

Section 5. Submitting Claims to Medicaid

Time Limits for Filing Claims

All Medicaid claims, except inpatient claims and nursing facility claims, must be received by EDS within 365 days of the **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.

Claims for behavioral health services provided to recipients of the Piedmont Cardinal Health Plan (PCHP) catchment area must be filed with the PCHP within 90 days of the date the service was provided.

Submitting Claims Electronically

The process of submitting claims to Medicaid through electronic media is referred to as electronic commerce services. EDS will process claims submitted through file transfer protocol and asynchronous dial-up.

By submitting claims electronically, providers have the advantage of expedited claims processing and improved cash flow. Electronic claims software includes time-saving features such as automatic insertion of required claims information, retrieval of previously submitted claims from backup files, and generation of lists of commonly used billing codes. Claims submitted electronically by 5:00 p.m. on the cut-off date are processed in the next checkwrite.

Prior to submitting electronic claims, providers must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission (ECS) Agreement. The ECS Agreement must be submitted and approved prior to submitting claims electronically, regardless of how claims are submitted – through a clearinghouse, with software obtained from an approved vendor, or through the NCECS Web Tool. To obtain a copy of this agreement for either a group or an individual, visit NC Tracks website at <http://www.nctracks.nc.gov/provider/forms/>.

Billing electronically requires software that complies with the transaction standards mandated by HIPAA. Refer to **Section 10, Electronic Commerce Services**, for additional information about electronic billing and ECS services.

The rest of this section focuses on paper claim submissions.

Submitting Claims on Paper

There are some situations in which a claim must be submitted on paper. Only claims that comply with the exceptions listed on DMA's website (<http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>) may be submitted on paper. All other claims are required to be submitted electronically.

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

For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at <http://www.ncdhhs.gov/dma/mp/>. **N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA.**

Processing Paper Claims without a Signature

Providers are allowed to file **paper** claims without an original signature on each claim if the provider submits a **Provider Certification for Signature on File** form. (Providers who file claims electronically are not required to complete this form. Refer to **Submitting Claims Electronically** in this section.) Please note that out-of-state providers (providers beyond the 40-mile border of North Carolina border) are required to have a signature on each claim.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. For group physician/practitioner practices or clinics, each attending provider must sign a certification. Groups whose claims do not require an attending provider number—such as home health agencies, hospitals, and facilities (including adult care)—should have the certification signed by an individual who has authority to sign contracts on behalf of the provider.

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

A copy of the form is available on the NC Tracks website at <http://www.nctracks.nc.gov/provider/forms/>. Fax or mail completed certifications two weeks in advance of submitting claims without a signature.

National Drug Code

According to the Deficit Reduction Act of 2005 (DRA), all physician-administered drugs must be billed with appropriate HCPCS code, National Drug Code (NDC), and NDC units.

Each drug or biologic product approved by the Food and Drug Administration (FDA) is given a unique NDC number. The NDC is found on the package and/or vial of medication.

- Providers billing on a professional claim: When a HCPCS drug code, covered under the Physicians Drug Program (PDP), is billed at the detail level, the corresponding 11-digit NDC number must also be indicated for the corresponding detail. Refer to the fee schedule for the Physician's Drug Program for a list of covered PDP drugs (<http://www.ncdhhs.gov/dma/fee/>).
- Providers billing on an institutional claim: When billing outpatient hospital or dialysis services under Revenue Codes 25X, 634, 635, and/or 636, include the corresponding HCPCS code, NDC, and NDC units for the detail.
- Providers billing for drugs obtained through the 340B Drug Pricing Program are not excluded from the NDC requirement. The UD modifier must be appended to the applicable HCPCS procedure code and NDC properly identify the 340B drugs.
- Providers should not bill for a drug under a miscellaneous code if a more appropriate HCPCS code is available.
- Medicaid covers only rebatable NDCs.

For more information on NDC requirements, refer to the March 2009 Special Bulletin, *National Drug Code Implementation, Phase III*, and to articles published in the Medicaid bulletin. The Medicaid bulletin and special bulletins are available on DMA's website at <http://www.ncdhhs.gov/dma/bulletin/>.

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
Durable medical equipment suppliers	Direct-enrolled independent behavioral health providers
Free standing birthing centers	Health departments
Federally qualified health centers	HIV case management services
Hearing aid dealers	Independent diagnostic testing facilities
Home infusion therapy services	Independent practitioners
Independent laboratories	Local management entities
Local education agencies	Nurse midwives
Maternity Care Coordination/Child Services Coordination services	Nurse practitioners
Optical supply dealers	Optometrists
Outpatient behavioral health services provided by Community Intervention Services Agencies	Orthotics and prosthetics suppliers
Podiatrists	Personal care services
Portable X-ray services	Physicians
Private duty nursing services	Planned Parenthood (non-medical doctor) organizations
Rural health clinics	

Modifiers

Some provider types are mandated to bill Medicaid using modifiers. A modifier allows a provider to indicate that a service rendered to a patient has been altered by some special circumstance(s) while the code description remains the same. If no special circumstances exist and further description of the service rendered is not needed, the code should be billed without a modifier.

For additional billing information, refer to the service-specific clinical coverage policies on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

Instructions for Billing Professional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Claim Committee (NUCC). The NUCC instruction manual can be found at <http://www.nucc.org>. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies found at <http://www.ncdhhs.gov/dma/mp/>.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
1D	Medicaid Provider Number (MPN)
ZZ	Taxonomy Code

Note: Refer to **Section 11, National Provider Identifier**, for additional NPI information.

CMS-1500 Claim Example

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789K									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Patient, Joe										3. PATIENT'S BIRTH DATE MM DD YY SEX 01 15 62 M									
5. PATIENT'S ADDRESS (No., Street) 123 Fun Street										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY Fun Town					STATE NC					CITY					STATE				
ZIP CODE 11111					TELEPHONE (Include Area Code) (555) 555-5555					ZIP CODE					TELEPHONE (Include Area Code)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
11. INSURED'S POLICY GROUP OR FECA NUMBER										11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # if yes, return to and complete item 9 a-d.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I request payment for this claim. I also request payment for services described below. SIGNED _____										14. DATE OF CURRENT ILLNESS INJURY (Accident) OR PREGNANCY(LMP) FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17b. NPI 1234567890									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS										24i and 24j. (shaded) ZZ qualifier and attending taxonomy if applicable									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE									
C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER									
E. DIAGNOSIS POINTER										F. \$ CHARGES									
G. DAYS OR UNITS										H. ICD-9-CM Family Plan									
I. ID. QUAL.										J. RENDERING PROVIDER ID. #									
1. ZZ 321X00000Z										2. NPI 2234567222									
3. 24j. (not shaded) NPI for attending provider if applicable										4. NPI									
5. 33. Billing provider address and zip+4										6. 33. Billing provider address and zip+4									
25. FEDERAL TAX I.D. NUMBER										25. SSN EIN									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE PROVIDER LOCATION INFORMATION 123 That St That City, NC 27606-1234									
SIGNED _____										DATE _____									
33. BILLING PROVIDER INFO & PAYEE Provider Name or Organization 123 Any St Any City, NC 27523-5678										33a. Billing NPI 1987654320									
33b. ZZ qualifier with billing taxonomy if applicable ZZ 123D00000X										33b. ZZ qualifier with billing taxonomy if applicable ZZ 123D00000X									

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

17a. 1D qualifier only if entering CA override or an atypical provider number. Otherwise leave blank

17b. NPI for CA authorization or referral. Leave blank for CA overrides or atypical referring providers.

24i and 24j. (shaded) ZZ qualifier and attending taxonomy if applicable

24j. (not shaded) NPI for attending provider if applicable

32. Service facility address and zip+4

33. Billing provider address and zip+4

33a. Billing NPI

33b. ZZ qualifier with billing taxonomy if applicable

Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS primary care provider (PCP) numbers, Carolina ACCESS overrides, and referring provider information on Professional claims. Please make note of these filing requirements.

Professional Claims Processed with CA PCP Authorization

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	No	1D	Qualifier 1D represents Medicaid provider number (MPN). This block is only to be utilized if a referring MPN is atypical.
17a (larger shaded box)	PCP Referral Number	No	CA PCP Medicaid provider number	This block is only to be utilized if a referring MPN is atypical.
17b	NPI (National Provider Identifier)	Yes	CA PCP NPI number	Enter the CA PCP NPI linked to the PCP referral number.

Professional Claims Processed with CA Override

Block	Block Name	Required Field Yes / No	Value	Explanation
17	Name of Referring Provider	No		
17a (smaller shaded box)	Qualifier	Yes	1D	Qualifier 1D represents Medicaid provider number.
17a (larger shaded box)	CA Override Number	Yes	EDS-issued CA override number.	Contains 2 alpha characters and 5 numeric characters. (ex. CA12345)
17b	NPI	No		Will not have NPI of referring provider.

Billing Institutional (UB-04/837I) Claims

The following provider types submit Institutional claims:

- Adult care homes
- Ambulance services
- 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

Instructions for Billing Institutional Claims

These instructions apply to N.C. Medicaid only and are not intended to replace instructions issued by the National Uniform Billing Committee (NUBC). The NUBC instruction manual can be found at <http://www.nubc.org>. N.C. Medicaid programs and policies are addressed separately and maintained by the authorized sections of DMA. For information related to claim filing requirements and billing guidelines, refer to N.C. Medicaid program information and policies, found at <http://www.ncdhhs.gov/dma/mp/>.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Qualifier: Identifies whether the number to the immediate right on the claim represents a value.

Qualifier	Value
G2	Medicaid Provider Number (MPN)
DN (Form Locator 78 only)	Referring Provider Information
B3	Taxonomy Code

Note: Refer to **Section 11, National Provider Identifier**, for additional NPI information.

UB Claim Example

1 Medicaid Facility Provider 123 Any St Any City, NC 27523-5678		2 123 That St That City, NC 27523-5678		3a PAT. CNTL. # b. MED. REC. #		4 TYPE OF BILL	
8 PATIENT NAME		9 PAT. S. #		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
b		c		d		e	
10 BIRTH		11 SEX		12 ACCT STATE		13	
91 CODE		92 CODE		93 CODE		94 CODE	
95		96		97		98	
99		100		101		102	
103		104		105		106	
107		108		109		110	
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115		116		117		118	
119		120		121		122	
123		124		125		126	
127		128		129		130	
131		132		133		134	
135		136		137		138	
139		140		141		142	
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151		152		153		154	
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167		168		169		170	
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539		540		541		542	
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567		568		569		570	
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859		860		861		862	
863		864		865		866	
867		868		869		870	
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951		952		953		954	
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Quick Reference Guides for Carolina ACCESS Providers

Outlined below are specific requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides and referring provider information on Institutional claims. Please make note of these filing requirements.

Institutional Claims Processed with CA PCP Authorization

Form Locator	Description	Required Field Yes / No	Value	Explanation
78 (blank field 1)	Provider Type Qualifier Code	Yes, if applicable	DN	DN indicates referring provider.
78 (blank field 2)	NPI	Yes, if applicable	CA PCP NPI number	
78 (blank field 3)	Qualifier	No	G2	Qualifier G2 represents Medicaid provider number. This block is only to be utilized if a referring MPN is atypical.
78 (blank field 4)	PCP Referral Number or CA Override Number	No	CA PCP Medicaid provider number	Enter the current CA PCP number This block is only to be utilized if a referring MPN is atypical.
78 (blank field 5) Last	Last Name of Referring Provider	No		
78 (blank field 6) First	First Name of Referring Provider	No		

Institutional CA Claims Processed with CA Override Number

Form Locator	Description	Required Field Yes / No	Value	Explanation
78(blank field 1)	Provider Type Qualifier Code	No		
78 (blank field 2)	NPI	No		
78 (blank field 3)	Qualifier	Yes	G2	Qualifier G2 represents Medicaid provider number.
78 (blank field 4)	CA Override Number	Yes	EDS-issued override number	Contains 2 alpha characters and 5 numeric characters. (ex. CA12345)
78 (blank field 5) Last	Last Name of Referring Provider	No		.
78 (blank field 6) First	First Name of Referring Provider	No		

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)

Refer to Clinical Coverage Policy #4A, *Dental Services*, on DMA's website at <http://www.ncdhhs.gov/dma/services/dental.htm>, for instructions on completing the ADA claim form.

Definitions

MPN: Medicaid Provider Number, Medicaid-issued 7-digit number received upon enrollment.

NPI: National Provider Identifier, NPPES-issued 11-digit number received upon request.

Taxonomy Code: 10-character code that represents provider type and specialty.

Please refer to the claim example on the following page.

Note: Refer to **Section 11, National Provider Identifier**, for additional NPI information.

Billing Pharmacy Claims

DMA mandates that all providers use the online, real-time Point of Sale (POS) system to process pharmacy claims. Paper and modem claims are allowed only in certain instances.

The online POS system automatically performs eligibility verification, drug validation, pricing, and edits and audits followed by Pro-DUR before the pharmacy dispenses a prescription. Immediate assurance of the amount to be paid for the prescription reimbursement submitted through online claims is sent on the next Medicaid checkwrite.

POS reduces follow-up accounting for Medicaid claims by allowing for the correction of any errors before the recipient receives the prescription. Pharmacists receive all of the reject codes immediately when a claim is submitted through POS; other submission methods are limited to returning the first reject encountered.

Where appropriate, a claim may be filed manually. The manual pharmacy claim form allows for billing 10 separate prescriptions within the same month of service. It may be used to bill for prescriptions dispensed to one recipient or for prescriptions dispensed to 10 different recipients.

Additional information on submitting Pharmacy claims can be found on DMA's website at <http://www.ncdhhs.gov/dma/pharmacy/>. Pharmacy newsletters are published monthly on DMA's website at <http://www.ncdhhs.gov/dma/pharmnews/>.

Medicare Crossover Claims

Professional Claims

Professional claims filed to Medicare as the primary payer should be crossed over automatically to Medicaid. In order for the crossover claim to process, the NPI on the Medicare claim must be on file for a North Carolina MPN. It is the provider's responsibility to check the Medicaid Remittance and Status Report to verify that the claim was crossed over from Medicare.

Providers may verify that their NPI number is on file with Medicaid via the NPI and Address Database on DMA's website at <http://www.ncdhhs.gov/dma/WebNPI/default.htm> or by contacting EDS Provider Services at 1-800-688-6696 or 919-851-8888.

Note: Only one NPI can be reported for each MPN. If you have more than one NPI with Medicare but one MPN with Medicaid, you must choose the appropriate NPI to report to Medicaid.

Claims that do not crossover and have been paid by Medicare can be filed as an 837 professional transaction completing the Coordination of Benefits (COB) loop. Refer to the implementation guide at <http://wpc-edi.com> and the N.C. Medicaid HIPAA Companion Guide on DMA's website at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm> for instructions on completing the 837 professional transaction.

Claims that do not cross over, have been paid by Medicare and are included on the electronic submission exceptions list (<http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm>) can also be filed on a CMS-1500 claim form. The paper claim form must be submitted with the Medicare voucher attached. If claims do not cross over, have been paid by Medicare, and are not included on the electronic submission exceptions list, the claims must be submitted electronically.

Institutional Claims

Not all Institutional claims filed to Medicare will cross over automatically to Medicaid. Following are examples and instructions for Institutional claims that will not cross over automatically to N.C. Medicaid. Refer also to **Reimbursement Guidelines** on page 5-14 and to **Medicare Health Maintenance Organization** on page 5-15 for additional information.

- Out-patient, bill type 13X, claims do not crossover to NC Medicaid. However, providers should file 837 institutional (837I) transactions completing the Coordination of Benefits (COB) loop. Refer to the implementation guide and the N,C. Medicaid HIPAA companion guide for instructions on completing the 837I.
- A Medicare payment that is applied in full to the deductible and coinsurance resulting in a zero or negative payment on the Medicare EOB must be submitted on paper UB-04 claim form with the Medicare EOB and a Resolution Inquiry form attached.. The Medicare zero payment should be reported and the claims should be mailed to EDS PVS with “Medicare 0 Payment” noted on the envelope.
- Institutional claims that are denied by Medicare Part A or B for reasons other than eligibility can be overridden using the appropriate occurrence codes on an 837I.
- If Medicaid denies a claim for Medicare eligibility but Medicare was not in effect on the dates of service, submit a paper claim with a copy of the Common Working File (CWF) and a resolution inquiry form.

Copayments

Services covered by **both** Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the appropriate Medicaid copayment.

Carolina ACCESS Primary Care Providers

Services covered by **both** Medicare and Medicaid are not subject to Carolina ACCESS PCP referral authorization. However, if Medicare denies the service and the provider submits the claim to Medicaid, the provider may be responsible for the Carolina ACCESS PCP referral.

Prior Approval

Medicaid does not require prior approval for Part B services that are covered by Medicare, except for those prescription drugs that are covered by Medicare Part B that require prior approval by Medicaid (see **Section 6, Prescription Drugs**). However, if Medicare does not cover a service and Medicaid requires prior approval, the provider must obtain prior approval.

Annual Visit Limitation

Services covered by **both** Medicare and Medicaid are not subject to the annual visit limit per state fiscal year (July 1 through June 30). However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be subject to the annual visit limitation.

Hysterectomy, Sterilization, and Abortion Consents/Statement

Medicaid does not require sterilization consent forms, hysterectomy statements or abortion statements in order to reimburse the Medicaid allowed amount for these procedures when the procedure is covered by **both** Medicare and Medicaid.

However, if Medicare does not cover the procedure, Medicaid requires that the appropriate consent form/statement be submitted if a procedure is considered for coverage.

Durable Medical Equipment Span Dates

If a durable medical equipment claim is billed to Medicare with a span of dates, and the “to” date of service is in the future, providers must refile the claim to Medicaid after the “to” date of service on the claim has passed. Medicaid does not reimburse for future dates of service as Medicare does.

Optical Refractions

Because Medicare does not cover refractions, the service will be denied unless it is billed for a medical diagnosis. Providers must follow Medicare guidelines when billing for a refraction. If the patient also has Medicaid, the provider should bill Medicaid for refraction (CPT code 92015) with a refractive diagnosis. A copayment will be deducted for services not covered by Medicare unless the recipient qualifies for specific copayment exemptions.

Reimbursement Guidelines

Part B – Professional Claims (CMS-1500/837P)–Professional charges are reimbursed a specific percentage of the coinsurance and deductible in accordance with the Part B reimbursement schedule. The payment percentages are determined by the provider type and specialty. The payment percentages are available on DMA’s website at <http://www.ncdhhs.gov/dma/fee/> under “Medicaid Crossover Percentage Payment Schedule.” **Providers cannot bill the recipient for any remaining balance. Medicaid’s payment or non-payment is considered payment in full.**

Part B Only Inpatient – Institutional Claims (UB-04/837I)–Institutional claims do not automatically cross over to Medicaid for payment. Once Medicare has adjudicated the claim, providers must file the claim with Medicaid as a secondary claim. Instructions for filing the claim as a secondary claim are as follows:

- FL4 – Indicate the proper bill type
- FL31 through 36a-b, code A3-C3 – Indicate that the Medicare Part A benefits are exhausted. Lifetime Reserve days must also be exhausted.
- FL50 – Indicate Medicare as a payer.
- FL54 – Indicate the Medicare Part B payment. Do not include the contractual adjustment for the Medicare Part B payment.
- FL80 – Indicate that the patient has “No Medicare Part A benefits”.

Attach a copy of the Medicare Common Working File (CWF); do not attach a copy of the Medicare EMOB with the claim form. If the Medicare EMOB is attached to the claim form, the claim will process incorrectly for payment.

Medicaid will process the claim by first calculating the Medicaid allowable as if Medicaid were primary. The Medicare payment is subtracted from the Medicaid allowable. The balance from the subtraction is compared to the patient liability and the lesser of the two amounts is paid.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. The payment (or nonpayment) must be accepted as payment in full.

Condition code D7 may be used to override Medicare Part A and condition code D9 may be used to override Medicare Part B when services are non-covered or services do not meet Medicare criteria. These codes should not be used to override Medicare eligibility.

Professional or Dental Claim Denials for Non-covered Services

If a Professional or Dental claim is denied by Medicare as non-covered, providers may file the claim to Medicaid.

- If the claim is submitted to Medicaid on paper, providers must submit a Medicaid Resolution Inquiry Form and attach a Medicare voucher indicating the Medicare EOB denial.
- If the claim is submitted electronically through the 837 professional transaction (dental providers must file using the 837 dental transaction) refer to the instructions outlined for the PWK segment for the 2300 loop in the N.C. Medicaid HIPAA Companion Guide on DMA's website at <http://www.ncdhhs.gov/dma/hipaa/compguides.htm>.
- If the claim is submitted through the NCECS Web tool, providers must indicate that paper work related to the Medicare denial as a non-covered service is on file at the provider's site. This is done by selecting the "Yes" button for "Paperwork on file at Provider Site for Medicare Override?" in the Miscellaneous Claims portion of the web tool.

Providers must not override Medicare when Medicare denies the service for lack of medical necessity.

Medicare Health Maintenance Organization

Professional Services

In order for Medicaid to consider payment for Medicare Health Maintenance Organization (HMO), providers are requested to bill only the **cost share** amount shown on the **Medicare EOB. Medicaid liability is only for the Medicare HMO cost share.** When filing on the CMS-1500 claim form, the following blocks must be completed:

- Blocks 24F, 28, and 30 should reflect the Medicare HMO cost share amount only. If blocks 24F, 28, and 30 do not reflect the Medicare HMO cost share amount, the claim will be returned to the provider for correction.
- Block 29 should reflect third party insurance payments only. Providers are not to indicate the Medicare HMO payment in this block. If the recipient does not have a third party insurance payment, the block should be left blank. If the Medicare HMO payment is indicated in block 29, the claim will be returned back to the provider for correction.

HMO Example of CMS-1500 Claim Form Without Third Party Insurance, HMO EOB Attached:

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.		
From To				PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT (Early Plan)	ID. QUAL.	RENDERING PROVIDER ID. #		
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER								
01	01	09	01	01	09	11	99213			15 00	1		ZZ	251000000X		
													NPI	1234567890		
													NPI			
													NPI			
													NPI			
													NPI			
													NPI			
26. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
									<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 15 00		\$		\$ 15 00	

All CMS-1500 claims for Medicare HMO should be submitted with the Medicaid Resolution Inquiry Form indicating that the claim attached is a Medicare HMO. The Medicaid Resolution Inquiry Form, as well as the CMS-1500 claim form, **and Medicare HMO EOB** should be mailed to:

EDS
 PO Box 300009
 Raleigh, NC 27622

Institutional Services

In order for Medicaid to consider payment for Medicare HMO, providers are requested to bill all institutional charges on the UB-04 claim form. The claims should not be altered for processing purposes. **The claim should be billed to Medicaid as it was billed to Medicare HMO. Medicaid liability is only for the Medicare HMO cost share.** The following information is required for claim processing:

- The claims must be submitted with a Medicare EOB attached to the claim. If the EOB is on multiple pages, please submit all of the pages of the EOB with the claim.
- All charges should be reflected on the UB-04 claim form. Do not combine or destroy the integrity of the claim by “rolling up” the charges into one revenue code.
- If the recipient has patient monthly liability or deductible, the information should be reflected on inpatient stays, if applicable.
- FL47 – Indicate the total charges.
- FL54 – Indicate HMO payment
- FL55 – Indicate the cost share amount.
Note: The amounts listed in FL55 should reflect the Medicare HMO cost share amount only.
- FL56 – Enter your NPI
- FL57 – Enter your Medicaid Provider Number.
- FL80 – Write “This is a Medicare HMO claim”

HMO Example of UB-04 Claim Form, HMO EOB Attached

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HIPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES	49
110			090109	1	500.00		
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME Medicare HMO Indicator MC		51 HEALTH PLAN ID 123456 123456789A	52 REL. INFO	53 ASS. BCL	54 PRIOR PAYMENTS 100.00	55 EST. AMOUNT DUE 50.00	56 NPI 1234567890 57 OTHER PRV ID 123XXX 340XXXX
58 INSURED'S NAME		59 F. REL.	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		
66	67	A	B	C	D	E	F
		J	K	L	M	N	O
69 ADMIT DIX	70 PATIENT REASON DIX	a	b	c	71 PPS CODE	72 BCL	a
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	QUAL	73
74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 ATTENDING LAST	77 OPERATING LAST	78 OTHER LAST	79 OTHER LAST	FIRST	
c. OTHER PROCEDURE CODE	d. OTHER PROCEDURE DATE	e. OTHER PROCEDURE CODE	f. OTHER PROCEDURE DATE				
80 REMARKS		81 OCC #	82	83	84	85	86
This is a Medicare HMO		B3	282N00000X				

The UB-04 claim form with the Medicare HMO EOB attached should be mailed to:

DMA/Third Party Recovery
 2508 Mail Service Center
 Raleigh, NC 27699-2508