



DENTAL SEMINAR SEPTEMBER 2011



Presented by HP Enterprise Services and
The Division of Medical Assistance

Introduction

- Who's Who in Medicaid?
- DMA Website
- Greetings from DMA
- Dental Program Updates
- Billing to Medicaid
- Contacting Medicaid
- Questions & Answers
- EPSDT

Who's Who in Medicaid?

What is Medicaid?

- Title XIX of the Social Security Act
- Administered in North Carolina by the Division of Medical Assistance (DMA)
- Individual and families who can not afford health care costs
- Care provided by enrolled providers
- Coverage information

CMS Centers for Medicare & Medicaid Services



**NC Division of
Medical Assistance**



The Mission of DMA

- To provide access to high-quality, medically necessary health care for eligible North Carolina residents through cost-effective purchasing of health care services and products

<http://www.ncdhhs.gov/dma>

DMA- 8 Sections

- Recipient and Provider Services
- Clinical Policy and Programs
- Managed Care
- Quality, Evaluation, and Health Outcomes
- Finance Management
- Budget Management
- Program Integrity
- Information Technology and HIPAA

County Department of Social Services



- Determine eligibility
- Enroll recipient
- Maintain eligibility files
- Prior approval for adult care home enhanced care and case management

HP Enterprise Services



- Fiscal agent for Medicaid
- Process claims according to DMA policy and guidelines
- Establishes and maintains a sound relationship with Medicaid providers

DMA Website

<http://www.ncdhhs.gov/dma>



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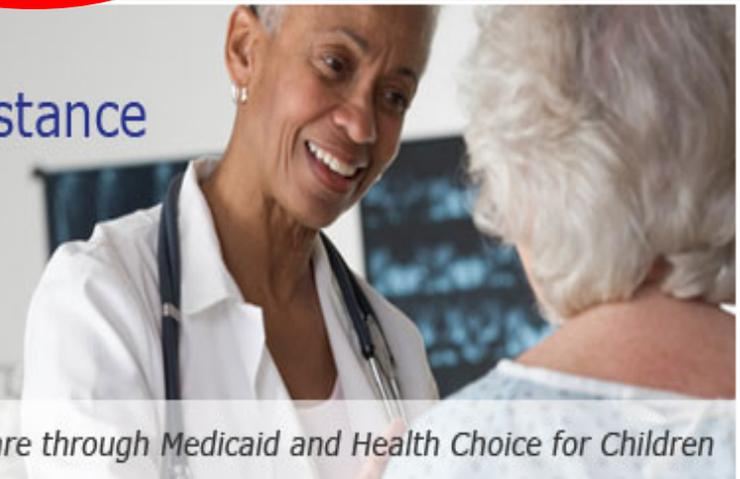
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NC Division of Medical Assistance



High quality health care through Medicaid and Health Choice for Children

What's New

- [Physician Referral Website for In-Home Care \(IHC\) Programs](#)
- [Prior Approval Information](#)
- [Preferred Provider Agreement for Incontinence Products](#)
- [CMS Announcement - 4/28/11](#)
- [Critical Access Behavioral Health Agencies](#)

Most Popular Pages

- [NC Tracks Website](#)
- [False Claims Act Education](#)
- [Fee Schedules](#)
- [Forms](#)
- [Fraud and Abuse Reporting](#)
- [Medicaid State Plan](#)
- [National Provider Identifiers](#)



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Medicaid and Health Choice Providers

Service specific information for North Carolina Medicaid providers. Please select the program or service from the menu below and click GO.

SELECT PROGRAM OR SERVICE Go

[Medicaid Information for Consumers](#)

[Health Choice Information for Consumers](#)

What's New

- [July 2011 Medicaid Bulletin](#)
- [July 2011 Pregnancy Medical Home Special Bulletin](#)
- [Physician Referral Website for In-Home Care \(IHC\) Programs](#)
- [June 2011 Pharmacy Newsletter](#)
- [Due Process and Prior Approval Procedures Special Bulletin, May 2011](#) (PDF, 86 KB)

Hot Topics

- [N.C. Medicaid Preferred Drug List \(PDL\)](#) (PDF, 262 KB) (revised 3/7/2011)
- [Incontinence Supplies; Prime Supplier Contract Pricing and Re-Priced Medicaid Reimbursement Rates - 04/14/11](#) (PDF, 53 KB)
- [Information from CMS- Provider Education Calls - 4/28/11](#) (Doc, 119 KB)
- [DMA 2010 Budget Initiatives](#)



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- ...Early Intervention Services (through CDORS)
- ...Enhanced Behavioral Health Services (CIS)
- ...Inpatient Behavioral Health Services
- ...Outpatient Behavioral Health Services
- ...MH/DD/SAS Health Plan Waiver
- ...Psychiatric Residential Treatment Facility (PRTF) Services
- ...Residential Treatment Facility Services
- ...School-Based Psychological Services
- ...Targeted Case Management for Individuals with Intellectual and Developmental Disabilities
- Be Smart Medicaid Family Planning Waiver
- Case Management - Adults and Children At-Risk of Abuse, Neglect, or Exploitation
- Care Coordination for Children (CC4C) (formerly Child Service Coordination)
- Chiropractic Services
- Community Alternatives Program (CAP)
 - ...CAP/C
 - ...CAP/Choice
 - ...CAP/DA
 - ...CAP/MR-DD
- Dental and Orthodontic Services**
- Durable Medical Equipment (DME)
- End-Stage Renal Disease Services

What's New

- [July 2011 Medicaid Bulletin](#)
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Dental and Orthodontic Services

[DMA Clinical Policy and Programs](#)[Mark W. Casey, DDS, MPH](#)[Dental Director](#)[Phone Number 919-855-4280](#)[Fax 919-715-2738](#)[Dental Services
Information for
Consumers](#)

Dental services are defined as diagnostic, preventive or corrective procedures provided by or under the supervision of a dentist. This includes services to treat disease, maintain oral health, and treat injuries or impairments that may affect a recipient's oral or general health. Orthodontics is defined as a corrective procedure for functionally handicapping conditions.

All services must maintain a high standard of quality and must be provided within the reasonable limits of those that are customarily available and provided to most persons in the community in accordance to Medicaid's policies and procedures.

As part of an ongoing effort to identify best practices and opportunities for improvement in children's Medicaid dental programs, CMS conducted eight State Medicaid dental program reviews between December and March of 2010, focusing on practices and program innovations that have successfully increased dental utilization in these states. The report highlights some of the innovations and initiatives found in these eight states including North Carolina.

- [Summary of Eight State Reports on Innovative State Practices for Improving the Provision of Medicaid Dental Services](#)
- Individual state reports can be downloaded from the [CMS Medicaid Dental Coverage Website](#)

[Dentistry](#) 

[Special Care Dentistry Association](#) 

[University of Washington, School of Dentistry - Special Needs Fact Sheets for Providers and Caregivers](#) 

For service requirements, coverage criteria and limitations, refer to:

- [Clinical Coverage Policy 4A, Dental Services](#) (PDF, 794 KB)
- [Clinical Coverage Policy 4B, Orthodontic Services](#) (PDF, 457 KB)



Medicaid Bulletins

For changes and updates to coverage criteria, billing information, and other program requirements refer to the N.C. Medicaid general and special bulletins.

- [Index of Articles for Dental Providers](#)
- [Index of All Bulletins](#)
- [All Bulletins by Date](#)



Dental and Orthodontic Services Forms

To see forms that apply to all providers, please visit our [Provider Forms](#) page.

- ADA Dental Claim Form - To order call 1-800-947-4746 or go online to www.adacatalog.org
- [Orthodontic Post Treatment Summary](#)
- [Orthodontic Treatment Extension Request](#)
- [Orthodontic Treatment Termination Request](#)
- [Supplement to Dental Prior Approval Form](#)

Dental Services Fee Schedules

- [Adobe Acrobat Format](#) - updated 01/01/11
- [Microsoft Excel Format](#) - updated 01/01/11
- [Adobe Acrobat Format](#) - updated 11/01/09
- [Microsoft Excel Format](#) - updated 11/01/09
- [Adobe Acrobat Format](#) - updated 10/01/09
- [Microsoft Excel Format](#) - updated 10/01/09



Dental Fee Schedule

NC Medicaid Dental Reimbursement Rates

Effective Date: January 1, 2011

CDT-2011/2012 (including procedure codes, descriptions, and other data) is copyrighted by the American Dental Association. © 2010 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CDT- 2009/2010 Code	Description	Medicaid Rate
D0120	Periodic oral evaluation	25.79
D0140	Limited oral evaluation - problem focused	36.76
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	36.35
D0150	Comprehensive oral evaluation - new or established patient	44.61
D0160	Detailed and extensive oral evaluation - problem focused, by report	68.27
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	28.73
D0210	Intraoral - complete series (including bitewings)	71.79
D0220	Intraoral - periapical first film	14.91
D0230	Intraoral - periapical each additional film	12.03
D0240	Intraoral - occlusal film	15.98
D0250	Extraoral - first film	21.52



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[How to Report Fraud and Abuse](#)

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Contact DMA

Division Contact Information

- [Division section contacts](#)
- [Locations and mailing addresses of our offices](#)

Contacts for Other Audiences

Consumer Contacts

- [CARE-LINE Information and Referral Service](#): Get answers to questions about Medicaid, Health Choice and all of our services. Call 1-800-662-7030 (English, Spanish), or 919-855-4400 in Wake County (7:00 a.m. to 11:00 p.m., 7 days a week).
- [More Medicaid contacts](#).

Providers

- [Health Choice provider contacts](#)
- [Medicaid provider contacts](#)

Greetings from DMA

Mark W. Casey, DDS, MPH

Dental Director

Mark.Casey@dhhs.nc.gov

919-855-4280

A Word From My Sponsor.....



- Customer-focused
- Anticipatory
- Collaborative
- Transparent
- Results Oriented

Recent Honors



- NC Medicaid was recognized by the Centers for Medicare and Medicaid Services (CMS) as one of eight states with high utilization of pediatric oral health services and/or innovative methods of delivering oral health services to Medicaid children

Recent Honors



- CMS reported that DMA and its partners are among a handful of State Medicaid agencies that have developed innovative initiatives to improve the delivery of services to publicly insured children
- The “Into the Mouths of Babes”/Physician Fluoride Varnish Program has been specifically cited as an innovative service delivery model by CMS

Provider Participation

- From SFY 2009 to SFY 2011 the number of actively participating billing providers (equivalent to the number of participating practices) who had received payment for at least one claim dropped from 1964 to 1658
- The number of participating attending providers (dentists rendering services) is estimated to be approximately 2100
 - Unable to come up with accurate figures due to MMIS limitations
- Despite drop in participating billing providers, access for children continues to improve and for adults it is about the same

Utilization/Access Measures

- CMS-416 Report in FFY 2010
51.6% of NC Medicaid children (ages 0-20) eligible for 90 days or more received at least one oral health care service during the reporting period

Utilization/Access Measures

- Dramatic improvement has been made for children in the 1-5 age group
 - 58% of all Medicaid children ages 1-5, who were eligible for dental benefits for six months or more, received at least one oral health care service in SFY 2009 versus SFY 2004 when 42% of these preschool children received services
 - NC Medicaid leads the nation in utilization of preventive oral health care services by children ages 1-5 and is third in the nation in utilization of any dental service by children in the same age group

Utilization/Access Measures

- In CY 2009, when a continuous enrollment requirement of 11 out of 12 months is used to calculate access rates, (HEDIS ADV-like), utilization improves for Medicaid children ages 2-21 to approximately 57% including children seen by physicians in fluoride varnish program
- These access rates approach the average reported by private dental insurance plans – 58% – according to both the Pew Children’s Dental Campaign and CMS

Pew Children's Dental Campaign

- Pew reported that 52% of NC Medicaid children ages 1-18 received at least one dental service in 2009
- #10 in the US and the best utilization rate in the southeast

N.C. Medicaid Dental Program

Program Updates

Effective December 1, 2010

- Limit intraoral – complete series (including bitewings) (D0210) to recipients ages 6 and older unless the service is rendered in the inpatient hospital, outpatient hospital, or ambulatory surgical center (Place of Service 1, 2, or F)
- Limit bitewings – three films (D0273) to recipients age 13 and older
- Limit any combination of resin-based posterior composites (D2391, D2392, and D2393) rendered on a single **posterior primary tooth** on the same date of service to the maximum reimbursement of D2393 (same total fee as D2393)

Effective January 1, 2011

- D3354

Pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration

- Limited to recipients under age 21

Effective January 1, 2011

- D7251

Coronectomy – intentional partial tooth removal

- D7295

Harvest of bone for use in autogenous grafting procedure

- Requires PA

SFY 2011-2012 Budget Changes

- Effective October 1, 2011, across the board rate reduction of 2.67% for many Medicaid provider types including dentists
 - Excludes Health Departments, FQHC, and RHC providers

- Scaling and root planing will be allowed every 24 months rather than every 12 months

SFY 2011-2012 Budget Changes

- Cast metal partial dentures (D5213 and D5214) will no longer be covered
- Frequency of replacement of acrylic partials (D5211 and D5212) will be changed from every 10 years to every 8 years

SFY 2011-2012 Budget Changes

- Total reimbursement for multiple fillings on one posterior tooth will be capped at the rate paid for a four surface restoration (composite resin D2394 or amalgam D2161)
 - Still report as separate fillings if the surfaces are not connecting or adjoining
 - Tooth #3 MOD and B restorations will be paid at the same rate as an MODB

SFY 2011-2012 Budget Changes

- Reimbursement rates paid for amalgams will be increased by 10% and rates paid for posterior composites will be decreased from 5-15%; closer to making the rates equal
 - Studies have shown that amalgam does not need to be replaced as frequently as composite resins on posterior teeth—New England Children’s Amalgam Trial
 - This action has been taken by several other State Medicaid agencies in the last few years

Additional Program Change

- Protective restoration (D2940) is not allowed as a base or liner under a restoration
- D2940 will deny if billed on the same date of service as any restorative procedure code for the same tooth number

NC Health Choice (NCHC) Claims

- Effective with dates of service on or after October 1, 2011, NCHC prior approvals and claims will be processed by HP Enterprise Services
 - For dates of service prior to the transition date of October 1, 2011, providers will continue to submit claims to BCBS
 - All claims that need to be processed by BCBS must be received by February 29, 2012

NCHC will Mirror Medicaid Policy with a Few Exceptions

- ❑ Prior approval is required for the extraction of symptomatic third molars (wisdom teeth)
- ❑ Orthodontic coverage is allowed for severe malocclusions caused by craniofacial anomalies like cleft lip and palate and other syndromic conditions
- ❑ No coverage for pre-prosthetic surgeries (alveoloplasty, tori removal, exostoses removal, and vestibuloplasty)
- ❑ EPSDT does not apply

A Review of Common Problems

From Provider Enrollment to Unintended Billing
Errors to Fraud, Waste and Abuse

Documentation for Payment Purposes

- Better to have too much in a dental record rather than too little
 - Minimize potential for litigation and to justify payment from a third party payer

- Example—Surgical extraction (D7210) vs. Non-surgical extraction (D7140)
 - Prior to January 1, 2011 the CDT code specified that the elevation of a flap was required

Documentation for Payment Purposes

- Effective January 1, 2011 - the surgical extraction code (D7210) was revised - surgical extraction requires removal of bone and/or sectioning and including elevation of a flap, if indicated
- Lesson learned— “if it is not documented, it did not happen”; true in the court of law and true in the eyes of a third party payer; important to remember to avoid recoup/repay

Upcoding

- Practice of reporting a code on a claim with a higher reimbursement rate than the code of the service actually rendered

- Surgical extraction (D7210) vs. non-surgical extraction (D7140)
 - In SFY 2010, adult recipients received 114,730 non-surgical extractions vs. 123,849 surgical extractions

- D0160—detailed and extensive oral evaluation -intended to be used for the evaluation of complicated oral conditions requiring multiple diagnostic modalities (temporomandibular joint dysfunction, complicated fractures, etc.)

Medical Necessity

- Medical necessity of a health care service should not be determined solely based on the policy limits of a third party payer
- Instead providers should use their best clinical judgment to determine the need for services
 - Bitewings every 12 calendar months (D0270 – D0274)
 - Full mouth debridement (D4355) on every patient
 - Occlusal sealants (D1351) or fluoride varnish (D1206) regardless of caries susceptibility
 - Ill-fitting or damaged dentures—replacement versus reline or repair

Policy Limits and Relation to Treatment Recommendations

- ❑ NC Medicaid is an entitlement program paid with state and federal tax dollars
- ❑ We all should be good stewards of the government's money—it's our money
- ❑ If the program can reduce the amount of funding paid for the inappropriate use of services, it can expand covered services and increase reimbursement rates

Awareness of Policy Limits and Coverage

- Providers are responsible for being cognizant of policy limits and coverage—including in the Medicaid provider enrollment agreement signed by the provider
- Unfamiliarity with the policy is not a defense when appealing recoupment actions

Awareness of Policy Limits and Coverage

- Alveoloplasty codes (D7310 and D7311)
 - Reporting D7311 when surgically removing a single erupted tooth or an impacted tooth in a quadrant where there are not three or more edentulous spaces
 - Removal of bone to remove the tooth is included in the reimbursement for the surgical extraction
 - NC Medicaid requires 3 or more teeth to be removed or a total of 3 or more edentulous spaces

Awareness of Policy Limits and Coverage

- Resin-based composite restorations are allowed to restore a carious lesion into the dentin or a deeply eroded area into the dentin
- Resin-based composite restorations are not covered as a preventive procedure and are not covered for treatment of cosmetic problems (*e.g., diastemas, discolored teeth, developmental anomalies*)
- NC Medicaid does not currently reimburse for preventive resin restorations (D1352)

Unbundling

- Reporting a pulpotomy for first visit where RCT is completed by the same provider at the next visit
- Reporting individual PA radiographs (D0220 and D0230) taken during RCT
- Reporting a larger filling as two or more separate smaller fillings
(MODL on #30 versus MO and DL on #30)

Key Concepts/Take Home Messages

- ❑ Citing low Medicaid reimbursement rates as a reason to cut corners regarding standards of care, billing practices, documentation submitted for prior approval and/or materials used in the care of Medicaid/NCHC patients is not acceptable

Key Concepts/Take Home Messages

- DMA is held accountable by many stakeholders—NCGA, federal and state auditors, the media, and NC taxpayers
 - Fraud, waste and abuse is taken seriously
 - Obama Administration/HHS focused on recovery efforts
 - HHS Secretary recently sent a letter to the Governors repeating the call for renewed vigilance—Medicaid payment error rate identified to be 9% by the feds

Key Concepts/Take Home Messages



- Medicaid Program Integrity does not accept the argument that this billing error should be allowed because the Medicaid payment system allows the provider to bill this way

Key Concepts/Take Home Messages

- No one wants to go back to the days when many covered services required prior approval
- To prove fraud, intent to deceive for material gain needs to be demonstrated
- DMA Dental Program and HP Enterprise Services Provider Services staff are available to answer policy, billing and coding questions

Helpful Links

- DMA Dental Services Clinical Coverage Policy:
 - <http://www.ncdhhs.gov/dma/mp/index.htm>
 - DMA Orthodontic Services Clinical Coverage Policy:
 - <http://www.ncdhhs.gov/dma/mp/index.htm>
 - DMA Dental Fee Schedule:
 - <http://www.ncdhhs.gov/dma/fee/index.htm>

Helpful Links

- NC Medicaid Dental FAQs:

- <http://www.ncdhhs.gov/dma/dental/>

- CMS Medicaid Dental Services Policy Issues:

- <https://www.cms.gov/MedicaidDentalCoverage/>

15 Minute BREAK



Electronic Commerce Services

ECS

Provider Types Billing Dental (ADA 2006/837D) Form

- Dentist
- Orthodontist
- Federally qualified health center (dental services only)
- Health department dental clinic (dental services only)
- Rural health clinic (dental services only)

Electronic Requirement

- The N.C. Medicaid Program requires all providers to file claims electronically

- Exceptions list

<http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm>



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Electronic Claim Exceptions

The following list outlines some of the situations in which a claim must be billed on paper. Only claims that comply with the exceptions listed below may be submitted on paper. All other claims are required to be submitted electronically. Providers will be notified of updates to the list through the Medicaid Bulletin.

List of Claims that May Be Filed on Paper (revised July 27, 2009)

- Medicare HMO (Part C) primary claims
- Medicare Part A inpatient claims submitted directly to Medicaid
- Nursing home crossovers submitted directly to Medicaid
- Services that require an invoice to be submitted with the claim including, but not limited to
 - Hearing aids and related items
 - Some visual aids
 - Unclassified and unlisted procedures
 - Undelivered dentures
 - Radiopharmaceuticals
 - Compounded injectable drugs billed with an unclassified HCPCS procedure code (for example, J3490)

- Any dental claim billed with one of the following ADA procedure codes:
 - D0340
 - D0470
 - D8680
- Dental claims for special consideration tooth number reviews
- Dental assistant surgeon claims with records
- Dental ambulatory surgical claims denoting total surgical time in field 24
- Visual field exams requiring medical justification billed with CPT procedure code 92081, 92082, or 92083 without one of the diagnosis codes listed in the table below:

Diagnosis Code List # 1			Diagnosis Code List # 2	
094.84	362.74	365.65	225.1	379.33
191.2	362.75	365.81	227.3	379.34
191.6	362.81	365.82	307.81	379.39
191.9	362.83	365.89	346.90	379.41
192.1	363.11	365.9	349.9	379.53
239.6	363.2	366.11	352.9	379.91
250	363.20	366.14	364.00	381.4
250.00	363.30	366.16	364.01	386.01
250.01	364.1	368.41	364.02	386.10
250.02	364.10	368.43	364.03	462
250.03	364.11	368.44	364.04	465.9
250.50	364.21	368.46	364.05	473.9
250.51	364.22	368.47	364.24	716.90
250.52	364.23	369	364.41	743.9
250.53	364.3	369.00	367.0	747.8
323.9	364.42	369.01	367.1	784.0
340	364.51	369.2	367.2	791.0
343	364.52	369.20	367.4	850.9

Electronic Claim Exemptions

- Undelivered dentures
- Dental claims for special consideration tooth number reviews
- Dental assistant surgeon claims with records
- Dental ambulatory surgical claims denoting total surgical time in field 24 (billed on the CMS-1500 Form)

Electronic Claims Submission



- HP Enterprise Services transmission methods

- Electronic Data Interchange (EDI) Support
 - Modem
 - Secure File Transfer Protocol (SFTP)
 - NCECSWeb Tool

1-800-688-6696 or 919-851-8888,
option 1

Electronic Claims Requirements

- Electronic Claims Submission Agreement Form
 - ▣ A separate agreement is required for each MPN
 - ▣ A new agreement must be submitted each time an individual is added to the group

<http://www.nctracks.nc.gov/provider/form>

- Trading Partner Agreement (TPA)
 - ▣ HP Enterprise Services

<http://www.ncdhhs.gov/dma/hipaa/>

Electronic Funds Transfer

- The N.C. Medicaid Program no longer issues paper checks for claims payment

- EFT Authorization Agreement

<http://www.ncdhhs.gov/dma/provider/forms.htm>

- HPES Financial Unit

- Fax: 919-816-3186

- E-mail: NCXIXEFT@hp.com

Electronic Availability of Remittance and Status Report

- Began PDF RAs, July 7, 2010
- Remittance and Status Reports in PDF Format and Correct Coding Initiative Information Request Form

<http://www.ncdhhs.gov/dma/provider/forms.htm>

- Available for 10 Checkwrites

NCECSWeb Tool

- Claim Submission
- Electronic Adjustments
- Recipient Eligibility Verification
- PDF RA
- CCI and MUE Denial Explanations



<https://webclaims.ncmedicaid.com/ncecs>

Recipient Eligibility

Recipient Determination

- Who

- ▣ County DSS

- ▣ List of all the county DSS offices

- <http://www.ncdhhs.gov/dss/local/>

- When

- ▣ First day of that month (usually)

- ▣ Last day of the month

- Benefit Categories

- ▣ Table in Section 2

Medicaid Program Name	Abbreviation	Fourth Character Class Identifier	Medicaid Eligibility
Special Assistance to the Blind	MSB	C or B	Recipient is eligible for full Medicaid coverage and payment of Medicare Part B premiums.
Special Assistance – Aid to the Aged	SAA	Q	Recipient is eligible for full Medicaid and payment of Medicare premiums, deductibles, and copayments.
Special Assistance – Aid to the Disabled	SAD		
Infants and Children	MIC	I, G, or N	Recipient is eligible for full Medicaid coverage
		F or H	Recipient is eligible for emergency coverage for approved dates of service.
Families and Children	MAF	C, G, N, T, or W	Recipient is eligible for full Medicaid
		M or P	Recipient has met a deductible and is eligible for Medicaid
		F, H, O, R, U, or V	Recipient is eligible for emergency coverage for approved dates of service.

Restricted Eligibility

- Medicaid for Pregnant Women (MPW)
- Medicaid Family Planning Waiver (MAF-D)
<http://www.ncdhhs.gov/dma/services/familyplanning.htm>
- MHDDSAS Health Plan Waiver (Formerly Piedmont Cardinal Health Plan)
<http://www.ncdhhs.gov/dma/services/piedmont.htm>
- MEDICARE-Aid or Medicare Qualified Beneficiary (MQB-Q)

Verifying Eligibility

- A recipient's eligibility status may change from month to month if financial and household circumstances change

- At each visit, verify the recipient's
 - ▣ Identity (if an adult)
 - ▣ Current eligibility
 - ▣ Medicaid program (benefit category)
 - ▣ CCNC/CA primary care provider information
 - ▣ Other insurance information

Verification Methods

- EDI
 - ▣ HIPAA transaction 270/271
 - ▣ Real-time eligibility
 - ▣ Batch transaction
- AVR
 - ▣ 1-800-723-4337, option 6
 - ▣ Recipient Eligibility and Coordination of Benefits
 - ▣ Appendix A
- NCECSWeb Tool
 - ▣ Recipient Eligibility Inquiry
- Appendix F
 - ▣ Overview of recipient eligibility verification methods
- DMA Claim Analysis
 - ▣ 919-855-4045
 - ▣ Over 12 months

NCECSWeb Tool Homepage

North Carolina
Electronic Claims Submission/
Recipient Eligibility Verification

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North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool is an online application for submitting HIPAA-compliant claims to N.C. Medicaid and for verifying recipient eligibility.

If you have any questions regarding the use of this system,
please call 1-800-688-6696 option 1 for the ECS Department.



North Carolina

Electronic Claims Submission

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Recipient Eligibility Inquiry

Please complete the selection criteria fields and click on the "Submit" button below to execute a search.

Selection Criteria

MID:	<input type="text"/>		Provider Medicaid Id:	<input type="text"/>	National Provider Id:	<input type="text"/>	<input type="button" value="Submit"/>	<input type="button" value="Clear"/>
Last Name:	<input type="text"/>		First Name:	<input type="text"/>				
DOB:	<input type="text"/>		SSN:	<input type="text"/>				
Elig From Date:	<input type="text"/>		Elig To Date:	<input type="text"/>				

Note: Valid search allowed are:

A. Search by MID B. Search by Name and DOB C. Search by SSN and DOB D. Search by Name and SSN

Use any of these methods to search

Tips:

- Use MPN or NPI
- If no date is keyed, it will reflect eligibility for the date of search
- Cannot check future date until the first of that month
- Can search back 365 days

Results Screen

Selection Criteria

MID: **Provider Medicaid Id:** **National Provider Id:**

Last Name: **First Name:**

DOB: **SSN:**

Elig From Date: **Elig To Date:**

Error Message:

No Errors

Recipient Information

Name: **MID:** **DOB:**

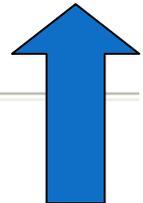
Eligibility Date: **Eligibility Status:** **Program Code:** MADQ

Carolina Access PCP Data

Medicare Information

HIC:

PART A and PART B



Medicaid Identification Card

ANNUAL MEDICAID IDENTIFICATION CARD

CASEHEAD NAME
CASEHEAD ADDRESS LINE 1
CASEHEAD ADDRESS LINE 2
CASEHEAD ADDRESS LINE 3
CASEHEAD ADDRESS LINE 4
CASEHEAD ADDRESS LINE 5

Recipient Signature _____
(Not valid unless signed)

USE OF THIS CARD BY ANYONE NOT LISTED ON THE CARD IS FRAUD
AND IS PUNISHABLE BY A FINE, IMPRISONMENT OR BOTH

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

RECIPIENT LD. RECIPIENT NAME
000.00.0000.N JONNXXXXX Q. PUBLIC

BIRTH DATE ##/##/#### ISSUE DATE SEPT 1, 2010

PRIMARY CARE PROVIDER NAME
PRIMARY CARE PROVIDER ADDRESS LINE 1
PRIMARY CARE PROVIDER ADDRESS LINE 2
PRIMARY CARE PHONE NO. AND AFTER HOURS NO.

For questions about your Medicaid coverage and/or to report
Medicaid fraud, waste or program abuse, please contact
CARE-LINE at 1-800-662-7030 or locally call 919-855-4400.

FOLD HERE

Cut along dotted lines

Common Eligibility Denials

- **EOB 11** – Recipient not eligible on service date
- **EOB 139** – Services limited to presumptive eligibility
- **EOB 191** – MID number does not match patient name
- **EOB 953** – Individual has restricted coverage, Medicaid only pays the part B premium

Submitting Claims to Medicaid

Submitting Claims Electronically

2011 Checkwrite Schedule

The following table lists the cut-off dates, checkwrite dates, and the electronic deposit dates for 2011.

Month	Checkwrite Cycle Cutoff Date	Checkwrite Date	EFT Effective Date
January	01/06/11	01/11/11	01/12/11
	01/13/11	01/19/11	01/20/11
	01/20/11	01/27/11	01/28/11
February	01/27/11	02/01/11	02/02/11
	02/03/11	02/08/11	02/09/11
	02/10/11	02/15/11	02/16/11
	02/17/11	02/24/11	02/25/11
March	02/24/11	03/01/11	03/02/11
	03/05/11	03/08/11	03/09/11
	03/10/11	03/15/11	03/16/11
	03/17/11	03/24/11	03/25/11
April	03/31/11	04/05/11	04/06/11
	04/07/11	04/12/11	04/13/11
	04/14/11	04/21/11	04/22/11
May	04/28/11	05/03/11	05/04/11
	05/05/11	05/10/11	05/11/11
	05/12/11	05/17/11	05/18/11
	05/19/11	05/26/11	05/27/11
June	06/02/11	06/07/11	06/08/11

5:00 PM Cut Off

Dental Guidelines

- Refer to Clinical Coverage Policy
 - ▣ 4A, Dental Services
 - ▣ 4B, Orthodontic Services

- Definitions:
 - ▣ MPN
 - ▣ NPI
 - ▣ Taxonomy

Dental ADA Claim Form

American Dental Association Dental Claim Form

HEADER INFORMATION								
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/ Title XIX								
2. Predetermination/Preauthorization Number								
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION								
3. Company/Plan Name, Address, City, State, Zip Code								
OTHER COVERAGE								
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)								
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)								
6. Date of Birth (MM/DD/CCYY)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)				
9. Plan/Group Number		10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other						
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code								
RECORD OF SERVICES PROVIDED								
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	09/01/2011		03			D2140		100.00
2	09/01/2011		UL			D4341		100.00
3								
4								
5								
6								

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code Smith, John		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#) 123456789A
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)

NCECSWeb Tool

North Carolina Electronic Claims Submission/Recipient Eligibility Verification Web Tool Instruction Guide

September 2009 Special Bulletin

<http://www.ncdhhs.gov/dma/bulletin/>

List Management



- Allows providers to create and modify list of frequently used billing information
- Expedites claim entry and submission

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 - Eligibility

Recipient Edit

Selection Criteria

Current Description

Modify Recipient

Recipient Last Name: Recipient First Name: Active:

Recipient Medicaid ID Number:

Patient Account Number: Medical Record Number:

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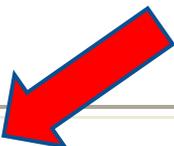
Selection Criteria

Add New Code and Description

Recipient Last Name:
 Recipient First Name:

Recipient Medicaid ID Number:

Patient Account Number:
 Medical Record Number:



Recipient Information: (1 record)

Recipient Last Name	Recipient First Name	Recipient Medicaid ID Number	Recipient Account Number	Medical Record Number	Status	Edit
Doe	John	123456789a	100JD		A	<input type="button" value="Edit"/>

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Dental Results

Selection Criteria

Claim
Type

Dental File: Current

Add

Edit

Copy

View All

History

Delete

View

Dental Information: (0 records)

RecipientLastName	RecipientFirstName	Recipient Account Number	Recipient Medicaid ID Number	Total Claim Charge	Balance Due
No data found					

Claims Entry

Dental

Selection Criteria

Claim Type: Dental Claim ID: New

Save Cancel
Delete

Recipient Information

Recipient Last Name:



Recipient First Name:

Medicaid ID:

Medical Record Number:

Patient Account Number:

Prior Authorization Number:

Provider Information

Provider Last

Dental

Selection Criteria

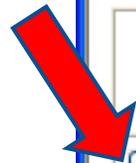
Claim Type: Dental Claim ID: New

Save Cancel
Delete

Recipient Information

Recipient Last Name:

Medical Record Number:



https://10.10.6.41/ncecs/Lists/RecipientSelect.asp?...

Recipient List

Selection Criteria

Recipient Information: (2 records)

	Recipient Last Name	Recipient First Name	Recipient Medicaid ID Number	Recipient Account Number	Medical Record Number
Select	doe	john	123456789a	fecc	
Select	doe	mary	123456789q	fecc	

Provider Information

Provider Last

Provider Information

Provider Last
Name or
Organization
Name:

SMILES



Provider
First
Name:

National
Provider
ID:

1234567890

Medicaid
Provider
Number:

Billing
Taxonomy:

123D00000X



Billing
Address:

123 SMILE STREET

Billing
City:

ANY CITY

Billing
State:

NC

Billing
ZIP:

12345-6789

Miscellaneous Claim Information

EPSDT: Follow-up No

Release of
Information: Yes No



EPSDT: Follow-up No

Release of Information: Yes No

Paperwork on file at Provider Site for Medicare
Override?: Yes No

Related Causes:

Auto Accident

Employment Accident

Other Accidental Injury

State of Auto Accident:

Date of Accident:

Original ICN:

Place of Service Facility Type Code:

Claim Submission Reason Code:

Rendering/Attending Information

R/A Provider First Name:

R/A Provider Last Name:

R/A Medicaid Provider Number:

R/A NPI:

R/A Taxonomy:

- 12-Home
- 21 -Inpatient Hospital
- 11-Office
- 22-Outpatient Hospital
- 31 -Skilled Nursing Facility



Dental Insurance Detail

Add/Edit Other Insurance

No Other Insurance

Dental Detail

Add/Edit Details

Information

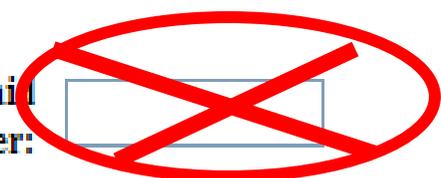
R/A Provider First Name:

R/A Provider Last Name:

R/A Medicaid Provider Number:

R/A NPI:

R/A Taxonomy:



Dental Insurance Detail



No Other Insurance

Dental Detail



No Dental Detail

Other Insurance Payment

Dental Insurance Add/Edit Details

Please complete the following form to create/edit Dental insurance detail items. Click the "Save" button to save the records and return to the main edit page. Click the "Cancel" button to abort the transaction.

Claim Type: DENTAL Claim ID: 905020101550374B74

Recipient Information

Last Name: DOE Medicaid ID: 123456789A

Dental Detail

#	Other Insurance Responsibility Sequence	Recipient Relationship to Insured	Other Insurance Claim Filing Indicator	Other Insurance Paid Amount	Other Insured Last Name	Other Insured First Name	Other Insured Member ID	Other Insu Name
<input type="button" value="Add"/> <input type="button" value="Clear"/>	P-Primary	18-Self	CI-Commercial Insurance Co.	120.00	Doe	John	4567	My Insura

Dental Add/Edit Details

Please complete the following form to create/edit Dental detail items. Click the "Save" button to save the records and return to the main edit page. Click the "Cancel" button to abort the transaction.

Claim Type:

DENTAL

Claim ID:

Save

Cancel

Recipient Information

Last
Name:

Medicaid
ID:

Dental Detail

#	ADA Procedure	Detail Charge	Place of Service	Prodecure Unit	Oral Cav
<input type="button" value="Add"/>	<input type="text"/>				



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Dental

Selection Criteria

Claim Type: Dental Claim ID: New

Recipient Information

Recipient Last Name: Recipient First Name: Medicaid ID:
Medical Record Number: Patient Account Number: Prior Authorization Number:

Provider Information

Provider Last Name or Organization Name: Provider First Name:
National Provider ID:
Medicaid Provider Number: Billing Taxonomy:
Billing Address: Billing City:
Billing State: Billing ZIP:

Saved Claim

Dental Results



Selection Criteria

Claim Type

Dental

File:

Current

Add

Edit

Copy

View All

History

Delete

View

Dental Information: (1 record)

	Recipient Last Name	Recipient First Name	Recipient Account Number	Recipient Medicaid ID Number	Total Claim Charge	Balance Due
<input type="radio"/>	doe	john	bft	123456789a	\$100.00	\$100.00

Submitting Completed Claims

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Claim Submission

Selection Criteria

Contact Information

Name:

Address:

City: State: Zip:

Phone:

Claim Submission Information: (1 record)

	Claim Type	Number of Claims	Total of Claims
<input type="radio"/>	Dental	1	\$100.00

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Claim Submission

Selection Criteria

Contact Information

Name:

Microsoft Internet Explorer
✕

?
This will submit all active Dental claims. Do you wish to Continue?

Claim Submission Information: (1 record)

	Claim Type	Number of Claims	Total of Claims
<input checked="" type="radio"/>	Dental	1	\$100.00

Batch ID Number

- ❑ Automatically archives submitted data
- ❑ Validates claim submissions
- ❑ Can access data for future use

The batch has been submitted. Click on the batch id to view the details.



BATCH ID [15390510000](#)

Resubmitting a Claim

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Dental Submitted Batches

Selection Criteria

List By Date From Date: Through Date:

Next 50

List All

Claim Type Dental

Copy **Detail**

Dental Submitted Batches: (1 to 50 of 59 records)

	Batch ID	Date Submitted	Submitted By	Number of Claims	Total Amount of All Claims
<input type="radio"/>	15590500431	06/04/2010	sub less than 100	7	\$106.00
<input type="radio"/>	15590500430	06/04/2010	sub over 100 dental	100	\$13357.32
<input type="radio"/>	13190500425	05/11/2010	aa	10	\$554.00
<input type="radio"/>	05390500421	02/22/2010	dental forsyth	1	\$100.00
<input type="radio"/>	05390500416	02/22/2010	dentak	1	\$100.00
<input type="radio"/>	05090500413	02/19/2010	new mpn npi	1	\$100.00
<input type="radio"/>	05090500411	02/19/2010	den mpn npi	1	\$100.00
<input type="radio"/>	07890500405	03/19/2009	TC10	1	\$100.00
<input type="radio"/>	08090500390	03/20/2008	q	2	\$12.00

North Carolina

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Dental Batch Details

Selection Criteria

Claim Type: Dental









Batch ID: 08290500441

Submitted

Date: 03/23/2011

Num Claims: 1

Batch Total:

\$200.00

Submitted By: aa

Dental Information: (1 record)

	Recipient Last Name	Recipient First Name	Recipient Account Number	Recipient Medicaid ID	Total Charge	Balance Due
	Campbell	Billy	MCR-Deny	947249979L	\$200.00	\$200.00

North Carolina

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Dental Results

Selection Criteria

Claim Type Dental File: Current

Add

Edit

Copy

View All

History

Delete

View

Dental Information: (108 records)

	Recipient Last Name	Recipient First Name	Recipient Account Number	Recipient Medicaid ID Number	Total Claim Charge
<input type="radio"/>	Campbell	Billy	Override-Pay	947249979L	\$200.00

Adjustments

Paper Adjustments

- Adjust a previously paid claim or claim requiring further review
- One adjustment – One ICN - One claim
- Always attach a copy of the RA

Electronic Adjustments



Voids and replacements can only
be submitted on claims that have
paid in history

If no payment has been made,
resubmit as a new day claim

Electronic Adjustments

- Providers can file two types of adjustments electronically
 - **Void** – claim will be recouped
 - **Replacement** – claim will be recoup and reprocessed

Electronic Adjustment NCECSWeb Tool

Miscellaneous Claim Information

EPSDT: <input type="radio"/> Follow-up <input type="radio"/> No	Release of Information: <input type="radio"/> Yes <input type="radio"/> No
EPSDT referral given to Patient?: <input type="radio"/> Yes <input type="radio"/> No	EPSDT Referral Type: <input type="text"/>
Paperwork on file at Provider Site for Medicare Override?: <input type="radio"/> Yes <input type="radio"/> No	

Related Causes:

- Auto Accident
- Employment Accident
- Other Accident Injury



State of Auto Accident:

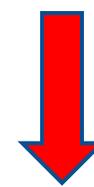
Date of Accident:

Original ICN:

Place of Service Facility Type Code:

Claim Submission Reason Code:

Adjustment Payer:
1-Original
7-Replacement
8-Void



Rendering/Attending Information

R/A Provider First Name:

R/A Provider Last Name:

Resolution Inquiries

- Medicaid Resolution Inquiry Form
 - ▣ Time limit overrides
 - ▣ Medicare overrides
 - ▣ Third-party overrides
 - ▣ Medicare HMO (Part C) CMS-1500 claims

<http://www.ncdhhs.gov/dma/provider/forms.htm>

- Attach
 - ▣ Claim
 - ▣ Copy of the RA
(835 transaction copies are not accepted)
 - ▣ Other information

Medicaid Resolution Inquiry Request

MEDICAID RESOLUTION INQUIRY

MAIL TO:
HP ENTERPRISE SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: Medicare Override Time Limit Override Third Party Override Medicare HMO

NOTE: PLEASE USE THIS FORM FOR OVERRIDES AND INQUIRIES ONLY.
CLAIM, RA_s, 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: _____

**Processing
Request**

**Claim Specific
Data**

**Additional
Information**

Time Limit Overrides



- 365 days of the date of service
- 18 months from the date of the denied RA
- 6 months for Third Party Insurance
- EOB 18 or 8918 = Time limit denials

Contacting N.C. Medicaid

Where do I send my...?

□ **Prior Approvals**

HP Prior Approval Unit
PO Box 31188
Raleigh, N.C. 27622

□ **Claims (paper)**

HP Enterprise Services
PO Box 30968
Raleigh, N.C. 27622

□ **Adjustments**

HP Enterprise Services
Adjustment Unit
PO Box 300009
Raleigh, N.C. 27622

I would like an onsite visit...

- ❑ HP Enterprise Services Provider Services Representatives
 - ❑ 1-800-688-6696 or 919-851-8888
 - ❑ Option 3
 - ❑ Basic Medicaid Billing Guide, Appendix D

Contacting N.C. Medicaid

- Call 1-800-723-4337
 - ▣ Automated Voice Response System
 - ▣ Appendix A

- Call 1-800-688-6696 or 919-851-8888
 - ▣ Appendix B
 - ▣ Press “1” – Electronic Commerce Services
 - ▣ Press “2” – Prior Approval
 - ▣ Press “3” – Provider Services
 - ▣ Press “0” – Operator

Contacting DMA

- Recipient Eligibility-within 12 months
 - ▣ Eligibility Verification Tool
 - ▣ AVRS – 1-800-723-4337

- Recipient Eligibility-over 12 months
 - ▣ DMA Claims Analysis – 919-855-4045

- Questions about coverage policy
 - ▣ DMA Dental Program – 919-855-4280



Q&A

EPSDT

Early and Periodic Screening Diagnosis and Treatment

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)



MEDICAID FOR CHILDREN

Contacts: Frank Skwara, MA, LMFT, BSN, RN
EPSDT Nurse Consultant
Division of Medical Assistance
Telephone #: 919-855-4260
FAX #: 919-715-7679

Why Health Check/ EPSDT are Important

- Promotes preventative health care by providing for early and regular medical and dental screenings.
- Provides medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening.

Health Check/EPSTD Overview

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSTD)** defined by federal law and includes:
 - Periodic Screening Services
 - Vision Services
 - Dental Services
 - Hearing Services
 - Other Necessary Health Care

EPSDT Overview CON'T.

- Recipients under 21 must be afforded access to the full array of EPSDT services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. Refer to the EPSDT provider web page or the Health Check or Basic Medicaid Billing Guides for a listing of these services.

NOTE: Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.

➤

EPSDT Criteria

- Must be listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- Must be medically necessary "to correct or **ameliorate** a defect, physical or mental illness, or a condition [health problem] identified by screening".

EPSDT Criteria CON'T.

“Ameliorate” means to:

- improve or maintain the recipient’s health in the best condition possible,
- compensate for a health problem,
- prevent it from worsening, or
- prevent the development of additional health problems.

EPSDT Criteria CON'T.

- Must be determined to be medical in nature.
- Must be generally recognized as an accepted method of medical practice or treatment.
- Must not be experimental, investigational.
- Must be safe.
- Must be effective.

EPSDT Features

- No Waiting List for EPSDT Services
- No Monetary Cap on the Total Cost of EPSDT Services
- No Upper Limit on the Number of Hours under EPSDT
- No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist or Other Licensed Clinician

EPSDT Features CON'T.

- No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered
- No Co-payment or Other Cost to the Recipient
- Coverage for Services that Are Never Covered for Recipients Over 21 Years of Age
- Coverage for Services Not Listed in the N.C. State Medicaid Plan

Important Points About EPSDT

- The full array of EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

Important Points About EPSDT CON'T.

- EPSDT services do not have to be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.

Important Points About EPSDT CON'T.

- EPSDT covers short-term and long-term services as long as the requested services will correct or ameliorate the child's condition. For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not ameliorate the child's condition taken as a whole, but need only be medically necessary to ameliorate one of the child's diagnoses or medical conditions.

EPSDT Operational Principles

- The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met.
- The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply. This includes the hourly limits on Medicaid Personal Care Services (PCS).

EPSDT Operational Principles

CON'T.

- Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT.
- Out of state services are **NOT** covered if medically necessary similarly efficacious services are available in North Carolina. Out of state services delivered without prior approval will be denied unless there is retroactive Medicaid eligibility.

EPSDT Operational Principles CON'T.

- Durable medical equipment (DME), assistive technology, orthotics, prosthetics, or other service requested do **NOT** have to be included on DMA's approved lists or be covered under a CAP waiver program in order to be covered under EPSDT subject to meeting the criteria specified in this policy.

EPSDT Operational Principles CON'T.

- The prohibition in CAP/C on skilled nursing for purposes of monitoring does not apply to EPSDT services if skilled monitoring is medically necessary. (Example: PDN)
- Case management is an EPSDT service and must be provided to a child with a Medicaid card if medically necessary to correct or ameliorate regardless of eligibility for a CAP waiver.

EPSDT Coverage And CAP Waivers

- CAP Waiver services are available only to participants in the CAP waiver programs and are not a part of the EPSDT benefit unless the waiver service is **ALSO** an EPSDT service.
- Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.

EPSDT Coverage And CAP Waivers CON'T.

- **ANY** child enrolled in a CAP program can receive **BOTH** waiver services and EPSDT services. However, the cost of the recipient's care must not exceed the waiver cost limit.
- If enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MRDD), prior approval to exceed \$100,000 per year must be obtained.

EPSDT Coverage And CAP Waivers CON'T.

- A recipient under 21 years of age on a waiting list for CAP services is eligible for necessary EPSDT services without any waiting list being imposed.
- EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services and **may be provided in the school setting, including to CAP-MRDD recipients.**

EPSDT Coverage And MH/DD/SA Services

- Staff employed by local management entities (LMEs) **CANNOT** deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or other appropriate DMA vendors if supported by a licensed clinician.

EPSDT Coverage And MH/DD/SA Services CON'T.

- LMEs may NOT use the Screening, Triage, and Referral (STR) process or the DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service. **Only DMA and its contractors can determine if a Medicaid recipient meets criteria for a covered Medicaid service.**

EPSDT Coverage And MH/DD/SA Services CON'T.

- Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or to an LME if handling PA in their catchment area.

EPSDT Coverage And MH/DD/SA Services CON'T.

- If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual diagnoses and behavioral disorders. All individual facts must be considered.

Requesting PA For A Covered State Medicaid Plan Service

- Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.
- EPSDT does **NOT** eliminate the need for prior approval if prior approval is required.

Requesting PA For A Covered State Medicaid Plan Service CON'T.

- Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. When state staff or vendors review a covered state Medicaid plan services request for PA or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver if that service is both a CAP and a waiver service.

Requesting PA For A Covered State Medicaid Plan Service CON'T.

- EPSDT requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision.

Requesting PA For A Covered State Medicaid Plan Service CON'T.

- If the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
- Additionally, all other EPSDT criteria must be met.

Requesting PA For A Covered State Medicaid Plan Service CON'T.

- It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

Services Formally Covered by CSHS

□ **Cochlear Implant and Accessories**

Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech or sound processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the implant manufacturer.

Services Formally Covered by CSHS

CON'T.

- **Pediatric mobility systems,**
including non-listed components,
should be sent to HP Enterprise Services using the
Certificate of Medical Necessity/Prior Approval
(CMN/PA form).
- **Augmentative and Alternate Communication
Devices** should be sent to HP Enterprise Services.

Services Formally Covered by CSHS

CON'T.

□ Oral Nutrition

Metabolic formula requests should be sent to DPH.

All other requests for formula that appear on the DMA fee schedules should be sent to HP Enterprise Services.

Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

Assistant Director
Clinical Policy and Programs

Inappropriate PA Requests Received By Vendors

- Vendors (CCME, HP Enterprise Services, ACS Pharmacy, MedSolutions, and ValueOptions, PBH, LMEs) may receive service requests for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests will be forwarded to the appropriate vendor for review.

Requesting PA For Non-Covered State Medicaid Plan Services

- Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act for recipients under 21 years of age.

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

Over-the-counter (OTC) Medications

If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS) but the drug does not appear on DMA's approved coverage listing of OTC medications, send the request to the Assistant Director, Clinical Policy and Programs, Division of Medical Assistance.

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

- Requests for Medicaid prior approval of DME, orthotics and prosthetics, and home health supplies that do not appear on DMA's lists of covered equipment should be submitted to the Assistant Director, DMA.

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

- Oral Nutrition

Formula that does not appear on the DMA fee schedules should be sent as an EPSDT request to:

Assistant Director
Clinical Policy and Programs

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

Effective with date of request September 1, 2008, Children's Special Health Services no longer authorizes payment for ramps, tie downs, car seats, and vests.

These items are not included in the durable medical equipment covered by Medicaid, nor are they covered under Early Periodic Screening, Diagnostic, and Treatment services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items may be considered.

Requesting PA For Non-Covered State Medicaid Plan Services CON'T.

- Requests for non-covered state Medicaid plan services and requests for a review when there is no established review process for a requested service should be submitted to:

Assistant Director for Clinical Policy
and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh, NC 27699-2501

FAX: 919-715-7679

Documentation Requirements

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes:

- documentation showing that policy criteria are met;
- documentation to support that all EPSDT criteria are met;
- evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

Documentation Requirements CON'T.

- Requests for non-covered state Medicaid plan services may be submitted on the Non-Covered State Medicaid Plan Services Request form for Children under 21 Years of Age.
- This form is located on the DMA website:
<http://www.ncdhhs.gov/dma/provider/forms.htm>

Due Process Procedures

- Requests for prior approval of covered and non-covered state Medicaid plan services are to be decided with reasonable promptness, usually within 15 business days. **No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.**

Due Process Procedures CON'T.

- If covered or non-covered services are denied, reduced, or terminated, written notice with appeal rights must be provided to the recipient and/or the authorized representative and copied to the provider.
- Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

Due Process Procedures CON'T.

- The Division's due process procedures fully apply and can be found on the provider page at <http://www.ncdhhs.gov/dma/provider/index.htm>

Due Process Procedures CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- “This is the responsibility of the school system.”
- “Close supervision, redirection, safety monitoring, assistance with mobility and other ADL’s, improving socialization and community involvement, and controlling behavior are not service goals covered under EPSDT.”
- “The services would not correct or improve the child’s diagnosis.”

Due Process Procedures CON'T.

The following are **NOT** acceptable reasons for denial of coverage under EPSDT:

- “EPSDT criteria do not include monitoring a child’s actions for an event which may occur.”
- “EPSDT services are not long term or ongoing.”
- “Teaching coping skills cannot be covered under EPSDT.”

EPSDT Websites

- **Basic Medicaid Billing Guide**

<http://www.ncdhhs.gov/dma/basicmed/>

- **Health Check Billing Guide**

<http://www.ncdhhs.gov/dma/healthcheck/index.htm>

- **EPSDT Provider Page**

[http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.
htm](http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm)

EPSDT Provider Website



DMA HOME

Medicaid Providers

A-Z Provider Topics

Calendars

Claims

Community Care (CCNC/CA)

Contacts for Providers

Enrollment

EPSDT and Health Check

Fee Schedules/Cost Reports

Forms

Fraud and Abuse

HIPAA

Library (bulletins, policies)

National Provider Identifier

Programs and Services

Seminars

ABOUT DMA

[DHHS](#) > [DMA](#) > [Medicaid Providers](#) > EPSDT and Health Check

EPSDT and Health Check

EPSDT

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. The services are required even if the services are not normally covered by children's Medicaid. [More EPDST Information](#)

[EPSDT and Health Check Information for Consumers](#)

Health Check

The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. [More Health Check Information](#)

EPSDT and Health Check Quick Links

- [EPSDT Policy Instructions \(updated November 24, 2008\)](#)
- [Health Check Billing Guide, April 2009](#)
- [Health Check Coordinator Directory](#)
- [Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age \(updated January 2009\)](#)

