Required, where applicable	Enter the codes for any additional surgical or diagnostic procedures performed during this period. Enter the eight-digit date of service. <b>Note:</b> A two-digit year is acceptable on paper claims. A four-digit year is <b>required</b> for electronic claims.
<b>83. b Other Phys. ID</b>	Required, where applicable	<b>For paper claims for services provided to CA enrollees, enter the PCP referral authorization here.</b> <b>For electronic claims, enter the PCP's referral authorization in field locator 11.</b>
<b>84. Remarks</b>	Required, where applicable	Enter any information applicable to the specific claim billed.
<b>85. Provider Representative Signature</b>	Required	The physician, supplier or an authorized representative must either: 1. sign and date all claims, or 2. use a signature stamp and date stamp (only script style stamps and black ink stamp pads are acceptable), or 3. if a Certificate of Signature on File has been completed and submitted to EDS, leave the signature block blank and enter the date only. Printed initials and printed signatures are not acceptable and will result in a denied claim.
<b>86. Date Bill Submitted</b>	Desired	Enter date the claim was submitted.

Sample UB-92 Claim Form

2		3 PATIENT CONTROL NO.		4 TYPE OF BILL 131	
Joe Provider 123 Any Street Any City, NC 12345		5 FED. TAX NO. 56-0000000		6 STATEMENT COVERS PERIOD FROM 101504 THROUGH 101504	
12 PATIENT NAME Recipient, Joe		13 PATIENT ADDRESS 123 Any Street, Any City, NC 12345			
14 BIRTHDATE 12051967	15 SEX m	16 MS s	17 DATE 101504	18 HR 09	19 TYPE 1
20 SRG 2		21 D HR 15	22 STAT 01	23 MEDICAL RECORD NO.	
32 OCCURRENCE DATE		33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE	36 OCCURRENCE DATE
37		38		39	
39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a		b		c	
b		c		d	
38 Medicaid P.O. Box 300010 Raleigh, NC 27622		39 CODE		40 VALUE CODES AMOUNT	
a		b		c	
b		c		d	
42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1 450	Emergency Level 3		101504	1	100 00
2 258	IV Solutions			1	30 00
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23 001	Total Charges				130 00
50 PAYER A Medicare M0000 B Medicaid DNC00		51 PROVIDER NO. 300000	52 REL INFO Y	53 ASG BEN Y	54 PRIOR PAYMENTS 40 00
55 EST. AMOUNT DUE 90 00		56			
57 <b>DUE FROM PATIENT</b>					
58 INSURED'S NAME A Recipient, Joe B Recipient, Joe		59 P REL 01	60 CERT. - SSN - HIC. - ID NO. 900000000A 900000000K		61 GROUP NAME
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES			
64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION	
67 PRIN. DIAG. CD. 57420		68 CODE	69 CODE	70 CODE	71 CODE
72 CODE		73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD. 78900
77 E-CODE		78			
79 P.C. 9	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID	83 OTHER PHYS. ID	
84 OTHER PROCEDURE CODE DATE		85 OTHER PROCEDURE CODE DATE	86 OTHER PHYS. ID		87 OTHER PHYS. ID
84 REMARKS		85 PROVIDER REPRESENTATIVE X Any Rep		86 DATE 101504	

UB-92 HCFA-1450

ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

## Sample UB-92 Claim Form

## UNIFORM BILL:

**NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/ beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

### **Billing on the ADA Claim Form**

Listed below are some of the provider types who bill on the American Dental Association (ADA) claim form:

- ◆ dentist
- ◆ federally qualified health center (dental services only)
- ◆ health department dental clinics (dental services only)
- ◆ rural health clinic (dental services only)

Refer to Clinical Coverage Policy # 4, Dental Services, on DMA's website at:

<https://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for instructions on completing the ADA claim form.

**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE**

**PROVIDER CERTIFICATION**

**FOR**

**SIGNATURE ON FILE**

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

**SIGNATURE:**

\_\_\_\_\_  
Print or Type Business Name of Provider

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Date

Group provider number to which this certification applies: \_\_\_\_\_

Attending provider number to which this certification applies: \_\_\_\_\_

Return completed form to: EDS  
Provider Enrollment  
P.O. Box 300009  
Raleigh, NC 27622

Sample of Medicare Crossover Reference Request

**MEDICARE CROSSOVER REFERENCE REQUEST**

Provider Name: \_\_\_\_\_

Contact Person (required): \_\_\_\_\_ Telephone (required): \_\_\_\_\_

Select the appropriate *Medicare Carrier/Intermediary/DMERC* from the following listing, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers. **If this section is not completed, the form will not be processed.** These are the only carriers for which EDS can currently cross-reference provider numbers.

<p><b>Medicare Part A Intermediaries</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Riverbend GBA Medicare Part A (Tennessee) <a href="http://www.riverbendgba.com">http://www.riverbendgba.com</a></li> <li><input type="checkbox"/> Palmetto GBA Medicare Part A. Effective November 1, 2001, Palmetto GBA assumed the role of North Carolina Part A intermediary from Blue Cross/Blue Shield of NC. (North Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a></li> <li><input type="checkbox"/> Trailblazer Medicare Part A (Colorado, New Mexico and Texas) <a href="http://www.the-medicare.com">http://www.the-medicare.com</a></li> <li><input type="checkbox"/> United Government Services Medicare Part A (Wisconsin) <a href="http://www.ugsmedicare.com">http://www.ugsmedicare.com</a></li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> Palmetto Medicare Part A (South Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a> *</li> <li><input type="checkbox"/> AdminaStar Medicare Part A (Illinois, Indiana, Ohio, and Kentucky) <a href="http://www.astar-federal.com">http://www.astar-federal.com</a> *</li> <li><input type="checkbox"/> Carefirst of Maryland Medicare Part A (Maryland) <a href="http://www.marylandmedicare.com">http://www.marylandmedicare.com</a> *</li> <li><input type="checkbox"/> Veritus Medicare Part A (Pennsylvania) <a href="http://www.veritusmedicare.com">http://www.veritusmedicare.com</a> *</li> <li><input type="checkbox"/> First Coast Service Options Medicare Part A, subsidiary of BCBS of Florida (Florida) <a href="http://www.floridamedicare.com">http://www.floridamedicare.com</a> *</li> </ul>
<p><b>Medicare Part B Carrier</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> CIGNA Medicare Part B (Tennessee, North Carolina, and Idaho) <a href="http://www.cignamedicare.com">http://www.cignamedicare.com</a></li> <li><input type="checkbox"/> AdminaStar Medicare Part B (Indiana and Kentucky) <a href="http://www.astar-federal.com">http://www.astar-federal.com</a> *</li> <li><input type="checkbox"/> Palmetto Medicare Part B (South Carolina) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a> *</li> </ul>	<p><b>Medicare Regional DMERC</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Palmetto Region C DMERC (Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas and the Virgin Islands) <a href="http://www.palmettogba.com">http://www.palmettogba.com</a></li> </ul>	

\*Trading Partners currently in testing phase.

**Action to be taken:**

**Addition** - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.  
Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

**Change** - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.  
Medicare Provider number: \_\_\_\_\_ Medicaid Provider number: \_\_\_\_\_

Mail completed form to: EDS - Provider Enrollment  
PO Box 300009  
Raleigh, NC 27622

or

Fax: 1-919-851-4014

1-800-688-6696

Revised (02/05)

## PRIOR APPROVAL

### Services Requiring Prior Approval

Prior approval (PA) may be required for some services or procedures to verify medical necessity. PA is for medical approval only. However, PA must be obtained before rendering a service or procedure that requires prior approval. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

A recipient must be eligible for Medicaid coverage on the date the procedure is performed and must meet all medical necessity prior approval criteria. Retroactive PA is only considered when a recipient who does not have Medicaid coverage at the time of the procedure is later approved for Medicaid with a retroactive eligibility date.

Before admitting patients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit.

Unless a service is exempt from the Carolina ACCESS (CCNC) referral and authorization requirement, providers must obtain a referral authorization from the Carolina ACCESS (CCNC) enrollee's primary care provider in addition to requesting PA for any service or procedure that requires PA. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-11 for additional information.

Most requests for PA are submitted in writing to the EDS Prior Approval unit. However, requests for approval for services to recipients with a diagnosis of mental retardation may be faxed to EDS. Other services may be approved verbally and followed up with the written request. Requests for optical refractions are approved through the AVR system. Except in emergency situations, **all** services provided to Medicaid recipients by **out-of-state** providers must be approved prior to rendering the service. Refer to individual clinical coverage policies for specific instructions regarding prior approval (<http://www.dhhs.state.nc.us/dma/mp/mpindex.htm>).

Where applicable, PA forms should be completed and mailed to:

Prior Approval Unit  
EDS  
P.O. Box 31188  
Raleigh, NC 27622

Refer to the following table for a list of services that require PA and the process for obtaining PA.

Service	Verbal Authorization	Written Authorization
Community Alternatives Program (CAP/AIDS, CAP/C, CAP/Choice, CAP/DA)	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	After receiving verbal approval, the completed N.C. Medicaid Program Long Term Care Services form (FL2) (372-124) must be received by EDS within 10 working days.
Dental		Complete a 2002 ADA claim form.

Service	Verbal Authorization	Written Authorization
Services		
Durable Medical Equipment	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval for emergency repairs to orthotics or prosthetics only.	Complete a Certificate of Medical Necessity and Prior Approval form Form 372-131(8/02).
Eye Examinations and Refractions	Call the AVR system at 1-800-723-4337 to receive verbal approval (or 1-800-688-6696 if the AVR system is not in service).	Complete a general Request for Prior Approval form (372-118) for medically necessary exceptions to the AVR system limitations.
Hearing Aids		Complete a general Request for Prior Approval form (372-118).
Hospice	Call 1-800-688-6696 or 1-919-851-8888 to report hospice benefit elections	
Intermediate Care/Mental Retardation Services	You may fax a copy of the N.C. Medicaid MR2 Mental Retardation Services form (372-123) to 1-919-233-6834.  Effective September 1, 2005, forms should be faxed to 919-575-1083.	After receiving a faxed or verbal approval, the N.C. Medicaid MR2 Mental Retardation Services form (372-123) must be received by EDS within 10 working days.  Effective September 1, 2005, forms must be submitted to the Murdoch Center within 10 working days and not to EDS.
Long-Term Care	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	After receiving verbal approval, the N.C. Medicaid Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 working days; or, submit an electronic FL2 through Provider Link.
MPW Recipients		Complete a general Request for Prior Approval form (372-118).
Out-of-State Non-Emergency Services	Call 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining Out-of-State approval. No authorizations can be granted verbally. All requests must be submitted in writing. The requests should be faxed to 1-919-233-6834.	Complete a general Request for Prior Approval form (372-118). A letter from the attending physician requesting Out-of-State services, indicating why the services cannot be done in North Carolina and medical records must accompany the prior approval form.
Outpatient Specialized Therapies		Fax a Prior Approval for Outpatient Specialized Therapies form and supporting documents to Medical Review of N.C. at 1-800-228-1437.
PCS-Plus	No verbal authorization option is available.	Complete a PCS-Plus Request Form (DMA 3000-A) and fax the form to 1-919-715-2628.
Prescription Drugs	Call ACS State Healthcare at 1-866-246-8505	

Service	Verbal Authorization	Written Authorization
Private Duty Nursing	Fax PDN referral form with letter of medical necessity to 1-919-715-9025. Call 1-919-855-4380 to receive verbal approval.	
Psychiatric Services, Inpatient (PRTF; Residential Child Care; Criterion #5; Out-of-State Residential Services)	Call ValueOptions at 1-888-510-1150.	
Psychiatric Services, Outpatient	Call ValueOptions at 1-888-510-1150.	
Out of State and State-to-State Ambulance Service	Call 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining Out of State and State-to-State Ambulance Services approval. No authorization can be granted verbally. All requests are reviewed in writing.	Complete a general Request for Prior Approval form (372-118). A completed and signed Out of State and State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the prior approval form.
Surgery	Call 1-800-723-4337 to verify if a surgery requires prior approval.	Complete a general Request for Prior Approval form (372-118). Include documentation supporting medical necessity.
Therapeutic Leave (over 15 consecutive days)	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	Follow up approval with a written general Request for Prior Approval form (372-118).

### ***General Requests for Prior Approval***

The Request for Prior Approval North Carolina Medicaid Program form (372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. Once a PA has been issued, it must be used within one year. The following services use this form:

- surgery
- out-of-state elective services
- services to Medicaid for Pregnant Women recipients
- hearing aid services
- therapeutic leave over 15 consecutive days
- out-of-state and state-to-state ambulance service

**Note:** A completed and signed State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the PA request.

- additional eye exam/refraction services beyond AVRS limitations
- transplants

### ***Requests for Prior Approval of Out-of-State or State-to-State Ambulance Service***

Prior approval is required for ambulance service by ground or air ambulance from North Carolina to another state, from one state to another, or from another state back to North Carolina. Prior approval for ambulance service is separate from prior approval for a medical procedure or treatment done out-of-state. Requests for PA must be submitted on the general Request for Prior Approval form (372-118) and the State-to-State Ambulance Transportation Addendum form (372-118A).

### ***Requests for Prior Approval of Long-Term Care Services***

The FL2 Long-Term Care Services form (372-124) is used by several programs for approval of long-term care nursing services. The following services use this form:

- out-of-state long-term care (nursing facility)
- in-state head injury rehabilitation
- long-term care nursing
- ventilator dependent care
- Community Alternatives Program (CAP-AIDS, CAP-C, CAP-Choice, CAP-DA)

All electronic requests for long-term care nursing services must be submitted through Provider Link using the FL2e form.

### ***Requests for Prior Approval of Services Provided to the Mentally Retarded***

This MR2 Mental Retardation Services form (372-123) is used to assist in the review of services provided to mentally retarded clients. The initial review may be obtained by telephone or fax but a completed form must be submitted within 10 days of receiving verbal approval for final processing.

### ***Requests for Approval of Optical Services***

Requests for Routine Eye Exams and Refractions – Eye refractions do not require PA. However, it is in the best interest of the provider to obtain approval. PA numbers may be obtained by calling the AVR system. If a second refraction is requested within the time limitation period, a general Request for Prior Approval form (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to **Appendix A** for information about using the AVR system.

Requests for Prior Approval for Visual Aids – All visual aids require prior approval and requests must be submitted on a Request for Prior Approval for Visual Aids form (372-017). In some cases, this form must be accompanied by required documentation. Refer to the Optical Services Manual on DMA's website <http://www.dhhs.state.nc.us/dma/optical.htm> for information on services and limitations.

***Requests for Prior Approval of Hearing Aids, FM systems, and Accessories***

All hearing aids, FM systems, and accessories require prior approval. Requests must be submitted using the general Request for Prior Approval form (372-118) along with a letter from the physician or otologist stating medical necessity, the results of a hearing evaluation (to include audiogram), and the results of the hearing aid selection/evaluation tests.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also, in block 10, document the type of aid being requested (i.e., ANALOG PROGRAMMABLE, DIGITAL PROGRAMMABLE, OR FM SYSTEM).
- In block 12 document the reason(s) the recipient requires the requested system.

***Requests for Prior Approval of Dental Services***

Requests for PA for dental services are submitted using the 2002 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Services Policy/Provider Manual (#4A, Dental Services, and #4B, Orthodontic Services) on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. In order to easily access information submitted for PA, providers are encouraged to make a copy for their office records and note the date the PA was mailed.

***Requests for Prior Approval for Durable Medical Equipment and Orthotic and Prosthetic Devices***

Some durable medical equipment (DME) items and orthotic and prosthetic devices (O&P) require PA. In those cases, the Certificate of Medical Necessity/Prior Approval (CMN/PA) form must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the DME item is medically necessary to maintain or improve a recipient's medical, physical or functional level and to ensure that it is suitable and appropriate for use in the recipient's private residence or adult care home.

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to the **Clinical Coverage Policy #5A, Durable Medical Equipment** and **Clinical Coverage Policy #5B, Orthotic and Prosthetic Devices**, on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for additional information.

***Enhanced Care (Adult Care Home Recipients) Approval Process***

The recipient's case manager and the county department of social services (DSS) approves the recipient for enhanced care services. The case manager calls this approval in to the fiscal agent and receives a service review number. The case manager then sends the resident and the provider a decision notice.

***Hospice Participation***

This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice providers must also notify EDS when hospice benefits are revoked, a patient is discharged or a patient transfers from one hospice facility to another. Hospice participation information may also be obtained using the AVR system for dates of service May 1, 2000 and after.

Refer to **Appendix A** for information about using the AVR system.

### ***Utilization Review for Psychiatric Services***

The Medicaid program contracts with ValueOptions to provide utilization review of acute inpatient/substance abuse hospital care for recipients through age 64, Psychiatric Residential Treatment Facilities (PRTF), Levels II through IV Residential Treatment Facilities (four beds or more), outpatient psychiatric services, and Criterion #5.

After the eighth visit, providers must obtain authorization from ValueOptions for continued outpatient mental health services for recipients over the age of 21. ValueOptions reviews and approves the requests based on medical necessity according to established criteria. Recipients under the age of 21 are allowed 26 unmanaged visits.

Copies of the PA form can be obtained by calling ValueOptions at 1-888-510-1150.

Refer to the **December 2001 Special Bulletin IV, Mental Health and Substance Abuse Services Guidelines**, on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> for additional information.

### ***Prior Approval for Outpatient Specialized Therapies***

The Medicaid program contracts with Medical Review of N.C. (MRNC) to perform the PA process for outpatient specialized therapies. PA is required for continued treatment after six unmanaged visits, per discipline, per provider type. The PA request should be made at approximately the second (2<sup>nd</sup>) or third (3<sup>rd</sup>) visit to allow sufficient time for processing.

A completed and signed **Prior Authorization Request for Outpatient Specialized Therapy Services Form** and supporting documents must be faxed to MRNC at 1-800-228-1437 for treatment to be continued. If appropriate, MRNC will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form is available on MRNC's website at <http://www.mrnc.org>.

Once these limits have been reached, PA must again be requested for continued treatment.

Refer to **Clinical Coverage Policy #10A, Outpatient Specialized Therapies**, on DMA's website at <http://www.dhhs.state.nc.us/dma/mp/mpindex.htm> for additional information.

### ***Requesting Prior Approval for Prescription Drugs***

The Medicaid program contracts with ACS State Healthcare to manage the PA process for the following prescribed drugs:

- Procrit, Epogen, Aranesp
- Neupogen
- OxyContin
- Growth hormones
- Provigil
- Celebrex (for persons 59 years of age or younger)
- Botox, Myobloc

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by phone, fax, e-mail or mail. Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can dispense a 72-hour supply without PA.

Copies of the prescription PA forms may be obtained by calling ACS State Healthcare at 1-866-246-8505 or online at <http://www.ncmedicaidpbm.com>.

### **Six Prescription Override Requests**

In 1982, the N.C. General Assembly established a limitation of six prescriptions per recipient per month. Exemption from this limitation is authorized by the Department of Health and Human Services “when the life of the patient would be threatened without additional care.” Therefore, patients being treated for one of the conditions listed below can be exempted from the dispensing limitation if that action is deemed necessary by the primary prescribing physician.

- end-stage renal disease
- chemotherapy and radiation therapy for malignancy
- acute sickle cell disease
- hemophilia
- end-stage lung disease
- unstable diabetes
- terminal stage, any illness, or life-threatening, any illness

Physicians can request exemption from the dispensing limitation for those Medicaid patients who qualify by completing and signing a Six Prescription Limit Override form (DMA-3098) and sending the form to the pharmacy of record for the recipient. Physician assistants (PAs) and family nurse practitioners (FNPs) are also allowed to sign the form. This form negates the requirement to write the diagnosis on every prescription for the purpose of exempting recipients from the dispensing limitation.

The physician may mail or fax the form to the recipient’s pharmacy of record or the recipient may be asked to give the form to the pharmacist when the prescriptions are filled. The form must be updated every six months to validate the recipients continued qualification for the six-prescription override.

In compliance with Medicaid rules, pharmacists are required to retain these forms on file for five years. To bill the Medicaid program for more than six prescriptions per month, pharmacists **must** keep this form on file in the pharmacy at all times.

Two categories of recipients are exempt from the dispensing limitation of six prescriptions per month due to participation in a specific program:

- recipients participating in the Community Alternatives Program (CAP)
- recipients who are less than 21 years of age are exempt under guidelines established through the Health Check Program and EPSDT

It is not necessary for a physician to complete a form to exempt these recipients from the dispensing limitation. The program information is incorporated into the eligibility files.

A copy of the **Six Prescription Limit Override form (DMA-3098)** is available on page 6-9 or on DMA’s website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### **Procedures for Approval and Reimbursement of Transplants**

When a hospital transplant team determines that a patient requires a transplant (solid organ or stem cell) all of the supporting documentation justifying the medical necessity for the procedure must be sent to the Clinical Policy and Programs section at DMA for preapproval **if Medicaid will be the primary payer.**

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure except when a recipient is later approved for Medicaid with a retroactive eligibility date.

Upon review of the documentation, the physician and the facility will receive a notification of approval or denial from the Clinical Policy and Programs section at DMA. DMA does not authorize transplants for enrollees who have Medicare or private insurance. In order for DMA to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the Medicare denial/payment with the request for coverage of the transplant, and the complete transplant evaluation packet. The packet is then reviewed for clinical criteria.

Sample of Six Prescription Limit Override Form



NORTH CAROLINA
MEDICAID PHARMACY PROGRAM

Six Prescription Limit Override Form

North Carolina Medicaid recipients are allowed only six prescriptions per month unless they have one of the diagnoses listed below. If the attending physician, physician assistant (PA) or family nurse practitioner (FNP) determines that a recipient is eligible for the override, he/she must check all diagnoses that apply, complete the rest of the form, and sign in his own handwriting.

- [ ] Acute Sickle Cell Disease
[ ] Hemophilia
[ ] End Stage Lung Disease
[ ] End Stage Renal Disease
[ ] Unstable Diabetes
[ ] Chemotherapy or Radiation Therapy for Malignancy
[ ] Any Life Threatening Illness or Terminal Stage of Any Illness

Recipient's Name \_\_\_\_\_

Recipient's MID Number \_\_\_\_\_

Facility \_\_\_\_\_
(Fill out only if in nursing facility or adult care home)

Physician, PA, FNP \_\_\_\_\_
(Must PRINT and SIGN, name must be LEGIBLE)

Prescriber's DEA No. \_\_\_\_\_

Date \_\_\_\_\_

\* THIS FORM MUST BE UPDATED EVERY SIX MONTHS IF THE RECIPIENT STILL QUALIFIES FOR THE SIX PRESCRIPTION OVERRIDE

\* THIS IS THE ONLY ACCEPTED FORM AND MUST BE KEPT ON FILE IN THE PHARMACY AT ALL TIMES

THIS FORM MAY BE REPRODUCED

## THIRD PARTY INSURANCE

### Medicaid Payment Guidelines for Third Party Coverage

Federal regulations require Medicaid to be the “payer of last resort.” This means that all third parties insurance carriers including Medicare and private health insurance carriers must pay before Medicaid processes the claim. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

If the Medicaid-allowed amount is more than the third party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay an additional amount.

Certain Medicaid programs are not considered “primary payers” regarding the payer of last resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- Vocational Rehabilitation Services
- Division of Health Services of the Blind
- Division of Health Services “Purchase of Care” Programs
  - ◆ Cancer Program
  - ◆ Prenatal Program
  - ◆ Sickle Cell Program
  - ◆ Crippled Children’s Program
  - ◆ Kidney Program
  - ◆ School Health Fund
  - ◆ Tuberculosis Program
  - ◆ Maternal And Child Health Delivery Funds

### Services Provided to Medicare-Eligible Medicaid Recipients

Medicaid denies claims for those recipients age 65 and older who are entitled to Medicare benefits but do not apply for Medicare. The provider may bill the recipient for Medicare covered services under these circumstances.

### Capitated Payments

When a provider accepts a capitated payment from a private plan and bills Medicaid for any balance, the provider must **bill only the copayment amount** due from the recipient. **Do not bill Medicaid the full charges**, even with the capitated amount indicated as an insurance payment. Medicaid is not responsible for any amount in excess of that amount for which the recipient is responsible.

### Discounted Fee-for-Service Payments

The Medicaid program makes payment to providers on behalf of recipients for medical services rendered but Medicaid is not an “insurer.” Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient’s private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount that the provider has agreed to accept as payment in full from the private plan.

## Noncompliance Denials

Medicaid does not pay for services denied by private health plans due to noncompliance with the private health plan's requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay for the service.

If the recipient has a private plan and does not inform the provider of such plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services, if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the services. If, however, the recipient does present the private payer information to the provider and that provider knows that he or she is not a participating provider in the plan or cannot meet any of the private plan's other requirements, the provider must inform the recipient of such and also tell the recipient that he or she will be responsible for payment of services.

Common noncompliance denials include failure to get a referral from a participating primary care provider (PCP), failure to go to a participating provider, failure to acquire a second opinion, failure to acquire prior approval, etc.

## Third Party Liability

### *Determining Third Party Liability*

The following information helps providers to determine if a Medicaid recipient has third party liability (TPL):

1. Check the recipient's Medicaid identification (MID) card for a third party insurance information. The insurance data block lists the codes for up to three health or accident insurance policies and Medicare Part A or Part B applicable to the recipient. Insurance information on the card includes:
  - insurance company name (by code)
  - insurance policy number
  - insurance type (by code)
  - recipient covered by policy
2. Providers should ask the recipient prior to rendering service if he or she has any additional health insurance coverage or other TPL. If health insurance is indicated, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive payment from the insurance company or a written denial.
3. Check the Remittance and Status Report (RA). When a claim is denied for other insurance coverage (EOB 94), the provider's RA will indicate the other insurance company (by code), the policyholder name, and the certificate or policy number.

If the insurance company or other third party payer terminates coverage, providers must complete a Health Insurance Information Referral (DMA-2057) and attach a copy of the written denial. Send the form and the claim to DMA's Third Party Recovery (TPR) section at the address indicated on the form.

The form is also used to report:

- lapsed insurance coverage
- insurance coverage not indicated on the MID card

A copy of the **Health Insurance Information Referral (DMA-2057)** form is available on page 7-11 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### ***Time Limit Override on Third Party Insurance***

All requests for time limit overrides due to a third party insurance carrier that does not respond within the Medicaid time limit must be submitted to the TPR section and include documentation verifying that the claim was filed to the third party insurance carrier in a timely manner. Time limit overrides may be granted if the claim is filed within 180 days of the third party denial or payment.

### ***Refunds to Medicaid***

When a provider does not learn of other health insurance coverage for a recipient until after receipt of Medicaid payment, the provider must:

1. File a claim with the health insurance company.
2. Upon receipt of payment, refund Medicaid the insurance payment or the Medicaid payment in full, whichever is less.
3. The provider may keep the larger payment.

Unless DMA requests in writing that refunds should be sent to another address, provider refunds are sent to EDS.

Refer to **Provider Refunds** on page 8-10 for additional information on refunds to Medicaid.

## **Personal Injury Cases**

### ***Tort (Personal Injury Liability)***

Medicaid recipients may qualify for other third party reimbursements because of an accident, illness or disability. A third party, other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

N.C. General Statute §108A-57 allows the State subrogation rights (i.e., the State has the right to recover any Medicaid payments from personal injury settlement awards).

### ***Provider's Rights in a Personal Injury Case***

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the TPR section. If the provider has knowledge of the accident at the time of filing the claim, a Third Party Recovery Accident Information Report (DMA-2043) must be submitted with the claim. A DMA-2043 must also be submitted when anyone requests a copy of the bill. A copy of the **Third Party Recovery Accident Information Report (DMA-2043)** is available on page 7-12 or on DMA's website at <http://www.dhhs/state.nc.us/dma/forms.html>.

The following information is required by the TPR section to pursue a case, and will assist the provider when filing a claim with the liability carrier:

- name of insurance company
- name of insured person responsible
- insurance policy number
- name and address of the attorney, if any

**Note:** A copy of a letter sent by an attorney or insurance carrier to the provider requesting information will suffice in lieu of the DMA-2043.

### ***Billing for Personal Injury Cases***

The provider must choose between billing Medicaid and billing the liability carrier. Providers **cannot** initially file a casualty claim with Medicaid, receive payment, and then bill the liability carrier (or the recipient) for the same service, even if the provider refunds Medicaid.

The provider cannot bill the recipient, Medicaid or the liability carrier for the difference between the amount Medicaid paid and the provider's full charges. (See *Evanston Hospital V. Hauck*, 1 F.3d 540 [7<sup>th</sup> Cir. 1993])

If the provider withholds billing Medicaid, the provider has six months from the date of a denial letter or receipt of payment from the insurance company to file with Medicaid, even where it is in excess of the 365-day filing deadline.

The following requirements must be met:

- The provider must file a claim with the third party carrier or attorney within 365 days from the date of service.
- The provider makes a bona fide and timely effort to recover reimbursement from the third party.
- The provider submits documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

### ***Payment for Personal Injury Cases***

When Medicaid payment is received, the provider is **paid-in-full** and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and receives a liability payment, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment.

Providers may receive liability payments when the providers have not pursued or sought third party reimbursement. The provider may not keep any liability payment in excess of Medicaid's payment. Pursuant to federal regulations and the *Evanston* case, there is a distinction between private health insurance payments and other liable third party payments.

### ***Refunds and Recoupments for Personal Injury Cases***

If Medicaid discovers that a provider received Medicaid payment and communicates with a third party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether or not the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

amount billed by provider to Medicaid	\$100.00
amount paid by Medicaid	\$50.00
amount paid by attorney/liability carrier	\$100.00
amount to be refunded to Medicaid	\$50.00
amount to be refunded to attorney/liability	\$50.00

### Third Party Liability – Commonly Asked Questions

#### 1. What is third party liability and how does it apply to me?

TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto or other liability carriers. There are state and federal laws, rules, and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services prior to Medicaid. The TPR section is responsible for implementing and enforcing these TPL laws. The TPR section implements and enforces these laws through both cost avoidance and recovery methods. Therefore, providers are required to seek payment from these third parties when you know of their existence prior to seeking payment from Medicaid.

#### 2. Why did my claim deny for EOB 094 "Refile indicating insurance payment or attach denial."?

The database indicates the recipient had third party insurance on the date of service for which you are requesting reimbursement. The records show this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you **must** file a claim with that insurance company prior to billing the Medicaid program. If you receive a denial that does not indicate noncompliance with the insurance plan or payment for less than your charges, bill the Medicaid program and, if appropriate, your claim will be processed. If the Medicaid allowable amount is greater than the insurance payment you received, Medicaid will pay the difference. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

If the insurance data was not indicated on the recipient's MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information on in the denial section of your RA.

**Note:** This denial code does not refer to Medicare.

#### 3. How do I determine the name and the address of the third party insurance company that is indicated on the recipient's MID card?

A list of Third Party Insurance Codes is available upon request from the TPR section or on DMA's website at <http://www.dhhs.state.nc.us/dma/tpr.html>. This code list provides the name and billing address for each code that is listed in the insurance data block on the MID card under the subheading "Name Code."

#### 4. How do I determine what type of insurance the recipient has?

The blue and pink MID cards list an insurance name code, policy number, and insurance type code. The buff MEDICARE-AID ID card lists the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third party resources as shown by the code on the MID card in the insurance data block under the subheading "Type."

The codes listed below are DMA codes and have no relationship with the insurance industry.

Code	Description	Code	Description
00	Major Medical Coverage	10	Major Medical & Dental Coverage
01	Basic Hospital w/Surgical Coverage	11	Major Medical & Nursing Home Coverage
02	Basic Hospital Coverage Only	12	Intensive Care Coverage Only
03	Dental Coverage Only	13	Hospital Outpatient Coverage Only
04	Cancer Coverage Only	14	Physician Coverage Only
05	Accident Coverage Only	15	Heart Attack Coverage Only
06	Indemnity Coverage Only	16	Prescription Drugs Coverage Only
07	Nursing Home Coverage Only	17	Vision Care Coverage Only
08	Basic Medicare Supplement		

If you have any questions, please call the TPR section, Cost Avoidance unit at 919-647-8100.

#### 5. What do I do when my claim denies for EOB 094 and no insurance is indicated on the MID card?

Refer to the RA that showed the claim denying for EOB 094. The insurance information, the policy holder's name, certification number, and a three-digit insurance code are listed below the recipient's name.

A list of Third Party Insurance Codes is available upon request from the TPR section or on DMA's website at <http://www.dhhs.state.nc.us/dma/tp.html>.

#### 6. What is considered an acceptable denial from an insurance company?

An acceptable denial is a letter or an EOB from the insurance company or group/employers on company letterhead that complies with the policy reflected in question #7. If a denial is questionable, the claim should be forwarded to the TPR section at the address listed below.

Division of Medical Assistance  
Third Party Recovery  
2508 Mail Service Center  
Raleigh, NC 27699-2508

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to EDS Provider Services at the address listed below.

EDS  
Provider Services  
P.O. Box 300009  
Raleigh, NC 27622

**7. Why did my claim deny for third party liability after I included an insurance denial as referred to in question #6?**

Due to recent changes in interpretation of federal laws, Medicaid denies payment for any service that could have been paid for by a private plan had the recipient or provider complied with the private plan's requirements.

Examples of common private plan noncompliance denials include:

- failure to get an authorization referral from a PCP
- nonparticipating provider
- failure to acquire a second opinion
- failure to acquire prior approval

In these circumstances, the provider may bill the recipient for these services provided the noncompliance was not due to provider error or the provider may appeal to the private plan.

It may be the provider's responsibility to secure such things as prior approval, referral authorization from the PCP or to fulfill other requirements of the private plans.

**8. What are the uses of the Health Insurance Information Referral Form (DMA-2057) and where do I obtain copies?**

The DMA-2057 form should be completed in the following instances:

- to delete insurance information, (i.e., a recipient no longer has third party insurance, but the MID card indicates other insurance)
- to add insurance information, (i.e., a recipient has third party insurance that is not indicated on the MID card)
- to change existing information (i.e., a recipient never had the third party coverage that is indicated on the MID card)

A copy of the form is available on page 7-11 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

**9. If the Medicaid recipient's private health insurance company pays the recipient directly, what may I bill the recipient?**

If the amount of the insurance payment is known, you may bill the recipient for that amount only. You may also file your claim to Medicaid indicating the third party payment amount in the appropriate block on your claim form and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, you may bill the patient the total charges until the payment amount is known.

**10. May I have an office policy that states I will not accept Medicaid in conjunction with a private insurance policy?**

Yes. A provider can refuse to accept Medicaid for recipients who also have third party coverage, even though they accept Medicaid for recipients who do not have third party coverage. However, providers must advise the recipient of their responsibility for payment before the services are rendered. The provider must obtain proper consent from the recipient for this arrangement.

**11. What do I do when a recipient or another authorized person requests a copy of a bill that I submitted to Medicaid?**

If you have already submitted the claim to Medicaid, whether you have received payment yet or not, and if you have the proper patient authorization, you may provide a copy of the bill to the recipient, an insurance company, an attorney or other authorized person. However, you can **ONLY** do so if you comply with the following requirement. All copies of any bill that has been submitted to Medicaid **MUST** state “**MEDICAID RECIPIENT, BENEFITS ASSIGNED**” in large, bold print on the bill. If you provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

**12. How do I determine the amount of refund due to Medicaid when Medicaid pays my claim and I subsequently receive payment from a third party insurance carrier?**

Once you have filed a claim with Medicaid and have received payment, your claim has been paid-in-full. Upon receipt of payment from the third party liability carrier, you must refund to Medicaid the amount of Medicaid’s payment and you must also refund to the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid’s payment for that service through assignment and subrogation. This includes the prohibition on the provider billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider’s full charges. This practice violates both state and federal laws.

The provider has the option to defer billing Medicaid and instead pursue a claim for full charges with the liability carrier. However, as long as the provider has filed a claim with the liability carrier within one year from the date of service, and is diligently pursuing reimbursement from that liability carrier, the provider may file a claim with Medicaid within 180 days of a denial or payment from that carrier, even though it may be greater than the 12-month time limit for filing with Medicaid.

**13. When do I file my claim to EDS and when do I file my claim to the TPR section?**

File your claim directly to EDS when:

1. The recipient has no private health insurance.
2. The insurance EOB reflects an insurance payment.
3. There is an insurance denial with the following reasons:
  - applied to the deductible
  - benefits exhausted
  - noncovered services (meaning the service was not and will never be covered under this policy)
  - pre-existing condition
  - Medicare/Medicaid dually eligible with no private health insurance

File your claim to the TPR section if the claim includes either a Health Insurance Information Referral Form (DMA-2057) or an insurance EOB indicating any other type of denial not mentioned in the question above.

**14. If the Medicaid recipient is required by their private insurance to pay a copayment amount, can this amount be collected up front at the time the services are rendered?**

No. The provider cannot bill the Medicaid recipient for the copayment amount unless the Medicaid payment is denied because the service was a noncovered service, and only then if the provider has advised the recipient in advance that the services are not covered.

## **Health Insurance Premium Payments**

### ***Payment of Health Insurance Premiums***

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer or AIDS. These recipients are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid recipients when the cost of the premium, deductible, and coinsurance is less than the anticipated Medicaid expenditure.

### ***Eligibility Determination***

To be eligible for Medicaid payment of premiums, the recipient must be authorized for Medicaid and have access to private health insurance. (In most cases it will be through an employer.) DMA will pay the premiums only on existing policies or those known to be available to the recipient (e.g., through COBRA). Premiums are only paid for a family coverage policy when the policy is cost effective and it is the only way the recipient can be covered. Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, coinsurance or cost-sharing obligations.

### ***Eligibility Process***

Medicaid reviews each recipient's case that meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost effectiveness determination, and notifies the recipient and the appropriate referral source.

When DMA determines that a group health insurance plan available to the recipient through an employer is cost effective, and the recipient is approved for participation in the HIPP program, the recipient is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. However, if it is determined that a non-group health plan is cost effective, DMA will pay the cost of the premium, coinsurance, and deductible of such a plan if the recipient chooses to participate.

### ***Where to Obtain Information***

Information about HIPP and the HIPP Application (DMA-2069) form are available through the local county department of social services (DSS) office. Brochures and applicable forms are also available in the local health departments, hospitals, hospices, rural health clinics, and Federally Qualified Health Centers (FQHC). A copy of the **HIPP Application (DMA-2069)** form is also available on page 7-13 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### **Medicaid Credit Balance Reporting**

Providers are required to submit a quarterly **Medicaid Credit Balance Report** (see page 7-14) reporting all **outstanding** Medicaid credit balances reflected in the accounting records as of the last day of each calendar quarter.

The report is used to monitor and recover “credit balances” due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. Credit balances include money that is due to Medicaid regardless of its classification in a provider’s accounting records.

For example, if a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to Medicaid. In these instances, the provider is responsible for identifying and repaying all of the monies due to Medicaid.

#### ***Completing and Submitting the Medicaid Credit Balance Report***

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The form provides space for 15 claims, but it may be reproduced as many times as necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the form.

Send the report to the TPR section at the address listed on the form no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31). **A report is required from hospital providers and long-term care facilities even if a zero (\$0.00) credit balance exists.**

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in the withholding of Medicaid payments until the report is received.

**Only** the completed form should be sent to the TPR section. Refunds or recoupment requests should be sent to EDS along with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to the TPR section.

Sample of Health Insurance Information Referral Form

Division of Medical Assistance

Health Insurance Information Referral Form

Recipient Name: \_\_\_\_\_

Recipient ID No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Health Ins. Co. Name (1) \_\_\_\_\_ Policy/Cert No. \_\_\_\_\_

(2) \_\_\_\_\_ Policy/Cert No. \_\_\_\_\_

Reason For Referral

- 1. \_\_\_\_\_ Recipient never covered by or added to above policy(s) (EOB attached)
- 2. \_\_\_\_\_ Recipient's insurance coverage terminated (EOB attached)
- 3. \_\_\_\_\_ New policy not indicated on Medicaid ID card (EOB or copy of insurance card attached) (Do not include Medicare)

Indicate type coverage:

_____ Major Medical	_____ Hosp/Surgical	_____ Basic Hospital
_____ Dental	_____ Cancer	_____ Accident
_____ Indemnity	_____ Nursing Home	

Attach original claim, a copy of the EOB or a copy of the insurance card and submit to: DMA - TPR, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) section will update the system and forward claims to EDS within 10 working days after receipt.

Provider Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Submitted By: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Sample of Third Party Recovery “Accident” Information Report**

RECIPIENT’S NAME:	
DATE OF BIRTH	
RECIPIENT’S MEDICAID ID# (IF KNOWN):	
RECIPIENT’S SOCIAL SECURITY NUMBER:	
COUNTY OF RESIDENCE	
DATE OF ACCIDENT:	
INJURY SUSTAINED:	
LAST DATE OF TREATMENT:	
<b>TYPE OF ACCIDENT:</b>	<input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Medical Malpractice <input type="checkbox"/> Product Liability <input type="checkbox"/> Other
INSURED RESPONSIBLE FOR ACCIDENT:	
POLICY/CLAIM NO.:	
INSURANCE COMPANY OR AGENT:	
MAILING ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	
RECIPIENT’S ATTORNEY:	
MAILING ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	
COMMENTS:	
SUBMITTED BY:	TITLE:
DATE:	TELEPHONE NO.:

**Mail Original To:** North Carolina Department of Health and Human Services  
 Division of Medical Assistance/Third Party Recovery Section  
 2508 Mail Service Center  
 Raleigh, NC 27699-2508  
 Telephone No.: (919) 647-8100





**Sample of Medicaid Credit Balance Report, continued**

**Instructions for Completing Medicaid Credit Balance Report**

Complete the “Medicaid Credit Balance Report” as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility’s **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/03)

Column 4 - The month, day, and year of ending service (e.g., 12/10/03)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: “81” if it is a result of a Medicare payment; “83” if it is the result of a health insurance payment; “84” if it is the result of a casualty insurance/attorney payment or “00” if it is for another reason. Please explain “00” credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508.**

## RESOLVING DENIED CLAIMS

### Claim Adjustments

#### *Resubmission of a Denied Claim*

The Medicaid Claim Adjustment form is used to adjust a previously paid claim or a denied claim with an EOB other than one of the EOBs from the list on page 8-6. Do not use the Medicaid Claim Adjustment form to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit.

When submitting adjustment requests, always attach a copy of any Remittance and Status Report (RA) related to the adjustment as well as any medical records that could justify the reason for paying a previously denied claim. It is suggested that providers include a corrected claim when submitting an adjustment but it is not required if the claim was filed electronically.

Within 30 days of filing a Medicaid Claim Adjustment Request form, the status of the claim will be listed on the RA as “pending.” If the status does not appear as pending, verify that the recipient’s Medicaid identification (MID) number and the internal claim number (ICN) are complete and correct. If the MID number or ICN is incorrect, refile the adjustment request with the correct information.

#### *Instructions for Completing the Medicaid Claim Adjustment Request Form*

The instructions for completing the Medicaid Claim Adjustment Request are listed below. A copy of the **Medicaid Claim Adjustment form** is on page 8-12 and on DMA’s website at <http://www.dhhs.state.nc.us/dma/forms.html>.

Line	Instruction
<b>Provider Number</b>	Indicate the billing provider’s number.
<b>Provider Name</b>	Enter the name of billing provider.
<b>Recipient Name</b>	Enter the recipient’s name exactly as it appears on the MID card.
<b>Recipient ID</b>	Enter the recipient’s MID number as it appears on the MID card.
<b>Claim Number</b>	Enter the ICN followed by the 5-character financial payer code as indicated on the RA. Always reference the original ICN even if you have a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number.
<b>Date of Service</b>	Enter the beginning and the ending date of service covered on the original claim.
<b>Billed Amount</b>	Enter the amount billed on original claim.
<b>Paid Amount</b>	Enter the amount paid on original claim.
<b>RA Date</b>	Enter the date the original claim was paid.
<b>Type of Adjustment</b>	Indicate reason for the adjustment (i.e., overpayment, underpayment, full recoupment, etc.).

**Instructions for Completing the Medicaid Adjustment Request Form**, continued

Line	Instruction	
<b>Changes or Corrections to be Made</b>	Indicate the reason for the adjustment:	
	<b>Units</b>	Indicate the correct number of units.
	<b>Dates of Service</b>	Indicate the correct date of service.
	<b>Third Party Liability</b>	Indicate the TPL amount on the adjustment form and include a copy of the TPL voucher showing payment.
	<b>Procedure/ Diagnosis Code</b>	Indicate the combined procedure code or revenue code and the corrected billed amount.
	<b>Patient Liability</b>	<p>Include the latest Patient Monthly Liability form (DMA-5016) pertaining to the date of service. Include all related RAs showing a liability amount applied to the claim.</p> <p>The adjustment request will be reviewed by DMA's Third Party Recovery section. If your RA indicates an EOB 9607 <i>Adjustment being reviewed for change in patient liability</i>, do not refile the adjustment, it will be processed for you, do not resubmit an adjustment. DMA resubmits these adjustments for the provider.</p>
	<b>Medicare Adjustment</b>	<p>Attach the original and the adjusted Medicare vouchers. Use the ICN for the previously paid claim for the claim referenced on the adjustment form.</p> <p>Indicate all related Medicare vouchers. If Medicare processing necessitates an adjustment payment of two separate claims, the provider should send both claim copies and both Medicare vouchers. Use the ICN for the denied duplicate claim for the claim referenced on the adjustment form.</p>
	<b>Billed Amounts</b>	Indicate the total billed amount on the adjustment request form. Do not use the difference of the original claim and the adjusted claim as the billed amount.
	<b>Further Medical Review</b>	Submit only the medical records, operative notes, anesthesia records, etc., that may affect the claims payment. These records are used by medical staff to determine whether to reimburse the providers or deny the adjustment as paid correctly.
	<b>Other – Duplicate Denials</b>	When filing an adjustment for a duplicate denial for a CMS-1500 claim, attach medical records or radiology reports for the dates of service in question. Do not submit the adjustment form or medical records with front and back copies. All records and forms are scanned on front side only.
<b>Specific Reason for Adjustment Request</b>	Indicate the reason for the adjustment. If the adjustment is a result of procedures not being combined, indicate the codes that are being combined. If the adjustment is necessitated by incorrect units, indicate the total number of correct units as it should have appeared on the original claim along with the corrected billed amount and the correct date of service.	
<b>Signature of Sender</b>	Indicate the name of the person filling out the form.	
<b>Date</b>	Indicate the date the adjustment request is submitted or mailed.	
<b>Phone number</b>	Indicate the area code and phone number for the person filling out the form.	

***Tips for Filing Adjustments***

The most common mistakes that are made when filing adjustments are:

- Incomplete or invalid MID information or ICNs.
- Multiple ICNs on the same form.
- The reason for the adjustment request is not specified or it is too general.
- A copy of the RA related to the request is not included when the form is submitted.
- The original ICN is not referenced on the form or a denied adjustment ICN is used.
- A partial payment or partial recoupment number is not referenced as the original ICN.
- The adjustment is filed after the 18-month time limit.

**Note:** If an adjustment is not filed until the 17th month from the date of service, the original claim may no longer be available in the system for adjustment. Submit adjustments as soon as possible so they can be processed within the 18-month time limit.

- Required documentation is missing from the adjustment request (i.e., Medicare vouchers, medical records, operative records, etc.).

The following tips will assist in completing the adjustment form.

- Complete only one adjustment form per claim; a separate adjustment request form for each line item on a single claim is not necessary.
- Reference only one ICN per adjustment form.
- If requesting a review of a previously denied adjustment, reference the original ICN and resubmit with all supporting documentation related to the adjustment. Do not reference the ICN for the denied adjustment.
- Include a copy of the appropriate RA with each adjustment request. If multiple RAs were involved in the claim payment process, include copies of each RA.
- Include a copy of the claim that is referenced on the adjustment request.

**Note:** This is not required for electronically submitted claims.

- When the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not obliterate previously paid details on the claim.
- Include pertinent information on a separate sheet of paper. Do not write information on the back of the adjustment form, RAs, etc.
- Ensure that all of the information submitted with the adjustment request is legible.
- Send only the medical records that pertain to the services rendered. If it is necessary to send records with other information included, identify the portion of the record that is significant to the adjustment request.
- Only the claim that pertains to the payment or denial in question should be submitted with the adjustment request. Do not submit any other claims with the adjustment request. Claims for service dates that have not been submitted should be filed as a new day claim, including late charges for codes not previously filed.
- When submitting an adjustment to Medicaid due to a Medicare adjusted voucher, attach both the original voucher and the adjusted Medicare voucher. Reference the ICN of the original voucher.
- If requesting a review of a previous partial payment or a partial recoup adjustment, reference the ICN for the adjustment and resubmit with all supporting documentation related to the adjustment.

***Submitting an Adjustment Electronically***

With the implementation of HIPAA standard claims transactions, adjustments may now be filed electronically. There are two separate actions that may be filed:

1. Void – in order to file a claim to be voided, the provider must mark the claim as a voided claim using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-92) on the 837 electronic claim transaction. The ICN for the original claim to be voided must also be provided. When processed, the claim associated with the original ICN will be recouped from the patient's record and the payment will be recouped from the providers RA.
2. Replacement – a replacement claim may be filed by completing a corrected electronic claim and marking the claim as a replacement using the Claim Submission Reason Field (Dental and CMS-1500) and Type of Bill (UB-92) on the electronic claim transaction. The ICN for the original claim to be replaced must also be provided. The original claim will be recouped from the patient's record and shown as a recoupment on the RA when the replacement claim processes and pays without error. If the replacement claim denies, the entire replacement process will deny, including the recoupment.

Paper adjustments will continue to be accepted and processed by N.C. Medicaid. Although adjustments may be filed electronically, providers are advised to file adjustments on paper when paper documentation is required.

**Pharmacy Claim Adjustments**

A Pharmacy Adjustment Request form is available for providers that DO NOT file point of sale (POS). This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the Pharmacy Adjustment Request form to:

- override a Maximum Allowable Cost (MAC) payment when medical necessity is properly documented
- correct an erroneous quantity or National Drug Code (NDC) for a paid prescription
- credit Medicaid for a billed and paid prescription that was never dispensed
- credit Medicaid for a billed and paid prescription for unit-dose drugs that were unused
- correct Pharmacy of Record denials when submitted with a copy of the Medicaid card stub

**Instructions for Completing the Pharmacy Adjustment Request Form**

The instructions for completing the Pharmacy Adjustment Request form are listed below. A copy of the **Pharmacy Adjustment Request form** is on page 8-13 and on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.htm>.

<b>Line</b>	<b>Instruction</b>
<b>Recipient Medicaid Number</b>	Enter the recipient's MID number as it appears on the MID card.
<b>Recipient Name</b>	Enter the recipient's name exactly as it appears on the MID card.
<b>Pharmacy Name and Provider Number</b>	Enter the name of the pharmacy and the pharmacy's Medicaid provider number.
<b>Rx Number</b>	Enter the prescription number assigned by the pharmacy to the prescription on claim to be adjusted.
<b>Drug Name</b>	Enter the name of the drug dispensed including the strength and the dosage form (abbreviated).
<b>NDC</b>	Enter the 11-digit NDC for the prescription.
<b>Quantity</b>	Enter the corrected quantity to be billed using up to five digits.
<b>Billed Amount</b>	Enter the corrected total to be billed for the prescription claim.
<b>Date Filled</b>	Enter the date the prescription was filled using the MM/DD/YY format.
<b>Claim Number</b>	Enter the ICN of the previously paid or denied claim.
<b>Denial EOB</b>	Do not enter information in this block unless the claim was denied with EOB 0985 <i>Exceeding Prescription Limitation</i> .
<b>Insurance Paid</b>	Indicate a correction of omission of Other Payer Amount by placing an "X" in this box. Indicate in the "Adjustment Reason" block that the adjustment request is for an omission of Other Payer Amount. Attach appropriate documentation of the other payer amount to the adjustment request.
<b>Adjustment Reason</b>	State why a correction is needed.
<b>Paid Amount</b>	Enter the amount of the last Medicaid payment for the claim identified by the ICN listed in the "Claim Number" block.

**EOB Denials that Do Not Require Filing an Adjustment**

In most situations, if one of the following EOBs is received and the validity is questionable, providers should not appeal by submitting an adjustment request. Adjustments submitted for these EOB denials will be denied with EOB 998 which states "Claim does not require adjustment processing, resubmit claim with corrections as a new day claim" or EOB 9600 which states "Adjustment denied; if claim was with adjustment it has been resubmitted. The EOB this claim previously denied for does not require adjusting. In the future, resubmit a new or corrected claim in lieu of sending an adjustment request." Also, if a claim does receive an EOB that is not included on this list, do not automatically file an adjustment because that may not be how that specific claim situation should be resolved. Please contact EDS Provider Services at 1-800-688-6696 or 919-851-8888 if there are any questions on how to resolve a specific denial. (Last Revision 12/15/04)

0002	0069	0128	0181	0237	0327	0572	0670	0860	0942
0003	0074	0129	0182	0240	0356	0576	0671	0863	0943
0004	0075	0131	0183	0241	0363	0577	0672	0864	0944
0005	0076	0132	0185	0242	0364	0579	0673	0865	0945
0007	0077	0133	0186	0244	0394	0578	0674	0866	0946
0009	0078	0134	0187	0245	0398	0580	0675	0867	0947
0011	0079	0135	0188	0246	0424	0581	0676	0868	0948
0013	0080	0138	0189	0247	0425	0584	0677	0869	0949
0014	0082	0139	0191	0249	0426	0585	0679	0875	0950
0017	0084	0141	0194	0250	0427	0586	0680	0888	0952
0019	0085	0143	0195	0251	0428	0587	0681	0889	0953
0023	0089	0144	0196	0253	0430	0588	0682	0898	0960
0024	0090	0145	0197	0255	0435	0589	0683	0900	0967
0025	0093	0149	0198	0256	0438	0590	0685	0905	0968
0026	0094	0151	0199	0257	0439	0593	0688	0908	0969
0027	0095	0153	0200	0258	0452	0604	0689	0909	0970
0029	0100	0154	0201	0270	0462	0607	0690	0910	0972
0033	0101	0155	0202	0279	0465	0609	0691	0911	0974
0034	0102	0156	0203	0282	0505	0610	0698	0912	0986
0035	0103	0157	0204	0283	0511	0611	0732	0913	0987
0036	0104	0158	0205	0284	0513	0612	0734	0916	0988
0038	0105	0159	0206	0286	0516	0616	0735	0917	0989
0039	0106	0160	0207	0289	0523	0620	0749	0918	0990
0040	0108	0162	0208	0290	0525	0621	0755	0919	0991
0042	0110	0163	0210	0291	0529	0622	0760	0920	0992
0041	0111	0164	0213	0292	0536	0626	0777	0922	0995
0046	0112	0165	0215	0293	0537	0635	0797	0925	0997
0047	0113	0166	0217	0294	0548	0636	0804	0926	0998
0049	0114	0167	0219	0295	0553	0641	0805	0927	1001
0050	0115	0170	0220	0296	0556	0642	0814	0929	1003
0051	0118	0171	0221	0297	0557	0661	0817	0931	1008
0058	0120	0172	0222	0298	0558	0662	0819	0932	1022
0062	0121	0174	0223	0299	0559	0663	0820	0933	1023
0063	0122	0175	0226	0316	0560	0665	0822	0934	1035
0065	0123	0176	0227	0319	0574	0666	0823	0936	1036
0067	0126	0177	0235	0325	0575	0668	0824	0940	1037
0068	0127	0179	0236	0326	0569	0669	0825	0941	1038

**Note:** This list is not all-inclusive.

**EOB Denials that Do Not Require Filing an Adjustment, continued**

1043	1233	2270	5225	7907	7944	7981	9104	9231	9295
1045	1275	2335	5226	7908	7945	7982	9105	9232	9600
1046	1278	2911	5227	7909	7946	7983	9106	9233	9611
1047	1307	2912	5228	7910	7947	7984	9174	9234	9614
1048	1324	2913	5229	7911	7948	7985	9175	9235	9615
1049	1350	2914	5230	7912	7949	7989	9180	9236	9625
1050	1351	2915	6703	7913	7950	7990	9200	9237	9630
1057	1355	2916	6704	7914	7951	7991	9201	9238	9631
1058	1380	2917	6705	7915	7952	7992	9202	9239	9633
1059	1381	2918	6707	7916	7953	7993	9203	9240	9642
1060	1382	2919	6708	7917	7954	7994	9204	9241	9684
1061	1396	2920	7700	7918	7955	7995	9205	9242	9801
1062	1399	2921	7701	7919	7956	7996	9206	9243	9804
1063	1400	2922	7702	7920	7957	7997	9207	9244	9806
1064	1404	2923	7703	7921	7958	7998	9208	9245	9807
1078	1422	2924	7705	7922	7959	7999	9209	9246	9919
1079	1442	2925	7706	7923	7960	8174	9210	9247	9947
1084	1443	2926	7707	7924	7961	8175	9211	9248	9993
1086	1502	2927	7708	7925	7962	8326	9212	9249	
1087	1506	2928	7709	7926	7963	8328	9213	9250	
1091	1513	2929	7712	7927	7964	8327	9214	9251	
1092	1866	2930	7717	7928	7965	8400	9215	9252	
1152	1868	2931	7733	7929	7966	8401	9216	9253	
1154	1873	2944	7734	7930	7967	8901	9217	9254	
1156	1944	2988	7735	7931	7968	8902	9218	9256	
1170	1949	3001	7736	7932	7969	8903	9219	9257	
1175	1956	3002	7737	7933	7970	8904	9220	9258	
1177	1999	3003	7738	7934	7971	8905	9221	9259	
1178	2024	5001	7740	7935	7972	8906	9222	9260	
1181	2027	5002	7741	7936	7973	8907	9223	9261	
1183	2147	5201	7788	7937	7974	8908	9224	9268	
1184	2148	5206	7794	7938	7975	8909	9225	9269	
1186	2149	5216	7900	7939	7976	9036	9226	9272	
1197	2235	5221	7905	7940	7977	9054	9227	9273	
1198	2236	5222	7901	7941	7978	9101	9228	9274	
1204	2237	5223	7904	7942	7979	9102	9229	9275	
1232	2238	5224	7906	7943	7980	9103	9230	9291	

**Note:** This list is not all-inclusive.

## Resolution Inquiries

The Medicaid Resolution Inquiry form is used to submit claims for:

- time limit overrides
- Medicare overrides
- third party overrides
- resolution inquiries

When submitting inquiry requests, always attach the claim and a copy of any RAs related to the inquiry request, as well as any other information related to the claim. Each inquiry request requires a separate form and copies of documentation (vouchers and attachments). Because these documents are scanned for processing, only single-sided documents should be attached to the inquiry request. **Do not attach double-sided documents to the inquiry request.** A copy of the **Medicaid Resolution Inquiry form** is on page 8-14 and on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

### *Time Limit Overrides*

All Medicaid claims, except hospital inpatient and nursing facility claims, must be received by EDS within 365 days of the **first date** of service in order to be accepted for processing and payment. All Medicaid hospital inpatient and nursing facility claims must be received within 365 days of the **last date** of service on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the RA date to refile a claim.

If the claim was initially received and processed within the 365-day time limit, that claim can be resubmitted on paper or electronically as a new day claim. The new day claim must have an exact match of recipient MID number, provider number, from date of service, and total billed. Claims that do not have an exact match to the original claim in the system will be denied for one of the following EOBs:

**0018** *Claim denied. No history to justify time limit override. Claims with proper documentation should be resubmitted to EDS Provider Services Unit.*

**8918** *Insufficient documentation to warrant time limit override. Resubmit claim with proof of timely filing - a previous RA, time limit override letter, or other insurance payment or denial letter within the previous six months.*

Because DMA and EDS have limited authority under federal regulations to override the billing time limit, requests for time limit overrides must document that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Correspondence from DMA and EDS about the specific claim received.
- An explanation of Medicare benefits or other third party insurance benefits dated within 180 days from the date of Medicare or other third party payment or denial.
- A copy of the RA showing that the claim is pending or denied. The denial must be for reasons other than time limit.

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received by EDS within the 365-day time limit.

If a claim is submitted for processing beyond the 365-day time limit, attach the claim and required documentation to the Medicaid Resolution Inquiry form and mail to the address indicated on the inquiry form.

**Instructions for Completing the Medicaid Resolution Inquiry Form**

The instructions for completing the Medicaid Resolution Inquiry form are listed below. A copy of the **Medicaid Resolution Inquiry form** is on page 8-14 and on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

<b>Line</b>	<b>Instruction</b>
<b>Provider Number</b>	Enter the billing provider's number.
<b>Provider Name and Address</b>	Enter the name and address of the billing provider.
<b>Recipient Name</b>	Enter the recipient's name exactly as it appears on the MID card.
<b>Recipient ID</b>	Enter the recipient's MID number as it appears on the MID card.
<b>Date of Service</b>	Enter the beginning and the ending date of service.
<b>Claim Number</b>	If the claim was previously processed, enter the ICN followed by the 5-character financial payer code as indicated on the RA. If this is the first submission, this information is not required.
<b>Billed Amount</b>	Enter the amount billed on the claim.
<b>Paid Amount</b>	If applicable, enter the amount paid on original claim.
<b>RA Date</b>	If applicable, enter the date the original claim was paid.
<b>Specific Reason for Inquiry</b>	Indicate the reason for the inquiry (i.e., time limit override, TPL override, Medicare override). Identify attachments (i.e., RAs, medical records, TPL or Medicare vouchers, etc.).
<b>Signature of Sender</b>	Indicate the name of the person filling out the form.
<b>Date</b>	Indicate the date the adjustment request is submitted or mailed.
<b>Phone number</b>	Indicate the area code and phone number for the person filling out the form.

## Recoupments

### *Automatic Recoupments*

If previously paid claims would cause a current claim to deny during the audit review, EDS will initiate an adjustment to recoup the previously paid charges. This procedure ensures proper payment of services rendered. The following list includes, but is not limited to, examples of automatic recoupments:

- A current claim is filed for dialysis treatment, which includes previously paid charges. EDS will initiate an adjustment to recoup the previous payments in order to pay the dialysis treatment code (i.e., lab, supplies, etc).
- A hospital files an inpatient claim on the same date of service as an outpatient claim. EDS will recoup the outpatient charges to pay the inpatient claim.
- A physician submits a claim and is paid for lab services that were performed at an independent lab. The independent lab also files a claim, which denies as a duplicate. EDS will initiate an adjustment to recoup the charges paid to the attending physician for the lab services and pay the claim submitted by the independent lab.
- The assistant surgeon's or anesthesiologist's claim is filed without the appropriate modifier and is paid as though it were the primary surgeon, subsequently causing the primary surgeon's claim to deny as a duplicate. When an adjustment request is received from the primary, EDS will initiate a recoupment of the incorrect payment from the assistant surgeon or the anesthesiologist in order to pay the surgeon. The assistant surgeon or anesthesiologist must then submit a corrected claim with the appropriate modifiers.

## Provider Refunds

Overpayments, third party reimbursements, and incorrect claim submissions may occur in the processing of Medicaid claims. The following section explains the Medicaid refund process. If the provider is not aware of other insurance coverage or liabilities for the recipient until after the receipt of Medicaid payment, the provider must still file a claim with the health insurance company, then refund to Medicaid the lesser of the two amounts received.

For example:

amount billed by provider to Medicaid	\$50.00
amount paid by Medicaid	\$40.00
amount paid by private insurance	\$45.00
amount to be reimbursed to Medicaid	\$40.00

Refunds are submitted in accordance with the following instructions:

1. Highlight on the RA the appropriate recipient, claim information, and dollar amount of the refund to apply to that recipient.

2. Attach a copy of the RA to the check.

If a copy of the RA is not available, document the information listed below by whatever means are available and include it with the check. This information is **required** in order to apply the funds against the correct provider claim and recipient history.

- provider number
- recipient name and MID number
- ICN
- date(s) of service
- dollar amount paid
- dollar amount of refund
- reason for refund (brief explanation)

An attempt will be made to contact the provider if any of this required information is missing. If the missing information has not been provided to EDS within 30 days, the check will be returned to the provider.

3. Make the refund check payable to EDS.

**Note:** If the refund is in response to a written request from DMA, make the refund check payable to DMA and mail it to the address indicated in the refund request letter

4. Mail the refund with the requested information to:

EDS  
ATTN: Finance  
P.O. Box 300011  
Raleigh, NC 27622-3011

Once refunds are entered into the system, the following data will appear on the next RA distributed to the provider:

- The Financial Items section will contain a listing of refunds issued and processed for the provider. EOB 0113 is indicated for any refund transaction.
- The Credit Amount field in the Claims Payment Summary will indicate the total amount of refund(s) processed, thereby giving credit for the returned funds. As a result of returning those funds, the "Net 1099 Amount" field is decreased by the refund amount to ensure the IRS is informed of the correct amount of monies received and kept by the provider. Refund transactions do not affect the Claims Paid, Claims Amount, Withheld Amount or Net Pay amount fields in this section.

If a refund is sent due to a claim billing error and you wish to resubmit the claim, please ensure that you have received credit on your RA as noted above. This will eliminate any possibility of the resubmitted claim being denied due to a duplicate claim.

Sample of Medicaid Claim Adjustment Request

MEDICAID CLAIM ADJUSTMENT REQUEST

(This form is not to be used for claim inquiries or time limit overrides.)
PLEASE COMPLETE THIS FORM IN BLUE OR BLACK INK ONLY

MAIL TO:

EDS ADJUSTMENT UNIT
PO BOX 300009 (NC Medicaid)
PO BOX 300020 (IPRS)
RALEIGH, NC 27622

A CORRECTED CLAIM
AND THE APPROPRIATE
RA MUST BE ATTACHED

EDS USE ONLY

One Step: \_\_\_\_\_

Provider #: \_\_\_\_\_ Provider Name: \_\_\_\_\_
Recipient Name: \_\_\_\_\_ MID#: \_\_\_\_\_

SUBMIT A COPY OF THE
RA WITH REQUEST

Claim #: [Grid of boxes for claim number]

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ Billed Amount: Paid Amount: RA Date:
Of To: \_\_\_\_/\_\_\_\_/\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_
Service: \_\_\_\_\_

Please check ( ) reason for submitting the adjustment request:

- Over Payment Under Payment Full Recoupment Other

Please check ( ) changes or corrections to be made:

- Units Procedure/Diagnosis Code Billed Amount
Dates of Service Patient Liability Further Medical Review
Third Party Liability Medicare Adjustments Other
(Attach all related Medicare Vouchers)

EDS USE ONLY
Do not write in this box

Please Specify Reason for Adjustment Request:

Signature Of Sender: Date: Phone #:
/ / ( ) -

EDS INTERNAL USE ONLY

Clerk ID#: \_\_\_\_\_ Sent to: \_\_\_\_\_ Date sent: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for review: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Outcome of review: \_\_\_\_\_

Date received back in the Adjustment Department: \_\_\_\_/\_\_\_\_/\_\_\_\_

Revised 01/26/05



Sample of Medicaid Resolution Inquiry Form

MEDICAID RESOLUTION INQUIRY

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: [ ] Medicare Override [ ] Time Limit Override [ ] Third Party Override

NOTE: PLEASE USE THIS FORM FOR OVERRIDES AND INQUIRIES ONLY. CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED. ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: \_\_\_\_\_

Provider Name and Address: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Recipient ID: \_\_\_\_\_

Date of Service: From: / / to / / Claim Number: \_\_\_\_\_

Billed Amount: \_\_\_\_\_ Paid Amount: \_\_\_\_\_ RA Date: \_\_\_\_\_

Please Specify Reason for Inquiry Request:

Signature of Sender: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

TO BE USED BY EDS ONLY

Remarks:
Revised 7/1/03

## REMITTANCE AND STATUS REPORT

### What is the Remittance and Status Report

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted to EDS, along with a detailed breakdown of payment. The RA is produced at the same time that checks or electronic funds transfers are generated. If the RA is 10 pages or less for any checkwrite, it is mailed with the reimbursement check. If the RA is more than 10 pages, it is mailed under separate cover.

To assist in keeping all claims and payment records current, retain all RAs. RAs should be kept in a notebook or filed in chronological order for easy reference.

Reviewing the RA is the first step in claim resolution. If you are unable to resolve the claim by reviewing the RA or have questions concerning claims payment, contact the EDS Provider Services unit for assistance at 1-800-688-6696 or 919-851-8888, option three.

### Remittance and Status Report Sections and Subsections

The RA is composed of information identified by subject headings. Each major subject heading is further divided into subsections depending on provider types or claim type.

#### *Paid Claims*

This section shows all of the claims that were paid or partially paid since the previous checkwrite. The subsections under this section are dependent upon provider type. For example, the Paid Claims section for hospital RAs is subdivided into:

- inpatient claims
- outpatient claims
- inpatient crossovers
- outpatient crossover claims

The Paid Claims section for physician RAs is subdivided into:

- medical claims
- screening claims for Health Check providers
- crossover claims

Claims are listed in each subsection alphabetically by the recipient's last name. A subtotal follows each subsection with the grand total following the entire section.

#### *Adjusted Claims*

This section shows the status of claims when requests for action have been made to correct overpayment, underpayment or payment to the wrong provider. Some of the most common causes for adjustments are clerical errors, incorrect claim information or incorrect procedure coding. There are no subsections under this heading.

#### *Informational Adjustment Claims*

This section is on the RA to comply with regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA). This section is informational and reports data related to refunds processed by Medicaid.

***Denied Claims***

This section identifies claims that have been denied for payment because of various improper or incomplete claim entries. The claims listed in this section are divided into subsections to indicate the type of bill that was processed. Claims are listed in each subsection alphabetically by the recipient's last name. A zero appears in all of the columns to the right of the "Non-Allowed" column. A denial explanation code is located in the far right-hand column. No action is taken by EDS on denied claims. To resolve the denial, providers must correct and resubmit the claim.

***Claims in Process***

This section lists claims that have been received and entered by EDS but are pending payment because further review of the claims is needed. Do not resubmit claims that are pending payment.

***Financial Items***

This section contains a listing of provider refunded payments, recoupments, payouts, and other financial activities that have taken place for the current checkwrite. The recoupments, refunds, and other recovered items appear as credits against the provider's total earnings for the year. Payouts appear as debits against the total earnings for the year. The explanation code beside each item indicates the type of action that was taken for that item.

***Claims Summary***

The Claims Summary section is only used for specific providers. It is divided into inpatient and outpatient subsections. Following each subsection is a summary of the revenue code totals from all of the claims listed in each subsection.

***Claims Payment Summary***

This section summarizes all payments, withheld amounts, and credits made to the provider for both the current checkwrite cycle – Current Processed – and for the current year – Year To Date Total.

***Financial Payer Code***

A financial payer code follows the internal control number (ICN) assigned to each claim. It is located on the first line of the claim data reflected on the RA. This financial payer code denotes the entity responsible for payment of the claims listed on the RA. Medicaid is the only financially responsible payer. Therefore, the Medicaid payer code, NCXIX, will be listed.

**Population Group Payer Code**

The RA reflects the population payer code for each claim detail. The population payer code is printed at the beginning of each claim detail line on the RA. The population payer code denotes the special program/population group from which a recipient is receiving Medicaid benefits. Examples of population payer codes are as follows:

Code	Name	Description
CA-I	Carolina ACCESS	All recipients enrolled in Medicaid's Carolina ACCESS (CCNC) program.
CA-II	ACCESS II	All recipients enrolled in Medicaid's ACCESS II (CCNC) program.
HMOM	Health Maintenance Organization (HMO)	All recipients enrolled in Medicaid's HMO program.
NCXIX	Medicaid	All recipients not enrolled in any of the above noted population payer programs. Any recipient not identified with Carolina ACCESS (CCNC), ACCESS II (CCNC) or HMO will be assigned the NCXIX population payer code to identify them with the Medicaid fee-for-service program.

Other population payers may be designated by DMA in the future.

**New Totals Following the Current Claim Total Line**

An additional line is added following each claim total line of the paid and denied claim sections of the RA for the following claim types:

- Medical (J)
- Dental (K)
- Home Health, Hospice and Personal Care (Q)
- Medical Vendor (P)
- Outpatient (M)
- Professional Crossover (O)

This additional line provides a summary of the original claim billed amount, original claim detail count, and the total number of financial payers.

Because they are not processed at the claim detail level and do not have multiple financial payers assigned, a summary of this information is not listed for the following claim types:

- Drug (D)
- Inpatient (S)
- Nursing Home (T)

**Summary Page**

For each Medicaid population payer identified on the RA, a summary page showing total payments by population payer is provided at the end of the RA. This provides population payer detail information for tracking and informational purposes.

### Remittance and Status Report Field Descriptions

Claims are listed alphabetically by the recipient's last name. The charge for each procedure or service billed for that recipient is listed on a separate line. Information about each charge is listed on the RA. The following table provides an explanation of the fields on the RA.

Field	Explanation
Name	The recipient's name is listed by last name in this field.
County Number	A numeric code for the recipient's county of residence is listed in this field.
RCC	The ratio of cost-to-charge, which indicates the percent of Total Allowed charge to be paid (where applicable), is listed in this field.
Claim Number	The unique 20-digit ICN assigned to each claim by EDS for internal control purposes is listed in this field.  <b>Note:</b> This number must be referenced when corresponding with EDS about a claim.
Recipient ID	The recipient's MID number is listed below the recipient's name.
Medical Record Number	If a provider chooses to use a medical record number when submitting a claim, the first nine characters of the number are displayed in this field. If no medical record number is entered on the claim, the RA will list the Medical Record Number as 0.
Population Group	The Population Payer Code denoting the special program/population group from which a recipient is receiving Medicaid benefits is listed in this field.
Service Dates	The "From" (beginning) date of service and the "To" (ending) date of service are listed in this field in the MMDDCCYY format.
Days or Units	The number of times a particular type of service is provided within the given service dates is indicated in this field. Depending on the provider type, either the number of days or the units of service is shown. Decimal quantities are appropriate.
Type of Service	The Medicaid conversion for the TOS billed is indicated in this field.
Procedure/ Accommodation/ Drug Code and Description	The procedure, service or drug code is listed in this column. For providers mandated to use modifiers when billing, the modifiers are printed below the description of service. These provider types will not show TOS except on claims for which TOS is still used (e.g., Health Check).
Total Billed	The total amount the provider bills for each procedure/service is listed in this column.
Non Allowed	The difference between the Total Billed column and the Total Allowed column is listed in this column.

**Remittance and Status Report Field Descriptions, continued**

Field	Explanation
Total Allowed	The total amount Medicaid allows for a particular procedure or service is listed in this column. The charge billed for each service is determined to be either a "covered charge" or a "noncovered charge." The Total Allowed is zero for a noncovered charge. (Total Allowed = Total Billed – Non-allowed)
Payable Cutback	The difference between the Medicaid allowed amount and the amount that Medicaid pays for a particular procedure or service based on the revenue code or reimbursement amount is entered in this column.
Payable Charge	The number in this column is the amount that Medicaid will pay the provider before other deductions (copayment, patient liability, third party liability) are taken. This is calculated by multiplying the amount in the Total Allowed column by the REIM X RCC or 100% of the statewide schedule or 100% of the billed amount, whichever is less.
Other Deducted Charges	Other sources of medical service funds must be deducted from the Payable Charge amount or cost before the Medicaid program pays the charge. These deductions include third party liability, patient liability, and copayment. (The deductions are listed below the claim information for each recipient.)  <b>Note:</b> For hospital claims, patient liability is deducted from the Total Billed and is shown in the non-allowed column.
Paid Amount	This column lists the amount paid to the provider. (Paid Amount = Payable Charge – Other Deducted Charges)
Explanation Codes	A numeric explanation code for each procedure or service billed is listed in this column. The code explains the method of payment or reason for denial. A list of the codes and descriptions is located on the last page of the RA.
Deductible (Spendedown)	The total amount of the deductible (spenddown) is listed below the claim information for each recipient. This amount is applied to the Billed Amount for each procedure or service billed until the total amount of the deductible is met.
Patient Liability Copayment Third Party Liability	A listing of these amounts follows the claim information. These items are totaled and entered in the Other Deducted Charges column. They are deducted from the Payable Charge.
Difference	Difference between the Medicaid projected payment (a calculation of the difference between the Medicaid allowable and the Medicare payment) and the actual Medicaid payment when Medicaid pays the Medicare co-insurance or deductible
Original Detail Count	The number of items (procedures or services) billed is listed in this field.
Total Financial Payers	The number of entities responsible for payment is listed in this field.

### Explanation of the Internal Claim Number

Each claim processed by the Medicaid program is assigned a unique 20-character Internal Claim Number (ICN). The ICN is used on the RA to identify the claim and to trace the claim through the processing cycle. The ICN identifies how and when EDS received the claim and how it was processed by assigning numeric codes for the following:

<u>Region</u>	<u>Year</u>	<u>Julian Date</u>	<u>Batch</u>	<u># of Claims in Batch</u>	<u>Payer Code</u>
The first two digits indicate whether the claim was submitted on paper, electronically by modem or diskette, electronically by magnetic tape or as an adjustment.	The next four digits indicate the year that the claim was received.	The next three digits indicate the date the claim was received in the EDS mailroom. The Julian calendar is used to identify the numerical day of the year. (For example, 001 = Jan 1 and 365 = Dec 31.)	The next three digits represent the identification number that is assigned to paper claims, which are batched into groups of 100 as they are received and scanned into the system.	The next three digits represent the number that is assigned to each claim within the batch of 100. (For example, 000 = first claim and 990 = last claim.)	The 5-character payer code denotes the entity responsible for payment of the claim. (For example, NCXIX = North Carolina Medicaid).

<u>Submission Type</u>	<u>Explanation of Region</u>	<u>Region</u>	<u>Year</u>	<u>Julian Date</u>	<u>Batch</u>	<u># of Claims</u>	<u>Payer Code</u>
Paper Submission	A paper claim received in the EDS mailroom and keyed by EDS.	10	2005	001	600	000	NCXIX
Electronic Submission (PC)	Claim submitted electronically through a personal computer by either modem or mail-in diskette.	25	2005	365	600	990	NCXIX
Electronic Submission (Tape)	Electronic claim submitted by magnetic tape.	15	2005	002	600	010	NCXIX
Medicare Crossover	Medicare crossover received by EDS from Medicare on magnetic tape. If the claim is not automatically crossed over from Medicare and the provider submits the claim copy and EOMB, the claim number will begin with a 10 indicating a paper claim.	40	2005	005	300	500	NCXIX
Adjustment Request	Adjustment requested by the provider, EDS or DMA. A previous payment was made on this claim.	90 or 95	2005	300	980	100	NCXIX
Refund	Refund sent to EDS from the provider.	91	2005	246	750	002	NCXIX

**Example:** Claim number 102005061600000NCXIX indicates a paper claim received by EDS mailroom on March 1, 2005. It is the first claim in batch 600.

## ELECTRONIC COMMERCE SERVICES

### **What Services are Available**

The EDS Electronic Commerce Services unit offers the following services to providers:

- Electronic Claims Submission
- Electronic Funds Transfer

### **Electronic Claims Submission**

The process of submitting claims to Medicaid through electronic media is referred to as Electronic Claims Submission (ECS). This type of claim submission offers the provider a low-cost, highly reliable alternative to paper claim submission. EDS currently processes claims through the following electronic formats: modem, magnetic tape, and diskette. Ninety percent of all Medicaid claims are currently submitted electronically. Electronic claims processing can improve the way Medicaid works through:

- **Improved Cash Flow**

Claims submitted electronically are processed faster than paper claims so payments are received more quickly. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed by the following checkwrite.

**Note:** The Electronic Cut-Off schedule and the Checkwrite schedule are available on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>.

- **Time Saving**

Billing software allows the user to quickly complete the claims entry process by providing time saving features such as automatically inserting certain pieces of information, retrieving old claims from backup files, and generating lists of commonly used billing codes.

- **Ease of Use**

ECS automates Medicaid claim tracking. By utilizing the capabilities inherent in some software packages, providers can create reports and track paid and denied claims. Electronic back-up files easily facilitate claim resubmission.

- **Support**

ECS analysts are available Monday through Friday, 8:00 a.m. through 4:30 p.m. at 919-851-8888 or 1-800-688-6696, menu option 1.

### **Billing Claims Electronically**

All providers who submit claims electronically – whether they are submitted through a clearinghouse or with software obtained from an approved vendor or from EDS – must complete and return an ECS provider agreement to DMA for each billing provider number. If the Medicaid billing number is a group number, page three of the agreement must be completed by all of the individuals in the group.

Notification of approval is mailed back to the requesting party within 10 working days. Notification of approval must be received from DMA before providers can begin billing electronically. To obtain a copy of this agreement, contact the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1.

Providers and clearinghouses who bill electronic HIPAA-compliant transactions directly to N.C. Medicaid are required to complete and submit a Trading Partner Agreement to EDS. The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. TPAs must be on file prior to testing electronic transactions with N.C. Medicaid. The EDS Electronic Commerce Services Unit will work with the trading partner's staff to exchange and analyze technical information. The TPA form is available on DMA's website at <http://www.dhhs.state.nc.us/dma/hipaa.htm>.

Billing with the North Carolina Electronic Claims Submission Web-based Tool – The North Carolina Electronic Claims Submission Web-based (NCECS-Web) tool is available to providers at no charge. NCECS-Web can only be used to bill claims to Medicaid. Providers are required to receive a **logon identification number** (also known as an **authorization number** or **submitter ID**) and **password** to access NCECS-Web. NCECS-Web will replace all previous versions of NCECS software issued by N.C. Medicaid.

Billing with Software Obtained from a Vendor - A variety of software programs that provide integrated health insurance billing are also available. Providers must obtain software from a vendor who has written the program using specifications adopted under HIPAA. For a list of approved vendors, call the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1.

After verifying that the vendor has tested their software with EDS, call the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1, to obtain a **logon identification number** and a **password**. It is not necessary to test the software prior to submitting claims. Once providers are notified that the logon and password have been activated, they can begin submitting claims electronically.

Billing with Software Written by your Office or Company – Facilities and providers who wish to develop their own billing software must obtain the appropriate proprietary specifications for the type of claims they will be submitting (nursing facility, hospital, PCS, etc.). HIPAA Transaction Implementation Guides may be obtained from Washington Publishing Company at [www.wpc-edi.com](http://www.wpc-edi.com). In addition, N.C. Medicaid Companion Guides, designed for use in conjunction with HIPAA Transaction Implementation Guides, may be found at <http://www.dhhs.state.nc.us/dma/hipaa/compguides.htm>. Once the software program has been written, call the ECS unit at 1-800-688-6696 or 919-851-8888, menu option 1, to obtain a **test logon identification number** and a **password**.

Providers are asked to submit 5 to 20 test claims electronically. These claims can be previously paid claims or new claims that will be submitted for payment at a later date. Claims must have valid information and dates of service that are not over one year old. The claims are tested for billing information and format accuracy.

The EDS Testing Coordinator contacts providers with test results within 5 to 7 working days. No payments are made on test claims. When testing is complete, the provider is responsible for refile the claims for payment. After successful completion of testing, a working logon identification number and password are assigned to the provider.

Billing through a Clearinghouse – Providers may choose to contract with a clearinghouse to submit claims to Medicaid. The clearinghouse must use HIPAA-compliant software. It is not necessary for providers to test the software. The clearinghouse handles all of the connection procedures and claim submission processes for the provider.

***Helpful Hints for Testing***

Listed below are helpful hints for successful testing:

- Learn how to bill Medicaid. The billing instructions provided in this document are the same whether billing electronically or on paper.
- Do not type dashes or spaces when entering the recipient's Medicaid identification (MID) number.
- Do not type decimal points or spaces when entering the diagnosis code(s).
- Some diagnosis codes and procedure codes must be billed as paper claims due to the need for further medical review.

***Electronic Data Interchange Services  
Value Added Networks***

Value Added Networks (VANs) refers to the services used for transporting data from point to point. Electronic Data Interchange (EDI) vendors offer the services that are needed to begin utilizing online services such as:

- interactive recipient eligibility verification
- batch claim transmission
- point-of-sale (POS) interactive claim transmission (for pharmacies)

***Interactive Recipient Eligibility Verification***

Providers may wish to contract the services of an EDI vendor for access to online recipient eligibility verification. Approved EDI vendors interface directly with the Medicaid recipient database maintained by EDS and provide network software verification services to providers at a reasonable cost. Providers also pay a transaction fee to Medicaid at a rate of \$.08 per transaction for each interactive (immediate real-time) inquiry and response and \$.06 per kilobyte of data for batch response. The transaction charges are deducted from the Net Pay Amount listed on the RA. The Adjusted Net Pay Amount equals the amount on the payment check.

The eligibility verification database is updated daily from the State's master eligibility file. This service option is available 24 hours per day, 7 days per week except during system maintenance: 1:00 a.m. to 5:00 a.m., EST on the 1<sup>st</sup>, 2<sup>nd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> Sunday and 1:00 a.m. to 7:00 a.m. on the 3<sup>rd</sup> Sunday.

To verify eligibility, providers must have:

1. the Medicaid provider's number to identify the provider making the inquiry
2. the recipient's MID number
3. either the recipient's social security number **OR** date of birth.
4. the date of service, which must be a specific date between the date of inquiry and the prior 12 months or a span of dates not more than one calendar month

The response to the eligibility inquiry includes:

1. the recipient's MID number
2. the name of recipient
3. the recipient's date of birth
4. the recipient's social security number if used to make inquiry
5. the coverage group for eligibility (e.g., MPW, MQB, MAA, etc.)
6. Managed Care enrollment, if applicable, including:
  - the HMO plan name and phone number
  - the name of the Carolina ACCESS (CCNC) primary care provider and phone numbers
7. Medicare part A or B
8. third party insurance coverage (data available up to three policies)

### Approved EDI Vendors

<b>WebMD Envoy</b>	<b>MediFax - EDI</b>
Two Lakeview Place	Building H
26 Century Blvd., Suite 601	1283 Murfreesboro Road
Nashville, TN 37214	Nashville, TN 37217-2421
Contact: Marketing Department	Contact: Marketing Department
1-800-845-6592	1-800-819-5003
<a href="mailto:service@webmd.net">service@webmd.net</a>	<a href="mailto:marketing@medifax.com">marketing@medifax.com</a>
<a href="http://www.webmd.com">http://www.webmd.com</a>	<a href="http://www.medifax.com">http://www.medifax.com</a>
<b>HDX</b>	<b>Passport Health Communications, Inc.</b>
51 Valley Stream Parkway	720 Cool Springs Blvd., Suite 450
Malvern, PA 19355-1751	Franklin, TN 37067
Contact: Marketing Department	Contact: Marketing, Lloyd Baker
1-888-826-9702	1-888-661-5657
<a href="http://www.siemensmedical.com">http://www.siemensmedical.com</a>	<a href="mailto:lloyd@passporthealth.com">lloyd@passporthealth.com</a>
	<a href="http://www.medicheck.com">http://www.medicheck.com</a>
<b>MedData</b>	
2100 Rexford Road, Suite 300	
Charlotte, NC 28211	
Contact: Marketing, Anne Brade	
1-877-633-3282	
<a href="mailto:info@medconnect.net">info@medconnect.net</a>	
<a href="http://www.medconnectonline.com">http://www.medconnectonline.com</a>	

**Important Telephone Numbers for Electronic Commerce Services**

Call 1-800-688-6696 or 919-851-8888, menu option 1, for inquiries on the following topics:

- ECS provider agreement
- EDI vendors
- software vendor list/file specifications
- NCECS-Web
- logon authorization
- tape RA requests
- transmission issues

To submit bisynchronous transmissions, dial 919-233-6839.

**Electronic Funds Transfer**

EDS offers Electronic Funds Transfer (EFT) as an alternative to paper checks. This service enables Medicaid payments to be automatically deposited in the provider's bank account. EFT guarantees payment in a timely manner and prevents checks from being lost or stolen.

To initiate the automatic deposit process, providers must complete and return the **Electronic Funds Transfer Authorization Agreement for Automatic Deposit form**. To confirm the provider's account number and bank transit number, a voided check must be attached to the form. A separate EFT form must be submitted for each provider number. Providers must submit a new EFT form if they change banks or bank accounts. A copy of the form is on page 10-8 or can be obtained on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>.

Completed forms can be returned by fax to the EDS Financial Unit at 919-816-3186 or by mail to the address listed on the form. Providers will continue to receive paper checks for two checkwrite periods before automatic deposits begin or resume to a new bank account. Providers can verify that the EFT process for automatic deposits has been completed by checking the top left corner of the last page of their RA, which will indicate **EFT number** rather than **check number**.

**Note:** EFT is not available to providers who have been terminated or providers with federal or state garnishments.

**Electronic Commerce Services - Commonly Asked Questions****1. What is the automatic deposit process?**

EDS generates a list of deposits on an electronic wire, which represents payments to providers who have chosen automatic deposit. This electronic wire is sent to the Federal Reserve Bank, which makes the transactions to the providers' bank. Simultaneously, the EDS account is debited for the funds.

**2. What are the advantages to automatic deposit?**

The major advantage is that automatic deposit eliminates needless worry about check delays and checks lost in the mail. It generally takes 2 to 3 weeks to reissue a lost check.

**3. How do I enroll for automatic deposit?**

Providers must complete an **Electronic Funds Transfer Authorization Agreement for Automatic Deposit form**. A copy of the form is available on page 10-8 or on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>. A separate form must be completed for each provider number your organization plans to enroll. A voided check **must** also be attached for each bank account to verify the account number and bank transit number.

**4. Where do I send my completed forms?**

Mail the completed form along with a voided check for each bank account to:

EDS  
P.O. Box 300011  
Raleigh, NC 27622  
ATT: Finance-EFT

Or fax to: EDS, ATT: Finance-EFT, 919-816-3186

**5. How will I know when my form has been processed and direct deposit begins?**

The last page of your RA indicates the method of your payment for that checkwrite. A "check number" or an "EFT number" is in the top left corner beneath your provider number.

**6. How long does it take for deposits to be credited to our account?**

Funds are automatically deposited into your account within four days of the checkwrite date. A copy of the Electronic Cut-off schedule and the Checkwrite schedule are available on DMA's website at <http://www.dhhs.state.nc.us/dma/prov.htm>.

**7. How can I be sure my bank received the money?**

Once EDS has completed the automatic deposit, it is each provider's bank's responsibility to receive the transaction and post it to your account. Transactions can be confirmed by calling your bank's Automatic Clearing House (ACH) department. You will need to provide the ACH department with your account number, the checkwrite date, and the amount of the transaction. This information can be obtained from your RA or by calling the Automated Voice Response (AVR) system at 1-800-723-4337.

Refer to **Appendix A** for instructions on using the AVR system.

**8. What do I do if I change my bank or my bank account?**

Simply fill out a new form with the new information. There is an interim time period of two checkwrites during which you receive a paper check before your automatic deposit resumes to the new bank account. Special tests are run during this time to verify accuracy with your new bank account. The top left corner of the last page of your RA will indicate "EFT number" rather than "check number" when your automatic deposit resumes.

**9. Will my RA go to the bank or to my current mailing address?**

The method of RA delivery does not change. RAs are sent to the mailing address on file with the Medicaid program.

**10. Are recoupments debited from my account?**

No. Completing the EFT form only authorizes Medicaid to make deposits to your account. However, your deposit may be reduced by claim recoupments as shown on the RA.

**11. Who do I call if I have a question about my automatic deposit?**

Call the ECS unit at 1-800-688-6696 or 919-851-8888.

Sample of Electronic Funds Transfer Authorization for Automatic Deposits Form

Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits

Electronic Data Systems (EDS) offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. This service will enable you to receive your Medicaid payments through automatic deposit at your bank while you continue to receive your Remittance and Status Report (RA) at your current mailing address. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page, attach a voided check, and return it by mail or fax to:

EDS, 4905 Waters Edge, Raleigh, NC, 27606
Or
Fax: 919-816-3186, Attention: Finance-EFT

EDS will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we receive this form. After that, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA, in the top left corner, it will state "EFT number", rather than "Check number", when the process has begun. Contact EDS Provider Services at 1-800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to EFT, and for helping us to make the Medicaid payment process more efficient for the Medicaid provider community.

We hereby certify this checking or savings account is under our direct control and access; therefore, we authorize Electronic Data Systems to initiate credit entries to our checking or savings account indicated below and the bank name below, hereafter called BANK NAME, to credit the same account number.

BANK NAME
BRANCH ADDRESS
CITY STATE ZIP CODE
BANK TRANSIT/ROUTING NO.
ACCOUNT NO.
CHECKING OR SAVINGS

This authority is to remain in full force and effect until EDS has received written notification from us of its termination in such time and in such a manner as to afford EDS a reasonable opportunity to act on it.

PROVIDER NAME
BILLING PROVIDER NUMBER
DATE SIGNED

Please list a name and telephone number of someone to contact with questions EDS may have on initiating this automatic deposit.

CONTACT TELEPHONE NUMBER

A VOIDED CHECK MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER FOR US TO PROCESS YOUR EFT.

Your Name 0101
123 Any Street
Anytown, USA 12345
Date
Pay to the Order of \$
Dollars
Bank of Anytown
Anytown, USA
For VOID SIGNATURE
123456789 11111111 0101

\* ONE EFT REQUEST FORM PER PROVIDER NUMBER

Revised 2/2004

## APPENDIX A

## N.C. MEDICAID PROGRAM AUTOMATED VOICE RESPONSE SYSTEM

24 Hours Per Day

1-800-723-4337

Except 1:00 a.m. to 5:00 a.m. on the 1<sup>st</sup>, 2<sup>nd</sup>, 4<sup>th</sup>, & 5<sup>th</sup> Sunday,  
and 1:00 a.m. to 7:00 a.m. on the 3<sup>rd</sup> Sunday

The Automated Voice Response (AVR) system allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. Using a touch-tone telephone, providers may inquire about the following:

☎ Current Claim Status	☎ Checkwrite Information	☎ Drug Coverage Information
☎ Procedure Code Pricing	☎ Prior Approval Information	☎ Recipient Eligibility Verification
☎ Hospice Participation	☎ Refraction Benefit Limitation	☎ Dental Benefit Limitations
☎ Managed Care Enrollment		
[Carolina ACCESS (CCNC), ACCESS II (CCNC) or HMO]		

Refer to the following transaction codes and information before placing your call. (Note: Providers will be allowed up to 15 transactions per call.)

<u>Transaction</u>	<u>Description</u>	<u>Required Information</u>
1	Verify Claim Status	Provider Number, MID, "FROM DOS", Total Billed Amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing and Modifier Information	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or Modifier Code and MID
6	Recipient Eligibility and Coordination of Benefits; Managed Care Status; Transfer of Assets Information; and CAP Program Enrollment	Provider Number, MID or SSN#, DOS, and "FROM DOS" <b>Note:</b> Response includes HMO or Carolina ACCESS (CCNC) PCP Name and Phone Number
7	Sterilization Consent or Hysterectomy Statement	Provider Number, MID, and DOS
9	To Repeat Options 1-7	

**Alphabetic Data Table**

The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to press the asterisk (\*) key before entering the numeric codes.

A- *21	E- *32	I- *43	M- *61	Q- *11	U- *82	Y- *93
B- *22	F- *33	J- *51	N- *62	R- *72	V- *83	Z- *12
C- *23	G- *41	K- *52	O- *63	S- *73	W- *91	
D- *31	H- *42	L- *53	P- *71	T- *81	X- *92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone key pad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

**Note:** Refer to the **July 2001 Special Bulletin II, Automated Voice Response System Provider Inquiry Instructions** for detailed instructions on using the AVR system. This special bulletin is available on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

## APPENDIX B

### CONTACTING EDS TELEPHONE INSTRUCTIONS

To access the EDS Provider Services Unit, Prior Approval Unit or Electronic Commerce Services Unit (ECS), call **1-800-688-6696** or **919-851-8888**.

Calls made from a touch-tone telephone will be routed to these units by an automated attendant. You may also access other units through the operator. Instructions for using our automated attendant are below:

For Electronic Commerce Services “Press 1”	For Prior Approval “Press 2”	For Provider Services “Press 3”
<p>If you select Electronic Claims Submission from the main menu, you will be prompted to:</p> <p><b>“Press 1 to reach an ECS Analyst”</b></p>	<p>If you select Prior Approval from the main menu, you will be prompted to:</p> <p><b>“Press 2 for Optical or Hearing Aid”</b></p> <p><b>“Press 3 for Long-Term Care, Surgery, or Out-of-State”</b> (This also includes Psychiatric and Ambulance prior approval)</p> <p><b>“Press 4 for Dental”</b></p> <p><b>“Press 5 for DME”</b></p> <p><b>“Press 9 for Enhanced Care, Therapeutic Leave or Hospice”</b> (This includes High Risk Intervention providers)</p>	<p>If you select Provider Services from the main menu, you will be prompted to:</p> <p><b>“Press 6 if you are a Physician’s Office, County Health Department, Independent Practitioner or Local Education Agency”</b> (This includes Health Check, Eye Care, Chiropractor, Ambulatory Surgery, Independent Practitioner, Nurse Midwife, Nurse Practitioner, Radiologist, Podiatrist, Health Related Services in Public School, Certified Registered Nurse Anesthetist, Independent Diagnostic Testing Facility, Independent Mental Health providers, and Anesthesiology providers)</p> <p><b>“Press 7 if you are a Hospital or a Long-Term Care Facility”</b> (This includes CDSAs, Mental Health, Psychiatric Residential Treatment Facility, Residential Child Care Facility (Level II-IV), Nursing Facility, Hearing Aid, and Dialysis providers)</p> <p><b>“Press 8 if you are a Pharmacy, Dental, Home Health Care, Personal Care, Durable Medical Equipment or Domiciliary Care Facility”</b> (This includes Ambulance, Community Alternatives Program, Durable Medical Equipment, DSS/DHS, Hospice, Home Infusion Therapy, Private Duty Nursing, Personal Care, Rural Health, FQHC, Adult Care Homes, At Risk Case Management, and HIV Case Management providers)</p>

**“For operator assisted calls, stay on the line or press “0.”**

Once you select the appropriate unit, your call will be transferred to an individual or placed in a queue for the first available agent. All calls placed in a queue are handled in the order in which they are received.

## APPENDIX C

## CONTACTING MEDICAID

## Telephone Contact List

Topic	Phone Number	Other Resources
Accident Related Issues	DMA Third Party Recovery 1-919-647-8100	<b>Third Party Recovery "Accident" Information Report</b> <a href="http://info.dhhs.state.nc.us/dma/forms.html">http://info.dhhs.state.nc.us/dma/forms.html</a>
ACH/PCS Retroactive Requests with DMA	Facility and Community Care 919-855-4260	
Advanced Directives	DMA Clinical Policy 1-919-855-4260	<b>Information on Advanced Directives is also available from the N.C. Extension Service</b> <a href="http://www.ces.ncsu.edu/depts/fcs/slide3/slide1.htm">http://www.ces.ncsu.edu/depts/fcs/slide3/slide1.htm</a>
Automatic Deposits (Electronic Funds Transfer)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	<b>Automatic Deposit (EFT) Form</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>
Baby Love	DMA Clinical Policy 1-919-855-4320	<b>Baby Love Program</b> <a href="http://www.dhhs.state.nc.us/dma/babylove.html">http://www.dhhs.state.nc.us/dma/babylove.html</a>
Billing Issues/Claim Inquiries	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	
Carolina ACCESS (CCNC)	DMA Managed Care 1-919-647-8170	<b>Managed Care Program</b> <a href="http://www.dhhs.state.nc.us/dma/mangcarewho.html">http://www.dhhs.state.nc.us/dma/mangcarewho.html</a>
Carolina ACCESS (CCNC) Enrollment Verification	AVR system 1-800-723-4337	<b>Using AVR to Check CA (CCNC) Enrollment – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Checkwrite Information	AVR system 1-800-723-4337	<b>Online Checkwrite Schedule</b> <a href="http://www.dhhs.state.nc.us/dma/2003check.htm">http://www.dhhs.state.nc.us/dma/2003check.htm</a>  <b>Using AVR to Access Checkwrite Schedule – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Claims Status	AVR system 1-800-723-4337	<b>Using AVR to Check Claim Status – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Community Alternatives Program Retroactive Requests	DMA Community Care 1-919-855-4340	
Coverage Issues	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	<b>Medicaid Medical Coverage Policies</b> <a href="http://www.dhhs.state.nc.us/dma/mp/mpindex.htm">http://www.dhhs.state.nc.us/dma/mp/mpindex.htm</a>
Denials for Eligibility	DMA Claims Analysis Unit 1-919-855-4045	
Denials for Reasons other than Eligibility or Private Insurance	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	<b>Medicaid Claim Adjustment Form</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>
Drug Utilization Review	DMA Program Integrity 1-919-647-8140	<b>Drug Utilization Review Section</b> <a href="http://www.dhhs.state.nc.us/dma/pipage3.htm">http://www.dhhs.state.nc.us/dma/pipage3.htm</a>
Electronic Claims Submission	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	<b>Electronic Commerce Services Agreement Form</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>

## APPENDIX C

## Telephone Contact List, continued

Topic	Phone Number	Other Resources
Electronic Funds Transfer (Automatic Deposits)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	<b>Automatic Deposit (EFT) Form</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>
Electronic Data Interchange (EDI)	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	
Eligibility Information – current day	AVR system 1-800-723-4337	<b>Using AVR to Check Eligibility Status – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Eligibility Information for dates of service over 12 months	DMA Claims Analysis Unit 1-919-855-4045	
Enrollment – Providers [including Carolina ACCESS (CCNC)]	DMA Provider Services 1-919-855-4050	<b>Provider Enrollment Packages</b> <a href="http://www.dhhs.state.nc.us/dma/provenroll.htm">http://www.dhhs.state.nc.us/dma/provenroll.htm</a>
Fee Schedules	DMA Financial Operations 1-919-855-4200 Fax: 919-715-0896	<b>Fee Schedule Request Form</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>  <b>DME, HIT, Orthotics and Prosthetics, and other Fee Schedules</b> <a href="http://www.dhhs.state.nc.us/dma/fee/fee.htm">http://www.dhhs.state.nc.us/dma/fee/fee.htm</a>
Forms	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	<b>Most forms, including blank claim forms, are available online</b> <a href="http://www.dhhs.state.nc.us/dma/forms.html">http://www.dhhs.state.nc.us/dma/forms.html</a>
Fraud and Abuse – Pharmacy	DMA Program Integrity 1-919-647-8140	<b>Pharmacy Review Section</b> <a href="http://www.dhhs.state.nc.us/dma/pipage3.htm#dur">http://www.dhhs.state.nc.us/dma/pipage3.htm#dur</a>
Fraud and Abuse – Other	DMA Program Integrity 1-919-647-8000	<b>Program Integrity</b> <a href="http://www.dhhs.state.nc.us/dma/pi.html">http://www.dhhs.state.nc.us/dma/pi.html</a>
Health Care Connection	DMA Managed Care 1-919-647-8170 or 1-704-373-2273	<b>Managed Care Program</b> <a href="http://www.dhhs.state.nc.us/dma/mangcarewho.html">http://www.dhhs.state.nc.us/dma/mangcarewho.html</a>
Health Check – Health Check Program	DMA Managed Care 1-919-647-8170	<b>Health Check Billing Guide 2005 –April 2005 Special Bulletin III</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Health Check - EPSDT	Clinical Policy and Programs 919-855-4260	<b>DMA EPSDT Policy Statement</b> <a href="http://www.dhhs.state.nc.us/dma/prov.htm">http://www.dhhs.state.nc.us/dma/prov.htm</a>
Health Insurance Payment Program	DMA Third Party Recovery 1-919-647-8100	
HMO Risk Contracting	DMA Managed Care 1-919-647-8170	<b>Managed Care Program</b> <a href="http://www.dhhs.state.nc.us/dma/mangcarewho.html">http://www.dhhs.state.nc.us/dma/mangcarewho.html</a>
Medicaid Bulletins	EDS Provider Services 1-800-688-6696 or 1-919-851-8888	<b>General and Special Bulletins are available online</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Medicare Crossovers	EDS Provider Enrollment 1-800-688-6696 or 1-919-851-8888	
NCECSWeb	EDS Electronic Commerce Services 1-800-688-6696 or 1-919-851-8888	<b>To access NCECSWeb</b> <a href="https://webclaims.ncmedicaid.com">https://webclaims.ncmedicaid.com</a> <a href="https://webclaimstest.ncmedicaid.com">https://webclaimstest.ncmedicaid.com</a>

## APPENDIX C

## Telephone Contact List, continued

Topic	Phone Number	Other Resources
Piedmont Cardinal Health Plan (PCHP)	Piedmont Provider Relations 1-800-958-5596	
Preadmission Screening and Annual Resident Review (PASARR)	First Health Services Corporation 1-800-639-6514	
Preadmission Review for Inpatient Psychiatric Admissions/Continued Stay	ValueOptions 1-888-510-1150	<b>ValueOptions North Carolina Service Center</b> <a href="http://www.valueoptions.com/provider/nc_medicaid/main.htm">http://www.valueoptions.com/provider/nc_medicaid/main.htm</a>
Prior Approval	EDS Prior Approval Unit 1-800-688-6696 or 1-919-851-8888  AVR system 1-800-723-4337	<b>Using AVR to Check PA Status – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Prior Authorization for Outpatient Specialized Therapies	DMA Clinical Policy 919-855-4310  Medical Review of NC 1-800-228-3365	<b>Outpatient Specialized Therapies – Clinical Coverage Policy 10A</b> <a href="http://www.dhhs.state.nc.us/dma/mp/mpindex.htm">http://www.dhhs.state.nc.us/dma/mp/mpindex.htm</a>  <b>Medical Review of NC</b> <a href="http://www.MRNC.org">http://www.MRNC.org</a>
Prior Authorization for Prescription Drugs	ACS State Healthcare 1-866-246-8505	<b>Prior Authorization for Prescription Drugs – April 2002 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>  <b>NC Medicaid Pharmacy Program</b> <a href="http://www.dhhs.state.nc.us/dma/pharmpa.htm">http://www.dhhs.state.nc.us/dma/pharmpa.htm</a>  <b>ACS State Healthcare website</b> <a href="http://www.ncmedicaidpbm.com/">http://www.ncmedicaidpbm.com/</a>
Private Insurance Update	DMA Third Party Recovery 1-919-647-8100	
Procedure Code Pricing	AVR system 1-800-723-4337	<b>Using AVR to Check Procedure Codes – July 2001 Special Bulletin II</b> <a href="http://www.dhhs.state.nc.us/dma/bulletin.htm">http://www.dhhs.state.nc.us/dma/bulletin.htm</a>
Provider Enrollment	DMA Provider Services 1-919-855-4050	<b>Provider Enrollment Packages</b> <a href="http://www.dhhs.state.nc.us/dma/provenroll.htm">http://www.dhhs.state.nc.us/dma/provenroll.htm</a>
Rate Setting and Reimbursement	DMA Financial Operations 1-919-855-4200	
Third Party Insurance Code Book	DMA Third Party Recovery 1-919-647-8100 Fax: 1-919-715-7705	<b>Third Party Insurance Codes</b> <a href="http://www.dhhs.state.nc.us/dma/tpr.html">http://www.dhhs.state.nc.us/dma/tpr.html</a>
Time Limit Overrides	DMA Claims Analysis 1-919-855-4045	

**APPENDIX C**

**EDS Address List**

<b>Adjustments/Medicaid Resolution Inquiries</b> EDS PO Box 300009 Raleigh, NC 27622	<b>ADA Claims</b> EDS PO Box 300011 Raleigh, NC 27622
<b>CMS-1500 Claims</b> EDS PO Box 30968 Raleigh, NC 27622	<b>Drug Rebates</b> EDS PO Box 300002 Raleigh, NC 27622
<b>General Correspondence</b> (Name of EDS Employee) EDS PO Box 300009 Raleigh, NC 27622	<b>Hysterectomy Statements</b> EDS PO Box 300012 Raleigh, NC 27622
<b>Medicare Crossovers (Part A Only)</b> EDS PO Box 300011 Raleigh, NC 27622	<b>Medicare/Medicaid Part B Only</b> EDS P.O. Box 30968 Raleigh, NC 27622
<b>Nursing Facility Claims-Medicare/Medicaid Part B Only</b> Attn: Nursing Facility Claims EDS P.O. Box 300009 Raleigh, NC 27622	<b>Pharmacy Claims</b> EDS PO Box 300001 Raleigh, NC 27622
<b>Prior Approval Requests</b> EDS PO Box 31188 Raleigh, NC 27622	<b>Returned Checks</b> EDS PO Box 300011 Raleigh, NC 27622
<b>Sterilization Consent Forms</b> EDS PO Box 300012 Raleigh, NC 27622	<b>UB-92 Claims</b> EDS PO Box 300010 Raleigh, NC 27622
When sending Certified mail, UPS or Federal Express, send to:  EDS (Name of EDS Employee or Department) 4905 Waters Edge Drive Raleigh, NC 27606	

**APPENDIX C**

**DMA Address List**

<p><b>Carolina ACCESS (CCNC)</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	<p><b>Claims Analysis and Medicare Buy-in</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>
<p><b>Clinical Policy and Programs</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	<p><b>Community Care Program</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>
<p><b>Eligibility Unit</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	<p><b>Financial Operations</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>
<p><b>Managed Care</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	<p><b>Program Integrity</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>
<p><b>Provider Services</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	
<p>Medicaid Credit Balance Reports and correspondence addressed to the Third Party Recovery Unit must be addressed to:</p> <p style="padding-left: 40px;"><b>Third Party Recovery Unit</b>                  Division of Medical Assistance                  2508 Mail Service Center                  Raleigh, NC 27699-2508</p>	
<p>If you do not know which DMA section or unit's address to use, send correspondence to the following general address:</p> <p style="padding-left: 40px;"><b>(Name of DMA employee)</b>                  Division of Medical Assistance                  2501 Mail Service Center                  Raleigh, NC 27699-2501</p>	
<p>When sending Certified mail, UPS or Federal Express, send to:</p> <p style="padding-left: 40px;">Division of Medical Assistance                  1985 Umstead Drive                  Raleigh, NC 27626</p>	

**APPENDIX D**

**EDS PROVIDER SERVICES REPRESENTATIVES**

**1-800-688-6696 or 919-851-8888**

<b>Specialty A – Physician</b>	<b>Specialty B – Hospitals</b>	<b>Specialty C – Community Care</b>
Ambulatory Surgery	Community Based Rehabilitation Services	Adult Care Homes
Anesthesiology	Dialysis	Ambulance
Chiropractor	Hearing Aid	At-Risk Case Management
CRNA	Hospital	CAP
Eye Care	Mental Health	Dental
Head Start	Long Term Care	DME
Health Department	Psychiatric Residential Treatment Facilities	FQHC/Rural Health (Health Check)
Health Related Services in Public Schools	Residential Child Care Facilities (Level II-IV)	HIV Case Management
Independent Diagnostic Testing Facilities		Home Health
Independent Mental Health Providers		Home Infusion Therapy
Independent Practitioner Program (IPP)		Hospice
Nurse Midwife		Personal Care Services
Nurse Practitioner		Pharmacy
Physicians		Private Duty Nursing
Planned Parenthood		
Use the grid on the following page to identify the provider representative for your specialty when contacting EDS Provider Services to schedule an on-site visit.		

**APPENDIX D****EDS Provider Services Representatives, continued****Physician Representatives**

<b>Myranda Harper</b>	<b>Shakera Sims</b>	<b>Kari Smith</b>	<b>Chris Ferrell</b>
Avery	Alexander	Alamance	Beaufort
Buncombe	Alleghany	Bladen	Bertie
Burke	Anson	Brunswick	Camden
Cherokee	Ashe	Caswell	Carteret
Clay	Cabarrus	Chatham	Chowan
Cleveland	Caldwell	Columbus	Craven
Gaston	Catawba	Cumberland	Currituck
Graham	Davidson	Duplin	Dare
Haywood	Davie	Harnett	Durham
Henderson	Forsyth	Hoke	Edgecombe
Jackson	Guilford	Johnston	Franklin
Lincoln	Iredell	Lee	Gates
Macon	Montgomery	Moore	Granville
Madison	Randolph	New Hanover	Greene
Mecklenburg	Richmond	Orange	Halifax
McDowell	Rowan	Pender	Hertford
Mitchell	Stanly	Person	Hyde
Polk	Stokes	Robeson	Jones
Rutherford	Surry	Sampson	Lenoir
Swain	Union	Scotland	Martin
Transylvania	Watauga		Nash
	Wilkes		Northampton
	Yadkin		Onslow
	Yancy		Pamlico
			Pasquotank
			Perquimans
			Pitt
			Rockingham
			Tyrell
			Vance
			Warren
			Wake
			Washington
			Wayne
			Wilson



**APPENDIX E****REQUESTING FORMS**

Refer to the following list for information on where to obtain forms.

<u>Form</u>	<u>Call or Copy</u>
ADA Dental Claim Form	ADA, 1-800-947-4746
Adult Care Home Personal Care Services Physician Authorization and Plan of Care (DMA-3050R)	EDS, 1-800-688-6696
Carolina ACCESS Medical Exemption Request	See page 4-33
Carolina ACCESS Override Request	See page 4-32
Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form	See page 4-26
Carolina ACCESS Provider Info Change Form	See page 3-18
CMS-1500 Claim Form	Office Supply Store
Electronic Funds Transfer (EFT) Authorization Agreement	See page 10-8
Fee Schedule Request	See page 3-14
Health Department Health Check Agreement	See page 4-24
Health Insurance Information Referral (DMA-2057)	See page 7-11
Health Insurance Premium Payment (HIP) Application	See page 7-13
Medicaid Claim Adjustment Form	See page 8-12
Medicaid Credit Balance Report	See page 7-14
Medicaid Resolution Inquiry	See page 8-14
Medical Record Release Form (for WIC Exchange of Information forms)	See page 4-31
Medical Transportation Assistance Notice of Rights (DMA-5046)	EDS, 1-800-688-6696
Medicare Crossover Reference Request	See page 5-30
Medicaid Provider Change Form	See page 3-16
Personal Care Services Physician Authorization and Plan of Care (DMA-3000)	EDS, 1-800-688-6696
Personal Care Services-Plus (PCS-Plus) Request Form (DMA 3000-A)	EDS, 1-800-688-6696
Pharmacy Adjustment Request	See page 8-13
Pharmacy Claim Form	EDS, 1-800-688-6696

\* Indicates the form is available on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>

**APPENDIX E**

<b><u>Form</u></b>	<b><u>Call or Copy</u></b>
Prior Approval Forms	
Certificate of Medical Necessity and Prior Approval Form (for DME)	EDS, 1-800-688-6696
FL2 Long-Term Care Services Form (372-124)	EDS, 1-800-688-6696
Request for Prior Approval N.C. Medicaid Program Form (372-118)	EDS, 1-800-688-6696
MR2 Mental Retardation Services Form (372-123)	EDS, 1-800-688-6696
Prior Approval for Psychiatric Inpatient Services	ValueOptions, 1-888-510-1150
Supplement to Dental Prior Approval (DMA-6022)	EDS, 1-800-688-6696
Visual Aids Prior Approval Form (372-017)	EDS, 1-800-688-6696
Provider Certification for Signature on File	See page 5-29
Provider Visit Request	EDS, 1-800-688-6696
Referral for Diagnosis and Treatment	EDS, 1-800-688-6696
Six Prescription Limit Override Form (DMA-3098)	See page 6-8
Sterilization Consent Form	EDS, 1-800-688-6696
Trading Partner Agreement	EDS, 1-800-688-6696
Third Party Recovery Accident Information Report (DMA-2043)	See page 7-12
UB-92 Claim Form	Office Supply Store
Utilization Review Report – Long-Term Care - FL12	EDS, 1-800-688-6696
WIC Exchange of Information Form for Infants and Children	See page 4-30
WIC Exchange of Information Form for Women	See page 4-29

\* Indicates the form is available on DMA's website at <http://www.dhhs.state.nc.us/dma/forms.html>

**APPENDIX F****TABLE OF ACRONYMS**

<b>270/271</b>	HIPAA Compliant Eligibility Benefit Inquiry/Response Electronic Transaction ASC X12N 270/271 004010X092A1
<b>276/277</b>	HIPAA Compliant Claim Inquiry and Response Electronic Transaction ASC X12N 276/277 004010X093A1
<b>278</b>	HIPAA Compliant Health Care Services Review and Response Electronic Transaction ASC X12N 278 004010X094A1
<b>820</b>	HIPAA Compliant Payroll Deducted and Other Group Premium Payment for Insurance Products Electronic Transaction ASC X12N 820 004010X061A1
<b>834</b>	HIPAA Compliant Health Care Services Review and Response Electronic Transaction ASC X12N 278 004010X094A1
<b>835</b>	HIPAA Compliant Health Care Claim Payment/Advice Electronic Transaction ASC X12N 835 004010X091A1
<b>837</b>	HIPAA Compliant Health Care Claim Electronic Transaction ASC X12N 837 004010X096A1 Institutional ASC X12N 837 004010X097A1 Dental ASC X12N 837 004010X098A1 Professional
<b>AAF</b>	Work First Family Assistance Medicaid Assistance Category
<b>ACH</b>	Adult Care Home
<b>ACH/PCS</b>	Adult Care Home Personal Care Services
<b>ADA</b>	American Dental Association
<b>AVR</b>	Automated Voice Response System
<b>BCBSNC</b>	Blue Cross and Blue Shield of North Carolina
<b>CA (CCNC)</b>	Carolina ACCESS (CCNC)
<b>CAHPS</b>	Consumer Assessment of Health Plans Survey
<b>CAP</b>	Community Alternatives Program
<b>CCNC</b>	Community Care of North Carolina
<b>CLIA</b>	Clinical Laboratory Improvements Amendment
<b>CMN/PA</b>	Certificate of Medical Necessity and Prior Approval
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CPT</b>	Current Procedural Terminology
<b>DFS</b>	Division of Facility Services
<b>DHHS</b>	Department of Health And Human Services
<b>DMA</b>	Division of Medical Assistance
<b>DME</b>	Durable Medical Equipment
<b>DSS</b>	Department of Social Services
<b>ECS</b>	Electronic Commerce Services
<b>EDI</b>	Electronic Data Interchange
<b>EDS</b>	Electronic Data Systems
<b>EFT</b>	Electronic Funds Transfer
<b>EIS</b>	Eligibility Information System
<b>EOB</b>	Explanation of Benefits

**APPENDIX F**

<b>Table of Acronyms, continued</b>	
<b>EPDST</b>	Early Periodic Screening Diagnostic and Treatment Program (Health Check)
<b>FADS</b>	Fraud and Abuse Detection System
<b>FQHC</b>	Federally Qualified Health Center
<b>HEDIS</b>	Health Plan Employer Data Information Set
<b>HCPCS</b>	HCFA Common Procedural Coding System
<b>HIPP</b>	Health Insurance Premium Payment
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HIT</b>	Home Infusion Therapy
<b>HMO</b>	Health Maintenance Organization
<b>HSF</b>	Aid to Foster Care Children
<b>IAS</b>	Adoption Subsidy Assistance Category
<b>ICD-9-CM</b>	International Classification of Diseases, 9th Edition
<b>ICN</b>	Internal Claim Number
<b>ICF/MR</b>	Intermediate Care Facility for Mental Retardation
<b>LTC</b>	Long-Term Care
<b>MAA</b>	Aid to the Aged Medicaid Assistance Category
<b>MAB</b>	Aid to the Blind Medicaid Assistance Category
<b>MAC</b>	Maximum Allowable Cost
<b>MAD</b>	Aid to the Disabled Medicaid Assistance Category
<b>MAF</b>	Aid to Families Medicaid Assistance Category
<b>MCC</b>	Managed Care Consultant
<b>MIC</b>	Aid to Infants and Children Medicaid Assistance Category
<b>MID</b>	Medicaid Identification
<b>MMIS</b>	Medicaid Management Information Services
<b>MPW</b>	Aid to Pregnant Women Medicaid Assistance Category
<b>MQB</b>	Medicare Qualified Beneficiary
<b>MSB</b>	Special to the Blind Medicaid Assistance Category
<b>MTF</b>	Military Training Facility
<b>NCAC</b>	North Carolina Administrative Code
<b>NCECS</b>	North Carolina Electronic Claims Submission
<b>NCECS-Web</b>	North Carolina Electronic Claims Submission Web-based tool
<b>NCPDP</b>	National Council for Prescription Drug Programs
<b>NDC</b>	National Drug Code
<b>PA</b>	Prior Approval
<b>PASARR</b>	Preadmission Screening Annual Resident Review
<b>PCCM</b>	Primary Care Case Management
<b>PCHP</b>	Piedmont Cardinal Health Plan
<b>PCP</b>	Primary Care Provider
<b>PCS</b>	Personal Care Services
<b>PDN</b>	Private Duty Nursing

**APPENDIX F**

<b>Table of Acronyms, continued</b>	
<b>PI</b>	Program Integrity
<b>POS</b>	Point of Sale
<b>POS</b>	Place of Service
<b>RA</b>	Remittance and Status Report
<b>RHC</b>	Rural Health Clinic
<b>SAA</b>	Special Assistance Aid to the Aged
<b>SAD</b>	Special Assistance Aid to the Disabled
<b>SNF</b>	Skilled Nursing Facility
<b>SSI</b>	Social Security Income
<b>SURS</b>	Surveillance and Utilization Review System
<b>TOS</b>	Type of Service
<b>TOT</b>	Type of Treatment
<b>TPL</b>	Third Party Liability
<b>TPR</b>	Third Party Recovery
<b>UR</b>	Utilization Review
<b>USPHS</b>	U.S. Public Health Services
<b>USTF</b>	Uniformed Services Treatment Facilities
<b>VAN</b>	Value Added Network

## ***Index***

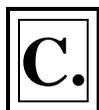
---

### **A.**

<b>Acronyms</b> .....	F-1
<b>ADA Claim Form Information</b> .....	5-27
<b>Adjusted Claims Section of the Remittance and Status Report</b> .....	9-1
<b>Adult Preventive Annual Health Assessments</b> .....	4-7
<b>Advance Directives</b> .....	3-9
Advance Directives Brochure.....	3-20
<b>Approved EDI Vendors</b> .....	10-4
<b>Automated Attendant Telephone Instructions</b> .....	B-1
<b>Automated Voice Response System</b>	
Instructions for Using the Automated Voice Response System.....	A-1

### **B.**

<b>Blue Medicaid Identification Card Information</b> .....	2-4
Example of Blue Medicaid Identification Card.....	2-6
<b>Billing Claims Electronically</b> .....	5-1, 10-1
Billing through a Clearinghouse.....	10-2
Billing with N.C. Electronic Claims Submission Web-based Tool.....	10-2
Billing with Software Obtained from a Vendor .....	10-2
Billing with Software Written by the Provider's Office or Company.....	10-2
<b>Billing for Personal Injury Cases</b> .....	7-4
<b>Billing on the ADA Claim Form</b> .....	5-27
<b>Billing on the CMS-1500 Claim Form</b> .....	5-2
Sample of CMS-1500 Claim Form.....	5-9
Instructions for Completing the CMS-1500 Claim Form.....	5-2
Place of Service Code Index.....	5-6
Type of Service Index .....	5-8
<b>Billing on the UB-92 Claim Form</b> .....	5-11
Example of UB-92 Claim Form .....	5-25
Instructions for Completing the UB-92 Claim Form.....	5-11
<b>Billing the Recipient</b> .....	3-4
<b>Buff MEDICARE-AID ID Card Information</b> .....	2-9
Example of Buff MEDICARE-AID ID Card .....	2-10



<b>Capitated Payments</b> .....	7-1
<b>Carolina ACCESS Override Requests</b> .....	4-12
Carolina ACCESS Override Request Form.....	4-34
<b>Carolina ACCESS Medical Exemption Request Form</b> .....	4-35
<b>Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form</b> .....	4-28
<b>Carolina ACCESS Provider Enrollment Report</b> .....	4-6
Modified Example of CA Provider Enrollment Report of Current Enrollees.....	4-18
Modified Example of CA Provider Enrollment Report of New Enrollees.....	4-17
Modified Example of CA Provider Enrollment Report of Terminated Enrollees.....	4-19
<b>Carolina ACCESS Provider Information Change Form</b> .....	3-18
<b>Carolina ACCESS (CCNC) Provider Participation</b> .....	4-3
Requirements for Participation.....	4-3
Sanction Appeals.....	4-6
Sanctions.....	4-5
Terminations.....	4-6
<b>Carolina ACCESS Provider Reports</b> .....	4-6
Emergency Room Management Report.....	4-7, 4-21
Enrollment Report.....	4-7, 4-17, 4-18, 4-19
Quarterly Utilization Report.....	4-7, 4-24, 4-25
Referral Report.....	4-7, 4-22
<b>Carolina ACCESS Provider Requirements</b> .....	4-7
24-Hour Coverage Requirement.....	4-8
Adult Preventive Annual Health Assessments.....	4-7
Health Check Services.....	4-7
Hospital Admitting Privileges Requirement.....	4-9
Medical Records Guidelines.....	4-9
Standards for Office Wait Times.....	4-9
Standards of Appointment Availability.....	4-8
Transfer of Medical Records.....	4-10
Women, Infant, and Children (WIC) Special Supplemental Nutrition Program Referrals.....	4-9
<b>Carolina ACCESS Referrals and Authorizations</b> .....	4-11
Carolina ACCESS Override Requests.....	4-12
Exempt Services.....	4-12
Referral Documentation.....	4-11
Referrals for a Second Opinion.....	4-11
<b>Centers for Medicare and Medicaid Services</b> .....	1-1
<b>Civil Rights Act, Provider Compliance</b> .....	3-2
<b>Claim Adjustments</b> .....	8-1
EOB Denials that Do Not Require Filing an Adjustment.....	8-6
Instructions for Completing the Medicaid Claim Adjustment Request Form.....	8-1
Resubmission of a Denied Claim.....	8-1
Tips for Filing Adjustments.....	8-3
<b>Claim Form Instructions</b>	
CMS-1500 Claim Form Instructions.....	5-2
UB-92 Claim Form Instructions.....	5-11



<b>Claim Form Examples</b>	
CMS-1500 Claim Form.....	5-9
UB-92 Claim Form.....	5-25
<b>Claims Analysis Unit.....</b>	<b>2-12</b>
<b>Claims Section of the Remittance and Status Report.....</b>	<b>9-1</b>
Claims in Process .....	9-2
Claims Payment Summary .....	9-2
Claims Summary .....	9-2
<b>CMS-1500 Claim Form</b>	
Sample of CMS-1500 Claim Form.....	5-9
Instructions for Completing the CMS-1500 Claim Form.....	5-2
<b>Commonly Asked Questions</b>	
Carolina ACCESS .....	4-14
Electronic Commerce Services.....	10-5
Provider Information .....	3-10
Third Party Liability .....	7-5
<b>Completing and Submitting the Medicaid Credit Balance Report .....</b>	<b>7-10</b>
Medicaid Credit Balance Report Form.....	7-14
<b>Completing the WIC Exchange of Information Forms .....</b>	<b>4-30</b>
<b>Conditions of Participation, Provider .....</b>	<b>3-2</b>
Civil Rights Act.....	3-2
Disclosure of Medicaid Information .....	3-2
Medical Record Documentation.....	3-3
Payment in Full .....	3-3
Rehabilitation and Disabilities .....	3-2
<b>Contacting Medicaid.....</b>	<b>C-1</b>
DMA Address List .....	C-5
EDS Address List .....	C-4
Telephone Contact List .....	C-1
<b>Copayments .....</b>	<b>2-15</b>
Copayment Exemptions .....	2-15
<b>County-Issued Medicaid Identification Cards .....</b>	<b>2-11</b>

## ***Index***

---

### **D.**

<b>Denied Claims</b> .....	8-1, 9-2
Claim Adjustments .....	8-1, 9-1
Medicaid Claim Adjustment Request Form .....	8-12
Medicaid Resolution Inquiry Form .....	8-14
Pharmacy Adjustment Request Form .....	8-13
Pharmacy Claim Adjustments .....	8-4
Remittance and Status Report.....	9-1
Resolution Inquiries.....	8-8
<b>Dental Services, Prior Approval</b> .....	6-4
<b>Department of Health and Human Services</b> .....	1-1
<b>Department of Social Services</b> .....	1-2
<b>Determining Third Party Liability</b> .....	7-2
Health Insurance Information Referral Form .....	7-11
<b>Disclosure of Medicaid Information</b> .....	3-2
<b>Discounted Fee-for-Service Payments</b> .....	7-1
<b>Division of Medical Assistance Organization Roles</b> .....	1-3
Financial Operations.....	1-5
Information Services .....	1-5
Managed Care.....	1-3
Clinical Policy and Programs .....	1-3
Program Integrity .....	1-6
Recipient and Provider Services.....	1-3
<b>DMA Address List</b> .....	C-5
<b>Documentation, Provider's Medical Records</b> .....	3-3
<b>Durable Medical Equipment, Prior Approval</b> .....	6-5

### **E.**

<b>Early and Periodic Screening, Diagnostic, and Treatment</b> .....	1-5
<b>EDS Address List</b> .....	C-4
<b>EDS Provider Services Representatives</b> .....	D-1
<b>Electronic Claims Submission</b> .....	10-1
Billing Claims Electronically .....	5-1, 10-1
Helpful Hints for Testing.....	10-3
<b>Electronic Commerce Services</b> .....	10-1
Commonly Asked Questions .....	10-5
Electronic Claims Submission.....	5-1, 10-1
Electronic Data Interchange Services .....	10-3
Electronic Funds Transfer .....	10-5
Electronic Funds Transfer Authorization Agreement for Automatic Deposit.....	10-8
Important Telephone Numbers for Electronic Commerce Services .....	10-5
What Services are Available.....	10-1
<b>Electronic Data Interchange</b> .....	10-3
Approved EDI Vendors.....	10-4
Interactive Recipient Eligibility Verification .....	10-3
Value Added Networks .....	10-3

## ***Index***

---



<b>Electronic Data Systems</b> .....	1-2
<b>Electronic Funds Transfer</b> .....	10-5
Electronic Funds Transfer Authorization Agreement for Automatic Deposit.....	10-8
<b>Eligibility Categories, Recipient</b> .....	2-1
<b>Eligibility Denials</b> .....	2-12
EOBS for Eligibility Denials.....	2-13
<b>Eligibility Determination</b>	
Health Insurance Premium Payments.....	7-9
Recipient Eligibility .....	2-1
<b>Eligibility Process, Health Insurance Premium Payments</b> .....	7-9
<b>Eligibility, Recipient</b>	
24-Visit Limitation .....	2-14
Copayments .....	2-15
Eligibility Categories.....	2-1
Eligibility Denials.....	2-12
Eligibility Determination.....	2-1
Eligibility Reversals .....	2-2
Medicaid Identification Cards .....	2-3
Retroactive Eligibility .....	2-2
Verifying Eligibility .....	2-11, 10-3
What is Medicaid.....	2-1
When Does Eligibility Begin.....	2-1
<b>Eligibility Reversals</b> .....	2-2
<b>Emergency Conditions, Carolina ACCESS Appointment Availability</b> .....	4-8
<b>Emergency Room Management Report</b> .....	4-6
Example of Emergency Room Management Report.....	4-21
<b>Enhanced Care (Adult Care Home Recipients) Approval Process</b> .....	6-5
<b>Enrollment Procedure, Provider</b> .....	3-1
<b>Enrollment Report</b> .....	4-6
Modified Example of Enrollment Report.....	4-17, 4-18, 4-19
<b>EOB Denials that Do Not Require Filing an Adjustment</b> .....	8-6
<b>EOBs for Eligibility Denials</b> .....	2-13
<b>Exempt Services, Carolina ACCESS Referrals</b> .....	4-11
<b>Explanation of the Internal Claim Number</b> .....	9-5



<b>Fee Schedule Requests</b> .....	3-3
<b>Fee Schedule Request Form</b> .....	3-15
<b>Financial Items Section of the Remittance and Status Report</b> .....	9-2
<b>Financial Operations</b>	
Fee Schedule Request Form .....	3-15
Fee Schedule Requests .....	3-3
Organization Role.....	1-3
<b>Financial Payer Code Section of the Remittance and Status Report</b> .....	9-2

## ***Index***

---

### **F.**

#### **Forms**

Carolina ACCESS Medical Exemption Form .....	4-35
Carolina ACCESS Override Request Form.....	4-34
Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form .....	4-28
Carolina ACCESS Provider Information Change Form.....	3-18
Electronic Funds Transfer Authorization Agreement for Automatic Deposits .....	10-8
Fee Schedule Request Form .....	3-15
Health Department Health Check Agreement .....	4-26
Health Insurance Information Referral Form .....	7-11
Health Insurance Premium Payment (HIPP) Application .....	7-13
Medicaid Claim Adjustment Form .....	8-12
Medicaid Credit Balance Report Form.....	7-14
Medicaid Resolution Inquiry Form .....	8-14
Medical Record Release Form .....	4-32
Medicare Crossover Reference Request.....	5-29
Notification of Change in Provider Status Form .....	3-17
Pharmacy Adjustment Request Form .....	8-13
Provider Certification for Signature on File .....	5-28
Requesting Forms .....	E-1
Six Prescription Limit Override Form.....	6-8
Third Party Recovery "Accident" Information Report.....	7-11
WIC Exchange of Information Form for Infants and Children .....	4-32
WIC Exchange of Information Form for Women .....	4-31

### **G.**

<b>General Requests for Prior Approval</b> .....	6-3
<b>General Requirements, Provider Enrollment</b> .....	3-1
Licensure .....	3-1
Provider Agreements .....	3-1
Service Location.....	3-1

### **H.**

<b>Health Check</b> .....	1-4, 4-7
<b>Health Check Services</b> .....	4-7
Sample Health Department Health Check Agreement .....	4-26
<b>Health Department Health Check Agreement</b> .....	4-26
<b>Health Insurance Information Referral Form</b> .....	7-11
<b>Health Insurance Premium Payments</b> .....	7-9
Eligibility Determination.....	7-9
Eligibility Process.....	7-9
Health Insurance Premium Payment (HIPP) Application .....	7-13
Payment of Health Insurance Premiums.....	7-9
Where to Obtain Information .....	7-9
<b>Health Insurance Premium Payment (HIPP) Application</b> .....	7-13

## ***Index***

---

### **H.**

<b>Helpful Hints for Testing Electronic Claim Submittals</b> .....	10-3
<b>High-Risk Intervention Approval Process</b> .....	6-5
<b>HMO Risk Contracting</b> .....	4-36
In-Plan Benefits.....	4-36
Out-of-Plan Benefits.....	4-37
<b>Hospice Participation Approval Process</b> .....	6-5
<b>Hospital Admitting Privileges Requirement, Carolina ACCESS</b> .....	4-7
Carolina ACCESS Patient Admission Agreement/Formal Arrangement Form .....	4-28
<b>How to Report a Change in Provider Status</b> .....	3-5

### **I.**

<b>Important Telephone Numbers for Electronic Commerce Services</b> .....	10-5
<b>Information Services, Organization Role</b> .....	1-5
<b>Informational Adjustment Claims</b> .....	9-1
<b>In-Plan Benefits, HMO Risk Contracting</b> .....	4-36
<b>Instructions for Completing the Medicaid Resolution Inquiry Form</b> .....	8-9
Medicaid Resolution Inquiry Form .....	8-14
<b>Instructions for Completing the Medicaid Claim Adjustment Request Form</b> .....	8-1
Medicaid Claim Adjustment Form .....	8-12
<b>Instructions for Completing the Pharmacy Adjustment Request Form</b> .....	8-5
Pharmacy Adjustment Request Form .....	8-13
<b>Interactive Recipient Eligibility Verification</b> .....	10-3
Approved EDI Vendors .....	10-4

### **L.**

<b>Licensure Revocation or Suspension</b> .....	3-6
<b>Long-Term Care Services, Prior Approval</b> .....	6-4

### **M.**

<b>Managed Care</b>	
Health Check .....	4-7
HMO Risk Contracting.....	4-36
Organization Role.....	1-3
Program Operations and Development.....	1-3
Provider Information .....	4-1
Quality Management .....	1-4
<b>Managed Care Programs</b> .....	4-1
Carolina ACCESS .....	4-1
ACCESS II/III .....	4-1
HMO Risk Contracting.....	4-36



<b>Managed Care Provider Information</b> .....	4-1
Carolina ACCESS – Commonly Asked Questions .....	4-14
Carolina ACCESS Provider Participation .....	4-3
Carolina ACCESS Provider Reports .....	4-6
Carolina ACCESS Provider Requirements .....	4-7
Carolina ACCESS Referrals and Authorizations .....	4-10
Example of Emergency Room Management Report .....	4-21
Example of Quarterly Utilization Report .....	4-23
Example of Referral Report.....	4-22
Instructions for Completing the WIC Exchange of Information Forms .....	4-29
Instructions for Using the Quarterly Utilization Report .....	4-23
List of Regional Managed Care Consultants .....	4-20
Managed Care Recipient Enrollment.....	4-2
Medical Exemption Requests .....	4-12
Modified Example of CA Provider Enrollment Report.....	4-17, 4-18, 4-19
Patient Disenrollment .....	4-13
Sample of Carolina ACCESS Medical Exemption Request Form .....	4-35
Sample of Carolina ACCESS Override Request Form .....	4-34
Sample of Carolina ACCESS Patient Admission/Formal Agreement.....	4-28
Sample of Health Department Health Check Agreement .....	4-26
Sample of Medical Record Release Form .....	4-33
Sample of WIC Exchange of Information Form for Infants and Children .....	4-32
Sample WIC Exchange of Information Form for Women.....	4-31
<b>Managed Care Recipient Enrollment</b> .....	4-2
Recipient Education.....	4-2
<b>Medical Exemption Requests</b> .....	4-12
Sample of Carolina ACCESS Medical Exemption Request Form .....	4-35
<b>Medical Record Release, Carolina ACCESS</b> .....	4-33
<b>Medicaid Claim Adjustment Request Form</b> .....	8-12
<b>Medicaid Credit Balance Reporting</b> .....	7-10
Completing and Submitting the Medicaid Credit Balance Report .....	7-10
Medicaid Credit Balance Report Form.....	7-14
<b>Medicaid Identification Cards</b> .....	2-2
Blue and Pink Medicaid Identification Card Information .....	2-4
Buff MEDICARE-AID ID Card Information.....	2-9
County-Issued Medicaid Identification Cards .....	2-11
Example of Blue Medicaid ID Card .....	2-6
Example of Buff MEDICARE AID ID Card .....	2-10
Example of Pink Medicaid ID Card .....	2-8
Piedmont Cardinal Health Plan Information .....	2-7
Piedmont Cardinal Health Plan Card .....	2-8
<b>Medicaid Payment Guidelines for Third Party Coverage</b> .....	7-1

## ***Index***

---

### **M.**

<b>Medicaid Provider Information</b> .....	3-1
Advance Directives .....	3-9
Conditions of Participation .....	3-2
Program Integrity Reviews .....	3-7
Provider Information – Commonly Asked Questions .....	3-10
Provider Responsibilities .....	3-4
Qualifications for Enrollment .....	3-1
Reporting Changes in Provider Status .....	3-5
<b>Medicaid Provider Change Form</b> .....	3-17
<b>Medicaid Resolution Inquiry Form</b> .....	8-14
<b>Medicare Crossover Reference Request</b> .....	5-29

### **N.**

<b>New Totals Following the Current Claim Total Line on the Remittance and Status Report</b> .....	9-3
<b>Noncompliance Denials</b> .....	7-2
<b>N.C. Electronic Claims Submission Web-based Tool</b> .....	10-2

### **O.**

<b>Optical Services, Prior Approval</b> .....	6-4
Routine Eye Exams and Refractions .....	6-4
Visual Aids .....	6-4
<b>Orthotic and Prosthetic Devices, Prior Approval</b> .....	6-5
<b>Out-of-Plan Benefits, HMO Risk Contracting</b> .....	4-37
<b>Overpayments, Provider</b> .....	3-5

### **P.**

<b>Paid Claims, Remittance and Status Report</b> .....	9-1
<b>Paper Reviews, Program Integrity Reviews</b> .....	3-7
<b>Patient Disenrollment, Carolina ACCESS</b> .....	4-13
<b>Payment for Personal Injury Cases</b> .....	7-4
<b>Payment in Full</b> .....	3-3
<b>Payment of Health Insurance Premiums</b> .....	7-9
<b>Payment Suspension</b> 3-6	
<b>Personal Hearings, Program Integrity Reviews</b> .....	3-8
<b>Personal Injury Cases</b> .....	7-3
Billing for Personal Injury Cases .....	7-4
Payment for Personal Injury Cases .....	7-4
Provider’s Rights in a Personal Injury Cases .....	7-3
Refunds and Recoupments for Personal Injury Cases .....	7-4
Tort (Personal Injury Liability) .....	7-3



<b>Pharmacy Adjustment Request Form</b> .....	8-13
<b>Pharmacy Claim Adjustments</b> .....	8-4
Instructions for Completing the Pharmacy Adjustment Request Form .....	8-5
Pharmacy Adjustment Request Form .....	8-13
<b>Piedmont Cardinal Health Plan (PCHP)</b> .....	1-7
<b>Pink Medicaid Identification Card Information</b> .....	2-4
Example of Pink Medicaid Identification Card .....	2-8
<b>Place of Service Code Index</b> .....	5-6
<b>Population Group Payer Code</b> .....	9-3
<b>Prescription Drugs, Prior Approval</b> .....	6-6
<b>Prior Approval</b> .....	6-1
Procedures for Approval and Reimbursement of Transplants .....	6-7
Services Requiring Prior Approval.....	6-1
Six Prescription Limit Override Form .....	6-8
Six Prescription Override Requests .....	6-6
<b>Processing Paper Claims without a Signature</b> .....	5-1
Provider Certification for Signature on File Form.....	5-28
<b>Program Integrity</b>	
Determining Areas for Review .....	3-6
Miscellaneous Information for a PI Review .....	3-7
Organization Role.....	1-6
Paper Reviews .....	3-8
Personal Hearings .....	3-8
Providers Responsibilities with a PI Review .....	3-7
Self-Referral Federal Regulation.....	3-8
<b>Program Operations and Development, Managed Care</b> .....	1-3
<b>Provider Enrollment, Carolina ACCESS</b> .....	4-3
<b>Provider Participation, Carolina ACCESS</b> .....	4-3
Requirements for Participation.....	4-3
Sanctions .....	4-5
Sanction Appeals .....	4-6
Terminations.....	4-6
<b>Provider Information</b>	
Advance Directives .....	3-9
Commonly Asked Questions .....	3-10
Conditions of Participation.....	3-2
Program Integrity Reviews.....	3-7
Provider Responsibilities.....	3-4
Qualifications for Enrollment .....	3-1
Reporting Changes in Provider Status.....	3-5
<b>Provider Responsibilities</b>	
Billing the Recipient.....	3-4
Overpayments.....	3-5
Third Party Liability .....	3-4
Verifying Recipient Eligibility .....	3-4
<b>Procedures for Approval and Reimbursement of Transplants</b> .....	6-7
<b>Provider Refunds</b> .....	7-3, 7-4, 8-10
<b>Provider's Rights in a Personal Injury Case</b> .....	7-3
<b>Provider Services Representatives, EDS</b> .....	D-1

## ***Index***

---

### **Q.**

<b>Qualifications for Enrollment, Provider</b> .....	3-1
Enrollment Procedure .....	3-1
General Requirements .....	3-1
Tax Information.....	3-1
<b>Quality Management, Managed Care</b> .....	1-4
<b>Quarterly Utilization Report</b> .....	4-7
Example of Quarterly Utilization Report .....	4-24
Instructions for Using the Quarterly Utilization Report.....	4-23

### **R.**

<b>Recipient and Provider Services, Organization Role</b> .....	1-3
<b>Recipient Education, Carolina ACCESS</b> .....	4-2
<b>Recipient Eligibility</b>	
24-Visit Limitation .....	2-14
Copayments .....	2-15
Eligibility Categories.....	2-1
Eligibility Denials.....	2-12
Eligibility Determination.....	2-1
Eligibility Reversals .....	2-2
Medicaid Identification Cards .....	2-3
Retroactive Eligibility .....	2-2
Verifying Eligibility .....	2-11
What is Medicaid.....	1-1
When Does Eligibility Begin.....	2-1
<b>Recoupments</b>	
Automatic Recoupments .....	8-10
Personal Injury Cases .....	7-4
<b>Referral Documentation, Carolina ACCESS</b> .....	4-11
<b>Referral Report</b> .....	4-7
Example of Referral Report.....	4-22
<b>Referrals for a Second Opinion</b> .....	4-11
<b>Refunds</b>	
Third Party Liability .....	3-5, 7-4
Personal Injury Cases .....	7-3
Provider Refunds.....	7-4, 8-10
<b>Regional Managed Care Consultants</b> .....	4-20
<b>Rehabilitation and Disabilities Acts</b>	
<b>Remittance and Status Report</b> .....	9-1
Explanation of the Internal Claim Number .....	9-5
Remittance and Status Report Field Descriptions .....	9-4
Remittance and Status Report Sections and Subsections .....	9-1
What is the Remittance and Status Report .....	9-1
<b>Remittance and Status Report Field Descriptions</b> .....	9-4



<b>Remittance and Status Report Sections and Subsections</b> .....	9-1
Adjusted Claims .....	9-1
Claims in Process .....	9-2
Claims Payment Summary .....	9-2
Claims Summary .....	9-2
Denied Claims .....	9-2
Financial Items .....	9-2
Financial Payer Code.....	9-2
Informational Adjustment Claims .....	9-1
New Totals Following the Current Claim Total Line.....	9-3
Paid Claims.....	9-1
Population Group Payer Code .....	9-3
Returned Claims .....	9-2
Summary Page.....	9-3
<b>Reporting Changes in Provider Status</b> .....	3-5
Carolina ACCESS Provider Information Change Form.....	3-18
How to Report a Change .....	3-5
Licensure Revocation or Suspension.....	3-6
Medicaid Provider Change Form .....	3-17
Payment Suspension.....	3-6
Sanctions .....	3-6
Termination of Inactive Providers.....	3-6
Voluntary Termination .....	3-6
What Changes Must be Reported.....	3-5
<b>Requesting Forms</b> .....	E-1
<b>Requests for Prior Approval</b>	
Dental Services.....	6-5
Durable Medical Equipment.....	6-5
Enhanced Care (Adult Care Home Recipients).....	6-5
Hospice.....	6-5
Long-Term Care Services.....	6-4
Optical Services.....	6-4
Prescription Drugs.....	6-6
Psychiatric Services.....	6-6
Services Provided to the Mentally Retarded .....	6-4
<b>Resolution Inquiries</b> .....	8-8
Instructions for Completing the Medicaid Resolution Inquiry Form .....	8-9
Medicaid Resolution Inquiry Form .....	8-14
Time Limit Overrides .....	8-8
<b>Resolving Denied Claims</b> .....	8-1
Claim Adjustments .....	8-1
Medicaid Claim Adjustment Request Form .....	8-12
Medicaid Resolution Inquiry Form .....	8-14
Pharmacy Adjustment Request Form.....	8-13
Pharmacy Claim Adjustments .....	8-4
Provider Refunds.....	7-3, 7-4, 8-10
Resolution Inquiries .....	8-8
Recoupments .....	7-4, 8-10

**R.**

**Resubmission of a Denied Claim** ..... 8-1  
**Retroactive Eligibility, Recipient**..... 2-2  
**Returned Claims Section of Remittance and Status Report** ..... 9-2

**S.**

**Sanction Appeals**..... 4-6  
**Sanctions** ..... 3-6, 4-5  
**Services Provided to Medicare-Eligible Medicaid Recipients** ..... 7-1  
**Services Requiring Prior Approval**..... 6-1  
    Enhanced Care (Adult Care Home Recipients) Approval Process..... 6-5  
    General Requests for Prior Approval ..... 6-3  
    Hospice Participation Approval Process ..... 6-5  
    Requesting Prior Approval for Prescription Drugs ..... 6-6  
    Requests for Optical Services..... 6-4  
    Requests for Prior Approval for Durable Medical Equipment..... 6-5  
    Requests for Prior Approval of Dental Services ..... 6-5  
    Requests for Prior Approval of Out-of-state or State-to-state Ambulance Services ..... 6-4  
    Requests for Prior Approval of Long-Term Care Services ..... 6-4  
    Requests for Prior Approval of Services Provided to the Mentally Retarded ..... 6-4  
    Utilization Review for Psychiatric Services..... 6-6  
**Six Prescription Override Requests** ..... 6-7  
    Six Prescription Limit Override Form..... 6-8  
**Standards of Appointment Availability, Carolina ACCESS** ..... 4-8  
    Emergency Conditions ..... 4-8  
    Urgent Conditions ..... 4-8  
**Submitting Claims Electronically**..... 5-1, 10-1  
    Billing through a Clearinghouse..... 10-2  
    N.C. Electronic Claim Submission Web-based Tool  
    Software Obtained from a Vendor ..... 10-2  
    Software Written by the Provider’s Office or Company ..... 10-2  
**Submitting Claims on Paper** ..... 5-1  
**Submitting Claims to Medicaid** ..... 5-2  
    Billing on the CMS-1500 Claim Form..... 5-1  
    Billing on the UB-92 Claim Form..... 5-11  
    Processing Paper Claims Without a Signature ..... 5-1  
    Provider Certification for Signature on File Form ..... 5-28  
    Submitting Claims Electronically..... 5-1, 10-1  
    Time Limits for Filing Claims..... 5-1  
**Summary Page Section of the Remittance and Status Report** ..... 9-3

## ***Index***

---



<b>24-Hour Coverage Requirement, Carolina ACCESS</b> .....	4-7
<b>24-Visit Limitation</b> .....	2-14
24-Visit Limit Exemption Requests .....	2-14
<b>Table of Acronyms</b> .....	F-1
<b>Tax Information, Provider</b> .....	3-1
<b>Telephone Contact List</b> .....	C-1
<b>Terminations</b>	
Carolina ACCESS Providers .....	4-6
Inactive Providers .....	3-6
Voluntary Termination .....	3-6
<b>Third Party Liability</b>	
Commonly Asked Questions .....	7-5
Determining Third Party Liability .....	7-2
Health Insurance Information Referral Form .....	7-11
Provider Responsibilities .....	3-4
Refunds to Medicaid.....	7-3, 7-4, 8-10
Time Limit Override on Third Party Insurance .....	7-3
<b>Third Party Insurance</b> .....	7-1
Capitated Payments .....	7-1
Commonly Asked Questions, Third Party Liability .....	7-5
Discounted Fee-for-Service Payments .....	7-1
Health Insurance Information Referral Form .....	7-11
Health Insurance Premium Payments .....	7-9
Medicaid Credit Balance Reporting .....	7-10
Medicaid Payment Guidelines for Third Party Coverage.....	7-1
Noncompliance Denials.....	7-2
Personal Injury Cases .....	7-3
Service Provided to Medicare-Eligible Medicaid Recipients .....	7-1
Third Party Liability .....	3-5, 7-2
<b>Third Party Recovery “Accident” Information Report</b> .....	7-13
<b>Time Limit Overrides</b>	
Claim Denials .....	5-1
Third Party Insurance .....	7-3
<b>Time Limits for Filing Claims</b> .....	5-1
<b>Tips for Filing Adjustments</b> .....	8-3
<b>Transfer of Medical Records, Carolina ACCESS</b> .....	4-9
<b>Type of Service Index</b> .....	5-8



<b>UB-92 Claim Form</b>	
Example of UB-92 Claim Form .....	5-25
Instructions for Completing the UB-92 Claim Form.....	5-11
<b>Urgent Conditions, Carolina ACCESS Appointment Availability</b> .....	4-8
<b>Using the ADA Form to Request Prior Approval for Dental Services</b> .....	6-5
<b>Utilization Review for Psychiatric Services</b> .....	6-6

## ***Index***

---



<b>Value Added Networks</b> .....	10-3
Approved EDI Vendors.....	10-4
<b>Verifying Eligibility, Recipient</b> .....	2-11, 3-4, 10-3
Automated Voice Response System.....	2-11
Claims Analysis Unit.....	2-11
Electronic Data Interchange.....	2-11, 10-3
Verification Methods.....	2-11
<b>Voluntary Termination, Provider</b> .....	3-6



<b>What Changes Must be Reported, Provider Status</b> .....	3-5
<b>What is Medicaid</b> .....	1-1
<b>What is the Remittance and Status Report</b> .....	9-1
<b>What Services are Available, Electronic Commerce Services</b> .....	10-1
<b>When Does Eligibility Begin, Recipient</b> .....	2-1
<b>Where to Obtain Information, Health Insurance Premium Payments</b> .....	7-9
Health Insurance Premium Payment Application.....	7-13
<b>Who's Who in Medicaid?</b>	
Centers for Medicare and Medicaid Services.....	1-1
Department of Health and Human Services.....	1-1
Department of Social Services.....	1-2
Division of Medical Assistance.....	1-1
Electronic Data Systems.....	1-2
<b>Women, Infant, and Children (WIC) Special Supplemental Nutrition Program Referrals</b> .....	4-9
Instructions for Completing the WIC Exchange of Information Forms.....	4-30
Medical Record Release Form.....	4-33
WIC Exchange of Information Form for Infants and Children.....	4-32
WIC Exchange of Information Form for Women.....	4-31