



NCMMIS Provider Claims and Billing Assistance Guide

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1. What is NCTracks

In December 2008, the North Carolina Department of Health and Human Services (DHHS) awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a NC Medicaid Management Information System (MMIS) in support of health care administration for multiple DHHS divisions. The system, named NCTracks, is a multi-payer system that replaces and coordinates processing between the following:

- Existing Legacy Medicaid Management Information System (MMIS+) for the Division of Medical Assistance
- Integrated Payment and Reporting System (IPRS) for the Division of Mental Health/Developmental Disabilities and Substance Abuse Services
- Purchase of Medical Care Services (POMCS) for the Division of Public Health and the Office of Rural Health and Community Care

Providers contracted by Local Management Entities (LMEs) to perform state funded services for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) will continue to submit their claims to the LME.

The NCTracks Provider Portal will also serve as the conduit for training, determining claim status, retrieving Remittance Advice (RA), and other functions essential to effectively managing business with N.C. DHHS.



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2. Who's Who

2.1 CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that regulates and oversees all state Medicaid and State Children's Health Insurance Programs (SCHIP) programs. CMS is responsible for enforcing the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including national standards for electronic health care transactions, code sets, and National Provider Identifiers (NPI). In addition, CMS is responsible for developing the National Correct Coding Initiative (NCCI), a program designed to prevent improper payments when a provider submits incorrect procedure code combinations or to avoid payments of units of service that are medically unlikely to be correct, and other initiatives impacting health care.

2.2 DEPARTMENT OF HEALTH AND HUMAN SERVICES

The N.C. DHHS oversees the administration of numerous health care programs in the State of North Carolina, including Medicaid. DHHS is divided into 30 divisions and offices, which fall under four broad service areas: health, human services, administrative, and support functions. DHHS is the largest agency in state government, responsible for ensuring the health, safety, and well-being of all North Carolinians, providing the human service needs for fragile populations such as the mentally ill, deaf, blind, and developmentally disabled.

2.3 THE N.C. OFFICE OF MEDICAID MANAGEMENT INFORMATION SYSTEM SERVICES

The North Carolina Office of Medicaid Management Information System Services, (OMMISS) provides oversight and manages activities for the procurement and implementation of support systems and services for the NC Medicaid Management Information System (MMIS). The OMMISS also coordinates system-critical services for MMIS Reporting and Analytics, and the information technology infrastructure and systems for the Division of Health Service Regulation (DHSR).

2.4 DIVISION OF MEDICAL ASSISTANCE

The mission of the Division of Medical Assistance (DMA) is to provide access to high-quality, medically necessary health care for eligible North Carolina residents through cost-effective purchasing of healthcare services and products. DMA administers the N.C. Medicaid and N.C. Health Choice programs by:

- Interpreting federal laws and regulations;
- Overseeing regulatory affairs (Medicaid State Plan and N.C. Administrative Code);
- Providing outreach and education to providers and beneficiaries;
- Establishing, publishing, and monitoring clinical policy;
- Establishing all fees and rates;
- Establishing and overseeing provider enrollment and termination requirements;
- Maintaining third-party insurance files and conducting beneficiary financial recovery activities;
- Maintaining the Eligibility Information System (EIS);
- Administering Medicaid managed care programs;
- Publishing provider bulletins and other communication tools; and,

- Monitoring program fraud, waste, and abuse

2.5 DIVISION OF PUBLIC HEALTH

In 1989, the [Division of Public Health](#) (DPH) was transferred from the Department of Human Resources to the Department of Environment, Health, and Natural Resources (DEHNR). Legislation was enacted in 1997 to transfer most of the DPH back to the Department of Human Resources, and to change the name of the Department of Human Resources to the Department of Health and Human Services.

The Administrative, Local, and Community Support (ALCS) section of the DPH provides both direct and indirect services to the public and local health agencies. Much of its work focuses on providing support that allows the business of public health to operate as seamlessly as possible, so that the DPH may better serve the public.

2.6 OFFICE OF RURAL HEALTH AND COMMUNITY CARE

The mission of DHHS, in collaboration with our partners, is to protect the health and safety of all North Carolinians and provide essential human services.

In 1973, the Office of Rural Health and Community Care (ORHCC) was created within the DHHS by Governor Jim Holshouser. At its inception, ORHCC was charged with assisting underserved communities by creating and supporting a network of rural health centers across the state. Since then, the charge has expanded to empowering communities and populations by developing innovative strategies to improve access, quality, and cost-effectiveness of health care for all. ORHCC provides services in every county in North Carolina and supports rural health centers with funding and technical support. ORHCC also helps to place medical, psychiatric, and dental providers in communities throughout the state. Rural hospitals, as well as many statewide medical facilities that treat poor and uninsured residents, may receive help through grant funds. Qualifying patients may take advantage of drug companies' free and low-cost drug programs through ORHCC's medication assistance program.

2.7 DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is charged with implementing the state's public mental health, developmental disability and substance abuse service system and priorities.

The Division's central administration consists of the Director's Office and five sections organized along functional lines: Community Policy Management, Resource/Regulatory Management, Advocacy and Customer Service, and Operations Support and Clinical Policy.

Its programs are governed by rules created by the DMH/DD/SAS Commission. It is advised by the State Consumer and Family Advisory Committee.

The Division works closely with the N.C. Division of State Operated Healthcare Facilities, which manages all mental health, developmental disability, and substance abuse facilities.

2.8 COUNTY DEPARTMENTS OF SOCIAL SERVICES

Each county Department of Social Services (DSS) is responsible for the following:

- Determining beneficiary eligibility for N.C. Medicaid and N.C. Health Choice programs
- Enrolling beneficiaries in managed care programs
- Maintaining all beneficiary eligibility files

2.9 PUBLIC CONSULTING GROUP

Public Consulting Group (PCG) is the contractor that supports Program Integrity in post-payment claims review initiatives. It is also one of the State's Recovery Audit Contractors (RACs). PCG is working on behalf of the DMA to assist providers with mandated screening and training requirements in accordance with Federal regulations – 42 CFR 455.410 and 455.450.



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3. NCTracks Provider Portal

The new NCTracks Provider web Portal has been designed with ease of use and productivity in mind. Providers have the capability through the Portal to manage aspects of their business with the NCTracks system. The enhanced functionality allow providers to more efficiently manage changes, update record(s), add services to a location, participate in electronic communications and listservs, as well as manage affiliations to billers, groups and organizations. The functionality allow for the automation of the Prior Approval (PA) process, checking beneficiary eligibility, checkwrite information, RAs and most functions that were performed only through the Automated Voice Response System (AVRS). Most of the automation accessible by the provider will allow for real-time processing and information retrieval. The Portal serves to enhance providers' access, productivity, and management of their information, and expedite business processes.

Providers are able to participate in web-based tutorials, register for instructor led classes and seminars and request site visits through the Portal. All training materials are available for retrieval and downloading.

Providers are able to establish and manage staff access to their records, use electronic signature capabilities, and upload documentation to further streamline and reduce time-consuming paper processing.

3.1 PROVIDER PORTAL MESSAGE CENTER

- **Announcements** – provide information regarding key activities within the program;
- **Inbox** – communication from NCTracks to providers will be displayed in the Inbox. Communications may include RAs, approval letters, key communications, etc.;
- **Quick Links** – provide easy access to health-related information including Medicaid Bulletins, provider manuals, training, and other DHHS websites; and,
- **Subscriptions** – providers will be able to select available subscription services to custom tailor their home page.

3.2 PROVIDER PORTAL FUNCTIONS

All provider functions can be launched from the Provider Portal home page using the navigation tabs presented at the top of the screen. Once in the Provider Portal, users with authorized access have the ability to:

- Perform provider enrollment and maintenance functions;
- Inquire on beneficiary eligibility and enrollment¹;
- Submit original claims, claim adjustments and prior approval requests¹;
- Review claims payment and status information¹;
- Access Prior approval requests¹;
- Access State-approved forms;

¹ Providers of DMH/DD/SAS State-funded services will continue to contact their contracted LME.



- Access provider training information including provider workshop registration, training materials, training evaluation forms, bulletins, broadcast emails, supporting documentation for training; and,
- Enter registration to receive notifications and/or facilitate communications appropriate to each DHHS division and health plan supported by NCTracks.

4. Provider Enrollment

4.1 ENROLLMENT APPLICATION

Providers must be enrolled in DHHS to render services. Providers must complete and submit a Provider Enrollment Application for their specific provider type. The online Enrollment Application is available through the NCTracks Provider Portal.

All applications, including applications for a new practice location, shall be screened and assigned a categorical risk level of "limited," "moderate," or "high." Provider types and specialties that fall into the moderate- and high-risk categories are subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency within the previous 12 months. [Senate Bill 496 §108C-3](#) further defines provider types that fall into each category. If a provider fits within more than one risk level, the highest level of screening will be applicable (42CFR 455.450, NC Session Law 2011-399, NCG.S. 108C-(3)).

North Carolina Health Choice (NCHC) providers must still enroll directly with DMA/CSC, regardless of whether or not these providers accept Medicaid. This also applies to providers billing Medicaid for children aged 0-3, as children these ages are not covered by the LME-MCO waiver at this time. Most new behavioral health providers are considered Moderate or High risk and should expect pre-screening. More information will be forthcoming regarding procedures for providers enrolling through both DMA/CSC and the LME-MCOs.

4.1.1 Group Provider Enrollment Packets

Providers who want to enroll as groups must complete and submit an online Provider Enrollment Application via the NCTracks Provider Portal for their specific provider type categorized as "organization." Examples of group providers are dental offices, hospitals, skilled nursing facilities, home health agencies, and physician offices.

4.1.2 Individual Provider Enrollment Packets

Providers who want to enroll as individuals must complete and submit an online Provider Enrollment Application via the NCTracks Provider Portal for their specific provider type categorized as "individual." Examples of individual providers are dentists, physicians, physician assistants, and nurse practitioners.

4.1.3 Atypical Providers

"Atypical" providers are providers who do not provide healthcare services and will not be issued NPI numbers. Atypical providers are individuals or businesses that bill Medicaid for services rendered but do not meet the definition of a healthcare provider according to the NPI Final Rule 45 CFR 160.103 (for example, non-emergency transportation providers). Atypical providers will use system-generated provider identification numbers to file their claims.

4.1.4 In Addition to the Enrollment Application

In accordance with Sections 6401(a), 10603 and Section 1866(j) of the Affordable Care Act (ACA), prior to initially being enrolled, providers will be required to undergo screenings and attend trainings as designated by the N.C. DHHS in accordance with NCGS § 108C-9, including, but not limited to, the following:

- How to avoid common billing errors
- Audit procedures, including explanation of the process the Department uses to extrapolate audit results

- How to identify beneficiary fraud
- How to report suspected fraud or abuse
- Due process and appeal rights

4.1.5 Provider Enrollment and Re-Enrollment Fee

In accordance with Section 1866(j) (2) (C) (i) (I) of the Affordable Care Act (ACA), an application fee is required from providers and suppliers who are newly enrolling, revalidating or establishing a new practice location, or in response to a CMS revalidation request.

Session Law 2011-145 Section 10.31(f) (3) mandates that DMA collect a \$100 enrollment fee from providers upon initial enrollment and re-enrollment with the Medicaid/Health Choice programs and at three-year intervals when the provider is re-credentialed (re-verification).

Initial enrollment is defined as an enrollment by a provider who has never enrolled to participate in the Medicaid / Health Choice programs. All new individual providers are required to pay the \$100 enrollment fee. All new organizations are also required to pay the \$100 enrollment fee unless there is another active Medicaid/Health Choice provider with the same EIN who has already paid the enrollment fee.

Re-verification is the process that providers must complete every three years to remain active Medicaid/Health Choice providers. All individual providers are required to pay the \$100 enrollment fee. All organizations are also required to pay the \$100 enrollment fee unless there is another active Medicaid/Health Choice provider with the same EIN who has already paid the re-verification fee.

4.2 PAYMENT OF PROVIDER FEES

Providers can submit payment with their electronic application by selecting their method of payment through the NCTracks Provider Portal. Providers will receive an electronic payment summary and confirmation. Providers are encouraged to print the confirmation page for their records. Payments will be posted and the payment status will be updated in the NCTracks Provider Portal within two business days of being received.

Providers should make every effort to remit payment promptly. Applications will not be processed if payment is not received. **If payment is not received within 30 days of the date of the application, the application will be voided, and the applicant will be required to reapply.**

If providers have any difficulties using the PayPoint system, other than with the method of payment, they can contact the NCTracks Call Center for assistance. Call Center Agents (CSAs) will have access to the PayPoint Virtual Terminal to assist providers who need to make application fee payments. DHHS strongly encourages providers to use PayPoint. PayPoint is safe, secure, and will expedite completion of applications in NCTracks that require payment of a fee.

4.3 QUALIFICATIONS FOR ENROLLMENT

The general requirements for provider enrollment are as follows:

4.3.1 Licensure, Accreditation, Endorsement and Certification

Providers must be licensed, accredited, endorsed and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but ALL providers must complete an application and an N.C. DHHS Provider Administrative Participation Agreement. All providers are responsible for maintaining the required licensure, endorsement,

and accreditation specific to their provider type to remain qualified and are required to notify N.C. DHHS immediately if a change in status occurs. For detailed information regarding specific requirements for each provider type, refer to the [Provider Qualifications and Requirements Checklist](#) on the NCTracks website at <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html> or contact the EVC Operations Center at 866-844-1113.

Note: Behavioral Health Managed Care Organizations that operate under the Mental Health, Developmental Disabilities, and Substance Abuse Services Plan waiver are responsible for enrolling behavioral health providers in their respective provider networks.

4.3.2 Service Location

Services must be provided at a site within the State of North Carolina or, for some services, within 40 miles of the North Carolina border. Out-of-state providers are eligible for enrollment only under the following conditions:

- For reimbursement of services rendered to Medicaid beneficiaries in response to an emergency, or if travel back to the State would endanger the health of the beneficiary;
- For reimbursement of prior-approved non-emergency services; and,
- For reimbursement of medical equipment and devices that are not available through an enrolled provider located within the State of North Carolina or in the 40-mile border area.

Out-of-state providers are required to adhere to all North Carolina, rules, regulations, laws, and statutes governing healthcare delivery under the North Carolina Medicaid program.

For a list of ZIP Codes that are within the 40-mile border area, refer to the out-of-state ZIP Code list on the NCTracks website at <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information/zip-codes.html>.

4.3.3 Re-Verification Requirements

Providers are required to re-verify each enrolled provider every three years to confirm that the provider continues to meet the conditions of participation for enrollment as a Medicaid provider. This process includes criminal background checks and queries.



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5. Provider Provisioning

5.1 NORTH CAROLINA IDENTITY MANAGEMENT (NCID)

Access to the NCTracks Provider Portal requires an NCID. Providers who already have an NCID can use it to access NCTracks. Providers who do not have an NCID can find detailed instruction in the Tool Kit “How to Obtain an NCID” via the NCTracks Provider Portal. To obtain an NCID, go to <https://ncidp.nc.gov/pmf/Registration.html>.

Those who have an NCID, but have forgotten the password, can go to <https://ncid.nc.gov> and click on the link “forgot your Password?” NCID registration and passwords are controlled by the N.C. Office of Information Technology Services (ITS).

An NCID is required to complete the Currently Enrolled Provider (CEP) Registration, to register for training, and to access the new NCTracks Provider Portal. Providers will need to obtain an NCID for their Office Administrators and additional NCIDs for staff who will access NCTracks.

5.2 USER ACCESS

NCTracks enables Office Administrators (owners or managing employees) to control the access that each member of their provider organization has to information in the NCTracks Provider Portal, by granting role-based access to the features of NCTracks based on the job responsibilities of the user. Each person who will access the NCTracks Provider Portal will need their own NCID.

Office Administrators can designate one or more User Administrators to administer ongoing system access. Office Administrators (or User Administrators) can then grant staff members access to the portal, as desired. Office Administrators and User Administrators are encouraged to take the training available in SkillPort regarding Office Administrator functions.



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6. Community Care of NC/Carolina ACCESS (CCNC/CA)

The N.C. DMA operates a statewide Primary Care Case Management (PCCM) program for the state's Medicaid beneficiaries called Carolina ACCESS. The Carolina ACCESS (CA) program was initiated in 1991 and successfully increased access to medical homes. By enrolling beneficiaries into a medical home, the need for beneficiaries to seek primary care services and basic care in hospital emergency departments is reduced.

In 1998, Community Care of North Carolina (CCNC) was created using the existing infrastructure and established 14 community networks that created local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid beneficiaries. These 14 regional networks cover all 100 North Carolina counties. Each network has an administrative entity that contracts with the DMA. North Carolina continues to operate the original Carolina ACCESS PCCM program; however, most primary care providers are now members of a regional network and a majority of Medicaid beneficiaries are enrolled with a provider.

Population management, care management, and coordination of treatment and prevention are provided to beneficiaries enrolled with a network provider. Networks and providers receive increases in the per-member/per month (PM/PM) management fee for enhanced case management services for subsets of populations that are high-risk, high-acuity, high-cost, and frequently have complex co-morbid conditions. In addition to the services stated below, enhanced services include, but are not limited to, a comprehensive and integrated package of high-risk screening/assessment, triage, referral, hospital transitions, pharmacy reviews, medication reconciliation, inpatient, and emergency department diversion with care management across the continuum of care.

The networks provide population health management by:

- Furnishing preventive services and information;
- Systematic data analysis to target beneficiaries and providers for outreach, education, and intervention;
- Monitoring system access to care, services, and treatment including linkage to a medical home;
- Monitoring and building provider capacity;
- Monitoring quality and effectiveness of interventions to the population;
- Supporting the medical home through education and outreach to beneficiaries and providers; and,
- Facilitating quality improvement activities that educate, support, and monitor providers regarding evidence-based care for best practice/national standards of care.

Networks provide disease management by:

- Educating network providers on evidence-based standards of care to ensure that high-risk, high-acuity beneficiaries receive appropriate care; and,
- Educating beneficiaries about disease states and self management.

Currently, 14 CCNC regional networks include more than 3,000 physicians across North Carolina.

The following is a list of the networks in CCNC:

- ACCESS Care
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake/Johnston Counties
- Community Care Partners of Greater
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

*Networks are paid PM/PM management fees based on the number and type of enrollees.

6.1 CCNC/CA PROVIDER PARTICIPATION AND ENROLLMENT

6.1.1 Requirements for Participation in Primary Care Case Management Program

DMA and CSC work together to recruit and enroll Primary Care Physicians (PCPs) into the CCNC/CA program. CSC is responsible for processing the applications and enrolling providers into the program. DMA is responsible for establishing PCP participation requirements, assisting providers in carrying out CCNC/CA policies and procedures, and recruiting providers into the program. Questions about the CCNC/CA program or requirements for participation can be answered by the regional consultants and DMA staff. Regional consultant contact information is available <http://www.ncdhhs.gov/dma/ca/mcc.pdf>.

NCTracks allows providers to enroll in CCNC/CA and select a CCNC/CA contact person. Providers whose applications have been denied or voided may reapply at any time unless a sanction has been imposed upon the provider's participation by DMA.

Providers are required to report any changes regarding their practice's status to CSC. Failure to report a change in practice status may result in termination from the Medicaid program, or PCCM program and sanctions imposed by DMA, including recoupment of PM/PM management fees. To report changes to the Medicaid program, CCNC/CA providers must submit a Managed Change Request (MCR) through the NCTracks Provider Portal.

1	CCNC/CA enrollment option is available to all eligible providers requesting enrollment in the Medicaid Health Plan.
2	At the time the provider answers 'Yes' to the question 'Do you want to apply for CCNC/CA?', the System will validate the provider is enrolled as a Provider Type/Specialty/Area of Specialization that is an eligible CCNC/CA Provider Type.
3	A <u>CCNC/CA Eligible Provider Types List</u> hyperlink is available on this page for viewing the CCNC/CA eligible types list.
4	If the provider answers 'Yes' to the question 'Do you want to apply for CCNC/CA?', the provider will be required to complete the CCNC/CA Contact Person, CCNC/CA Participating Providers, and the Preventive and Ancillary Services pages.

6.2 BENEFICIARY ENROLLMENT IN CCNC/CA

The county DSS is responsible for enrolling beneficiaries with a medical home. Enrollment requirements are based on the beneficiary's Medicaid program aid category and classification of eligibility.

Beneficiaries in any of the mandatory categories that receive Medicare become optional for enrollment.

Beneficiaries whose enrollment is mandatory are informed about the CCNC/CA program and enrolled during the Medicaid application process. Beneficiaries are strongly encouraged to select a medical home from the list of PCPs serving their county of residence. Beneficiaries who do not choose a medical home are assigned by the county DSS based on location, medical history, and restrictions of the provider.

Enrollment considerations:

- In areas that do not have access to CCNC/CA primary care providers for all potential enrollees, efforts are made to preserve existing provider-patient relationships
- Beneficiaries whose third-party insurance is an HMO or who have Tri-Care may be exempted from Carolina ACCESS if their PCP does not participate with CCNC/CA
- At the discretion of the county DSS and the provider, beneficiaries may choose a provider whose Carolina ACCESS agreement does not include their county of residence in the

provider's service area. Beneficiaries who need transportation assistance are generally limited to their county of residence or to a contiguous county

- Each family member may have a different medical home
- Enrollees in either the Medicaid or Health Choice program may request to change their medical home without cause at any time by contacting the county DSS.

North Carolina has chosen to enroll beneficiaries of both Medicaid and Medicare (known as duals, or dually eligible beneficiaries) on an opt-out basis when the beneficiary is in a category that grants full Medicaid coverage. This means that dual beneficiaries are notified that they have been enrolled and the name of the medical home to which they have been enrolled. They are also notified that they should contact the local DSS to choose a different provider or to declare their intention to opt out of the program.

(Providers may not charge copayments for services covered by both Medicare and Medicaid. A dual beneficiary may be charged a copayment if required for services that are not covered by Medicare but are covered by Medicaid).

All optional beneficiaries are notified via letter or verbally by the caseworker at the local county DSS that they can request to enroll, disenroll or change medical homes at any time. This information is also contained in the educational material provided to all beneficiaries at enrollment. Beneficiaries can communicate their choice either in writing or verbally to the local DSS.

Although federal regulations state that foster children must remain optional for enrollment in a managed care program, the "Fostering Connections to Success and Increasing Adoption Act of 2008" requires each state to provide a plan to ensure ongoing oversight and coordination of health care for foster children. North Carolina is meeting this need by enrolling foster children in a medical home through the CCNC/CA program. Guardians of children in foster care can choose to withdraw a foster child from enrollment or change PCPs at any time by notifying the DSS verbally or in writing.

6.3 ENROLLING BENEFICIARIES WITH A CCNC/CA MEDICAL HOME AT THE PROVIDER'S OFFICE

- Inform beneficiaries of their right to choose any CCNC/CA) primary care provider who is accepting new beneficiaries, and their right to change primary care providers at any time pursuant to processing deadlines;
- Enrollment is optional for some beneficiaries, including pregnant women and Medicare beneficiaries. Providers must inform optional beneficiaries of their right to disenroll in the program at any time in the future. Optional beneficiaries may discuss enrollment options by contacting their local DSS. For a listing of all the county DSS offices, refer to www.ncdhhs.gov/dss/local/;
- Complete the enrollment form and it send to the CCNC/CA contact at the DSS in the county where the beneficiary resides. The form can be found on the DMA website at www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm; and,
- Provide the Medicaid beneficiary with a CCNC/CA Member handbook. Handbooks may be obtained by contacting the DMA at 919-855-4780. A copy of the handbook is also available on the DMA website at www.ncdhhs.gov/dma/ca/carehandbook.pdf.

Those with questions regarding enrolling beneficiaries can contact their Regional Consultant. Contact information for your Regional Consultant is available at: www.ncdhhs.gov/dma/ca/MCC_0212.pdf.

6.4 MEMBER IDENTIFICATION

CCNC/CA enrollees are identified by information on their Medicaid identification (MID) card. The name, address, and the daytime and after-hours telephone numbers of the medical home/primary care provider are listed on the MID card. **To insure they have the most current PCP enrollment information, providers are encouraged to verify this information when they verify Medicaid eligibility at each visit.**

The table below identifies mandatory, positional, and ineligible beneficiaries by program aid category.

MANDATORY	OPTIONAL	INELIGIBLE
AAF/Work First-Cash Assistance with Medicaid	MPW-Medicaid for Pregnant Women	MQB and RRF/ MRF
MIC (N) and MIC (1)-Medicaid for Infants and Children	HSF-State Foster Home Fund	Beneficiaries in — Deductible status
MAABD –Medicaid for the Aged, Blind or Disabled (Without Medicare)	IAS-Medicaid with IV-E Adoption Subsidy and Foster Care	CAP Cases with a monthly deductible
MAF-Medicaid for Families	End Stage Renal Disease Patients	Aliens eligible for Emergency Medicaid only
SAD – Special Assistance for the Disabled (Without Medicare)	SSI beneficiaries under age 19	Nursing Facility residents [does not include ICF-I/DD*] *Intermediate Care Facilities for those with Intellectual and Developmental Disabilities
SAA-Special Assistance for the Aged (Without Medicare)	Native Americans (members of a Federally Recognized Tribe)	MAF-D-Family Planning Waiver
MIC-J and MIC-K children enrolled in Health Choice * Native	MAABD –Medicaid for the Aged, Blind or Disabled (With Medicare)	MIC-L-Health Choice Re-Enrollment Buy In
Native Americans	SAA-Special Assistance for the Aged (With Medicare)	MAF-W-Breast and Cervical Cancer Medicaid
	SAD – Special Assistance for the Disabled (With Medicare)	
	Benefit Diversion Cases	

6.4.1 Beneficiary Education

The county DSS is responsible for beneficiary education about CCNC/CA. Enrollees are provided with a Carolina ACCESS member handbook (available in English and Spanish) that informs them of the rights, responsibilities, and benefits of being a member.

It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CCNC/CA PCPs are expected 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**.

Providers should inform each enrollee about the following:

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

6.4.2 The Process for Referring a CCNC/CA Beneficiary to another Provider

Coordination of care is a required component of Community Care of North Carolina/Carolina ACCESS (CCNC/CA).

Authorization for payment of services to another provider must be considered for medically necessary or urgent services even when a beneficiary has failed to establish a medical record with a PCP.

- All authorizations and consultations, including services retroactively authorized, must be referred by the PCP.
- Recommendations for referrals to specialists for follow-up care after discharge from urgent care centers must be made to CCNC/CA primary care providers for their assessment and authorization.
- Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals for routine follow-up care after discharge from a hospital must be made to the PCP. Referrals to a specialist for follow-up care after discharge from a hospital require PCP authorization and should be coordinated through the PCP's office.
- If surgery is recommended, CCNC/CA primary care providers are required to refer beneficiaries for a second opinion at the request of beneficiaries.
- If beneficiaries disagree with their PCP's decision regarding referrals for specialty services or other care, the beneficiaries should be advised of their option to choose a different CCNC/CA primary care provider.
- All referrals must be documented in the beneficiary's medical record. (If PCPs do not have medical records for the beneficiary, they should document the referral on the referral log. PCPs are encouraged to keep a log of all referrals for ease in management of the Referral Report).

6.4.2.1 Managed Care Referrals: Submission

A Referral is defined as a request by the PCP for a beneficiary to be evaluated and/or treated by a different provider. Referrals can be made prior to the date of service or issued for retroactive dates of service at the discretion of the PCP.

There are three media types a provider can choose to process a referral in NCTracks:

- Web Portal – Allows the provider to enter a referral directly in NCTracks via the Provider Web Portal for real time processing.
- Telephone – The provider can call the CSC Customer Support Center to request a referral be entered on their behalf.
- Fax – The provider can fax the Referral Request Form to CSC and the Managed Care Specialist will enter the referral in NCTracks for the provider. All fax requests must be submitted on the Referral Request Form.

Claims submitted for reimbursement of a service authorized by a beneficiary’s Carolina ACCESS PCP must include the PCP’s referral authorization number. **The referral authorization is the PCP’s NPI number.** The exception is if the PCP is atypical.

NCTracks allows providers to electronically submit Managed Care Referrals to other providers for evaluations and/or treatments.

6.4.2.2 Accessing the Referral Entry Screen

From the **Provider Portal**, users can access the **Referral Entry** screen to begin submitting a Managed Care Referral.



Exhibit 6-1. Managed Care Referral Entry

Step	Action
1	Hover over the Referral tab.
2	Click the Referral Entry link.

6.4.2.3 Referral Information & Submission

The **Referral Information** screen allows the user to enter the reason for the referral as well as to whom the beneficiary is being referred.

The screenshot shows a web form titled "REFERRAL INFORMATION". It contains several fields: "Referral Type" (dropdown menu), "Mental Health" (checkbox), "# of Visits" (text input), "Effective Begin Date" (calendar icon), "Notes" (text area), "Reason" (dropdown menu), "Unlimited Visits" (checkbox), and "Effective End Date" (calendar icon). Below this is a section titled "REFERRED TO PROVIDER" with an "NPI" field, a "Validate" button, and a "Select Favorite..." button. At the bottom, there is a summary of provider information: Last Name: BRENNER, First Name: ALAN, Address1: 10 GAINING DR, City: CHAPEL HILL, State: NC, ZIP Code: 27514-4220, Phone, and Fax. Navigation buttons "Previous" and "Submit" are at the bottom.

Step	Action
1	Referral Type: Select the reason for the referral from the drop-down list.
2	Mental Health: Indicate if it is a mental health referral. Reason: Select the reason for the mental health referral from the drop-down list.
3	# of Visits: Enter the number of visits being referred or select the Unlimited Visits checkbox if the number of visits is unlimited.
4	Effective Begin Date: Enter the date the evaluation and/or treatment is expected to begin.
5	Effective End Date: Enter the date the evaluation and/or treatment is expected to end.
6	Notes: Enter additional information about the referral.
7	Referred to Provider (select one of the following options): <ul style="list-style-type: none"> Enter an NPI and click the Validate button. Click the Select Favorite ... button and select the provider from the NCTracks: Provider Favorites list.
8	Click the Submit button.

6.4.3 Managed Care Referrals Inquiry

The **Referral Inquiry** screen is used for inquiring about Managed Care Referrals and Overrides. From the **Provider Portal**, users can access the **Referral Inquiry** screen to begin the inquiry.



Exhibit 6-2. Managed Care Referral Inquiry

Step	Action
1	Hover over the Referral tab.
2	Click the Referral Inquiry link.

6.4.3.1 Managed Care Referral Inquiry Search

The **Referral Search** section allows the user to indicate if the inquiry is for a Managed Care Referral or Override. After making the selection, the screen refreshes and displays the appropriate search options (the exhibit below depicts a Managed Care Referral inquiry). The user must indicate if the provider is listed as the referring provider, the referred to provider, or both.

There are three ways to search for a referral:

- **Referral #** only
- **Recipient ID** and the **Effective Begin Date & Effective End Date**
- **Recipient ID** and the **Submitted Date & Submitted End Date**



Step	Action
1	Inquiry Type: Select the Referral radio button.
2	Display results showing your role as Select Referring Provider, Referred To Provider, or Both .
3	Enter <u>one</u> of the following search criteria: Referral #: Enter the unique identifier of an approved PA submission, Recipient ID

Step	Action
	and Effective Begin Date and Effective End Date Recipient ID and Submitted Date and Submitted End Date
4	Click the Search button.

Upon submission of the search criteria, the application refreshes and displays the results of the search under the **Referral List** section.

The **Referral List** displays the general information about the referral. The user can click the **Referral #** link to review notes written by the referring provider for the referred to provider.

REFERRAL LIST											
Referral #	Type	Recipient Name	Recipient ID	Referring Provider	Referred To Provider	Status	# of Units	Units Remaining	Effective Begin Date	Effective End Date	Submitted Date
1	REFERRAL					DENIED	0.000	0.000	3/1/2013	3/1/2013	2/22/2013

Step	Action
5	Click the Referral # link.

6.4.4 Managed Care Overrides

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 CCNC/CA enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers may request an override.

CCNC/CA Overrides are authorization issued by the Managed Care Specialist and/or State Staff for CCNC/CA enrolled beneficiaries.

- Overrides will authorize the providers to provide services without a PCP referral. Override requests will only be considered if extenuating circumstances beyond the control of the individual parties affect the access to medical care.
- Overrides will not be considered for current, future, or past dates of service, unless the PCP listed on the MID card has been contacted and refused to authorize treatment.
- Once the Managed Care Specialist or State Staff has received an override request, he or she makes a determination based on policy.

Providers needing a Managed Care Override must submit a DMA CA Override Request Form to the Managed Care Specialist or call the CSC Customer Support Center.

There are three different media types where a provider can submit an Override Request:

- **Mail** – The provider can mail the Override request to CSC along with all supporting documentation.
- **Telephone** – The provider can call the CSC Customer Support Center to request an Override for future dates of service or if the patient is in the doctor's office waiting for treatment.
- **Fax** – The provider can fax the Override Request Form to CSC and the Managed Care documentation.

Current/Future Dates of Service

The Provider can call the CSC Customer Support Center to request an Override for future dates of service or if the patient is in the Provider's office waiting for treatment (sometimes referred to as an Emergency Override).

Override Requests for future dates can only be granted within the same month of the request. Providers cannot issue an override for the next month, as Medicaid eligibility is determined month by month. Current or future dates of service can be made via telephone.

6.4.4.1 Accessing the Managed Care Inquiry Screen

The **Referral Inquiry** screen is used for inquiring about Managed Care Referrals and Overrides. From the **Provider Portal**, users can access the **Referral Inquiry** screen to begin the inquiry.



Step	Action
1	Hover over the Referral tab.

6.4.4.2 Managed Care Override Inquiry Search

The **Referral/Override Search** section allows the user to indicate if the inquiry is for a Managed Care Referral or Override. After making the selection, the screen refreshes and displays the appropriate search options (the exhibit below depicts a Managed Care Override inquiry).

There are three ways to search for an override:

- Override # only
- Recipient ID *and* the Effective Begin Date & Effective End Date
- Recipient ID *and* the Request Date & Request End Date

6.4.4.3 Referral List

Upon submission of the search criteria, the application refreshes and displays the results of the search under the **Referral List** section.

The **Referral List** displays the general information about the referral. The user can click the **Referral #** link to review notes written by the referring provider for the referred to provider.

Step	Action
1	Inquiry Type: Select the Override radio button.
2	Enter <u>one</u> of the following search criteria: Override #: Enter the unique identifier for the override, Recipient ID and Effective Begin Date and Effective End Date Recipient ID and Request Date and Request End Date
3	Click the Search button.

Referral #	Type	Recipient Name	Recipient ID	Referring Provider	Referred To Provider	Status	# of Units	Units Remaining	Effective Begin Date	Effective End Date	Submitted Date
	REFERRAL					DENIED	0.000	0.000	3/1/2013	3/1/2013	2/22/2013

6.4.4.3.1 Override List

Upon submission of the search criteria, the application refreshes and displays the results of the search under the **Override List** section.

The **Override List** displays the general information about the override.

Override #	Recipient Name	Recipient ID	Provider	Status	Effective Begin Date	Effective End Date	Request
				A	2/1/2013	2/10/2013	2/26/2013

Note: PCP authorization is not the same as prior approval (PA). Some services require BOTH PA and PCP authorization.

CCNC/CA authorization does not take the place of prior approval mandated in DMA clinical policy.

6.4.4.3.2 Services Exempt from CCNC/CA Authorization

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

- Ambulance services
- At-risk case management
- Care management provided by the CCNC network
- Community Alternatives Program (CAP) services
- Dental care
- Developmental evaluations
- Emergency department services and inpatient hospital services when admitted from the emergency department. Physician services provided in the inpatient setting still require authorization from the PCP.
- Eye care services [limited to CPT codes 92002, 92004, 92012, 92014, 92015, and 92018 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]
- Family planning (including Norplant)
- Health Department services
- Hearing aids (for beneficiaries under the age of 21)
- Hospice
- Independent and hospital lab services
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist
- Services performed in a psychiatric hospitals and psychiatric facilities (see note below)
- Services provided by schools and programs directly billed by the school
- Outpatient behavioral health services provided to beneficiaries age 21 and older

Note: CCNC/CA enrollees are instructed to contact their PCP for assistance in locating dental providers enrolled with the Medicaid program. A list of dental providers is available on DMA's website at www.ncdhhs.gov/dma/dental/dentalprov.htm. Beneficiaries can also be referred to their county DSS (for a list of all the county DSS offices, please refer to www.ncdhhs.gov/dss/local/). Area Health Check Coordinators also maintain a list of dentists that provide services to the under age 21 population. For a list of Health Check Coordinators, refer to www.ncdhhs.gov/dma/provider/provcontacts.htm.

Note: Outpatient behavioral health services provided to beneficiaries under the age of 21 require a referral from a Carolina ACCESS PCP, or alternatively from a Medicaid-enrolled psychiatrist or the Medicaid utilization review contractor – MCO.

6.4.4.3.3 Primary Care Case Management Program Sanctions

Failure to meet the terms outlined in the CCNC/CA 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 primary care case management/coordination fees may be withheld or recouped;
- 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 N.C. Medical Board; and,
- The PCP may be terminated from the CCNC/CA 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 a beneficiary 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. DMA maintains the right to waive sanctions based upon the specifics of the case or upon the recommendation of the CCNC network. Management fees will not be recouped from the CCNC network due to a provider's failure to report practice changes.

Misrepresentation, misuse or abuse of the CA provider's referral number by any provider may result in recoupment of paid claims and termination from the Medicaid program. CA providers should monitor their monthly **Carolina ACCESS Referral Report** and report discrepancies to DMA.

6.4.5 Pregnancy Care Management and Care Coordination for Children

The Pregnancy Care Management program provides care management for the pregnant Medicaid population. In most cases, care management is provided by the Local Health Department, through a contract with the local CCNC network. Each Pregnancy Medical Home (PMH) has a care manager assigned to the practice. Providers must submit all risk screenings to their care manager within seven business days. Care managers are expected to conduct a thorough assessment of all priority patients within 30 days.

Non-PMH prenatal care providers and other community agencies may refer a patient for assessment with a pregnancy care manager, who evaluates the patient's level of need and develops a care plan accordingly.

Pregnant Medicaid patients identified as being at risk for poor birth outcomes receive individualized case management services. The level of service provided is in proportion to the individual's identified needs. Care managers closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome. Care managers are an integral part of the patient's care team.



6.4.6 COMMUNITY CARE OF NORTH CAROLINA PROVIDER PORTAL

This CCNC Provider Portal was released in August 2010 to improve patient care and care coordination for North Carolina Medicaid recipients. Providers and other members of the care team may access care team contact information, visit history, and pharmacy claims history for their Medicaid-enrolled patients. Population management and quality reporting is also available for primary care medical home providers. The portal is available to practices, hospitals, and agencies engaged in quality improvement and care coordination through CCNC.

6.4.6.1 Secure Web Access to the Medicaid Patient Record

- Contact information for the patient's primary care and specialist physicians, mental health services provider, Health Check coordinator, Durable Medical Equipment (DME) supplier, home health or personal care service provider, and pharmacy;
- Visit history (including inpatient, emergency department, office visit, and imaging history);
- Medication list and pharmacy claims history;
- Laboratory results when available and clinical alerts indicating when recommended care is overdue; and,
- Contact information for care management or clinical pharmacy consultation through CCNC.

6.4.6.2 Why use the Provider Portal?

The Provider Portal provides key information from Medicaid claims and other sources that may be missing from the patient provider chart or electronic health record.

The portal allows providers to:

- View patient encounter information that occurred outside of your local clinic or health system (including hospitalizations, emergency department visits, primary care and specialist visits, laboratory and imaging);
- Review medication regimen (including fill history and adherence indicators; and whether medications have been prescribed by other providers);
- Access a compendium of low-literacy patient education materials, and evidence-based practice tools for screening and assessment, health coaching and disease management;
- Retrieve medication information for patients in multiple languages, in video or print format; and,
- Access population management reports and quality metrics for your own patient population.

6.4.6.3 Provider Portal Signup

1. How do I access the Provider Portal?

2. To register, go to <https://portal.n3cn.org> and click on the “pre-register” option.
3. Complete the registration form and click “save.”
4. An email notification will be sent to providers and their networks. A network representative will contact providers or their designees to complete their registration.

More information on CCNC is available at www.communitycarenc.com.

6.4.7 Taxonomy

NCTracks uses the National Provider Identifier (NPI), The Healthcare Provider Taxonomy Code (HCPTC) and location in the processing of claims. **This approach replaces the current use of Medicaid Provider Numbers.** Taxonomy codes for the specified provider reporting levels (attending, rendering, service facility, etc.) will be required on all claim types except pharmacy (although pharmacy providers will select taxonomy codes in the provider enrollment/reenrollment process for their provider records).

6.4.7.1 Healthcare Provider Taxonomy Code Set (HCPTC)

The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions. Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers. The Code Set consists of two sections: Individuals and Groups of Individuals and Non-individuals. The Code Set is updated twice a year, effective April 1 and October 1. The Code Set is available from the Washington Publishing Company at www.wpc-edi.com/reference. The Code Set is maintained by the national Uniform Claim Committee, www.NUCC.org. The Code set is a Health Insurance Portability and Accountability (HIPAA) standard code set. As such, it is the only code set that may be used in HIPAA standard transactions to report the type/classification/specialization of a health care provider when such reporting is required.

When applying for a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES), a health care provider must select the Healthcare Provider Taxonomy Code or code description that the health care provider determines most closely describes the health care provider’s type/classification/specialization, and report that code or code description in the NPI application. The Healthcare Provider Taxonomy Code or code description information collected by NPPES is used to help uniquely identify health care providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care.

6.4.7.2 Healthcare Provider Taxonomy Codes (HCPTC) and NCTracks

The Healthcare Provider Taxonomy Codes and code descriptions that health care providers select when applying for NPIs may or may not be the same as the categorization used by DHHS in enrollment and credentialing activities. Many DHHS providers submit taxonomy codes on claims today. However, **the taxonomy code a provider is currently using may not align with the taxonomy codes designated by the State for use in the new NCTracks system.** It is important that providers use the appropriate taxonomy code from their provider record based on the service rendered and location.

Providers may have more than one taxonomy code per location. **New** DHHS providers who enroll will designate their taxonomy during the enrollment process, using a drop-down list based on the Division specified provider enrollment, licensing, and credentialing guidelines. **Existing** providers will be able to view and/or update their taxonomy codes using the “Manage Change” process in the NCTracks Provider Portal. Providers are encouraged to verify their taxonomy

codes and locations at <http://ncmmis.ncdhhs.gov/taxonomy.asp>. This web page allows providers to enter their NPI or EIN and view the taxonomy codes and locations currently on record for that NPI or EIN. Providers can change their taxonomy codes through the “Enrollment” feature in the NCTracks Provider Portal.

In case of discrepancies or omissions, providers must make corrections online at www.nctracks.nc.gov. Changes to a provider’s taxonomy must be verified, which can take up to a week. While the change is pending, providers could have claims denied. To prevent this, providers should use the Enrollment “Status and Management” button in the secure NCTracks Provider Portal to ensure the changes have been accepted before submitting claims. (See the eLearning CBT courses on “Provider Records” and “Updating Provider Data” in SkillPort via the secure NCTracks Provider Portal.

Note: Claims submitted in NCTracks with codes that do not match the provider taxonomy will be denied.

It is important that providers use the appropriate taxonomy code from their NCTracks provider record based on the service rendered and the rendering/attending provider location when submitting claims to the NCTracks system to facilitate timely adjudication. Providers must also verify the billing provider taxonomy code on the claim matches one of the taxonomy codes listed on the NCTracks billing provider record and is appropriate for the claim being billed.

Both the group/billing provider and the rendering provider have their own taxonomy codes, which should be reflected on the claim. (The only exception to this is for DMH claims. DMH claims can have a group taxonomy code assigned to the rendering provider.)

Providers submitting batch/X12 claims electronically (not via the web portal) will need to use the service facility field to indicate the rendering/attending provider location. Taxonomy codes are required on all claim types except pharmacy.

6.4.7.3 Location and Healthcare Provider Taxonomy Codes (HCPTC) and NCTracks

Because NCTracks relies on taxonomy codes to assign service location properly, submitted claims with service codes that do not correlate to provider taxonomy and location on file will deny. Accurate information on where services are rendered is vital to ensuring claims process correctly in NCTracks. NCTracks uses the service facility address to assign the appropriate service location and ultimately the appropriate payment. **In cases where the submitted service address does not match provider address data on file, or invalid service address information is on file (such as a P.O. Box), claims can fail.**

6.4.7.4 Atypical Providers and Healthcare Provider Taxonomy Codes (HCPTC) in NCTracks

The National Provider Identifier (NPI) Final Rule stipulates that only entities who meet the definition of “health care providers” found at 45 CFR 160.103 are eligible for NPIs. There are a number of entities who do not meet this definition who are therefore not eligible for NPIs, but whose services are payable by NCTracks. The NPI final Rule refers to these entities as “atypical service providers” because the services they render are not “health care” services. Examples are non-emergency transport and physical alterations to living quarters for the purpose of accommodating disabilities. Atypical providers will use a system generated provider identification number to file claims and not a taxonomy number.



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7. Submitting Paper Claims

All claims are required to be submitted electronically with the exception of pharmacy claims for DPH providers. DPH providers will continue to submit pharmacy claims for prescription drugs on paper to CSC.

7.1 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 unless they submit a paper claim due to the exceptions list).

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. To avoid denials (which indicate that a **Provider Certification for Signature on File Form** has not been submitted), contact CSC at 1-800-688-6696 prior to submitting claims to verify that the system has been updated. A copy of the form is available on the NCTracks website at www.nctracks.nc.gov/provider/forms/.

7.2 Time Limit Overrides

Since DMA and CSC must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DMA or CSC about the specific claim received that is within 365 days of the date of service;
- 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; and,
- 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 CSC within the 365-day time limit.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the date of service on the claim, the provider has **180** days from the EOB date listed on the explanation of benefits from that insurance (whether the claim was paid or denied) to file the claim to Medicaid. The claim should be submitted electronically and a copy of the Third-Party or Medicare EOB can be uploaded as an attachment through the Provider.



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8. Submitting Electronic Claims

8.1 BILLING CLAIMS ELECTRONICALLY

The new NCTracks interactive Claim Submission System supplies a secure access, browser-based application for providers to enter claims transactions. The claims system is an electronic version of the **Professional (CMS-1500/837P), Institutional (UB-04/837I) and Dental (ADA 2006/837D) Claims** form. The claims are submitted in real-time, which means the user receives an immediate status notification of the claim (to-be-paid, to-be-denied, pending – “pend”). The advantages of the new claims processing system are:

- Provides a secure access, browser-based application for providers to enter claims transactions;
- Returns an immediate status notification of the claim on screen; and,
- Improves the accuracy, timeliness, and availability of information through an easy to use point and click interface.

8.2 TIME LIMITS FOR FILING CLAIMS

All Medicaid claims, except hospital inpatient and nursing facility claims, must be received by CSC within 365 days of the 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 last RA date to refile a claim.

8.2.1 Billing Professional (CMS-1500/837P) Claims

The following provider types submit professional claims:

Ambulatory surgery centers	At-risk case management services
Certified registered nurse anesthetists	Children’s Development Services Agencies
Chiropractors	Community Alternatives Program services
Critical Access Behavioral Health Agencies	Durable medical equipment suppliers
Federally qualified health centers	Free-standing birthing centers
Health departments	Hearing aid dealers
HIV case management services	Home infusion therapy services
Independent diagnostic testing facilities	Independent laboratories
Independent practitioners	Local education agencies
Local management entities	Nurse midwives
Nurse practitioners	Optical supply dealers
Optometrists	Personal care services
Orthotics and prosthetics suppliers	Podiatrists
Physicians	Portable X-ray services

- Private duty nursing services
- Rural health clinics
- Direct-enrolled independent behavioral health practitioners
- Maternity Care Coordination/Child Services Coordination services
- Outpatient behavioral health services provided by Community Intervention Services Agencies
- Planned Parenthood (non-medical doctor) organization

8.2.2 Creating a Professional Claim in NCTracks



Action	
1	Hover over Claims menu.
2	Choose Create Professional Claim – The Verify Patient screen displays.

8.2.2.1 Billing Institutional (UB-04/837I) Claims

The following provider types submit Institutional claims:

- Ambulance services
- Critical Access Behavioral Health Agencies
- Dialysis facilities
- Home health agencies
- Hospice services
- Hospitals
- Inpatient behavioral health services provided by Community Intervention Services Agencies
- Intermediate care facilities for individuals with mental retardation
- Nursing facilities
- Psychiatric residential treatment facilities
- Residential child care (Level II, III, and IV) facilities

8.2.2.2 Creating an Institutional Claim in NCTracks



Step	Action
1	Hover over Claims menu.
2	Choose Create Institutional Claim . The Verify Patient screen displays.

The **Claim Information** screen allows users to enter general information about an institutional claim. This web page contains a number of collapsible/expandable sections. Normal default behavior displays the sections collapsed. Sections collapse or expand when providers select **Yes** or **No** for entering information for those sections. Follow the steps below to enter the required information. Pay particular attention to the **Facility Type** for the claim. If the claim is an **Inpatient** claim, the **Admission Date** and **Admission Hour** are required.

8.2.2.3 Billing Dental (ADA 2006/837D) Claims

The following provider types submit Dental claims:

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

8.2.3 Creating a Dental Claim



Step	Action
1	Click Claims
2	Choose Create Dental Claim.

8.2.4 Creating a Pharmacy Claim in NCTracks



Step	Action
1	Hover over Claims menu
2	Choose Create Pharmacy Claim ; the Verify Patient screen displays

8.2.5 Creating a Pharmacy Claim Reversal in NCTracks

A Pharmacy Claims Reversal is used to reverse claims previously entered in NCTracks. To reverse, providers will need to know the claim Pharmacy's NPI number, Prescription Number, NDC and Date Dispensed.



Section	Action
1	Hover over Claims menu
2	Choose Pharmacy Claims Reversal . Create Pharmacy Reversal displays.



Section	Action
3	NPI/Atypical ID: Choose Pharmacy NPI # .
4	Prescription #: 123456789
5	National Drug Code: 00186502082 – NEXIUM 20 MG CAPASTZ
6	Date Dispersed: 3/11/2013
7	Click the Submit button.

8.2.6 Submitting Payment(s) From Other Payers

The **Other Payers** screen allows the user to enter information for third party payers on a **Professional Claim**. When **Yes** is selected, the **All Other Payers** section expands. If third party insurance policies are in effect, payments made by those policies will need to be reflected here. **All Other Payers** section has three required fields: Name, Date Paid, and Paid Amount.

If applicable, the user can add more than one payer, clicking the **Add** button. The **Clear** button clears the current entry information. To delete a payer, click the **Remove Service Line** button in the last column. **Exhibits 7-1** and **7-2** display adding **All Other Payer** line item and **Editing Row #1** details. In this exercise, there are no other payers assigned. Clicking **No** collapses the All Other Payers section. Clicking the **Next** button advances to the **Service(s)** screen.

Exhibit 7-1. Other Payers Screen

Step	Action
1	Would you like to add All Other Payers? Select Yes – the All Other Payers section expands.
2	Other Payers Name: Medicare
3	Date Paid: Choose a Date
4	Paid Amount: 15.00
5	Click Save Other Payer

8.2.7 Transmitting Attachments and Submitting the Claim

A user may want to add attachments to the claim such as Admittance Summary, Certifications, Diagnosis Report, Discharge Summary, EOB, Physicians orders, etc (these are examples and are not applicable to all claims). A provider can enter up to nine attachments.

After selecting the Attachment Type, use Transmission Codes to represent the method of delivery: Electronic, Email, File Transfer, Mail, and On Request.

Exhibit 7-2. Attachment Screen

Step	Action
1	Do you want to add attachments to the claim? Yes (Attachment section expands)
2	User can select attachment type from a list in the Attachment Type drop-down list.
3	User can select method of attachment from a list in the Attachment Transmission Code drop-down list.
4	Would you like to attach files? Select No (to collapse the Attachment section).

8.2.7.1 Submitting the Completed Claim

The **Submit** option becomes available once the **Attachments** page is active. If the user clicks the **Submit** button and any errors are found, an **Error Summary** dialog box will display. Fix the errors and click **Submit** again to resubmit the claim.

Exhibit 7-3. Submit Claim

Step	Action
1	Would you like to attach files? Select No radio button.
2	Click the Submit button.

8.3 N.C. MEDICAID IMPLEMENTATION OF THE NATIONAL CORRECT CODING INITIATIVE

The Patient Protection and Affordable Care Act [(H.R. 3590) Section 65607 (Mandatory State Use of National Correct Coding Initiative (NCCI))] requires state Medicaid programs to incorporate NCCI methodologies into their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported.

The two components of NCCI are procedure-to-procedure edits (CCI) and medically unlikely edits (MUE).

- CCI procedure-to-procedure edits are for practitioners, ambulatory surgical centers, and outpatient hospital service (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level) that define pairs of HCPCS/CPT codes that should not be reported together.
- MUE are units of service edits for practitioners, ambulatory surgical centers, outpatient hospital service (only for drugs, high-tech images, ultrasounds, and labs as they are billed at a CPT/HCPCS code level), and DME. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct (e.g., claims for excision of more than one appendix or more than one hysterectomy).

DMA implemented these components on March 31, 2011 to comply with the NCCI mandate. For more information on NCCI, refer to DMA's website at www.ncdhhs.gov/dma/provider/ncci.htm

Providers are reminded that:

- Services must be reported correctly;
- Multiple HCPCS/CPT codes should not be reported when a single comprehensive HCPCS/CPT;
- Code describes these services;
- A procedure should not be fragmented into component parts;
- A bilateral procedure code should not be unbundled into two unilateral procedure codes; and,
- Down coding and up coding should be avoided.

8.3.1 Additional Correct Coding Edits Implementation

DMA plans to implement additional correct coding guidelines to enhance our current claims processing system. These new correct coding guidelines and edits will be nationally sourced by organizations such as the Centers for Medicare & Medicaid Services (CMS) and The American Medical Association (AMA). These edits will identify any inconsistencies with CPT, AMA, CMS, and/or DMA policies and will deny the claim line.

For example, the edits will ensure that:

- The appropriate procedure code is utilized based on age and gender of the patient;
- If a procedure code is submitted that requires a primary procedure code, DMA will verify that the primary procedure code has been submitted;
- Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS; For example, certain procedure codes are not permitted to be performed outside of an inpatient setting;

- Obstetric services including ante partum care, delivery, and postpartum care are billed appropriately according to CMS guidelines and DMA policy;
- The appropriate Evaluation and Management (E&M) codes are utilized for new patients and established patients;
- Certain services related to a surgical procedure are included in the payment of the global surgery package; These services would include E&M and related surgical procedures performed by the same physician for the same patient; and,
- Duplicate services are not submitted for the same provider, same patient for the same date of service.

Providers may refer to the NCCI and Additional Correct Coding Edits web page on DMA's website, www.ncdhhs.gov/dma/provider/ncci.htm, for a description of the additional edits module and implementation timeline

8.4 TRADING PARTNER AGREEMENTS

A Trading Partner Agreement (TPA), defined in 45 CFR 160.163 of the transaction and code set rule, is a contract between parties who have chosen to exchange information electronically. The TPA stipulates the general terms and conditions by which the partners agree to exchange information electronically. The document defines participant roles, communication, privacy and security requirements, and identifies the electronic documents to be exchanged. TPAs are used by all entities that wish to establish an electronic relationship with the N.C. DHHS programs supported by NCTracks. TPAs must be on file prior to testing electronic transactions with NCTracks.

An Electronic Data Interchange (EDI) Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, clearinghouse etc.) that transmits electronic data to, or receives electronic data from, another entity.

Trading partner registration, which includes electronic signature of the Trading Partner Agreement (TPA), generation of Transaction Supplier Number (TSN) is an on-line process and the instructions are provided below. Clearing houses, service bureaus, trading partners, billing agents, and other entities that intend to exchange electronic transactions with NCTracks must sign the TPA and be enrolled into NCTracks. Providers who are not enrolled in NCTracks cannot enroll as a Trading Partner until registered and credentialed with NCTracks. Contact NCTracks EVC at 866-844-1113 or visit the following site <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html>.

The NCTracks website contains links to all forms and related information for enrollment as a Trading Partner. Refer to www.ncdhhs.gov/dma/dental/dentalprov.htm for additional information and a variety of useful quick links such as Frequently Asked Questions (FAQs), enrollment instructions, and complete set of companion guides on NCTracks.

For NCTracks HIPAA Companion Guides, visit the following site:
<http://www.nctracks.nc.gov/provider/guides/index.html>

Note that all entities should obtain an NCID before enrolling into NCTracks. Information on how to obtain a NCID is described below:

NCID Registration: <https://ncid.nc.gov>

NCID FAQs: https://www.ncid.its.state.nc.us/NCID_FAQ2.asp

Contact information and instructions for enrolling as a NCTracks Trading Partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information is mentioned below.

NCTracks Support Services Contact Information

Phone: 1-800-688-6696

Email: NCTracksprovider@nctracks.com

Website: <https://www.nctracks.nc.gov/content/public/providers.html>

Electronic Data Interchange (EDI) Technical Assistance

Phone: 1-800-688-6696

Email: NCMMIS_EDI_Support@csc.com

Website: <http://www.nctracks.nc.gov/provider/index.html>

Companion Guides: <https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html>

Provider/Trading Partner Enrollment

NCTracks Enrollment Link

Phone: 1-800-688-6696

Email: NCTracksprovider@nctracks.com

<https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html>

Note: Detailed data specifications are published separately by the industry committees responsible for their creation and maintenance.

8.5 BILLING WITH SOFTWARE OBTAINED FROM A CONTRACTOR

A variety of software programs that provide integrated health insurance billing are available. Providers must obtain software from a contractor who has written the program using specifications adopted under HIPAA.

After verifying that the contractor has tested their software with CSC, complete a Trading Partner Agreement (TPA) located on DMA's website at www.ncdhhs.gov/dma/hipaa/. Once your TPA is processed, providers may begin billing immediately.

8.6 BILLING WITH SOFTWARE WRITTEN BY YOUR OFFICE OR COMPANY

Facilities and providers may develop their own software for electronic claims filing. This software must comply with the electronic standards as adopted under HIPAA. HIPAA Transaction Implementation Guides may be obtained from Washington Publishing Company at www.wpc-edi.com. In addition, N.C. Medicaid Companion Guides, designed for use in conjunction with HIPAA Transaction Implementation Guides, may be found on NCTracks Provider Portal.

9. Prior Approval

Prior approval (PA) for Medicaid may be required for some services, products, or procedures. PA establishes compliance with clinical coverage policy or program criteria. This basic medical necessity determination is based on the documentation submitted by the provider. If PA is required, it must be obtained **before** rendering a service, product, or procedure. **Obtaining PA does not guarantee payment, ensure beneficiary eligibility on the date of service, or guarantee a post-payment review to verify that the service was appropriate and medically necessary.** A beneficiary must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

PA for Public Health is required for all services but may be requested up to 365 days after the service is rendered. Providers will be able to create and submit most PA requests with attachments as electronic documents, as required, via the web portal. Providers will also have the ability to determine if a specific service or procedure requires prior approval.

NCTracks will continue to support the processing of paper PA forms. Providers submitting paper PA forms will still be able to check the status of any PA request via the Provider Portal, after the paper document has been scanned, imaged, and indexed for document control and tracking purposes

9.1 GENERAL REQUESTS FOR PRIOR APPROVAL

PA forms are used to assist in the review of medical necessity for requested services. Providers submitting PA requests in writing are strongly encouraged to use forms published by the service-specific Utilization Review contractor (UR contractor). However, UR contractors will consider all relevant information that is submitted, regardless of whether it is included on a particular form. To access PA forms, contact the service-specific UR contractor. Once a PA has been issued, it must be used within the time limit set forth by the PA **OR** within 365 days, whichever time period is less.

All PA requests can be submitted electronically via the provider portal, including FL2, Hospice Reporting, Transplants, and Visual Aid. The multi-copy paper forms are a thing of the past. The provider portal is designed with drop-down menus wherever possible so the user can select the entry, thus reducing errors and delays from additional information requests. In addition, the request is immediately placed in the queue for review.

- All PA requests previously sent to HP, DMA, DPH (POMCS), or ACS (pharmacy) will be sent directly to CSC.
- The wait for mailed PA requests stamped with an approval is ended. The provider portal allows a user to see real-time statuses of PA requests regardless of who made the decision (CSC, MedSolutions, CCME, etc.) Denial letters with appeal rights will still follow the same requirements.
- Many of the drug classes that require PA have been designed so that if the clinical criteria have been met, the request can be automatically approved by the system. The user will receive a PA number, and the status of the request.
- All DMA Medical (Medicaid/ Health Choice) PA requests (Durable Medical Equipment, Visual Aid, Hearing Aid, Surgery, etc.) will be required to have a taxonomy code and location for the requesting, billing, and rendering providers. The taxonomy code will be systematically validated against what is on the provider file for that location, as well as determining if the taxonomy code is valid for the service requested. It is very important that providers use the new NCTracks automated forms. While CSC can still process the

old paper forms, it is likely that there will be a delay due to manual processing requirements for the old forms.

- There will be a HIPAA compliant 278 prior approval transaction available in October 2013, after the July go-live date. However, the transaction is limited. Due to the specific requirements for different PA types as defined by N.C. DHHS, the transaction does not support the ability to answer specific clinical questions.
- AVRS Inquiry has been replaced with web-based inquiry. Much of the functionality needed to find a PA record in the AVRS has been removed, and replaced by more robust functionality in the provider portal. In addition, Dental Benefit Limitations and Refraction Confirmation can be performed in the provider portal.

Services Requiring PA	Previous Contractor/Division	New Contractor
Transplants, EPSDT	DMA	CSC
Public Health (POMCS)	DPH	CSC
Prescription Drugs	ACS	CSC
<ul style="list-style-type: none"> • Certain medical and surgical procedures • Out-of-state elective services • Services to recipients with Medicaid for Pregnant Women (MPW) • Hearing aid services • Therapeutic leave over 15 consecutive days • Routine eye exams or refraction series beyond established limitations • Out-of-state and state-to-state ambulance services • Transplants • Nursing facility level of care 	HP	CSC
Preadmission Screening and Resident Reviews (PASRR) for individuals before admission to North Carolina nursing Facilities	HP	HP

10. Verifying Beneficiary Eligibility

10.1 VERIFYING ELIGIBILITY

A beneficiary's eligibility status may change from month to month if financial and household circumstances change. For this reason, **providers are required to verify a Medicaid beneficiary's eligibility each time a service is rendered.** Providers may verify a beneficiary's eligibility in various methods outlined in the subsection below, **Verification Methods.**

10.1.1 Verification Methods

Providers may verify a beneficiary's eligibility using the following methods:

- NCTracks Provider Portal
- AVRS
- EDI (batch)

10.2 VERIFYING RECIPIENT ELIGIBILITY USING THE NCTRACKS PORTAL

Online eligibility verification through NCTracks takes a different approach than the one health care providers may have grown accustomed to seeing in legacy systems. Rather than naming individual programs for which a recipient is eligible, NCTracks displays the health plans and benefits for which the recipient qualifies. This simplification of the information displayed is an important difference between legacy systems and NCTracks.

For example, a beneficiary may be enrolled in a specific North Carolina Medicaid program, such as Medicaid for Infants and Children (MIC) or Medicaid for Adults with Disabilities (MAD). Those program abbreviations that providers saw onscreen in legacy systems do not appear in NCTracks. What a provider verifying recipient eligibility will see instead is the Health Plan in which the beneficiary is enrolled (Medicaid, Health Choice, Public Health, Mental Health, or Rural Health). Beneath the Health Plan is a list of benefits the recipient is eligible to receive.

This section of the guide will go into further detail about accessing and using the information available through the NCTracks Verify Recipient screen. Providers whose business or system requirements best function with a beneficiary's program name and abbreviation can make that determination by using a crosswalk table available in the Provider Portal of the NCTracks main website, www.nctracks.nc.gov.

Using the Verify Recipient screen, providers are able to conduct eligibility inquiries on an individual beneficiary by using the provider's NPI number, and various combinations of the beneficiary's information (to include: Recipient ID, First Name, Date of Birth, Last Name and Social Security Number) and Date of Service.

When conducting a DMA inquiry, the dates of service may be for 12 months through the current calendar month. When conducting a DPH inquiry, the dates of service may be for 12 months in the past, the current calendar month, and 12 months into the future.

Exhibit 10-1. Verify Recipient Screen

Step	Action
1	NPI/Atypical ID: Select the NPI/Atypical ID from the drop-down list
2	Recipient Information: Enter recipient data using one of the following combinations: <ul style="list-style-type: none"> • Recipient ID • Recipient ID, Last Name and Date of Birth • Recipient ID, First Name and Last Name • First Name, Last Name and Date of Birth • Date of Birth and Social Security Number
3	Date of Service: Enter From date or use the calendar icon.
4	Date of Service: Enter To date or use the calendar icon.
5	Click the Check Eligibility button to display search results

10.2.1 Individual Eligibility Response

The Provider Eligibility Response page displays the search results based on the given search criteria. A provider can view the Search Criteria, Recipient Information, and Coverage Details.

When applicable, recipient response details include information regarding benefit plans, monthly liability amounts, Medicare, other insurance, and service limits.

Verification of eligibility is not a guarantee of payment. **DPH cannot guarantee payment because funding for services may be exhausted.** If eligibility is denied and the provider confirms eligibility was verified by giving the tracking number, DMA will honor the eligibility verification.

Exhibit 10-2. Provider Eligibility Response

Section	Description
1.	Search Criteria displays the search criteria used for the results. This section includes Recipient ID, Dates of Inquiry, Verified On: (date and time), and Tracking #.
2.	About the Recipient displays recipient demographic information. This section includes Name, Gender, Last Well-Child Check, Date of Birth, and Recipient ID
3.	Cost Sharing Balance – Threshold to Current Date displays the cost sharing information. This section includes a valid through date, Tracking Period, Out of Pocket (OOP) Max, and Amount Applied to OOP.

4 Coverage Details

Period Selection: 02/01/2013-02/28/2013

5 CAROLINA ACCESS INFORMATION

Primary Care Provider: _____ Daytime Phone: _____
 Address: _____ After Hours Phone: _____

6 CCNC Admin Entity: _____ Daytime Phone: _____

RECIPIENT INFORMATION

7 - HEALTH PLAN: MEDICAID

Benefit Plan	Dates of Enrollment	Managing Entity	Address	Daytime Phone	After Hours Phone
Medicaid	02/01/2013 - 02/28/2013				

- HEALTH PLAN: HEALTH CHOICE

Benefit Plan	Dates of Enrollment	Managing Entity	Address	Daytime Phone	After Hours Phone

- HEALTH PLAN: PUBLIC HEALTH

Benefit Plan	Dates of Enrollment	Managing Entity	Address	Daytime Phone	After Hours Phone

- HEALTH PLAN: RURAL HEALTH

Benefit Plan	Dates of Enrollment	Managing Entity	Address	Daytime Phone	After Hours Phone

Hospice Information

Hospice Indicator: N Start Date: _____ End Date: _____

Exhibit 10-3. Coverage Details Section

Section	Description
4.	Coverage Details displays: Period of Selection.
5.	Carolina Access Information displays: Primary Care Provider, Address, CCNC Admin Entity, Daytime Phone, After Hours Phone, and Daytime Phone.
6.	Recipient Information displays eligibility information for the period requested for the following health plans: Medicaid, Health Choice, Public Health, and Rural Health. Each health plan section includes Benefit Plan, Dates of Enrollment, Managing Entity, Address, Daytime Phone, and After Hours Phone.
7.	Hospice Information displays: Hospice Indicator, Start Date, and End Date.

8 RECIPIENT MONTHLY LIABILITY

This Monthly Liability Information is valid as of 02/04/2013

Date Segments: -

Monthly Liability: _____ Liability Balance: _____

9 MEDICARE INFORMATION

Medicare #: _____ Part A Eligible : **No** Part B Eligible : **No**

Part C Eligibility

Group Health Org : _____ Plan Name : _____

Coverage Type : _____

Part D Eligibility

Group Health Org : _____ Plan Name : _____

Coverage Type : _____

10 OTHER INSURANCE

Type	Company Name	Company Address	Company Phone	Policyholder	Policy #	Group Policy #	Coverage Dates

11 PHARMACY OPT-IN

Type	Pharmacy Name	Pharmacy Phone #

Exhibit 10-4. Payer Section

Section	Description
8.	Recipient Monthly Liability displays the recipient's monthly liability totals and balance. This section contains Monthly Liability valid through date, Date Segments, Monthly Liability, and Liability Balance.
9.	Medicare Information displays the recipient's Medicare insurance information. This section contains Medicare #, Part A Eligible, and Part B Eligible. In addition, Part C & D Eligibility details Group Health Org, Coverage Type, and Plan Name.
10.	Other Insurance displays information regarding insurance policies, when the recipient has insurance coverage other than Medicare. This section contains Type, Company Name, Company Address, Company Phone, Policyholder, Policy #, Group Policy #, and Coverage Dates.
11.	Pharmacy Opt-In displays information regarding the pharmacy the recipient has chosen. This section contains Type (if pharmacy is primary or secondary), Pharmacy Name, and Pharmacy Phone #.

PHARMACY OPT-IN														
Type	Pharmacy Name	Pharmacy Phone #												
<p>Information regarding these services is provided for informational purposes only and is not a guarantee of payment. Payment for services is subject to criteria and limitations documented in the applicable Medicaid policy manual. Please refer to your NC Medicaid policy manual or call CSC Provider Services at 1-800-XXX-XXXX</p>														
<p>12 MEDICAID SERVICE LIMITS</p> <table border="1"> <thead> <tr> <th>Service Type</th> <th>Allowed Amount / \$</th> <th>Time Period</th> <th>Available Amount / \$</th> <th>Message (restriction)</th> <th>Previous Date of Service</th> </tr> </thead> <tbody> <tr> <td colspan="6">?</td> </tr> </tbody> </table>			Service Type	Allowed Amount / \$	Time Period	Available Amount / \$	Message (restriction)	Previous Date of Service	?					
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<p>13 SICKLE CELL SERVICE LIMITS</p> <table border="1"> <thead> <tr> <th>Service Type</th> <th>Allowed Amount / \$</th> <th>Time Period</th> <th>Available Amount / \$</th> <th>Message (restriction)</th> <th>Previous Date of Service</th> </tr> </thead> <tbody> <tr> <td colspan="6">?</td> </tr> </tbody> </table>			Service Type	Allowed Amount / \$	Time Period	Available Amount / \$	Message (restriction)	Previous Date of Service	?					
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<p>14 INFANT/TODDLER SERVICE LIMITS</p> <table border="1"> <thead> <tr> <th>Service Type</th> <th>Allowed Amount / \$</th> <th>Time Period</th> <th>Available Amount / \$</th> <th>Message (restriction)</th> <th>Previous Date of Service</th> </tr> </thead> <tbody> <tr> <td colspan="6">?</td> </tr> </tbody> </table>			Service Type	Allowed Amount / \$	Time Period	Available Amount / \$	Message (restriction)	Previous Date of Service	?					
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<p>15 ADAP SERVICE LIMITS</p> <table border="1"> <thead> <tr> <th>Service Type</th> <th>Allowed Amount / \$</th> <th>Time Period</th> <th>Available Amount / \$</th> <th>Message (restriction)</th> <th>Previous Date of Service</th> </tr> </thead> <tbody> <tr> <td colspan="6">?</td> </tr> </tbody> </table>			Service Type	Allowed Amount / \$	Time Period	Available Amount / \$	Message (restriction)	Previous Date of Service	?					
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<p>16 TRANSFER OF ASSETS SANCTION</p> <table border="1"> <thead> <tr> <th>Date Range</th> <th>Message</th> </tr> </thead> <tbody> <tr> <td colspan="2">?</td> </tr> </tbody> </table>			Date Range	Message	?									
Date Range	Message													
?														

Exhibit 10-5. Opt-In Section

Section	Description
12.	Medicaid Service Limits displays information about the recipient's service limits. This section contains Service Type, Allowed Amount/\$, Time Period, Available Amount, Message (restriction), and Previous Date of Service.
13.	Sickle Cell Service Limits displays information about Sickle Cell service limits. This section contains Service Type, Allowed Amount/\$, Time Period, Available Amount, Message (restriction), and Previous Date of Service.
14.	Infant/Toddler Service Limits displays information about Infant/Toddler service limits. This section contains Service Type, Allowed Amount/\$, Time Period, Available Amount, Message (restriction), and Previous Date of Service.
15.	ADAP Service Limits displays information about AIDS Drug Assistance Program (ADAP) service limits. This section contains Service Type, Allowed Amount/\$, Time Period, Available Amount, Message (restriction), and Previous Date of Service.
16.	Transfer of Assets Sanction displays information about asset transfers for the recipient. This section contains Date Range and Message.

11. Adjustments

11.1 TRANSACTION CONTROL NUMBER (TCN)

The TCN is the 16-character claim control identifier auto-assigned in NCTracks. The TCN number is comprised of the following data: date the claim enters adjudication, sequential batch number, line number reference for separated or split claim, and adjustment code.

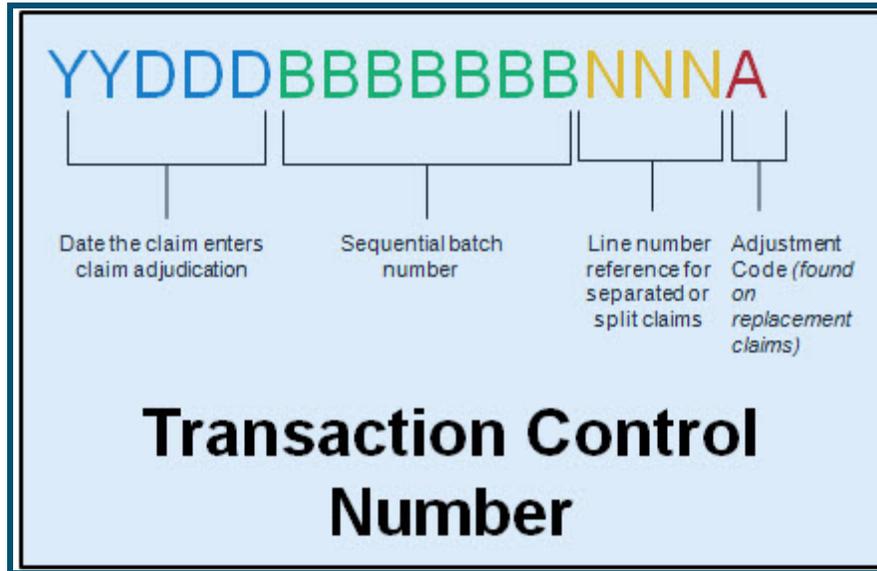


Exhibit 11-1. Transaction Control Number

11.2 CAUSES FOR ADJUSTMENTS

Providers may submit claims electronically using the x12 837 transaction or from the NCTracks Provider portal for Professional, Institutional, and Dental claims. Pharmacy claims can be submitted through the provider portal or electronically using National Council for Prescription Drug Programs NCPDP. With the requirement to accept electronic attachments, the need for providers to submit paper is greatly reduced. Therefore, when providers find they need to submit an adjustment to void or replace a previously paid claim, they may use their 837 or the provider portal to submit the adjustment and include any attachments electronically. **The provider portal can only be used to adjust claims that were originally submitted through the portal.**

Other scenarios where adjustments are warranted are from triggers from within NCTracks that affect the claim such as retro-eligibility for Medicaid. Mass Adjustments supports the Fiscal Agent's (FA) ability to perform adjustments on a mass selection of claims, e.g., a rate change to a procedure that is retroactive. The claim criteria are entered in the adjustment request where the claims are selected and set up for adjustment processing. The mass adjustments workflow supports batch processing of adjustment requests or in real-time to accommodate situations where the FA must perform the provider-initiated adjustment on behalf of the provider.

11.3 CLAIM STATUS AND CLAIM COPY

NCTracks Provider Portal allows providers to search the status of a claim and copy the claim details to a new a new claim allowing for the resubmission of a claim. This claims process is the same for all claim types.

The Claim Status screen is use to search for a status of a claim. In the NCTracks Provider portal, the Claims Status option is located under the Claims menu The Claim Status Request screen has three sections: Base Information, Claim Search, and Claims (Results). The required fields are Dates of Service (From and Two) and Recipient ID. Use more fields to return a quicker and more accurate response. All required fields are denoted by a red asterisk.

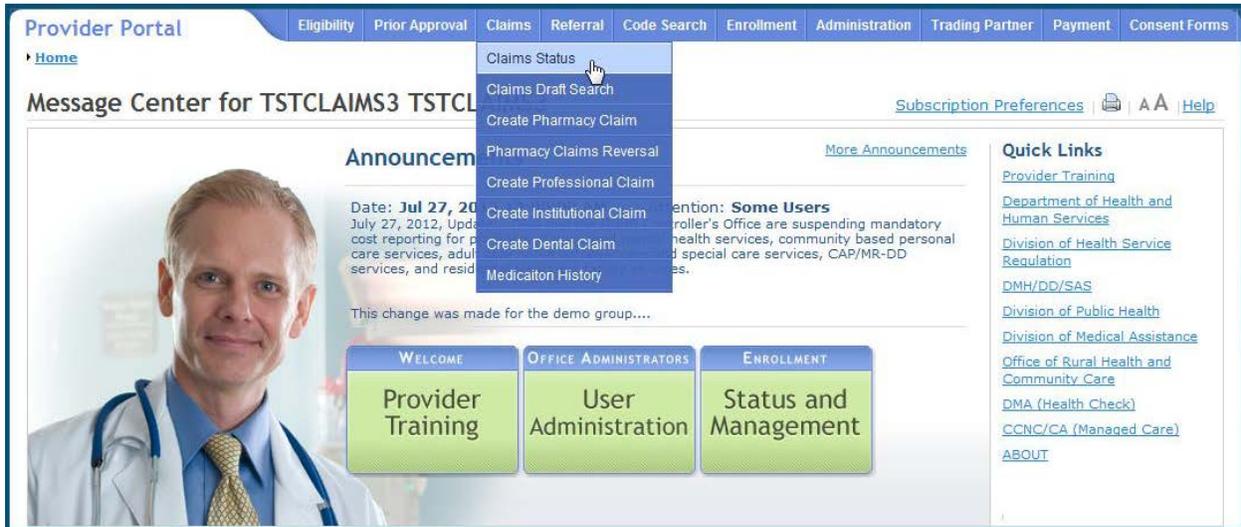


Exhibit 11-2. Claim Status

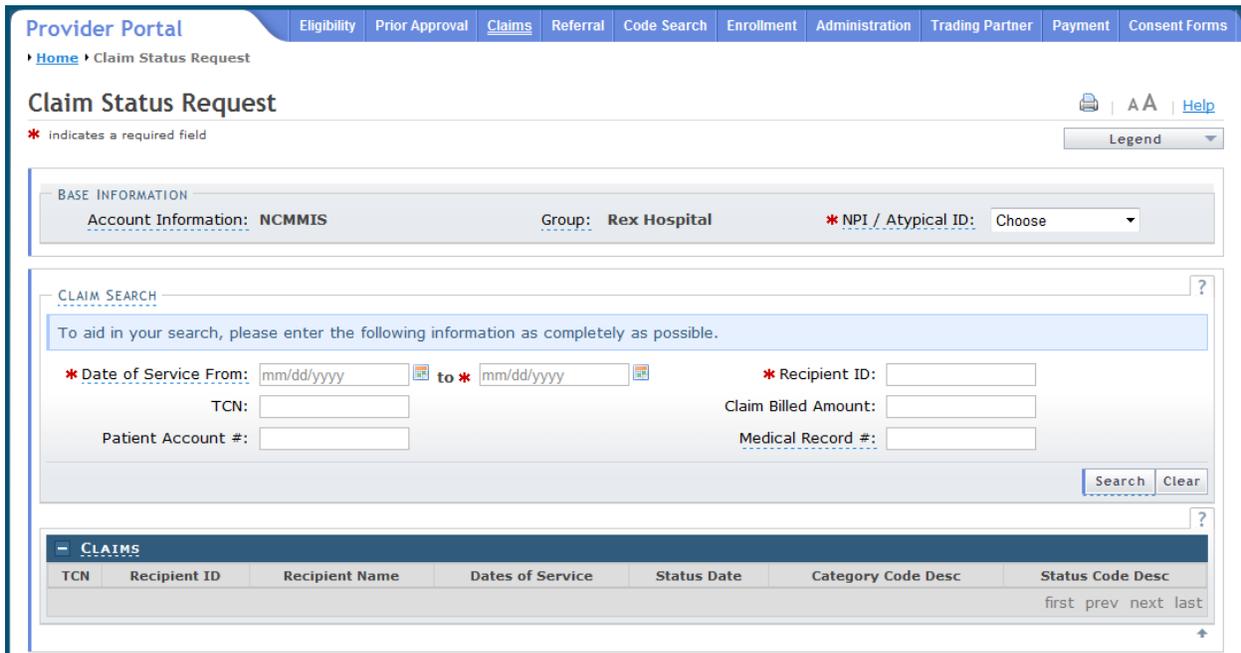


Exhibit 11-3. Claims Status Request

Provider Portal | Eligibility | Prior Approval | Claims | Referral | Code Search | Enrollment | Administration | Trading Partner | Payment | Consent Forms

Home > Claim Status Request

Claim Status Request

* indicates a required field

Legend

BASE INFORMATION

Account Information: **NCMMIS** Group: [REDACTED] * NPI / Atypical ID: [REDACTED]

CLAIM SEARCH

To aid in your search, please enter the following information as completely as possible.

* Date of Service From: 02/25/2013 to * 02/25/2013 * Recipient ID: [REDACTED]

TCN: [REDACTED] Claim Billed Amount: [REDACTED]

Patient Account #: [REDACTED] Medical Record #: [REDACTED]

Search Clear

CLAIMS

TCN	Recipient ID	Recipient Name	Dates of Service	Status Date	Category Code Desc	Status Code Desc
[REDACTED]	[REDACTED]	[REDACTED]	02/25/2013 - 02/25/2013	03/27/2013	F2 - FINALIZED/DENIAL-THE CLAIM/LINE HAS BEEN DENIED.	585 - Denied Charge or Non-covered Charge

1 results (displaying page 1 of 1) first prev 1 next last

Exhibit 11-4. Claim Status Request Result

11.4 RESUBMITTING A CLAIM THROUGH THE PROVIDER PORTAL

The resubmitting process starts with the provider searching for the original claim that was previously adjudicated. If the original claim resulted in a denial, the provider can submit a new claim using the saved draft of the original claim. This can be done by conducting a search accessing the Claims Draft Search screen. The denied claim cannot be used to submit an adjustment. Only paid original claims are eligible for adjustments.

The provider has the option to enter a claim completely from scratch, with the adjustment indicators noted in the Claim Frequency type Code and original Claim No.

Exhibit 11-5. Claims Draft Search Screen

11.4.1 Claim Information Tab on the Create Claim Screen

The provider updates the Claim Frequency Type Code to 7-Replace-PC or 8-Void-PC, and adds the original claim number to the Original Claim Ref # field. This information will trigger adjustment processing.

Exhibit 11-6. Claim Information Tab

11.4.2 Attachments Tab on the Create Claim Screen

Often the need for adjustments includes the request for attachments. The provider will have the ability to include any appropriate attachments to support the adjustment.

Exhibit 11-7. Create Professional Claim Screen for Submit

11.5 HEALTH CHECK

The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. There is no separate enrollment in Health Check. If someone is eligible for Medicaid and is under the age of 21, they automatically receive Health Check services. Together, Health Check and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provide for the complete care of children and youth in Medicaid.

Health Check claim details will be reported on Professional Claims Layout section of the RA. Procedure Code, Description, Total Units, Total Billed, Total allowed, Paid amounts, and EOB code will be reported in the Professional Claim section of the RA.

There will be a separate RA section for Health Check fees, which will include:

- Dates of Service
- Rate Cohort code and description
- Number of Claims
- Paid Amount

For changes and updates to coverage criteria, billing information, and other program requirements refer to the Health Check Billing Guide and the N.C. Medicaid general and special bulletins links in NCTracks.

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>



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12. Resolving Denied Claims

The following explanations of benefit (EOB) codes used by Medicaid/Health Choice are listed below with suggested resolution. Although the suggested resolution is for common denial cases, each claim may present a unique processing scenario. For further information or claim research, contact CSC for claim-specific analysis.

EOB	EOB DESCRIPTION	POSSIBLE RESOLUTION
4450	CLAIM DENIED. EXACT DUPLICATE OF PREVIOUSLY PAID CLAIM WITH THE SAME MEDICARE TCN	REVIEW BILLING COMPONENTS AND RESUBMIT THE CLAIM IF NECESSARY
3100	THE TAXONOMY CODE FOR THE RENDERING PROVIDER IS MISSING OR INVALID	CORRECT OR ADD THE TAXONOMY CODE AND RESUBMIT THE CLAIM IF NECESSARY
8599	THE BENEFIT PLAN IS NOT MATCHING PROVIDER OR RECIPIENT	VERIFY THE PROVIDER IS APPROPRIATE FOR THE RECIPIENT'S BENEFIT PLAN AND RESUBMIT THE CLAIM IF NECESSARY
4701	MISSING BILLING TAXONOMY CODE	NO TAXONOMY SUBMITTED FOR THE BILLING PROVIDER
3102	THE TAXONOMY CODE FOR THE BILLING PROVIDER IS MISSING OR INVALID	PROVIDER SUBMITTING TAXONOMY CDE NOT APPROPRIATE FOR CLAIM BEING BILLED
3101	THE TAXONOMY CODE FOR THE ATTENDING PROVIDER IS MISSING OR INVALID	CORRECT OR ADD THE TAXONOMY CODE AND RESUBMIT THE CLAIM IF NECESSARY
0317	FILE ADJUSTMENT USING CBC CODE THAT INCLUDES ALL COMPONENTS BILLED AND COMBINE CHARGES	RESUBMIT THE CLAIM TO INCLUDE ALL REQUIRED BILLING COMPONENTS
0046	PROVIDER ID IS NOT ELIGIBLE ON SERVICE DATE	VERIFY PROVIDER ID WAS ELIGIBLE TO BILL ON THE DATE OF SERVICE AND RESUBMIT THE CLAIM IF NECESSARY
1104	UNACCEPTABLE PRICE/UNIT. CHECK QUANTITY AND PRICE	CLAIM PRICING – AT THE DIRECTION OF DHHS, NCTRACKS HAS IMPLEMENTED SOME PHARMACY PRICING RULES THAT DIFFER FROM LEGACY. THESE RULES INCLUDE:- PRICING DIFFERENCES IN REGARDS TO AWP AND PERCENTAGES ARE BEING DISCUSSED AND WILL BE ADDRESSED PRIOR TO NCTRACKS GO LIVE.-O EXPANDED MAXIMUM ALLOWED CHARGE (EMAC) – NCTRACKS DOES NOT USE EMAC IN PRICING PHARMACY CLAIMS. THE LEGACY SYSTEM DOES USE EMAC. NCTRACKS WILL ALLOW FOR THIS AT GO LIVE. NO ACTION REQUIRED DURING POP. PROVIDERS SHOULD STAY TUNED FOR UPCOMING MEDICAID BULLETINS REGARDING PHARMACY PRICING.



EOB	EOB DESCRIPTION	POSSIBLE RESOLUTION
3114	PROVIDER DOESN'T HAVE QUALIFYING CONDITIONS TO GET A VALID QUALIFIER	NCTRACKS USES THIS ADDRESS TO ASSIGN THE APPROPRIATE SERVICE LOCATION AND ULTIMATELY THE APPROPRIATE PAYMENT. IF YOU RECEIVED AN EOB FAILURE OF 07014, PROVIDERS NEED TO UTILIZE THE NCTRACKS EVC SYSTEM TO REVIEW/UPDATE THEIR SERVICE ADDRESS INFORMATION ON FILE PRIOR TO THE NCTRACKS IMPLEMENTATION DATE OF JULY 1, 2013. GO TO WWW.NCTRACKS.NC.GOV TO OBTAIN A PROVIDER CHANGE FORM TO UPDATE YOUR SERVICE ADDRESS
2221	AN INVALID DIAGNOSIS/ICD-9 CODE WAS SUBMITTED ON THE CLAIM	CORRECT THE DIAGNOSIS/ICD 9 CODE AND RESUBMIT THE CLAIM IF NECESSARY
0328	MULTIPLE PANEL TEST CODES BILLED ON SAME DAY TO EQUIVALENT PANEL TEST CODE	REVIEW BILLING FOR ACCURACY AND RESUBMIT THE CLAIM IF NECESSARY
2493	DRUG DISPENSED IS AN EARLY REFILL (OVERUSE ALERT)	THIS IS AN INFORMATIONAL ALERT
0079	THIS SERVICE IS NOT PAYABLE TO YOUR PROVIDER TAXONOMY IN ACCORDANCE WITH MEDICAID GUIDELINES	REVIEW THE BILLED SERVICES FOR ACCURACY AND RESUBMIT IF NECESSARY
2208	THE REVENUE CODE BILLED REQUIRES PROCEDURE CODE TO BE ATTACHED	REVIEW BILLING COMPONENTS FOR MISSING PROCEDURE CODE. ATTACH THE REQUIRED PROCEDURE CODE AND RESUBMIT THE CLAIM IF NECESSARY
1723	DRUG NOT ON PDL. PHARMACY PA REQUIRED	OBTAIN PA WHEN BILLING FOR THIS DRUG
1722	PHARMACY PA REQUIRED	PRIOR AUTHORIZATION MUST BE OBTAINED BEFORE BILLING THIS PHARMACY CLAIM
1739	PHARMACY PRIOR APPROVAL AND NON-PREFERRED DRUG OVERRIDE NEEDED FOR DRUG CATEGORY	THIS IS AN INFORMATIONAL EOB. IT'S INTENDED TO COMMUNICATE TO THE PROVIDER THAT THE PA REQUIREMENT CAN BE OVERRIDDEN. EDIT 1118 WILL POST WHEN A CLAIM THAT HAS FAILED 1099, 1100 OR 1101 HAS A GC3 OR GCN CONSTRAINED WITHIN A SYSTEM LIST.
0286	INCORRECT AUTHORIZATION NUMBER ON CLAIM FORM. VERIFY NUMBER AND REFILE CLAIM	VERIFY THE RECIPIENT PCP
0013	SERVICE REQUIRES PRIOR	OBTAIN PRIOR APPROVAL BEFORE

EOB	EOB DESCRIPTION	POSSIBLE RESOLUTION
	APPROVAL	RENDERING AND BILLING THIS SERVICE
2310	PROCEDURE CODE IS NOT COVERED OR NOT ON FILE FOR DATES OF SERVICE	THIS IS A NON-COVERED PROCEDURE ON THE DATE OF SERVICE
0005	NDC MISSING, INVALID OR NOT ON STATE FILE. CORRECT 11 DIGI CODE REQUIRED. VALID COMPOUND NDC /OR COMPOUND INDICATOR AND ALL INGREDIENT NDC'S REQUIRED, SEE PHARMACY MANUAL	CORRECT OR ADD THE NDC TO THE BILLING. PLEASE REVIEW THE PHARMACY MANUAL FOR ADDITIONAL INSTRUCTIONS
0920	CLIA IDENTIFICATION NUMBER IS UNKNOWN TO N.C. MEDICAID. CONTACT YOUR STATE CLIA AUTHORITY	N.C. PROVIDERS CONTACT N.C. DFS, CLIA, PO BOX 29530 RALEIGH NC 27626-0530

12.1 CCI/MUE DENIALS

EOBs have been created to indicate a claim that was denied for a CCI/MUE or other National Correct Coding Initiative (NCCI) edit. Providers will have the ability to view the denials via the NCECS Web Tool, which will provide a detailed explanation of why the edit was invoked and the supporting industry (CMS, American Medical Association, etc.) standards justifying the denial.

Providers must determine if the denied claim can be resubmitted to Medicaid for reconsideration by viewing the following link from the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>

By selecting the code, the provider can determine based upon the modifier column how the CCI denial may be resolved.

If the NCCI edit responsible for a CCI denial has a modifier indicator of "1," the provider can make modifications to the previously submitted claim by submitting a new day claim with an appropriate modifier appended to the procedure code.

If the NCCI edit responsible for a CCI denial has a modifier indicator of "0," the claim cannot be corrected and resubmitted as a new day claim. Refer to **Appealing a CCI/MUE Denial** in this section for additional information.

Modifier Indicator	Definition
"0" Not Allowed	There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider.
"1" Allowed	The modifiers associated with NCCI are allowed with this code pair when appropriate.

12.1.1 MUE Denials

Providers must determine the allowed units of service by viewing the appropriate MUE table from the CMS website at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>



[Home](#) > [Medicaid](#) > [By-Topic](#) > Data and Systems

The National Correct Coding Initiative in Medicaid

The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. For information about, and edits for, the Medicare NCCI program, please visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

The Affordable Care Act of 2010 required CMS to notify states by September 1, 2010, of the NCCI methodologies that were compatible with Medicaid. [State Medicaid Director Letter #10-017](#) notified states that all five Medicare NCCI methodologies were compatible with Medicaid. The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.

Updated information on CMS requirements for implementation of the NCCI methodologies in state Medicaid programs is contained in the [CMCS Informational Bulletin of January 30, 2012](#), and the [Medicaid NCCI Fact Sheet](#).

Types of NCCI Edits

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

Following is an example of the data listed in the MUE tables.

Current Procedural Terminology © 2012 American Medical Association. All Rights Reserved.

Current Procedural Terminology (CPT) is copyright 2012 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

CPT® is a trademark of the American Medical Association.

HCPCS/CPT Code	Outpatient Hospital Services MUE Values
0001M	1
0002M	1
0003M	1
0019T	1
0042T	1
0051T	0
0052T	0
0053T	0
0054T	2
0055T	2
0058T	1
0059T	1
0071T	1
0072T	1
0073T	2

If the claim is denied because the billed units of service exceed the allowed units, the provider can make modifications in the previously submitted claim by submitting a new day claim with the corrected units of service. If the provider feels that the exceeded units of service are medically reasonable, the denial may be appealed.

12.1.2 Appealing a CCI/MUE Denial

Providers may submit a letter requesting reconsideration of a CCI/MUE denial to DMA at the address listed below. The request must include documentation supporting medical necessity.

Division of Medical Assistance
Appeals Unit
Clinical Policy and Programs
2501 Mail Service Center
Raleigh, N.C. 27699-2501

Requesting a reconsideration of a CCI/MUE denial is not equivalent to the adjustment process.

12.2 PROVIDER CLAIMS DENIAL RECONSIDERATION REVIEWS

The purpose of the regulations contained in 10A NCAC 22J .0101-.0105 is to specify the rights of providers to appeal reimbursement rates, payment denials, disallowances, payment adjustments and cost settlement disallowances and adjustments. The process to appeal a **claims denial** is summarized below. Please note that provider appeals for actions taken by program integrity and appeals about reimbursement rates, disallowances, payment

adjustments and cost settlement disallowances and adjustments are excluded from the process below. These actions should be appealed to the DHHS Hearing Office and the DMA Finance Management Section, respectively.

- A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement and adjustments and within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances, and payment adjustment means that all administrative actions necessary to have a claim paid correctly have been taken by the provider and DMA or the fiscal agent has issued a final adjudication.
- If no request is received within the respective 30- or 60-day periods, the State agency's action shall become final.
- A request for reconsideration review must be in writing, signed by the provider, and contain the provider's name, address, provider number, and telephone number. The request must state the specific dissatisfaction with DMA's action and explain all efforts made to have the claim(s) pay. Additionally, the redacted RA showing the claim denial, medical records, and any other information the provider wishes to submit to support medical necessity for the service or that the claim denied incorrectly should be submitted with the provider claims denial reconsideration review request.
- Reconsideration review requests should be mailed to Appeals Section, Clinical Policy and Programs, DMA at the DMA's current address.
- Following the review, DMA shall render a decision in writing and send it by certified mail to the provider. The decision shall be made within 30 calendar days or such additional time thereafter as specified in writing during the 30 day period,
- If the provider disagrees with the reconsideration review decision, he may request a contested case hearing at the Office of Administrative Hearings in accordance with 10A NCAC 01.
- Once a final overpayment or final erroneous payment is determined to exist by DMA, action will be taken immediately to recover such overpayment or erroneous payment. If the provider's appeal is successful, repayment will be made to the provider.

13. Remittance and Status Report

The Remittance and Status Report (RA) is a computer-generated document showing the status of all claims submitted thru NCTracks, along with a detailed breakdown of payment. The RA contains information necessary for providers to resolve any issues concerning the adjudication and payment of their claims.

Providers will have access to electronic views of their remittance reports via the secure NCTracks Portal. Providers will also be able to inquire online regarding payment status from multiple payers (DMA, DMH/DD/SAS, DPH, and ORHCC).

NCTracks produces RAs in one of two formats: A PDF version of the paper layouts or electronic RAs using the HIPAA approved EDI 835 transaction set. The provider can elect how they wish to receive the RA notification.

NCTracks generates electronic RAs via ANSI ASC X12N standards, using the Health Care Payment and Remittance Advice (835) transaction set per HIPAA regulations. For capitation claims HIPAA mandates that the 820 (Payroll Deducted and Other Group Premium Payment for Insurance Products) transaction set is produced to report those claims. All pended claims are reported separately by including them in the Health Care Payer Unsolicited Claim Status (277U/277P) transaction set.

NCTracks gives the provider access to the RA forms via the following:

- Provider message screen
- Email Notification
- Report2Web
- Paper form

RA notifications are posted to the Inbox of the Provider portal Message Center. The link will open an electronic version of the printed RA.

When the RA and/or notifications are published to the Message Center, an email is also sent to the provider's e-mail account informing them that items have been posted to the Message Center.

Inbox [All Messages \(4\)](#)

Provider	Status	Message	Date
	Read	Provider - Remittance Advice -	
	Unread	Provider - Remittance Advice -	
	Unread	Provider - Remittance Advice -	
	Unread	Provider - Remittance Advice -	
	Unread	Provider NPI / ATYPICAL ID - Remittance Advice -	

13.1 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.

All RAs have the same basic data flow and layout. The RAs are sorted by the following criteria:

- Claim Type
 - Professional
 - Dental
 - Institutional
 - Pharmacy
- Claim Status
- Claim Document Type (Encounter and Fee-for-Service Claim)
- Recipient Last Name and First Name

Summary totals are reported at the end of:

- All claim types
- Each claim type
- Different claim statuses within the same claim type
- Different claim adjustment type codes within the same claim type

All RA types will have a Provider Notification page and a Summary Page. All other pages are contingent upon the type of claims activity.

13.1.1 RA Layouts

The Professional RA broadly characterizes remittance layouts for Practitioner, Medicare Part B Crossover, Clinic, Hearing Aid, Private Duty Nursing Personal Care Services, Independent Laboratory/X-Ray, Mental Health, DME/O&P (Durable Medical Equipment /Orthotic & Prosthesis), Ambulance, Home Infusion Therapy, Services, Professional Capitation, and Optical Claims.

The Institutional Remittance contains the remittance layout for Inpatient, Medicare Part A Crossover (inpatient crossover), Long-Term Care, Hospice, Home Health, Institutional Capitation, Residential Health Care, Outpatient, Medicare Part B Crossover UB (outpatient crossover), and Institutional Ambulance Claims.

The Dental Remittance contains the remittance layout for Dental claims.

The Pharmacy Remittance contains the remittance layout for Pharmacy Claims.

13.1.2 Paper Remittance Layout

The following layouts are used to display the claim and financial transaction information on paper remittances:

- Provider Notification
- Provider Summout
- Payment Header
- Professional Remittance

- Dental Remittance
- Institutional Remittance
- Pharmacy Remittance
- Financial Transactions Remittance
- Accounts Receivable Remittance
- Management Fees Remittance

13.1.3 Paid Original Claims

The Professional Paid Original Claims page details payments allowed towards the claim.

The Pharmacy Paid Original Claims page details payments, allowed towards the claim, differs slightly from the Professional, Institutional and Dental type of claim. It adds an RX ID and has no need for an ending Date of Service. Nor does it have sections for: Day/Units, Non-Allowed, Payable Cutback, Payable Charges, or Other Charges.

The top section of the remittance form gives the total details for that claim transaction. Multiple procedures in the claim will be separated out by line number.

- Recipient Name
- Recipient ID
- Original TCN
- Transaction Control Number
- Dates Of Service
- Claim Service Begin and End Date
- Days/Units
- Quantity or Units Submitted
- Total Billed
- Claim Charge Amount
- Non Allowed
- Tot Allowed
- PYBLE Cutback charge
- Other Charges
- Paid Amount
- Claim Reimbursement Amount
- HIC (Medicare Health Insurance Claim number)
- Patient Account Number and Medical Record Number

13.1.4 Denied Original Claims

The Denied Original Claims page displays the recipient name and ID and then details as to why a claim was denied. The RA may represent several claims designated by their Transaction Control Number (TCN) and shows the Dates of Service, Days/Units Total Billed, Non Allowed/Total Allowed, Payable Cutback/Payable Charges, Third-Party Liability (TPL) Amount, Other Charges, and Paid Amount. It also provides the Patient Account Number and Medical Record Number.

The top set of numbers gives providers the particulars of the Denied Original Claim. Then it breaks down the claim record per line item (LI), charges allowed or denied, dates of services, applicable charges, and Rendering Provider ID.

The next section designates the following:

- LI number
- Benefit Plan
- Procedure Code Short Description
- Dates of Service
- Total Billed
- NON Allowed
- Allowed
- Line item error details
- EOB code
- Errors code
- Remark code
- Adjustment Reason Code

A legend will only be provided for the EOB codes. The EOB Description page is a legend for the EOB codes.

RECIPIENT NAME		ICN	DATES OF SERVICE	DAYS/UNITS	NON ALLOWED	TYBLE CUTBACK	TPL AMT	PAID
RECIPIENT ID		ORIGINAL ICN	SERVICE	TOTAL BILLED	TOT ALLOWED	FYBLE CHARGES	OTHER CHARGES	AMOUNT
HIC :		PATIENT ACCOUNT NUMBER :	MEDICAL RECORD NUMBER :	0.00	100.00	0.00	0.00	0.00
DED :		0.00 PAT LIAS :	0.00 COPAY :	0.00	0.00	0.00	0.00	0.00
HIC :		PATIENT ACCOUNT NUMBER :	MEDICAL RECORD NUMBER :	0.00	100.00	0.00	0.00	0.00
DED :		0.00 PAT LIAS :	0.00 COPAY :	0.00	0.00	0.00	0.00	0.00
LI	BENEFIT	PROC CODE - DESC						
NO	PLAN							
01		A0200-NON-EMERGENCY TRANSPORTATION: ANCILLARY:		0.00	100.00	0.00	0.00	0.00
		**		100.00	0.00	0.00	0.00	0.00
RENDERING PROV ID:								
EOB :								
ERRORS : 00322								
REMARK CODE : H76								
ADJUSTMENT REASON CODE : A1								

The page-header section, which appears on each page, contains the following:

- On the top-left, the provider name and address
- Center, N.C. DHHS and Remittance Statement
- On the top-right, providers will find the process date and time, page number, checkwrite date, remittance type, Provider ID and remittance number.

	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS REMITTANCE STATEMENT	PROCESS DATE: PROCESS TIME: 11:50:29:00 PAGE: 1 CHECKWRITE DATE: PROVIDER NOTIFICATION PROV ID: REMITTANCE NO:
	NC	PROVIDER NOTIFICATION
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS REMITTANCE STATEMENT		
- FINANCE SIT TEST (ALL) : THIS MESSAGE WILL BE DISPLAYED TO ALL PROVIDERS IRRESPECTIVE OF PAYER. THE MESSAGE WILL BE CHECKED FOR WRAPPING AND TRUNCATION OF WORDS. - FINANCE TEST (MULTI) - ONLY PAYERS WITH **D M H** SHOULD RECEIVE THIS MESSAGE ON THE PROVIDER NOTIFICATION PAGE.		
11:50:29:00 PROVIDER NOTIFICATION PROV ID: REMITTANCE NO:		

13.1.5 Summout Page

A Summout indicates that a provider had claim activity during the payment cycle but is receiving no payment.

- SUMMOUT (No Payment).
- A message appears on the Summout page: No payment will be received this cycle.
- If there were a payment, a Payment Header page is generated instead of the Summout page.
- A message appears on the Summout page: No payment will be received this cycle. See remittance for details.

	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS REMITTANCE STATEMENT	PROCESS DATE: PROCESS TIME: 16:10:49:00 PAGE: 2 CHECKWRITE DATE: SUMMOUT PROV ID: REMITTANCE NO:
	NC	SUMMOUT

13.1.6 Payment Header

A Payment Header page indicates that the total payment amount on a provider's remittance will be paid via an Electronic Funds Transfer (EFT) or a check.

If there is a payment, a Payment Header page is generated instead of the Summout page. This RA contains only a Denied Original Claim. A Summout is not generated for providers receiving

electronic remittances. Providers receiving paper remittances will always get a Summit, EFT header, or paper check along with their remittance.

	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS REMITTANCE STATEMENT		PROCESS DATE: PROCESS TIME: 11:50:29:00 PAGE: 2 CHECKWRITE DATE: PAYMENT HEADER PROV ID: REMITTANCE NO:
	NC	PAYMENT HEADER	

PAYER :	1	PAYER NAME: DGA	PAYMENT NUMBER : 000000000000	PAYMENT AMOUNT :	\$1,673.40
TOTAL ASSOCIATED AMOUNT :		\$1,673.40			

13.1.7 Summary Pages

The Summary Page Remittance lists the following information:

- Summary Totals for all claim types
- Summary of Paid Claims by benefit plan
- Week to Date Claims Financial Summary Information
- Month to Date Claims Financial Summary Information
- Year to Date Claims Financial Summary Information
- 1099 information as of the current Checkwrite cycle
- CLIA (Clinical Laboratory Improvement Amendments) and DEA (Drug Enforcement Agency) clarification messages

	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NCTRACKS REMITTANCE STATEMENT		PROCESS DATE: PROCESS TIME: 11:50:29:00 PAGE: 10 CHECKWRITE DATE: SUMMARY PAGE PROV ID: REMITTANCE NO:
	NC	SUMMARY PAGE	

PROVIDER :	TOTALS			
	TOTAL PAID ORIGINAL	1,673.40	NUMBER OF CLAIMS	5
	TOTAL PAID ADJUSTMENTS	.00	NUMBER OF CLAIMS	0
	TOTAL PAID VOIDS	.00	NUMBER OF CLAIMS	0
	NET TOTAL PAID	1,673.40	NUMBER OF CLAIMS	5
	TOTAL DENIED ORIGINAL	.00	NUMBER OF CLAIMS	0
	TOTAL DENIED ADJUSTMENTS	.00	NUMBER OF CLAIMS	0
	NET TOTAL DENIED	.00	NUMBER OF CLAIMS	0
	NET TOTAL PENDED	.00	NUMBER OF CLAIMS	0

TOTALS BY BENEFIT PLAN				
BENEFIT PLAN NUMBER	BENEFIT GROUPING DESCRIPTION	CURRENT PAID AMOUNT	YTD PAID AMOUNT	
	MEDICAID	1,673.40	1,673.40	

14. Provider Training

14.1 PROVIDER TRAINING AND WORKSHOP ENROLLMENT

NCTracks provider training is accomplished through two complementary delivery methods: Instructor-Led Training (ILT) and e-Learning (Computer-Based Training). This approach supports different learning styles and accommodates various work schedules. Instructor-Led Training can be attended in person or remotely via webinar.

NCTracks Provider Training includes Computer-Based Training (CBT) courses which can be taken at any time, on a provider's schedule, that provide important information about how to use the new NCTracks system. There are also recorded webinars, participant guides, and job aids that can be downloaded for future reference, using SkillPort, the Learning Management System for NCTracks.

The NCTracks Training Tool Kits provide guidance regarding what courses should be taken based on the role in a provider's organization, and instructions on how to use SkillPort. There is also a "Crash Course" to help providers come up to speed quickly on the new system, including links to all of the key information trainees need to know, in one document.

14.2 SKILLPORT

SkillPort is the Learning Management System (LMS) for NCTracks. Providers can use SkillPort to register for Instructor-Led Training (ILT), whether they plan to attend in person or remotely (via webinar). SkillPort is also used to take e-Learning Computer-Based Training (CBT) courses. Providers can access SkillPort from within the NCTracks Provider Portal.

14.2.1 How to Access and Register for Training in SkillPort

NCTracks Provider Training is accessed through the secure Provider Portal, which requires an NCID. Those who already have an NCID can click on the NCTracks Training Login button to access the secure NCTracks Provider Portal. Those who need an NCID can click on the button for NCID Self Service or navigate to the NCID website at <https://ncid.nc.gov> and register. For more information, see the "How to Obtain an NCID" reference the NCID Took Kit at:

http://ncmmis.ncdhhs.gov/files/updates/NCTRACKS_Tool_Kit_NCID.pdf

The following are step-by-step instructions for accessing and registering for training using SkillPort:

14.2.2 Accessing SkillPort for the First Time

1. Navigate to NCTracks at <http://www.nctracks.nc.gov>.
 - a. Ensure that your internet browser settings will allow pop-ups.
 - b. Click on the "Providers" tab, which is located to the right of the "Home" tab.
 - c. Click on the link "NCTracks Secure Portal" located on the upper right side of the web page.
2. Course attendees will be taken to the NCTracks Secure Login page. Before keying in your NCID and password, select the User Role from the drop-down menu. Options include Provider, State Employee, LME, and CSC Staff. State-owned providers should select Provider.
3. Next, enter your NCID and password. Those who have forgotten their password can navigate to the NCID website at <https://ncid.nc.gov> and answer the security questions to retrieve/reset the password.

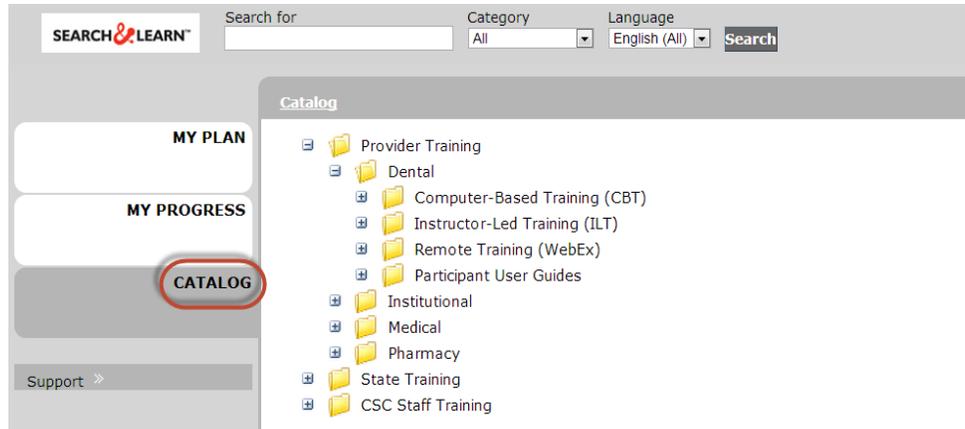
4. Successful entry of your NCID and password will place trainees into SkillPort. The first step in the registration process is to complete your profile in SkillPort. Click on the “My Profile” link in the upper right corner of the screen and then click on the menu option “Update Your User Profile.” Some of the information will be pre-populated from the login page. Provide (or confirm) information for each of the required fields:
 - a. First Name – Confirm first name
 - b. Last Name – Confirm last name
 - c. Email address – Confirm work email address
 - d. User Role – Select one from the drop down box (Provider, LME)
 - e. NPI – Providers must enter their NPI (or atypical provider number, if applicable). If your provider organization has multiple NPIs, list the one you work with most frequently.
 - f. Provider Type – Select one from the drop-down menu (Dental, Institutional, Medical, Pharmacy, or Not Applicable). This corresponds to the claim type a provider most frequently bills. Those who are not providers should select “Not Applicable.”
 - g. DHHS Division – Select one from the drop-down menu (DMA, DMH, DPH, ORHCC, OMMISS, Other, N/A). Providers should select the division that they most frequently bill.



5. Once you have entered all of the fields in the Profile, click on the “Update Profile” button. You will see a confirmation message indicating successful update of the profile.

14.3 ENROLLING IN COMPUTER-BASED TRAINING

1. Select the “Catalog” navigational area on the left side of the screen to bring up the catalog of courses currently available. Click on the plus sign (+) next to the appropriate folder for your user role (Provider, LME). Providers should then click on the plus sign (+) next to the appropriate provider type (Dental, Institutional, Medical, or Pharmacy). SkillPort will display folders for Computer-Based Training, Instructor-Led Training, Remote Training, and Participant User Guides. Click on the plus sign (+) next to “Computer-Based Training” to display the list of available CBT courses. The “NCTracks Overview Provider Portal” course should be completed prior to any other NCTracks training. This course is pre-selected in the “My Plan” section of SkillPort.



2. To take a Computer-Based Training course, place the cursor over the course title and the word “Launch” will appear next to the course name. Click on the word “Launch” and the course will begin. For those who need to stop prior to completing the course, SkillPort will remember where they left off and they can resume taking the course at a later time.
3. Each e-Learning course includes questions upon completion to test understanding of the content presented. A passing score of 80% or higher is required to receive credit for the course. A course may be taken more than once.

14.3.1 Which Courses Should I Take?

NCTracks offers several self-paced CBT opportunities that provide additional information. Providers are encouraged to take both the Instructor-Led and CBT training courses, when permissible.

e-Learning (CBT) courseware includes topics such as:

- NCTracks Provider Portal Overview
- How to Read Your Remittance Advice
- Office Administrator Functions
- Updating Provider Data

Providers who use a Billing Agent or Clearing House are encouraged to take the training courses. It will provide an overall understanding of how the NCTracks system works and explain features required by all providers, such as how to retrieve an RA from the Provider Portal.

The following matrix is designed to help trainees understand what ILT and CBT training they should take based on the role they have in the provider organization. This is intended only as a guideline – in some smaller provider organizations, people may have several roles and need to take more courses. Provider Field Representatives will be able to provide additional training. The schedule for additional NCTracks training opportunities is posted on the NCTracks website at www.nctracks.nc.gov.

Note: If you are a provider for the DMH/DD/SAS, consult with your LME/MCO before enrolling in any training.

Course Title	Learning Asset	Front Office	Billing Office	Medical Coders	Insurance Clerk	Collections Office	Office Manager	Owner / Managing Employee
How to File a Claim	eLearning		X	X		X		
How to Read your Remittance Advice	eLearning					X		
NCTracks Provider Portal Overview	eLearning	X	X	X	X	X	X	X
Researching and Resubmitting Denied Claims	eLearning					X		
Prior Approval Requests and Inquiry	eLearning				X			
Provider Records- Functions and Updates	eLearning	X	X	X	X	X	X	
Updating Provider Data	eLearning						X	
Viewing Recipient Information and Eligibility	eLearning	X						
Rate Inquiry	eLearning		X					
Procedure Code Inquiry	eLearning			X				
Pharmacy Coverage Inquiry	eLearning				X			
Office Admin Functions	eLearning						X	X
Submitting a Claim	Instructor Led		X			X		
Prior Approval Part One	Instructor Led				X			
Prior Approval Part Two: Referrals/Overrides	Instructor Led				X			
Provider Enrollment/Web Portal Applications	Instructor Led	X	X	X	X	X	X	X
Patient Eligibility	Instructor Led	X						
Security: Provider User Provisioning	Instructor Led						X	X
AVRS Features	Job aid	X	X	X	X	X	X	
Contact Guide	Job aid	X	X	X	X	X	X	X



Appendix A. Automated Voice Response System (AVRS) – 800-723-4337

The Automated Voice Response System (AVRS) allows enrolled providers to readily access detailed information on the following N.C. Medicaid, N.C. Health Choice, and DPH topics using a touch-tone telephone:

Checkwrite Information

- Current Claim Status
- Prior Approval Information for DPH
- Recipient Eligibility Verification

Providers are granted access by entering either their National Provider Identifier (NPI) or Atypical ID Number. Provider and Recipient must be in the same health/benefit plan for all inquiries on recipient eligibility. Have the required information (below) available before placing the call:

Main Menu		
Option	Description	Required Information
1	Provider Services	NPI or Atypical ID

Provider Main Menu		
Option	Description	Required Information
1	Recipient Eligibility	Recipient ID, or SSN and DOB, and DOS
2	Claim Status	TCN or Recipient ID, Date of Service, Billed Amount
3	Checkwrite	N/A
4	DPH Prior Authorization	DPH Plan, PA Type, and Recipient ID

Check Recipient Eligibility Response Menu	
Option	Description
1	Recipient Eligibility Information (Medicaid, Health Choice, and DPH)
2	Carolina Access Enrollment Information
3	Division of Medical Assistance (DMA) Service Limits and Utilization

DMA Service Limit	
Option	Description
1	Outpatient Visits (Regular and Specialty)
2	Prescription Drugs
3	Therapeutic Leave Days

Other Coverage/ Restrictions
Program of All-Inclusive Care for the Elderly (PACE)

Restrictive Coverage- Recipient is not eligible for Medicaid claims payment

DMA Eligibility Playback Sequence			
1	Medicaid Program	12	Community Alternatives Program (CAP)
2	Health Choice for Children	13	Third Party Liability (TPL)
3	HMO Enrollment	14	Medicare
4	Family Planning Waiver	15	Prescription Drug Restrictions – Primary
5	Qualified Medicare Beneficiary (MQBB/MQBE) – Part B Premiums	16	Prescription Drug Restrictions – Specialty
6	Qualified Medicare Beneficiary (MQBQ) – Medicare Premiums, Deductibles, and Co Pays	17	Hospice
7	Medicaid for Pregnant Women	18	Recipient Cost Sharing- Premiums, Deductibles, and Co Pays
8	Incarcerated	19	Patient Monthly Liability
9	Carolina Access Response	20	Health Check Screening
10	Behavioral Health Services	21	Transfer of Assets
11	Behavioral Health Plan Innovations Waiver		

DMA permits inquiries up to the end of the current month, and up to 12 months prior to the current month. DPH permits eligibility inquiries on the date of service only up to 12 months in the future, and up to 12 months prior to the current month.

AVRS provides a reference number for DMA inquiries. Retain this number as verification of the eligibility response.



Appendix B. Contacting CSC by Mail and E-Mail

Mailing Information

General Correspondence:

CSC
P.O. Box 300009
Raleigh, N.C. 27622-8009

Prior Approval Requests:

CSC
P.O. Box 31188
Raleigh, N.C. 27622-1188

Provider Enrollment Supplemental Information:

CSC
Provider EVC Unit
P. O. Box 300020
Raleigh, N.C. 27622-8020

Courier Deliveries -- UPS or Federal Express:

CSC
[Name of CSC Employee or Department]
Suite 102
2610 Wycliff Road
Raleigh, N.C. 27607-3073

Note: All claims are expected to be submitted electronically to NCTracks. However, if paper versions of claims are permitted under State policy, they should be mailed to the following address:

CSC
P.O. Box 30968
Raleigh, N.C. 27622-0968

The NCTracks website address is www.nctracks.nc.gov (There is a “Contact Us” link at the bottom of every web page.)

Email correspondence should be directed to NCTracksProvider@nctracks.com.



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Appendix C. NCTracks Checkwrite Schedule

July 5, 2013 to January 2, 2014

Cutoff Date	Checkwrite Date	EFT Effective Date
07/05/2013	07/09/2013	07/10/2013
07/12/2013	07/16/2013	07/17/2013
07/19/2013	07/23/2013	07/24/2013
07/26/2013	07/30/2013	07/31/2013
08/02/2013	08/06/2013	08/07/2013
08/09/2013	08/13/2013	08/14/2013
08/16/2013	08/20/2013	08/21/2013
08/23/2013	08/27/2013	08/28/2013
08/30/2013	09/04/2013	09/05/2013
09/06/2013	09/10/2013	09/11/2013
09/13/2013	09/17/2013	09/18/2013
09/20/2013	09/24/2013	09/25/2013
09/27/2013	10/02/2013	10/03/2013
10/04/2013	10/08/2013	10/09/2013
10/11/2013	10/15/2013	10/16/2013
10/18/2013	10/22/2013	10/23/2013
10/25/2013	10/29/2013	10/30/2013
11/01/2013	11/05/2013	11/06/2013
11/08/2013	11/13/2013	11/14/2013
11/15/2013	11/19/2013	11/20/2013
11/22/2013	11/26/2013	11/27/2013
11/29/2013	12/03/2013	12/04/2013
12/06/2013	12/10/2013	12/11/2013
12/13/2013	12/17/2013	12/18/2013
12/27/2013	12/13/2013	01/02/2014

There will be fifty scheduled checkwrites per fiscal year.

The two weeks when there will not be a scheduled checkwrite are the week between Christmas Day and New Years Day and the last week in June (at the end of the State fiscal year).

Checkwrites will include payment, if any, from all of the DHHS divisions supported by NCTracks.



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Appendix D. Frequently Used Acronyms

Acronym	Definition	Acronym	Definition
ACH	Acute Care Home	NCXIX – Title XIX	North Carolina Title XIX (Medicaid)
ADA	American Dental Association	N.C. DHHS	North Carolina Department of Health & Human Services
AFDC	Aid for Families with Dependent Children	NCHC	North Carolina Health Choice
AHA	American Hospital Association	NDC	National Drug Code
AMA	American Medical Association	NF	Nursing Facility
CCNC/CA	Community Care of N.C./Carolina Access	NPI	National Provider Identifier
DSS	Division of Social Services (within N.C. DHHS)	OA	Office Administrator
DX	Diagnosis Code	OPH	Outpatient Hospital
E&M	Evaluation and Management Services	ORHCC	Office of Rural Health and Community Care
ECS	Electronic Claim Submission	OT	Occupational Therapy
EFT	Electronic Funds Transfer	OV	Override
FPW	Family Planning Waiver	PA	Prior Approval
LME	Local Management Entity	PAR	Participating Provider
LOS	Length of Stay	PCP	Primary Care Physician or Primary Care Provider
MAC	Maximum Allowable Cost	PHI	Protected health Information
MCO	Managed Care Organization	QMB	Qualified Medicare Beneficiary
MID	Medicaid Identification Number	R2W	Report2Web
MMIS+	Legacy Medicaid Management Information System	RC	Revenue Codes
MN	Medically Necessary	ST	Speech Therapy
MPW	Medicaid Pregnant Women	TCN	Transaction Control Number
Title XVIII	Medicare	TOS	Type of Service
TX	Treatment	U&C	Usual and Customary



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Appendix E. CSC Regional Provider Relations Representatives

CSC has Regional Provider Relations Representatives, serving all regions of the state of North Carolina. Provider site visits can be requested online using the NCTracks Provider Portal. Click on the “**Contact Us**” link, found at the bottom of every web page, complete the form, select the Subject “**Request a Site Visit**” from the drop down box, and click on “**Send**”. A Provider Relations Representative will be in contact to schedule a site visit.

Anita Adkins

Anita Adkins is the Provider Representative for the following counties:

- Bertie
- Camden
- Chowan
- Currituck
- Dare
- Edgecombe
- Gates
- Halifax
- Hertford
- Martin
- Nash
- Northampton
- Pasquotank
- Perquimans
- Pitt (including ECU)
- Tyrrell
- Warren
- Washington
- Wilson

Anne Ouellette

Anne Ouellette is the Provider Representative for the following counties:

- Buncombe
- Cherokee
- Clay
- Graham
- Haywood
- Henderson
- Jackson
- Macon
- Madison
- McDowell
- Mecklenburg
- Mitchell
- Polk
- Rutherford
- Swain
- Transylvania
- Yancey

Christine Mercedes Hahn

Christine Mercedes Hahn is the Provider Representative for the following counties:

- Bladen
- Brunswick
- Columbus
- Cumberland
- Robeson
- Sampson

Deborah LeBlanc

Deborah LeBlanc is the Provider Representative for the following counties:

- Beaufort
- Carteret
- Craven
- Duplin
- Greene
- Hyde
- Johnston
- Jones
- Lenoir
- New Hanover
- Onslow
- Pamlico
- Pender
- Wayne

Felecia Williams

Felecia Williams is the Provider Representative for the following counties:

- Durham (including Duke)
- Franklin
- Granville
- Orange
- Person
- Vance
- Wake

James Born

James Born is the Provider Representative for the following counties:

- Anson
- Cabarrus
- Davidson
- Davie
- Montgomery
- Richmond
- Rowan
- Stanly
- Union

Monika Dudikova

Monika Dudikova is the Provider Representative for the following counties:

- Chatham
- Harnett
- Hoke
- Lee
- Moore
- Randolph
- Scotland

Sandy Baglio

Sandy Baglio is the Provider Representative for the following counties:

- Alexander
- Alleghany
- Ashe
- Avery
- Burke
- Caldwell
- Catawba
- Cleveland
- Gaston
- Iredell
- Lincoln
- Surry
- Watauga
- Wilkes
- Yadkin

Shantel Hinton

Shantel Hinton is the Provider Representative for the following counties:

- Alamance
- Caswell
- Forsyth (including Wake Forest)
- Guilford
- Rockingham
- Stokes



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Appendix F. How to Obtain an NCID – For Providers

NCTracks, the multi-payer Medicaid Management Information System (MMIS), uses the North Carolina Identity (NCID) Management system for authentication to the new NCTracks Provider Portal. NCID is the standard identity management service provided to state, local, business, and individual users by the State of North Carolina.

Providers will need to obtain an NCID to be able to log on to the NCTracks Provider Portal. Each person in the provider office who will be accessing the NCTracks Provider Portal should have their own NCID. NCID will provide access to all integrated applications within the portal, based on the security profile, such as recipient eligibility inquiry, claims status inquiry, submission and inquiry of prior approvals and referrals, and review of remittance advices. NCID will also be required to take e-Learning (Computer-Based Training) courses and to register for Instructor-Led Training.

For providers who do not have an NCID, the following steps outline the process required to obtain an NCID:

1.	Go to the NCID website at <i>ncid.nc.gov</i> .
2.	Click on the link to “Register” for a new NCID account (in the blue bar).
3.	Select the type of account from the drop down box. State-owned providers should select “State Government Account”. All other providers should select “Business Account.”
4.	Click on the “Submit” button.
5.	Fill in all of the required fields on the screen, starting with “Requested User ID” (which is your NCID). You can make up whatever NCID you want to use.
6.	Once you have filled in all of the required fields on the screen, you will need to create a password for your NCID. It must adhere to the NCID password guidelines, which are displayed on the screen when you begin to type in the password field.
7.	Next, key in the CAPTCHA words displayed below the password fields. This step prevents the NCID website from receiving automated spam entries.
8.	Finally, select five challenge questions and provide the appropriate answers. The challenge questions will be used to verify your identity if you should ever need to reset your NCID password.
9.	Click on the “Create Account” button.
10.	You will receive an email shortly, sent to the email address you provided, to confirm your application. You must click on the link in the email to activate your NCID account. The account must be activated within 3 days of creation.



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Appendix G. Community Care of North Carolina/Carolina Access Provider Portal Information

Community Care of Western North Carolina

Buncombe, Henderson, Madison, McDowell, Mitchell, Polk, Transylvania, Yancey

Susan Grosvenor

sgrosvenor@ccwnc.org

828-348-2822

Community Care of the Lower Cape Fear

Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Annamarie Atwood

annamarie.atwood@carelcf.org

910-763-0200

AccessCare

Alamance, Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Caswell, Catawba, Chatham, Cherokee, Clay, Davidson, Graham, Haywood, Iredell, Jackson, Macon, Orange, Robeson, Sampson, Swain, Watauga, Wayne

Elizabeth Benfield

ebenfield@ncaccesscare.org

919-380-9962 x110

Carolina Collaborative Community Care

Cumberland

Cheryl Brees

cbrees@carolinacc.com

910-495-8476

Carolina Community Health Partnership

Cleveland, Rutherford

Holly Wall

holly.wall@clevelandcounty.com

704-669-3161

Community Care of Eastern Carolina

Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Nash, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Washington, Wilson, Tyrrell

Lisa Hager

Lisa.Hager@vidanthealth.com

252-227-2668

Community Care of Wake – Johnston Counties

Johnston, Wake

Annette French

afrench@wakedocs.org

919-387-3670

Community Care Partners of Greater

Mecklenburg Anson, Mecklenburg, Union

Don Mundy & Jose Quinones

jose.quinones@Carolinahealthcare.org

704-512-2283 or 704-512-2286

Community Health Partners

Gaston, Lincoln

Kristie Herndon

kherndon@gfhs.info

704-874-1933 /704-874-1935

Northern Piedmont Community Care

Durham, Franklin, Granville, Person, Vance, Warren

Pamela Phillips

phill010@mc.duke.edu

919.693.6898

Northwest Community Care

Davie, Forsyth, Stokes, Surry, Wilkes, Yadkin

Kelly Garrison

kbgarris@nwcommunitycare.org

336-716-2363

Partnership for Community Care

Guilford, Randolph, Rockingham

Jamie Alston

jalston@p4care.org

336-235-0930 x315

Community Care of the Sandhills

Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Scotland

Diane Bogatay

dbogatay@cc-sandhills.org

919-246-9806

Community Care of Southern Piedmont

Cabarrus, Rowan, Stanly

Lisa Mooneyham

lisamooneyham@ccofsp.com

704-262-1085

Appendix H. Referral Numbers and Points of Contact (For Providers)

Department Name	Contact Information	Reason for Referral
DHHS Customer Service Center	Phone- 1-800-662-7030 http://qa.dhhs.state.nc.us/ocs/careline.htm	An information and referral line to help citizens receive information and referral on human service agencies in government, nonprofit agencies and support groups.
Clinical Policy (DMA) (DMH)	http://www.ncdhhs.gov/dma/services/ Phone: 919-855-4260 Fax: 919-733-2796 http://www.ncdmh.net/staff/branchstaff.idc?code=DO-CP Phone: 919-733-7011 Fax: 919-508-0951	Caller is a provider who wants to know what the limitations are on how many beneficiaries they can service (Policy service limitations, reimbursement rates, etc).
County Department of Social Services (DSS)	http://www.ncdhhs.gov/dss/local/index.htm	Caller is a Medicaid Beneficiary who wants to know who their caseworker is. You will use the hyperlink to look up the caller's county and send them to correct number.
Division of Health Service Regulation (DHSR)	http://www.ncdhhs.gov/dhsr <ul style="list-style-type: none"> Acute and Home Care Licensure and Certification: 919-855-4620 http://www.ncdhhs.gov/dhsr/ahc/index.html Adult Care Licensure: 919-855-3765 http://www.ncdhhs.gov/dhsr/acls/index.html Mental Health Licensure and Certification: 919-855-3795 http://www.ncdhhs.gov/dhsr/mhlcs/mhpage.html Nursing Home Licensure and Certification: 919-855-4520 http://www.ncdhhs.gov/dhsr/mhlcs/mhpage.html 	Caller has questions about licensure requirements for a particular specialty that DHSR regulates.
Financial Management (DMA) (DMH)	http://www.ncdhhs.gov/dma/fee for rate information Rate Setting: Phone 919-814-0070 or Fax 919-814-0037 Hospital Rate Setting: Phone 919-647-8101 or Fax 919-715-4725 http://www.ncdmh.net/staff/branchstaff.idc?code=RRM-BUD Phone: 919-733-7013 Fax: 919-508-0954	Caller is questioning how much money they will be reimbursed for a service. (Important Note: If the caller is from a hospital they need to call the Hospital rate setting)
Health Choice	Provider: http://www.ncdhhs.gov/dma/healthcheck	Caller has questions about enrolling in Health Choice or becoming a Health



Department Name	Contact Information	Reason for Referral
	http://www.ncdhhs.gov/dma/epsdt http://www.ncdhhs.gov/dma/providerhc/index.htm Recipient: http://www.ncdhhs.gov/dma/medicaid/healthcheck.htm http://www.ncdhhs.gov/dma/healthchoice/contacts.htm	Choice provider. General questions to the Health Check Program.

Department Name	Contact Information	Reason for Transfer
Health Check Program	Health Check/EPSDT (DMA Clinical Policy) 919-855-4260 Health Check Coordinator List http://www.ncdhhs.gov/dma/ca/hcc.pdf	Caller is calling to find out about the EPSDT policy and its procedures for EPSDT services.
Hearing and Appeals	Medicaid Recipient http://www.ncdhhs.gov/dma/medicaid/rights.htm Health Choice Recipient http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm	Information for Provider to provide if Recipient is denied benefits.
Medicare	1-800-Medicare (633-4227) http://www.medicare.gov/default.aspx Office of Inspector General http://oig.hhs.gov/contact-us/	Caller has an OIG sanction on their account and they have questions on it.
Program Integrity-Reporting Fraud and Complaints	Recipient: http://www.ncdhhs.gov/dma/medicaid/contacts.htm http://www.ncdhhs.gov/dma/pi.htm Provider: http://www.ncdhhs.gov/dma/provider/fraud.htm All callers (Provider or Recipient) should be encouraged to complete the confidential online complaint form at: http://www.ncdhhs.gov/dma/fraud/index.htm	Caller is calling to report any type of Fraud Waste or Abuse; they have a complaint about Medicaid or DMA.
Provider Contacts	http://www.ncdhhs.gov/dma/provider/provcontacts.htm	Caller wants to know where they can get a list of numbers that can be used to contact various Medicaid departments.



Department Name	Contact Information	Reason for Transfer
Value Options	1-888-510-1150 http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm	Caller is calling to find out if they have been authorized for specific types of treatment.



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