

MEETING MINUTES

<b>Project Name:</b> IPRS	<b>Doc. Version No:</b> 1.0	<b>Status:</b> Final
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**Meeting Name:** IPRS Core Team Meeting  
**Facilitator:** Eric Johnson, DMH  
**Scribe:** Myran Harris  
**Date:** 3/07/2007  
**Time:** 10:30 – 11:50 a.m.  
**Location:** Hargrove, Conference Room D

**IPRS Core Team Attendees:**

- x Rick Kretschmer
- x Cheryl McQueen
- Gary Imes
- Joyce Sims
- x Rick DeBell
- x Carlisa Stallings
- x Thelma Hayter
- x Eric Johnson
- x Tim Sullivan

**Others:**

- x Jamie Herubin
- x Sandy Flores
- x Mike Frost
- x Myran Harris
- Chris Ferrell
- x Deborah LeBlanc

**Attendees:**

- x Alamance-Caswell
- x Albemarle
- x Catawba
- x Centerpoint
- x Crossroads
- x Cumberland
- x Durham
- x Eastpointe
- x Edgecombe-Nash
- x Five – County MHA
- x Foothills
- x Guilford
- x Johnston
- x Mecklenburg
- x Neuse
- x New River
- x Onslow-Carteret
- x OPC
- x Pathways
- x Pitt
- x Roanoke-Chowan
- x Rockingham
- x Sandhills Center
- x SE Center
- x SE Regional
- Smoky Mountain
- x Tideland
- x Wake
- x Western Highlands
- x Wilson-Greene

Attendees:

Item No.	Topics
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1. Roll call
2. Please mute phones or refrain from excess activity to help with communications. Please state your name and which “area program” you are from when you speak. **Please do not place IPRS Core Team call on hold because of potential distraction to call discussion.**
3. Upcoming Check-writes (cut-off dates) – March 8, 15, 22
4. Agenda items
  - **834 Beta Test Deadline (April 27)**
  - Beta Test (NPI) Requirements Review
    - 100 records/LME/submission; Format test; full cycle run, 835
    - Testing to Commence March (BOM)
  - Beta Test (834) Requirements Review
    - 20 records/LME/submission
    - Testing to Commence April (BOM)
  - Reminder...Send in NPI data
  - IPRS Questions or Concerns
  - MMIS Updates – Tim Sullivan & Chris Ferrell
  - NPI Questions/Concerns
  - Medicaid Questions or Concerns
5. DMH and/or EDS concluding remarks
  - a. For **North Carolina Medicaid** claim questions / inquires please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator.
    - i. Physician phone analyst (i.e. Independent Mental Health Providers)-4706
    - ii. Hospital phone analyst (i.e. Enhanced Service Provider /LME) - 4707
6. Roll Call Updates

Next Meeting: March 14, 2007

For assistance with IPRS claims, adjustments, R2Web, application access, etc.  
Call the IPRS Help Desk – 1-800-688-6696, ext 53355 or 919-816-4355,  
M-F, 8 a.m. - 4:30 p.m., excluding holidays.

IPRS Question and Answer email address – [iprs.ganda@ncmail.net](mailto:iprs.ganda@ncmail.net)

ADMINISTRATION NOTES (10:30 a.m. AREA PROGRAMS CONFERENCE CALL)	
Item No.	Topics
1.	Roll Call
2.	<p>Please mute phones or refrain from excess activity to help with communications. Please state your name and which "area program" you are from when you speak. <b>Also, please do not place IPRS Core Team call on hold because of potential distraction to call discussion.</b></p> <p><b>WELCOME TO TRAVIS NOBLES - new member of the IPRS team</b></p>
3.	<p><b>Upcoming Checkwrites –</b>  Eric: There was a checkwrite last week. The cutoff was March 1<sup>st</sup>. Are there any questions regarding that checkwrite? The next checkwrite cutoff will be March 8th. Are there any questions regarding this checkwrite?.</p>
4.	<p style="text-align: center;"><b>Agenda Items</b></p> <p>Eric: We do not have any new Agenda Items; however, there are a couple of things that are going to be spoken about. Cheryl is going to give you some information about YP820.</p> <p>Cheryl: We noticed in this past checkwrite that some of you received denials for procedure code YP820 requiring a prior approval. I just wanted to remind everyone that YP820 while it is basically a substance abuse service it is covered by the mental health target pops, but if it is provided to a client in the mental health target pop, we require a prior approval be set up in IPRS before that service is reported. It's more, just to double check that that truly is a service you want to report for a mental health client. So that's just a little reminder because we did see some denials in this past checkwrite for that. Are there any questions about that?</p> <p>Q: Janet (Johnston) So for the AMCS target pop and you are billing procedure code YP820, it does require a prior approval for the Crisis target pop?</p> <p>A: Cheryl: Yes for any adult or child mental health pop group, so that would include the Crisis pop groups.</p> <p>Q: Janet: Our adult mental health, the crisis ones we got payment on the AMCS, we received payment on that. Should we have?</p> <p>A: Cheryl: Can you send an ICN to IPRS Q&amp;A?</p> <p>Q: Jeanna (Catawba) Just to make sure I understood what you are saying, if it's a child or adult mental health regardless of what category, it requires the prior approval before you can bill the YP820?</p> <p>A: Cheryl: Yes.</p> <p>Q: Tom (Western Highlands) Is that to say that if they had a substance abuse target pop then it doesn't require a prior approval?</p> <p>A: Cheryl: Correct.</p> <p>Q: Kim (Neuse) Does procedure code H0004 require a PA?</p> <p>A: Cheryl: After 26 occurrences of a particular pop group, then a PA is required. The pop</p>

groups are CMMED and CMSED.

Q: April (SE Regional) I have a question about the MQB denial code 953 for Medicaid, is there an edit that has been set up to allow those claims to go to IPRS to pay?

A: Cheryl: That has already been set up, they will come to IPRS and pay if the claim meets all of the criteria before routing to IPRS; the diagnosis code would need to be covered by the target pop, the attending provider would have to have the correct type and specialty and the procedure code would have to be covered by the target pop if all those things are valid then it would come to IPRS and pay.

Q: Kelly (Durham) What does Medicaid and/or IPRS identify as 26 occurrences? How many ever units are billed at one time?

A: Cheryl: An occurrence is basically a date of service.

Q: Kelly: Medicaid talks about 26 unmanaged sessions, 26 dates service billed.

A: Cheryl: That's how we do it on the IPRS side, I don't want to speak for Medicaid as I don't know how they do it but I feel like they do it the same way and I am getting a head nod they do.

Q: Jeanna (Catawba) One of the things that some of our providers are having an issue with is when a client is dually diagnosed with an adult mental health target pop and a substance abuse target pop and they are being seen by two different providers, the substance abuse provider is not able to get paid out of the substance abuse funds because the mental health target pop pays first and there are still funds available and so they are getting denied and we don't actually have an adult mental health fund in the contract. So, I know that this isn't a new issue but an ongoing one, so I am looking for some creative solutions as to how to earn substance abuse dollars where we need to earn them so we can pay.

A: Cheryl Can you send that question to IPRS Q&A please?

Q: Eric: Where are we with the 834?

A: Cheryl: On the 834 Beta Test, the Beta Test will start in April but you can send them in now to do your format testing to make sure your 834 has the correct segments and valid values in the segments as we can with the Translator. Our next run is next week so you need to have your 837 submitted to the address we gave you. That address is [ncxixiprsecs@eds.com](mailto:ncxixiprsecs@eds.com). So for both the 834 format test and 837 format or content test you need to send your files to that email address. There are details listed on the agenda about the number of records we are looking for and the actual dates. Are there any questions about either the 834 testing or 837 testing?

Q: Cheryl (Edgecombe) Does everybody have to content test? Or would it just be random or how does that work?

A: Cheryl: Everybody has to format test but not everybody has to content test for the 834. We are trying to get one LME for each vendor so that we can make sure that it will work across vendors. **For the 837, we are encouraging as many people as possible to be Beta Testers. If your claims work in Beta Test then your claims are going to work in production. I would encourage everybody to be a 837 Beta Tester.**

Q: Naomi (Guilford) For the 837 we are just sending in IPRS test for content right now?

A: Cheryl: Medicaid is doing their own Beta testing and they have their own list of people they contacted or contacted them, so they have their own list of Beta Testers.

Q: Naomi - So if we are okay with our content testing for IPRS claims we should be okay with Medicaid claims?

A: Cheryl - Yes. You can send Medicaid claims into IPRS for Beta Testing but you will not get an 835 back for them.

Q: Naomi – So we wouldn't know if they are okay or not?

A: Cheryl: No not on paper. We would probably let you know if there was a problem.

Eric: Thanks for that update Cheryl. Are there any more NPI related questions?

Q: Tom: (Western Highlands) I am trying to understand the mapping solution for the non Y code services and how the type/specialty combinations you'll use as a mapping solution. Can someone describe that process and how it will work?

A: Cheryl: When your claim comes in, let's say we are going to try to resolve your billing provider. If that NPI maps to multiple billing provider numbers, then we will use the procedure code of the attending provider to help us determine the billing provider. We're going to look at the procedure code based on a crosswalk, we have set the types and specialties that are valid for that procedure code. So, if it is an endorsed service it has to have a 112/something type/specialty. The something being dependant upon the type of procedure code it is. If it is an OBH Code it may be provided by a physician or a licensed social worker, each of those have different type and specialty combinations. So we're going to take that procedure code and we're going to look at the attending provider numbers that are valid for this attending provider NPI that was sent in. If it is an endorsed service and if one of those legacy attending providers numbers has a type and specialty that matches what's valid for that procedure code, we're going to use it on the claim. Once we have identified that, that will help us determine the billing provider number we should be using. We know if our attending provider is a 112/something service level number then we know our billing provider number has to be a core number. There is an edit in place that says a core number and a service level number go together. Based on that we will be able to narrow down our billing providers using their types/specialties. If there are multiple billing providers that have a 112/116 core number type/specialty then we will look at the zip code submitted on the claim and use that to help us determine which of these core numbers to pick. Does that help?

Q: Tom (Western Highlands) We will send the NPI on the 837 as the billing.

A: Cheryl: You will send an NPI for potentially the billing, attending, referring and service facility location.

Q: Tom: What type/specialty is associated with the NPI that you are able to crosswalk it to the procedure code?

A: Cheryl: There's no type/specialty that is associated with the NPI, but the NPI is associated with billing provider numbers and these billing provider numbers have different type and specialties depending on the type of billing provider that they are. Your 34049 number has a 074/113 type/specialty. A core number for endorsed services has a 112/116 type/specialty. A physician group number has 022/026 type/specialty. Multi-specialty group number I think is 110/112, but I'm not sure. So when you send that NPI in,

we're going to read against the database and get all the billing provider numbers that have that NPI associated with it.

Q: Tom: So you will look at the IPRS database legacy numbers, and the associated NPIs?

A: Cheryl: Correct. We will get back all of the legacy numbers that have that NPI. When we get them back we're going to have their corresponding types and specialties.

Q: Tom: As it is registered in the IPRS provider database?

A: Cheryl: Correct. If we don't get a one to one match, we will look at the attending provider to try and help us to determine which billing provider to use, and we're going to follow that same logic by taking that NPI that you submitted and we are going to return all of the IPRS legacy attending provider numbers for your LME that have that NPI associated with them and we are also going to get their type and specialties. Then we will look at the code and we are going to say this is an endorsed service and its type specialty is 112/132 (example) we're going to look at our attending provider legacy number that we have returned. Do any of them have a type/specialty of 112/132? If there is only one we will use that one. If there are multiples that are 112/132 then we're going to go with the zip code for service facility location and help narrow it down to attending provider. Once we have picked our attending provider let's say our attending provider is an endorsed service, from that we know our billing provider has to be a core number and then we look at the type/specialty and pick the corresponding billing provider and it works exactly the same for OBH codes.

Q: Tom: The difference with the OBH codes is that you could have multiple types and specialties related to a procedure code and it's possible that multiple providers could be at the same address?

A: Cheryl: Each provider should have their own NPI. An NPI is assigned to a person or an agency. So for an OBH code each doctor is going to have their own NPI.

Q: Tom: So a provider could not assign one NPI to multiple individually Direct Enrolled Providers?

A: Cheryl: Should not no. Unless that provider has different types and specialties.

Q: Tom: What about if it is a group practice, with two or more psychiatrists?

A: Cheryl: Each psychiatrist should have their own NPI.

Q: Tom: If a provider chooses to give one NPI to all of their psychiatrists, then this logic would not hold up.

A: Cheryl: Then he would be in violation of the NPPES rules.

Q: Tom: Where is that rule?

A: Cheryl: There's a series of White Papers on the NPPES website talking about who should be getting NPI numbers and how they should be assigned. Each individual person if they provide health care services needs to get their own NPI number and then the agency may in addition get one or many NPI numbers depending on how they decide to subpart.

Q: Tom: I was under the impression that it was up to the provider to determine how they would assign their NPIs, enumerate and subpart.

A: Cheryl: It is up to the agency to decide how they want to subpart their agency. As far as an individual person, each individual person needs to get their own NPI. For example at Wake Med Hospital, all of the physicians will get their own NPI numbers and then Wake Med may decide to get one number that represents Wake Med, one number that represents the X-Ray unit, one number that represents the Pharmacy unit, one number that represents the Mental Health unit or they may decide they do not want to do that all.

That is the part that is up to them to decide how they want to subpart when it is a large agency but each individual person will be getting their own NPI.

Q: Tom: I attended the NPI seminars being held and I don't think that is being clearly conveyed to the providers. With that requirement that mapping solution logic should work, but I don't think the providers know to do this. At the seminars they didn't say that each individual clinician needs to have their own NPI.

A: Beth (Pathways) If a person can operate as a legal entity they have to have an NPI and technically those folks that can direct enroll can operate independently on their own so they are legal entities. That's how it was put to us and maybe that wasn't clarified by them but that's what I understood it to mean that every individual would need an NPI.

Q: Tom: Is a legal entity a clinician that is a sole proprietor that is doing business by himself and not among a group.

A: Beth: Yes, he's a legal entity because he can obtain a business license.

Q: Cheryl (Edgecombe Nash) I had a provider call me recently because they got their NPI number but concerned about the foster homes they have. Do each one of them need to have their own NPI or would that one number cover for them?

A: Cheryl: That depends on how that agency decides they want to subpart.

Q: Cheryl: Tom to address your concerns about providers not knowing, I know that Medicaid is in the process of working on a letter to send out to all providers who have not yet registered their NPIs or who Medicaid feels they should be accepting an NPI, so that may help clarify that when that letter goes out and I am not sure when it will be going out.

A: Tom: That sounds as though that would be helpful.

Q: Jeanna (Catawba) I was at the training on yesterday and there are two types of letters they are actually going to be sending out. They showed us the different formats. One of the letters says "NO NPPES LETTER ON FILE" that will be the second letter sent. One letter will be that you don't have an NPI established with them and they think you should, they will give you the Medicaid legacy number they think should have an NPI, then there is one where they have NPIs but don't have a copy of your letter certification from NPPES and they will send you that and show you what your NPI is and your legacy numbers that you are missing too.

A: Cheryl: Thanks Jeanna!

Jeanna: Regarding the Foster Care, one of our foster cares in Catawba was told by someone at the State level that they had to get an NPI for their Therapeutic Foster Care Home and cross reference it at NPPES with our Medicaid ID. Since there was no taxonomy code that came close to describing exactly what they do, they were told to choose a taxonomy that came closest. I just personally think that is going away from the idea of what this is supposed to be about. I have concerns about Therapeutic Foster Homes using our number any way they want to get an NPI until all that is worked out at DMA with regardless of whether they need one or not.

Q: Janet (Johnston) Can you explain the process once the provider obtains an NPI and sends that information to DMA, how is that information getting to the IPRS provider screen and what information is coming over with that?

A: Cheryl: For the Direct Enrolled Providers, they send their information to Medicaid,

Medicaid keys the information into their system, we have a nightly run where we go out and look at the Medicaid database and for all of the providers on the IPRS database who are directly enrolled into Medicaid, we will copy over any of the NPI information or any updates to the demographic information. That information will be automatically copied over to IPRS on a nightly basis.

Q: Tom: (WH) Can you explain how the taxonomy number will be used in the mapping solution?

A: Cheryl: The taxonomy is kind of the "Hail Mary", where we're just going to see if we can find something. We will take the taxonomy that was submitted on the claim and there is crosswalk set up where Medicaid has identified legacy types and specialties that correspond to a taxonomy, when the taxonomy comes in we go out and get the type/specialty that Medicaid has identified as valid for that taxonomy and again we will look to see if an attending provider number that we have returned has that type and specialty. If it does, we will pick it.

Q: Jeanna (Catawba) If it doesn't will you deny it?

A: Cheryl: If it doesn't, I believe we are at the end of our mapping solution and we will move spaces to the attending provider because we would not have been able to resolve it.

Q: Jeanna: That's like the last resort right after you have gone through all those other hoops first? My concern would be at trying to do this that some may not have chosen the right taxonomy to fit. Then if that's the final criteria we could all be getting all these denials because we didn't know what they needed.

A: Cheryl: That's right. That sums up why everybody should be Beta Testers! It's the taxonomy that you submit on the claim that we are going to use. Nowhere in the database do we store a taxonomy for a provider. Whatever comes in on the claim is the taxonomy we will use. That's why we request that when you send the taxonomy in that you send it in at the attending provider level and not at the billing provider level

Q: Tom (WH) We could test all day long but if the provider doesn't know that the taxonomy that they are choosing is part of the mapping solution and could possibly cause a denial and if they don't know that it's being associated with the procedure code related taxonomy type/specialty, there seems to be a disconnect.

A: Cheryl: Well keep in mind this is the last resort and it's whatever is sent in on the claim and it's not really associated with a procedure code type and specialty, it's strictly at the provider level, when we look at the taxonomy. We don't take procedure code into account at all. All we do is say you sent this taxonomy on the claim, what type and specialties match up with that and do any of my attending providers have that type and specialty?

Q: Tom: I might be confused because I thought when we were talking earlier about the procedure codes, you were going to crosswalk that to an internal type and specialty table and compare that to the billing or attending provider type and specialty. So that doesn't have anything to do with the taxonomy.

A; Cheryl: No it's a different table. They both use types and specialties but in different ways.

Q: Tom: The only taxonomy you would use is the one we submit on the claim.

A: Cheryl: Correct, that's the only one we have.

Q: Tom: As a last resort you will compare the taxonomy on the claim to the provider type and specialty?

A: Cheryl: We'll take that taxonomy and determine whether it relates, for example, to type and specialty 123/567 and do any of the attending providers that we have selected using the NPI have a 123/567 type and specialty and if so that is the one we will pick. That may or may not be valid for the procedure code but since we couldn't resolve it using the procedure code we are "Hail Marying" it with the taxonomy.

Q: Jeanna (Catawaba) Does all of this happen at the front end and so it would take longer for files to be picked up and all the checks to give you the 997?

A: Cheryl: Yes, it's at the front end but it should not delay the length of time it takes you to get your 997 back.

Q: Jeanna: It took 30 minutes for one file to get out of the mailbox, so we came back the next morning at 6:00 but it was still taking 20 – 30 minutes to get it picked up from the mailbox. So I was wondering if any of this was delaying it's ability to pick up and do it's initial stuff?

A: Cheryl: This isn't in production yet, so no.

Jamie: We will see if any delays were being reported and see what the cause of that was.

Eric: But again, the reason why we were moving the checkwrite cut off date from Friday to Thursday was to take care of all of the mapping solution steps that Cheryl described and a whole lot more of the mapping solutions that are happening on Friday instead of the claims starting to process on the Friday like it was earlier.

Q: Tom (WH) I'm just trying to seek some clarification and make sure I understand this correctly. Your first attempt to the mapping solution is to compare the attending provider NPI that is billed on the 837 and the procedure code you will map that back to the legacy number comparing the type and specialty?

A: Cheryl: That's the second step, the first step is that we get a one to one match, if we don't then yes we will look at the procedure code and it's types and specialties and comparing that to the types and specialties of the multiple attending providers that we have received.

Q: Tom: Can I assume among the OBH procedure codes that the types and specialties are among the ones that are on the fee schedules that are allowable and reimbursable?

A: Cheryl: Yes I always look at the Special Bulletin but the fee schedule would be a better place to look for the type and specialty combinations.

Q: Tom (WH) Is your procedure code crosswalk to type and specialty available to us?

A: Cheryl: Since that is a Medicaid call, send that to IPRS Q& A. I am not sure what information they make public.

Q: Cheryl: Are there any other NPI questions?

Eric: Are there any other IPRS related Questions?

**IPRS Questions or Concerns**

Q: Kelly (Durham) Are we going to talk about the Crisis memo that came out yesterday? Eligibility is moving to 14 days, I just wanted to make sure whether it's 14 plus 1 or is it truly 14?

A: Cheryl: We are adding 13 to the day that you send.

Q: Kelly: If we send 14 days date range , you're not going to do anything to it are you?

A: Cheryl: Right, if you send in less than 14, for example if you send in 8 days, it stays as 8 days.

Q: Kelly: The effective date is 3/15, is that submission date or date of service?

A: Cheryl: As of 3/15, you will be able to start sending the segments.

Q: Kelly: One last question, I just noticed on the service array that 90862 hasn't been added to the Crisis Service pops, is that still true, can we bill for these services?

A: Cheryl: Yes, the array hasn't been updated but you can bill for these services.

Q: Sandy (Crossroads) The effective date says 3/15, is that DOS?

A: Cheryl: Yes that part of it is DOS March 15.

Q: Sandy: If we have a service that we provide today but didn't get billed until March 15<sup>th</sup>, the hierarchy would not be changed it would still have to come out of the Crisis Target pop?

A: Cheryl: We will get with the Division to clarify because it is a bit ambiguous in the memo.

Q: Sandy: Are you going to send out a memo?

A: Cheryl: Yes and we will bring it up in Core Team next week

Q: Faye (Mecklenburg) We're sending our 837 with multiple diagnosis codes on it, if a consumer is dually diagnosed with mental health and substance abuse diagnosis it may have four diagnosis codes related to those disability areas. However, we're getting denials, is it hitting against the first diagnosis on the 837 to determine if it is a valid claim or is it looking at all of the diagnosis codes? It's indicating diagnosis is incorrect.

A: Cheryl - If it is an invalid diagnosis code denial then one of the eight diagnosis codes that can be on the claim is an invalid diagnosis code. If you are getting an 8599, we're looking at the first four diagnosis codes when determining benefit package. So, any of those first four diagnosis codes can be used to help determine the benefit package.

Q: Faye: We have a consumer who receives tons of personal assistance and he has schizophrenia diagnosis and also mental retardation diagnosis, both went on the claim but it denied for diagnosis. Just trying to figure out if it is reading the first one and not the second diagnosis code as to why it denied?

A: Cheryl : Did it deny for diagnosis or 8599?

Q: Faye: Diagnosis.

A: Cheryl: What is the EOB on it?

Q: Faye: I don't have that in front of me right now.

A: Cheryl: Can you send some examples of that to IPRS Q&A?

Q: Faye: In regards to time periods with uploading rates, if we send in a new ME number and rates this week, how long does it take to have the rates uploaded in your system?

Q: Cheryl: Are you contacting Rick or Kent with them?

A: Faye: We send them directly to Rick.

Q: Cheryl: Once Rick sends it over to us, it does not take long, it's just however long it takes Rick to get it sent to IPRS.

### Medicaid Questions or Concerns

Q: Kerry (Eastpointe) We had several clients that we billed Community Support and IPRS paid the services and we've had the money recouped from IPRS and sent to Medicaid. Medicaid is denying them for an 0082 (not valid diagnosis). When we called Medicaid, they said it really wasn't that, but was because another provider had been paid for the services. We've called the provider and they are saying there has not been another provider that paid. Can I send in some examples?

A: Cheryl: Send it to IPRS Q&A and we'll forward them.

Q: I had a provider call me yesterday who has their Direct Enrolled number for residential dated back to 2/1/07, and she said she's been trying to bill for February services and she couldn't get them billed and when she called to check on them, they told her they had a memo that says they are supposed to continue to bill through the LME through 4/30/07. She doesn't know what to do because we thought once they got their number they weren't suppose to bill through us. Also, another problem would be the Value Options authorization is still under Sandhills billing number. The provider doesn't know what to do because she can't get the services paid for and I need to know whether we can bill for her?

A: Cheryl: Please send to IPRS Q&A and we will send it to DMA.

Q: Beth (Pathways) Is there any official notification of who the person is that has replaced Carol Robinson?

A: Cheryl: I haven't seen any notification.

Q: Tom: (WH) Is the value authorization specific to the provider or the consumer?

A: Eric: Please send to IPRS Q&A and we will send to DMA.

Q: Victoria (Tideland) Regarding the email about the CDSA age range for children 3-4? Can we send in those services now?

A: Cheryl: You should be able to send them in on next week's checkwrite 3/16.

Q: Tom (WH) If those CDSA denials are beyond the 365 days, Medicaid timely filing limit, will you allow us to rebill those without a timely filing override?

**Integrated Payment and Reporting System (IPRS)**

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	<p>A: Cheryl: Please refer to the email that was sent out this morning regarding this.</p> <p>Q: Beth (Pathways) The email doesn't actually say that you can resubmit after next week's checkwrite. Is that what we are hearing?</p> <p>A: Eric: Let us get clarification and get back to you on that.</p> <p>Q: Tom (WH) Would EDS consider refiling those claims?</p> <p>A: Cheryl: That would be up to Medicaid not EDS. Please forward to IPRS Q&amp;A and we will forward to DMA. It was a policy change so depending on whether they feel like they made the original policy in error or not will determine whether or not we submit the claims automatically.</p>
5.	<p>DMH and/or EDS concluding remarks</p> <ul style="list-style-type: none"><li>• For <b>North Carolina Medicaid</b> claim questions / inquires please call EDS Provider Services at 1-800-688-6696 or 1-919-851-8888 and enter the appropriate extension listed below or 0 for the operator.<ul style="list-style-type: none"><li>i. Physician phone analyst (i.e. Independent Mental Health Providers)-4706</li><li>ii. Hospital phone analyst (i.e. Enhanced Service Providers / LMEs) - 4707</li></ul></li></ul>
6.	Roll Call Updates