JOB AID
Provider Adjustment, Time Limit & Medicare Override

OVERVIEW

This Job Aid provides instructions on when and how to use the Medicaid Resolution Inquiry Form Medicaid and the Claim Adjustment Request Form. Additional information on the following types of requests are detailed in this job aid; review of a previously paid or denied claim, claim replacement or void, time limit override, and Medicare and/or Third Party Liability (TPL) overrides.

MEDICAID RESOLUTION INQUIRY FORM

The Medicaid Resolution Inquiry Form is used to submit Medicaid claims for:

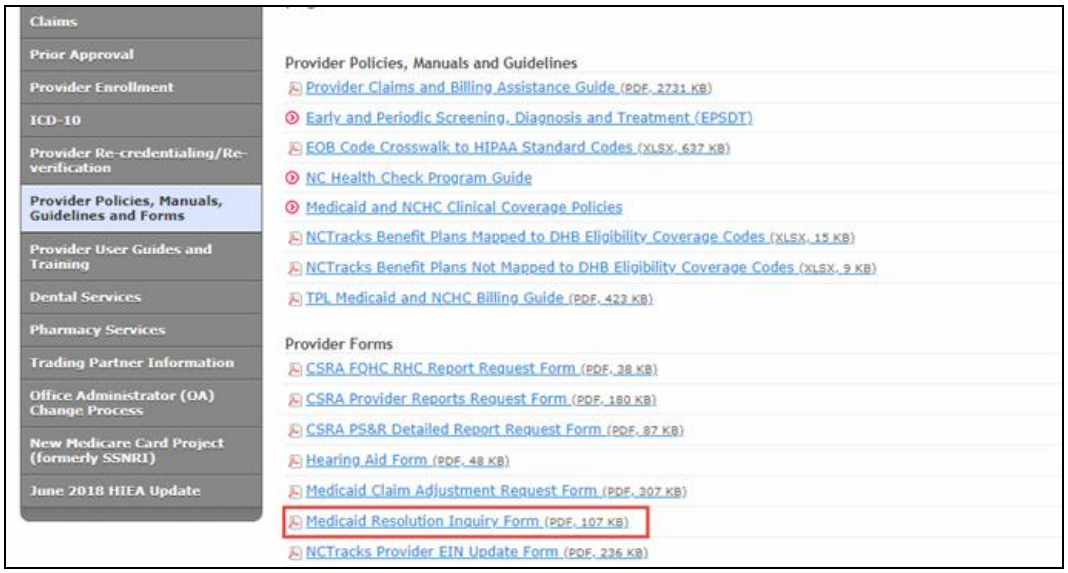
- Medicare overrides
- Time limit overrides

When submitting inquiries, always use the **Medicaid Resolution Inquiry Form** located on the NCTracks Provider public page. Overrides will not be issued on claims without this form. Each inquiry requires a separate form and copies of documentation (Explanation of Benefits, vouchers, and attachments). Since these documents are scanned, attach only single-sided documents to the inquiry. **Do not attach double-sided documents to the inquiry.**

To access the form:

1. Go to the NCTracks Provider Home page: https://www.nctracks.nc.gov/content/public/providers.html
2. Select the **Provider Policies, Manuals, Guidelines and Forms** hyperlink on the left-hand side of the screen.

3. Go to the **Provider Forms** section at the bottom of the page.
4. Click **Medicaid Resolution Inquiry Form.**



5. Complete and upload or mail this form to CSRA at the address specified or displayed on the form.

When submitting inquiry requests always attach the claim, a copy of any RAs related to the inquiry request, and any other information related to the claim. Each inquiry request requires a separate form and copies of supporting documentation (Explanation of Benefits, vouchers, and attachments).

Medicare Overrides and Third-Party Liability

The time allowed to file a Medicare or Third-Party commercial insurance (including a Medicare Part C Advantage Plan insurer) request claim to Medicaid is 180 days from the Medicare or other Third party Explanation of Benefits (EOB) date, regardless of the service date on the claim or whether the claim was paid or denied. The section of the Medicare or other Third party EOB showing the Claim Action Reason Codes (CARC) details must be submitted with the request. When a Medicare claim is denied because the service/procedure is non-covered then a Medicare override can be requested. Providing all of the "other payer" information, including the CARC details, on your electronic claim (See Job Aid How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions) can provide this same override function in a more efficient manner than the paper form. Override requests for the denial of a covered Medicare or other Third Party service are not acceptable and should be corrected and resubmitted to Medicare.

Time Limit Overrides

All Medicaid claims (except hospital inpatient and nursing facility claims) must be received by NCTracks 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*** Remittance Advice (RA) date to refile a claim**.**

Requests for overrides must document that the original was submitted within the 365-day time limit. If the claim meets the 365-day time limit filing requirement, then it can be resubmitted as a new day claim (no override required) if all of the following data is an exact match:

- Beneficiary/Recipient Identification Number (RID)
- National Provider Identifier (NPI)
- Service Dates
- Total Billed Amount

Claims that do not have an exact match to the original claim in the system will be denied and one of the following EOB Codes will be displayed:

EOB Code	EOB Code Description
00018	Claim denied. No history to justify time limit override.
01738	Original transaction for rebill/reversal not posted as an NCPDP transaction
05103	Override request for timely filing is missing documentation

When a claim is denied due to not having an exact match, if the time limit requirements have been met then the claim can be resubmitted via the NCTracks Secure Provider Portal or on paper. The NCTracks Provider Portal will accept claims submission and appropriate documentation with a time limit override request indicated in the Delay Reason field. The Delay Reason Codes currently accepted in NCTracks are third party processing delay (#7) and the original claim was rejected or denied due to a reason unrelated to the billing limitation rules (#9).

Note: Effective February 5, 2017, the Medicaid Resolution Inquiry Form is no longer required if the claim requiring the time limit override is submitted electronically through the NCTracks Provider Portal or through a batch X12 transaction. For additional information, please read the NCTracks Medicaid Resolution Inquiry Form No Longer Required for Time Limit Overrides Announcement posted 02/03/2017.

The Division of Health Benefits (DHB) and NCTracks must adhere to all federal regulations to override the billing time limit; therefore, requests for time limit overrides must document that the original claim was submitted within the initial 365-day time period. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DHB or CSRA about the specific claim received that is within 365 days of the date of service.
- An explanation of Medicare or other Third-Party insurance benefits dated within 180 days from the date of Medicare service or other Third-Party payment or denial.
- A copy of the RA showing that the claim is pending or denied; the denial must be for reasons other than time limit.

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received within the 365-day time limit.

If the claim is a crossover from Medicare or another Third-Party commercial insurance (including a Medicare Part C Advantage Plan insurer), 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 Portal.

Note: For additional information, please refer to one of the following documents:

- Instructor Led Training – “Submitting a Time Limit Override Request Using NCTracks”
- Participant User Guide – “Submitting an Institutional Claim”
- Participant User Guide – “Submitting a Professional Claim”
- Participant User Guide – “Submitting a Dental Claim”

ADJUSTING A CLAIM THROUGH THE VOID AND REPLACEMENT PROCESS

With the implementation of standard claims transactions to comply with the Health Insurance Portability and Accountability Act (HIPAA), adjustments may be filed electronically. Electronic adjustments are the preferred method to report an overpayment or underpayment to NC Medicaid. There are two separate actions that may be filed:

A provider should use "void" when he/she needs to cancel or submit a refund for a previously paid claim.

- **Void** – Entire claim will be recouped.

A provider should "replace" a claim if he/she is updating claim information or changing incorrectly billed information. This term is interchangeable with adjusting a claim.

- **Replacement** – Entire claim will be recouped and reprocessed.

Note: In the NCTracks Secure Provider Portal, the Claim Information tab has two fields that must contain accurate data to ensure the newly submitted claim will process as an adjustment:

- **Claim Frequency Type Code:** 7-Replace-PC or 8-Void-PC
- **Original Claim #:** Must contain the original claim number

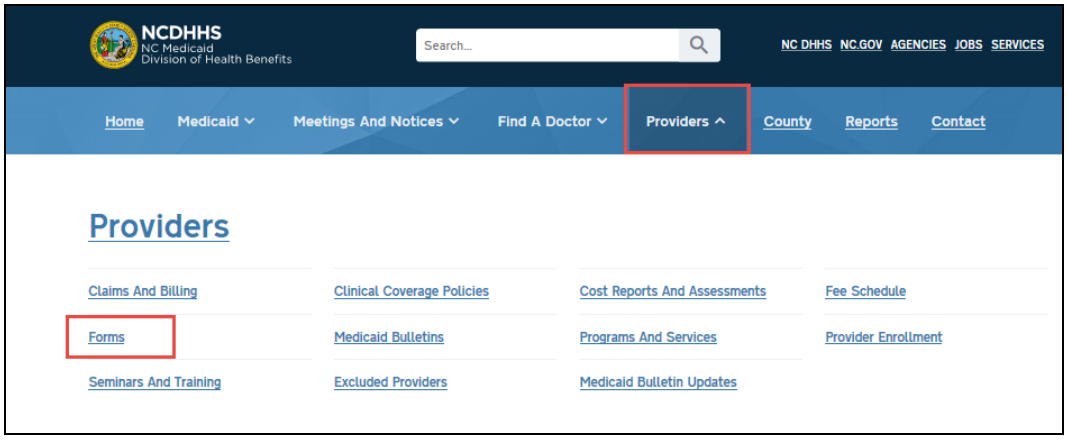
For additional information, please refer to the Participant User Guide, “Claim Adjustments.”

ADJUSTMENTS RELATED TO THIRD PARTY LIABILITY (TPL)

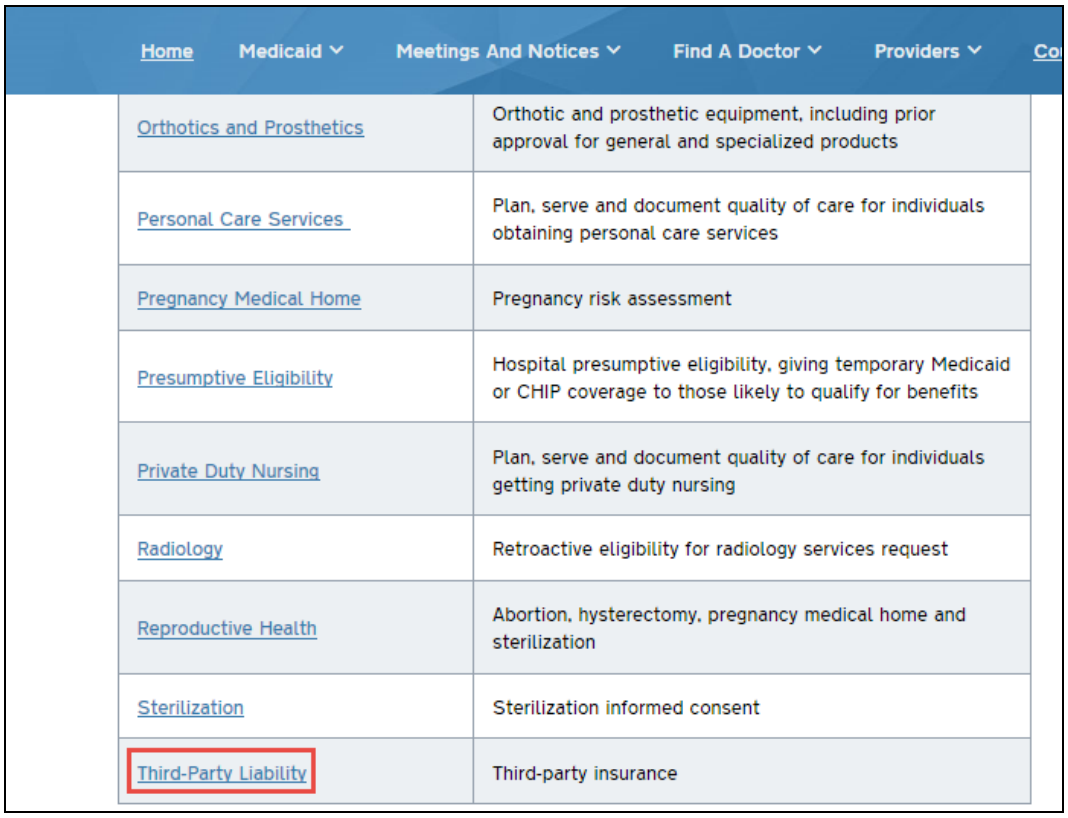
If it is found that a beneficiary has TPL and it was not on file when the claim was processed, it may be necessary for a provider to request an adjustment to the claim to account for the TPL payment.

The first step is to initiate an update to the beneficiary’s TPL information by submitting the online NC Provider 2057 Referral form. (This online form is also used if the beneficiary no longer has insurance.)

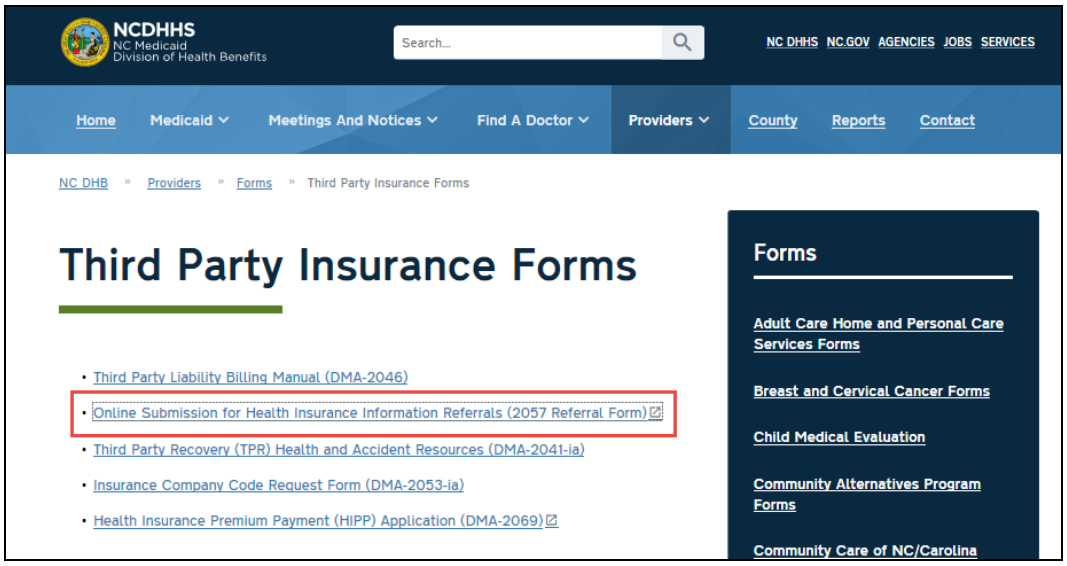
1. Go to the DHB website: https://medicaid.ncdhhs.gov/
2. Click **Providers** hyperlink in the top navigation bar.
3. Click **Forms** hyperlink on the left navigation menu.



4. Select **Third-Party Liability** Insurance Forms.



5. Choose **Online Submission for Health Insurance Information Referrals** link https://pierweb.hms.com/pierOnlineApp/tpl/FUSREFNC/memberPortal.htm



Note: Health Management Solutions (HMS) (DHB's TPL contractor) will update the beneficiary's record within 10 days of receipt of the 2057 referral form. Once the beneficiary's TPL information has been updated, the claim can be resubmitted through the void/replacement process.

An adjustment may also be required if the beneficiary's TPL carrier has changed the original amount of payment. If Medicaid has paid the claim with the TPL amount deducted and the TPL carrier has changed the original paid amount, file a replacement claim with the new TPL payment amount noted.

The Claim Adjustment Reason Codes (CARCs), Claim Adjustment Group Codes (CAGCs) will determine how NCTracks will react to TPL editing.

If a claim is denied by the Prior Payer, NCTracks will post the denial EOB 01843 - MEDICAID DENIED BASED ON CLAIM ADJUSTMENT REASON ASSIGNED BY PRIOR PAYER when the claim is submitted with prior payer CARC 97 reported at the claim header or detail line. The only exception will occur when a prior payer reports CARC 97 on the claim line with an Allowed Amount greater than zero.

Note: It is very important that you enter the CARCs and CAGCs on the claim just as they appear on the primary insurance EOB. Providers should NOT enter the codes at the header if they only apply to a single line on the claim.

For additional information please refer to the job aid, "How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions."

ADJUSTING A CLAIM USING THE MEDICAID CLAIM ADJUSTMENT REQUEST FORM

The claims adjustment process affords providers an opportunity to request a review of a previously processed claim. In some cases, an adjustment request must be submitted on paper. Please note, not all denials can be addressed through this process. Primary examples are non-adjustable EOB Codes and CCI/MUE denials discussed further later in this section.

You will have to submit an adjustment request utilizing the **Medicaid Claim Adjustment Request Form.** For example, if you receive:

EOB Code	EOB Code Description
00874	Multiple ER visits not allowed same date of service, same taxonomy qualifier. File adjustment if visits were separate occasion.

When requesting a Medicaid claim adjustment, please provide documentation of the medical necessity or extenuating circumstances that support the request for payment.

If a claim has been denied with an EOB **requesting** medical records, the claim should not be submitted as an adjustment request on the adjustment request form. The claim should be resubmitted as a new day claim with the requested records.

Common Denial Codes

The following EOB codes used by N.C. Medicaid/Health Choice are listed below with their suggested resolution(s). Although the suggested resolution(s) are for common denial cases, each claim may pose a unique processing scenario. For further information, contact the NCTracks Call Center for more claim-specific analysis/research.

EOB Code	EOB Code Description	EOB Code Resolution
08599	The benefit plan is not matching provider or recipient eligibility or the service covered	The provider should verify that for the dates of service billed, the NPI is active for the Benefit Plan, the recipient is eligible for the Benefit Plan, and the Procedure Code is covered for that benefit. Submit a corrected claim if necessary.
02310	Procedure code is not covered or not on file for dates of service	Provider should refer to their Clinical Coverage Policy and fee schedule to ensure that the Procedure Code is covered for the dates of service billed.
04564	System error from financial system	If DMH is the payer, the provider should ensure that all of the denied claims criteria are met per their Clinical Coverage Policy. For all other payers, the pended claims will continue to adjudicate once the budget issue is resolved.
05203	Service represented by this procedure code/modifier combination is not covered as billed.	Ensure that the Procedure Code and Modifier combination is covered by Medicaid.
05400	Exact duplicate-same rend prov/pcode/internal modifier/DOS/mod/bill amt/different TCN.	The provider should check paid history for the claim combination to ensure that the services are not paid in history for the same date of service, same procedure, same modifier, and same rendering provider.
00024	Procedure code, procedure/modifier combination or revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim	Provider can make corrections and resubmit the claim.
01760	Claim indicates Medicare is prior payer but no Medicare allowable amount is indicated for this detail.	Provider should verify Medicare payments are entered on claim lines appropriately as this EOB only post at the line level. Resubmit a corrected claim if necessary. If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare.
00079	This service is not payable to your provider taxonomy in accordance with Medicaid guidelines	The claim will fail the edit if the procedure code or revenue code is invalid for the provider taxonomy billed. Verify Claim Type assigned. Compare with the taxonomy and the Procedure Code or Revenue code billed to ensure the procedure code or revenue code is billable for that claim type and taxonomy code. The provider should submit a corrected claim if necessary.
02601	Procedure not covered under the family planning waiver	The provider should verify the recipient's eligibility coverage and Procedure Code/Modifier combination.
00167	No charge billed. Enter billed amount and submit detail as a new claim	Providers should verify the Medicare paid amount and Medicare allowed amount and submit a corrected claim if necessary

If you receive a denial EOB Code with instructions on how to refile (example, bill with modifier 51), correct the claim as stated in the EOB and submit the claim as a replacement claim.

CORRECT CODING INITIATIVE / MEDICALLY UNLIKELY EDITS (CCI / MUE) DENIALS

Three EOB Codes have been created to indicate a claim that was denied for a CCI / MUE or other National Correct Coding Initiative (NCCI) edit.

EOB Code	EOB Code Description
00585	CLAIM DENIED. PROCEDURE CODE BILLED IS ON THE MEDICAL UNLIKELY EVENT TABLE FOR THE NCCI
49270	NCCI EDIT
49280	NCCI OUTPATIENT HOSPITAL SERVICES EDIT

RESUBMISSION OF DENIED CLAIMS

The **Medicaid Claim Adjustment Request Form** is used to make an adjustment to previously paid claims or certain denied claims. Not all denials require an adjustment request. If adjustments are submitted for certain EOBs, the claim will be denied for EOB 998, which states, “Claim does not require adjustment processing, resubmit claim with corrections as a new day claim. If POS, reverse and resubmit” or EOB 9600, which states, “Adjustment denied. The EOB this claim previously denied with does not require adjusting. Correct/resubmit claim in lieu of adjustment request” In the future, resubmit a new or corrected claim in lieu of sending an adjustment request. Please contact the NCTracks Call Center at 1-800-688-6696 if there are any questions on how to resolve a specific denial. Do not use the **Medicaid Claim Adjustment Request Form** to inquire about the status of a claim or to submit a claim for dates of service that have exceeded the filing time limit. Use the **Medicaid Resolution Inquiry Form** if you have exceeded the filing time limit.

The **Medicaid Claim Adjustment Request Form** is used to make an adjustment to previously paid claims or certain denied claims. When an adjustment request is denied, the provider will receive an EOB code on their RA stating the reason(s) for denial. A list of the EOB codes can be found at the end of this document.

To access the form:

1. Go to the NCTracks Provider Home page: https://www.nctracks.nc.gov/content/public/providers.html
2. Select **Provider Policies, Manuals, and Guidelines** hyperlink on the left-hand side of the screen. https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

3. Go to the **Provider Forms** section at the bottom of the page.
4. Click **Medicaid Claim Adjustment Request Form.**

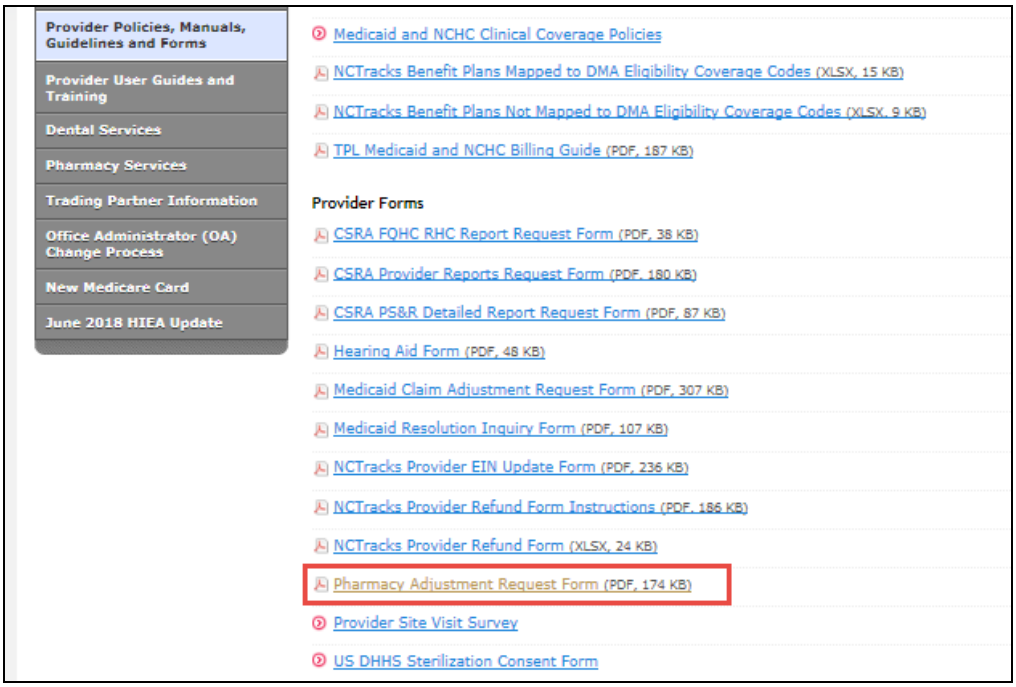
5. Complete and mail this form to CSRA at the address specified or displayed on the form.

PHARMACY CLAIM ADJUSTMENTS

A Pharmacy Adjustment Request Form is available for providers to use to request an adjustment to a Medicaid payment when the adjustment cannot be processed online. This form is used to request an adjustment to a Medicaid payment for prescription drugs. Claims that are denied with no payment can be resubmitted instead of adjusted. Use the Pharmacy Adjustment Request Form to do the following:

- Credit Medicaid for a billed and paid prescription that was never dispensed
- Credit Medicaid for a billed and paid prescription for drugs that were unused
- Correct National Drug Code (NDC), quantity, days' supply, date of service, billed amount, Rx number, or Third-Party payment

A copy of the Pharmacy Adjustment Request Form can be found on link to Provider Policies, Manuals and Guidelines page - https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html



RECONSIDERATION REVIEW REQUESTS

Appealing a Claim Denial or CCI / MUE Denial

Providers can request a reconsideration (appeal) review of a claim denial if an adjustment has been processed and denied. Providers can also request a reconsideration (appeal) review of a CCI / MUE denial. The appeal process requires documentation to support the medical necessity for the service being rendered. Providers may submit a letter requesting reconsideration of either denial to DHB at the address listed below.

Division of Health Benefits
Appeals Unit
Clinical Policy and Programs
2501 Mail Service Center
Raleigh, NC 27699-2501

Before sending a letter requesting reconsideration from DHB, providers should determine if it is appropriate to rebill the claim using a modifier.

EOB CODES AND DESCRIPTIONS

Below are commonly used EOB Codes and their description:

EOB Code	Adjustment EOB Code Description
00014	SERVICE DENIED PER MEDICAL CONSULTANT REVIEW
00049	MEDICAL NECESSITY IS NOT APPARENT
00060	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00074	REIMBURSEMENT AMOUNT EXCEEDS SET DOLLAR AMOUNT
00084	RECIPIENT IS PARTIALLY INELIGIBLE FOR SERVICE DATES. RESUBMIT A NEW CLAIM BILLING ONLY ELIGIBLE DATES OF SERVICE
00090	DUPLICATE CHARGE DENIED
00363	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00382	OPERATIVE RECORDS RECEIVED HAVE NO DATES OF SERVICE OR CONFLICTING DATES OF SERVICE, CORRECT CLAIM AND/OR RECORDS AND RESUBMIT BOTH AS AN ADJUSTMENT
00394	NOT IN ACCORDANCE WITH MEDICAL POLICY GUIDELINES
00553	TIMELY LIMIT EXCEEDED. RESUBMIT AS AN ADJUSTMENT WITH DOCUMENTATION OF TIME
00624	DUPLICATE PROCEDURE. SERVICE ALREADY PAID FOR A DIFFERENT DATE OF SERVICE
00716	EXCEEDS ONE PER DAY LIMITATION
00884	REBILL ADJUSTMENT WITH RECORDS DOCUMENTING UNITS
00893	MEDICAL NECESSITY NOT APPARENT FOR CRITICAL CARE/PROLONGED SERVICES AND CONSULTS ON THE SAME DAY
00896	ADDITIONAL PROCEDURE, SAME DATE OF SERVICE, PAID AT 50 PERCENT OF ALLOWABLE AMOUNT
00899	UNITS CUTBACK. MAXIMUM NUMBER OF UNITS PER DAY EXCEEDED
00901	NO ADJUSTMENT DUE
00959	MAXIMUM NUMBER OF UNITS PER DAY PREVIOUSLY PAID FOR THIS DATE OF SERVICE
01158	ANTEPARTUM PACKAGE RECOUPED. TOTAL OB PACKAGE PAID WHICH INCLUDES ANTEPARTUM CARE
01159	TOTAL OB PACKAGE, WHICH INCLUDES ANTEPARTUM CARE, HAS ALREADY BEEN PAID FOR THIS GESTATION PERIOD
00264	ADJUSTMENT DENIED, CLAIM DENIED CORRECTLY
00269	BILL MEDICARE PART A CARRIER
00271	REFILE ADJUSTMENT WITH ALL RELATED MEDICARE VOUCHERS. RESUBMIT WITH NECESSARY INFORMATION ALONG WITH A COPY OF ORIGINAL CLAIMS RA
00272	ADJUSTMENT REQUEST DENIED, ADJUSTMENTS ARE NOT PROCESSED FO RATE CHANGES
03120	PREVIOUSLY BILLED PROCEDURE. SURGERY PERFORMED DURING FOLLOW UP OF ANOTHER SURGERY REQUIRES A MODIFIER. IF CURRENT CLAIM IS ORIGINAL PROCEDURE, REQUEST RECOUPMENT OF PAID DETAIL AND RESUBMIT WITH MODIFIER