LME/MCO MANUAL FOR ENCOUNTER DATA SUBMISSION

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH BENEFITS

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Instruction Manual for Encounter Data Submission

Documentation change control is maintained in this Manual through the use of the Change Control Table shown below. All changes made to this Manual after the creation dates are noted along with the author, date, and reason for the change.

Change Control Table

Author of Change	Sections Changed	Description	Reason	Date
Adolph Simmons, Jr.	Entire document	Edits	Minor formatting edits to manual	7/1/2017
Leslie Downes	4	Voiding Encounters	Strengthening the language	3/14/2018
Adolph Simmons, Jr.	Entire document	Adding DHB and GDIT	Both the state organization and our IT vendor changed names this year.	5/1/2019
Adolph Simmons, Jr	Introduction	Closeout	Language included to inform user that the manual should be used for LME/MCO encounters only	6/1/2022

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Overview

Introduction

Since 2005, North Carolina has operated a pre-paid program under its 1915(b)/(c) Waiver for Mental Health (MH), Developmental Disability (DD), and Substance Abuse (SA) Services. This program expanded statewide for Prepaid Inpatient Health Plans (PIHPs) using Local Management Entities – Managed Care Organizations (LME-MCOs). The North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) requires each health plan to report all managed care paid encounters to NCTracks, North Carolina's Medicaid Management Information System (MMIS) which was implemented by GDIT in July 2013.

In February 2014, NCTracks began accepting encounters in the HIPAA 837 COB formats. PIHPs initially submitted encounters for dates of service beginning February 1, 2014 but have since been required to submit all claims paid on or after the PIHPs' effective date or July 1, 2012, whichever is later.

This manual serves as a guide to supplement contractual requirements, standard HIPAA encounter submission instructions, and companion guides provided by GDIT. PIHP contractual requirements may be more specific than the Federal rules.

As of 12/1/2022 all Encounters will be submitted to the Encounter Processing System (EPS) when the LME/MCOs become Tailored Plans as a part of North Carolina's 1115 Waiver. This manual should only be used to in support of encounters submitted up to 11/30/2022.

Encounter Definition

Encounters are records of medically-related services rendered by a PIHP provider to a DHB beneficiary enrolled with the capitated PIHP on the date of service. Encounters include services provided through either a capitation or fee-for-service (FFS) arrangement by the PIHPs. Encounters for all incurred services in the DHB managed care benefit package for which the PIHP has made payment must be reported. If there is a claim partially paid by the PIHP, only the paid details should be sent to the State. Denied lines should not be reported. Referrals to services that are covered by another payer should not be reported. Encounter services include, but are not limited to:

- Hospital services.
- Physician visits.
- Nursing visits.
- Laboratory tests.
- Radiology services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) services.
- Home health services.
- Behavioral health services.
- Substance abuse services.

Purpose of Encounter Collection

The purposes of encounter data collection are as follows:

Contractual Requirements

Contractor shall collect and submit service-specific encounter data in the appropriate 837 format, or in an alternative format, if approved by DHB. The PIHP shall submit to DHB an electronic record of every encounter between a network provider and an enrollee within 15 calendar days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter paid date. DHB shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The PIHP shall report all encounters that occur up to the date of the termination of this Contract.

Rate Setting

The Balanced Budget Agreement of 1997 (BBA) requires the use of base utilization and cost data that is derived from the services provided to the Medicaid eligibles in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the contract. In addition, the Centers for Medicare & Medicaid Services (CMS) requires that rates be based upon at least one year of recent data that is not more than five years old.

Quality Management and Improvement

DHB's 1915 (b)(c) Medicaid waiver program partially funded by CMS. Encounter data is analyzed and used by CMS and DHB to evaluate program effectiveness, monitor quality of care, analyze utilization levels and patterns, measure access to care, and evaluate PIHP performance. The utilization data from encounter records provides DHB with performance data and indicators. DHB will also use this information to audit the validity and accuracy of the reported measures per contract.

DHB strives for continuous quality improvement with encounter data. Continuous quality improvement focuses on measuring and improving the quality and quantity of data available to DHB. Data from PIHPs will continue to undergo data quality checks beyond the minimum criteria used in the edit process. The results of both the edits and ongoing data quality monitoring may be combined to develop plan-specific quality improvement measures.

DHB Responsibilities

Among other duties, DHB is responsible for administering the State's Managed Care program. Encounter data are instrumental tools in that effort. Administration includes conducting data analysis, providing business and technical supports to the PIHPs, training PIHP staff, producing feedback and comparative reports for the PIHPs, initiating and continuing discussions of data quality improvement with each PIHP, ensuring data confidentiality, and maintaining and disseminating the Prepaid Inpatient Health Plan Instruction Manual for Encounter Data Submission (Manual). In addition, DHB is responsible for the oversight of the contract and the activities of contractors, as well as performing comparative analysis of Medicaid managed care encounter data versus FFS claims data.

DHB encounter team responsibilities include production and dissemination of the Manual, the initiation and ongoing discussion of data quality improvement with each PIHP, and PIHP training. DHB will update the Manual on a periodic basis. Revisions to the Manual are noted in each subsequent update.

GDIT Responsibilities

GDIT is under contract with the State to provide MMIS services, including the acceptance of electronic encounter reporting through NCTracks from the PIHPs. GDIT is also responsible for maintaining the EDI process and assisting in the resolution of transmission and production issues. After the completion of each claims payment cycle, GDIT provides the PIHPs with an ANSI ASC X12N 835 Remittance Advice (835) as well as proprietary NCTracks encounter adjudication reports.

PIHP Responsibilities

PIHPs must evaluate the adequacy of, and revise if necessary, the data collection instruments and processes being used by providers and ensure accurate and complete encounter reporting for all recipients from their providers. PIHPs are responsible for ensuring that the appropriate provider, recipient, and service information are included on each encounter and that encounter files created by their vendor are submitted to NCTracks. If any processes are delegated, all communication must continue to be the PIHPs' responsibility.

The PIHP contract requires the PIHP to collect and submit, in the appropriate 837 format, service-specific encounter data. The PIHP shall submit to GDIT, an electronic record of every encounter between a provider and an enrollee within 15 calendar days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter paid date. The data shall include all services reimbursed by the PIHP starting on July 1, 2012 or the PIHPs effective date, whichever is later, and continuing until the termination date of the contract. In instances where the PIHP has received refunds from providers, PIHPs should submit voids for any submitted encounters involved as soon as possible after receipt of these funds.

PIHPs are expected to investigate encounter denials and be prepared to explain the underlying reasons for the identified data quality issue(s). The PIHP shall address 90% of reported errors within 30 calendar days and address 99% of reported errors within 60 calendar days. Such errors will be considered acceptably addressed when the PIHP has either confirmed and corrected the reported issue and resubmitted the encounter or disputed the reported issue with supporting information or documentation that substantiates the dispute. Any issues not fully addressed timely through the correction process may be escalated to the State. The PIHP should submit to their DHB Contract Manager and the Business and Technical Relationship Management Team an Excel workbook detailing the issues. The workbook should contain

1. Identification of the error/issue including some example encounter TCNs.
2. Steps that the MCO has taken to address/correct the issue/error.
3. Volume, i.e. number of affected encounters, of the impact of the issue
4. Dollar amount impact of the issue

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General HIPAA Information and Billing Requirements

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) legislation mandates that health care claims and related transactions be processed using standard electronic data interchange (EDI) format and content for covered entities. There are three HIPAA-compliant ANSI ASC X12N Provider-to-Payer-to-Payer coordination of benefits (COB) 837 transactions (837): institutional, professional, and dental services. PIHPs will use two of the 837 transaction formats to report encounters – 837I for Institutional claims and 837P for Professional claims. The type of transaction used will depend upon the type of service being reported. The table below shows the specific types of providers and the appropriate transaction PIHPs should use for reporting:

Type of Provider	837 Transaction
Hospital	837I — Institutional
Physician	837P — Professional
Nurse Practitioner	837P — Professional
Agencies	837P — Professional
Clinics	837P — Professional
Day Treatment	837P — Professional
Federally Qualified Health Center	837P — Professional
Alcohol/Substance Abuse Clinic	837P — Professional
Mental Health Clinic	837P — Professional
Community Residential Facility	837P — Professional
Private Clinic	837P — Professional

Implementation instructions are contained in detailed instruction manuals known as implementation guides (IGs). The IGs provide specific instructions on how each loop, segment, and data element in the specified transaction set is used. The ANSI ASC X12N Implementation Guides can be accessed at http://store.x12.org/store/healthcare-5010-consolidated-guides. Beginning January 1, 2012, all PIHPs had to be fully compliant with Version 5010 of the ASC X12 837 transactions.

In addition, GDIT has created and maintains NCTracks Companion Guides. The ANSI ASC X12N 837 (Healthcare Claim Transactions — Institutional and Professional) Companion Guides are intended for trading partner use in conjunction with the appropriate ANSI ASC X12N National Implementation Guide. These guides outline the procedures necessary for engaging in EDI with NCTracks and specifies data clarification, where applicable. The NCTracks Companion Guides can be found at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html.

This Manual will not provide detailed instructions on how to map encounters from the health plans' systems to the 837 transactions. The 837 IGs contain most of that information. This Manual provides additional instructions and support for DHB specific encounter requirements. Periodically,

DHB or GDIT will provide additional billing instructions through bulletins located at http://DHB.ncdhhs.gov/documents.

File Header Requirements

The encounter claims data from the PIHPs are identified by the value 'RP' present in X12 field BHT06 – Transaction Type Code. Fee for services transmissions have a 'CH' in that field.

Loop Requirements

DHB requires PIHPs to submit the amount the PIHP paid the provider in loop 2300 segment CN102. In addition, the PIHP should submit their NPI or Atypical Provider ID in loop 2300 segment CN104.

Professional Identifiers

PIHPs are required to submit the provider's NPI, Taxonomy Code, and 9-digit zip code on an encounter. The following table provides the guidelines for completion of the provider information on the 837 Encounter transactions for healthcare providers. If the provider that needs to be indicated is atypical, the G2 qualifier must be used. These guidelines are to be used when applicable. For example, if a referring physician is not required for the encounter being submitted, it would not be sent.

837 Professional	
Loop	**Guidelines**
2010AA — Billing	Billing Provider's NPI
	Billing Provider's 9-Digit Zip
2000A	Billing Provider's Taxonomy
2010AB — Pay-To	Address
2010BB REF*G2	PIHP's Subscriber ID
2310A — Referring	Referring Provider's NPI
2310B — Rendering	Rendering Provider's NPI
	Rendering Provider's Taxonomy
2420A — Rendering (line level)	Rendering Provider's NPI
	Rendering Provider's Taxonomy

837 Institutional	
Loop	**Guidelines**
2010AA — Billing	Billing Provider's NPI
	Billing Provider's 9-Digit Zip
2000A	Billing Provider's Taxonomy
2010AB — Pay-To	Address
2010BB REF*G2	PIHP's Subscriber ID
2310A — Attending	Attending Provider's NPI
	Attending Provider's Taxonomy
2330D — Operating	Operating Provider's NPI

2310C — Other	Other Provider's NPI

If the provider is not enrolled in NCTracks or the taxonomy submitted is not on the provider's NCTracks record, an error will be received. In an effort to reduce the number of denials received, the State distributes a nightly incremental and monthly full provider file to the PIHPs to assist in determining if a provider has been enrolled in NCTracks.

Financial Fields

The financial fields that DHB requests the PIHPs to report include:

- Header and Line Item Submitted Charge Amount.
- Header and Line Item PIHP Paid Amount.
- TPL Collection.

Header and Line Item Submitted Charge Amount

PIHPs should report the provider's charge or billed amount. If the submitted charge is billed as "$0.00", NCTracks will calculate the paid amount as zero since DHB pays the lesser of the submitted charge or the calculated fee amount. A value other than "$0.00" must be submitted when the provider bills on a FFS basis.

Header and Line Item Paid Amount

If the PIHP paid the provider for the service, the Paid Amount should reflect the amount paid and be reported as the monetary amount in the CN1 segment in loop 2300. The PIHPs NPI or atypical number should be reported as the reference identification on that same segment. The paid amount is stored in the encounter as a third-party liability (TPL) amount.

TPL Collection

If a third-party carrier is responsible for a portion of a claim, the PIHP should submit the primary TPL carrier payment amount in the COB loop of the 837 formats in encounter submissions.

Patient Status Code

Patient status code must be populated on inpatient encounter submissions. The list of codes accepted by NCTracks is in Appendix A of this Manual.

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Transaction HIPAA Testing and Certification

Introduction

The intake of encounter data from each of the contracted PIHPs is treated as a HIPAA compliant transaction by DHB and GDIT. As such, PIHPs are required to undergo Trading Partner testing with GDIT to receive certification prior to electronic submission of encounter data. The objective is to ensure that the submitter can generate a valid X12 transaction, submit the transaction to the NCTracks EDI system, and process the 999 acceptance or rejection transaction. The testing also ensures that the data submitted can be used to populate the proprietary internal record layout correctly so it can be processed in NCTracks. In order to simulate a production environment, PIHPs are requested to send real encounter data. GDIT does not define the number of encounters in the transmission; however, DHB will require a minimum set of encounters for each transaction type based on testing needs.

Test Process

Tier I

The first step in submitter testing is enrollment performed via GDIT EDI Services. Each PIHP must enroll with GDIT EDI Services to receive a Trading Partner Transaction Submitter Number (TSN) in order to submit electronic encounter data. The enrollment forms can be obtained at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html. After selecting the appropriate item from the companion guide list, the enrollment packet should be completed and returned to GDIT EDI Services. Most PIHPs will already have a TSN but are only permitted to receive electronic transactions, not to submit them. In this case, permission is granted for the PIHPs to be able to both transmit and receive. In the other cases, PIHPs will be assigned a Trading Partner Logon Name, and a TSN, and granted access to both send and receive transactions.

Trading Partners will have access to the EDIFECS' Ramp Management (RM), which is a self-service Web portal for on-boarding trading partners. It provides a best-practice approach to guide trading partners through every step of the ASC X12 HIPAA compliance and testing. A partnership exists between EDIFECS and NCTracks EDI Services to assist in compliance testing and tracking submitter test files prior to submission to NCTracks. EDIFECS will analyze each test file based on the seven levels of testing defined by WEDI Strategic National Implementation Process (SNIP).

Errors can occur at various levels within the 837. An interchange envelope contains the sender, receiver, and data type information for the header. If the syntactical analysis of the interchange header and trailer is invalid, the interchange will reject, and a 999 with a T1 segment will be forwarded by the GDIT Support Center to the PIHP. In this scenario, the entire transaction is rejected at the header level.

Once the transaction has passed interchange edits, it is subject to transaction set syntax errors. If the error occurs at the ST or SE level segments, the entire transaction within the ST/SE envelope is rejected. However, if the functional group consists of additional ST/SE transactions without errors, these transactions are processed. The 999 transaction contains accept and reject information. The reject information details the segment(s) or elements(s) where the error(s) occurred. Additional

information is provided on the GDIT EDI Submitter Testing Report. PIHPs will review this information, correct the errors, and resubmit the files until a clean file is produced.

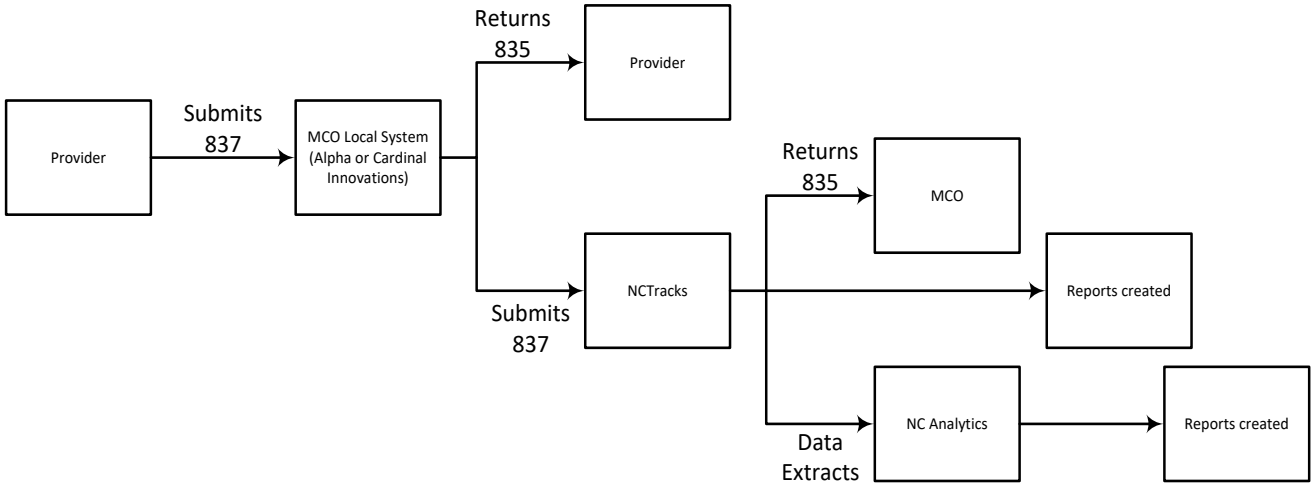
EDIFECS also provides HIPAADesk, a free on-line testing application available to the State. Please refer to the NCTracks Companion Guides to obtain instructions for obtaining a free copy of HIPAADesk. The RM website is https://sites.edifecs.com/index.jsp?NCTracks.

Testing Tier II

The next stage of testing is Tier II and is performed to ensure that the data content of the PIHP file is satisfactory. When submitting test files for Tier II and Tier III testing, PIHPs need to be sure to insert a "T" in data element 15 of the ISA segment of the envelope. Once the file has been accepted by GDIT EDI Services, the NCTracks pre-processors will check the data content while converting the encounter data claim into the NCTracks internal format. There are several reports that are created as part of the pre-processor series that will also be used during this testing phase to aid in validating the encounter claims data.

GDIT is responsible for evaluating the 'reject' reports produced from the pre-processors and forwarding the results to the PIHP and to DHB. GDIT will send the 'accepted' encounter data pre-processor reports to DHB for review. However, if the pre-processor editing rejects more than 50% of the encounter data claims, GDIT will notify the PIHP and assist them with identifying necessary corrections for resubmission purposes.

High Level Encounter Processing Overview



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Encounter Submissions

Introduction

The final tier of testing begins once a PIHP has successfully passed more than 50% of test encounter data claims through the pre-processors.

NCTracks Testing

GDIT will process the encounters through the NCTracks adjudication and payment cycles. During processing, NCTracks will apply standard edits to the encounters. Depending upon the level of edit, an individual encounter may deny at the header or at a line level. PIHPs will receive an X12 835 for all encounters processed. Each PIHP is required to examine the returned 835s and compare them to the encounter data claims (837s) submitted to ensure all submitted encounters are accounted for in the data collection. NCTracks will send the exception reports to the PIHPs and DHB for evaluation. GDIT staff is available to answer any questions that any PIHP may have concerning the exceptions.

When a PIHP has successfully completed this process, GDIT will ask the PIHP to submit full encounter files in a test mode. This gives GDIT a better idea of how best to phase-in the remaining months of historical encounter data that need to be processed. It will also help GDIT EDI Services ensure that they are handling the transmissions most efficiently for the number of encounter data claims that they are receiving. Exception reports are generated on the Monday following the weekend claims cycle.

Production Preparation

Upon completion of the above testing, PIHPs are ready to submit encounters in the production environment. PIHPs must insert a “P” in data element 15 of the ISA segment of the envelope. This value was set to ‘T’ for testing purposes. GDIT anticipates receiving files from each of the PIHPs in production mode approximately once a week.

Data Certification[1]

The BBA requires that when State payments to a PIHP are based on encounter data that is submitted by the PIHP, the data must be certified. This certification applies to enrollment data, encounter data, and any other information that is specified by the State. The certification must attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and to any documents submitted as required by the State. Encounter files submitted by the PIHPs are certified by a completed, signed Data Certification form. A completed, signed form is required to be faxed concurrently with each encounter submission. The data must be certified by each of the following individuals:

[1] CFR 42 § 438.604 — Data that must be certified; CFR § 438.606 — Source, content, and timing of certification.

The PIHP's Chief Executive Officer.
The PIHP's Chief Financial Officer.

An individual may have delegated authority to sign for, and who reports directly to the PIHP's Chief Executive Officer or Chief Financial Officer. A copy of the Data Certification form for Medicaid encounters is located in Appendix B. Contact DHB for a Word document version of the certification form.

Encounter Processing

837 files containing encounter data may be submitted on any day of the week. Submissions that are sent on Fridays cannot be guaranteed to be processed in that week's adjudication cycle. Multiple files can be sent within each week.

During the processing, there are a number of edits through which encounter claims must pass. A full listing of encounter edits, including disposition, is contained in the Encounter Edit Manual published by DHB. Some of the main editing that is done deals with the provider NPIs and taxonomies that are submitted on the claim. Not only must the NPIs submitted be enrolled in NCTracks, but the provider must have, on their NCTracks record, the taxonomy that is submitted on the claim. If errors are received for either of these items, the Provider Upload Process should be used to correct the data in NCTracks.

Encounter Remittance Information

Each Monday following the Friday payment cycle, NCTracks will send various reports to the PIHPs via the web portal Outbox. One of the items the PIHPs will receive is an X12N 835 transaction that includes encounters processed through NCTracks. The 835 transaction will detail whether each claim and claim line paid or denied.

Error Identification

The Claim Status Code field (CLP02) on an 835 transaction can be used to determine if an encounter paid or denied. If the Claim Status Code contains a value of '3', at least one detail line on the encounter paid. If the Claim Status Code contains a value of '4', the encounter denied.

If a detail line fails NCTracks encounter edits, an adjustment reason code, adjustment amount, and adjustment quantity are returned in the Claim Adjustment Segment (CAS). This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the encounter. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See 2.2.1, Balancing, and 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the 835 IG, for additional information.

A single CAS segment contains up to six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on, through the sixth adjustment trio (CAS17-CAS19).

Each adjustment reason is associated with a particular NCTracks exception. A cross-walk was created that maps the adjustment reason and remark codes to the appropriate EOB Code. The

EOB codes are proprietary explanations of why the claim detail denied. This cross-walk can be found as the third entry under Provider Policies, Manuals, and Guidelines at https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

In addition to the information contained on the 835 transaction, PIHPs are provided with a remittance advice to assist them in identifying repairable errors. Repairable errors resulting in service line denials will not be included in data for rate setting purposes. PIHPs are responsible for correcting and resubmitting service line denials. All corrected service lines are included in data for rate setting

Resubmissions

For errors that are repairable, the PIHP must make the correction to the service line(s) in their local system and resubmit the encounter. If the entire encounter denied, the PIHP must resubmit the entire encounter. If at least one of the lines on an encounter "paid", the encounter must be voided and replaced.

Voiding/Adjusting Encounters

If a provider refunds the PIHP for a paid claim, the PIHP must process that refund in the NCTracks system as well by voiding and replacing the encounter. PIHPs are required to submit a void and replacement of the entire encounter identified by the Transaction Control Number (TCN). Correction and resubmission of individual lines is not allowed.

In order to void or credit an encounter claim via an 837 transaction, at a minimum the provider number, beneficiary number, dates of service and TCN must match the original encounter data claim being voided. The voided transaction is identified by the presence of an '8' in the Frequency Code field (CLM05-3). Therefore, if an encounter was submitted in the 837P format and "paid", and subsequently, the PIHP wants to void it, the original 837P transaction should be used, the frequency code changed to '8', and the payer claim control number (REF*F8*) populated with the encounter TCN. To adjust a claim, follow the same logic, but change the frequency code to '7'. Detailed, payer-specific instructions are provided in the NCTracks Companion Guides found at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html. Below are the most recently published instructions for encounter void and replacement.

Void/Cancel and Replacement Instructions

Loop	Segment	Data Element	Comments
2300	CLM05-3	1325	Claim Frequency Type Code To correct or void a previously submitted claim, submit "**7**" for encounter adjustment to replace a prior claim or "**8**" for encounter void/cancel of a prior claim. See also 2300/REF02.
2300	REF01	128	Reference Identification Qualifier To cancel or adjust a previously submitted claim, submit "**F8**" to identify the Original Reference Number.
2300	REF02	127	Original Reference Number To cancel or adjust a previously submitted claim, please submit the **16-digit TCN** assigned by the adjudication system and printed on the remittance advice for the previously submitted claim that is being replaced or voided by this claim.

Outstanding Issues

Generally, the PIHP shall, unless otherwise directed by DHB, address 90% of reported errors within 30 calendar days and address 99% of reported errors within 60 calendar days. Such errors will be considered acceptably addressed when the PIHP has either confirmed and corrected the reported issue and resubmitted the encounter or disputed the reported issue with supporting information or documentation that substantiates the dispute. DHB may require resubmission of the transaction with reference to the original in order to document resolution.

After implementing the data management and error correction process, if any processing error(s) remain unresolved, the PIHP may present the outstanding issue(s) to DHB for clarification or resolution. These parties will review the issue(s) and transmit to the appropriate entity for resolution and respond to the PIHP with their findings. If the outcome is not agreeable to the PIHP, the PIHP can re-submit the outstanding issue(s) with supporting documentation to GDIT and DHB for reconsideration. The outcome determined by these entities will prevail.

Grievances

PIHPs have the right to file a grievance regarding rejected or denied encounters that are not denied as non-repairable. Grievances must be filed in a timely manner. A PIHP may believe that a rejected encounter is the result of an "NCTracks error." An NCTracks error is defined as a rejected encounter that (1) NCTracks acknowledges to be the result of its own error; and (2) requires a change to the system programming, an update to NCTracks reference tables, or further research by NCTracks, and therefore, requires NCTracks resolution to process the rejection.

A PIHP must notify DHB in writing within a 30-calendar day timeframe if it believes that the resolution of a rejected encounter rests on NCTracks rather than the PIHP. DHB will respond in writing within 30 days of receipt of such notification. DHB encourages PIHPs to provide written notice as soon as possible. The DHB response will identify the status of each rejected encounter problem or issue in question.

GDIT will review the PIHP’s notification and may ask the PIHP to research the issue and provide additional substantiating documentation, or GDIT may disagree with the PIHP’s claim of a NCTracks error. If a rejected encounter being researched by GDIT is later determined not to be caused by a NCTracks error, the PIHP will be required to make corrections to the encounter, if appropriate, and resubmit during the next billing cycle.

5

Continuous Quality Improvement

Introduction

In accordance with the BBA, DHB developed a quality strategic plan that serves as the guiding principles for the establishment of quality improvement efforts for the PIHPs. Continuous quality improvement is the method to identify opportunities for improving and demonstrating successful interventions for data management. Data from the PIHPs will continue to undergo data quality checks beyond the minimum criteria used in the NCTracks edit process. The result of edits and data quality improvement monitoring are combined to develop and ensure balanced quality, patient satisfaction, and financial measures. Interim monitoring and follow-up on identified quality problem areas is an integral component of DHB's encounter process.

Minimum Standards

There are three components to encounter data quality assessment: NCTracks Denials, Pay-and-Report edits, and Data Volume Assessment.

Denials

Denials are provided to DHB and PIHPs with an action code for correcting/adjusting, voiding, and resubmitting the encounters.

NCTracks Pay-and-Report Edits

Pay-and-Report Edits are provided to DHB and PIHPs for items that are processed through NCTracks but reported to DHB as questionable.

Data Volume Assessment

Data Volume Assessment refers to the evaluation of whether key services meet expected rates of provision, as demonstrated in the data. This is important to decide whether plans are submitting data, and ultimately, whether the actual level of services are adequate to meet contractual requirements, justify capitation rates, and provide appropriate access to care for the enrolled population. A core audit function includes determining whether DHB possesses all of the encounter data generated for a specific period.

APPENDIX A

Definitions

Term	Definition
Adjudicated Encounter File	An encounter file produced by a PIHP, which includes all encounter records adjudicated during the current encounter cycle. Adjudicated claims are claims processed to payment or denial.
Beneficiary	A person eligible to receive medical and/or behavioral health services.
Beneficiary Month	One enrollee who is enrolled in the Managed Care program for one month.
Capitation Rate	The monthly rate per enrollee, fixed annually in advance, paid by DHB to a contracted PIHP for managing the services described in the contracted Evidence of Coverage, whether or not the enrollee receives services during the period covered by the rate.
Care Management System	In this document, refers to an organized system for managing the medical and/or mental health and alcohol and drug abuse care of enrollees with complex care needs, including a primary care physician's (PCP) responsibility for providing and managing primary care, an EPSDT tracking system, a utilization management system with special procedures for high cost/high-risk cases, and care coordination.
Category of Service (COS)	COS is assigned by NCTracks based on data submissions with the following values:

COS	COS Description
0001	Ambulance
0002	Clinics - Free Standing
0003	Clinics - Health Department
0004	Clinics - Mental Health
0005	Hospital, Inpatient Ventilator Care
0006	Clinics - Rural Health
0007	Dental
0008	Family Planning - Free Standing
0009	NF - SNF Swing Vent Care
0010	Family Planning - Hospital Inpatient
0011	Family Planning - Hospital Outpatient
0012	Family Planning - Physician
0013	Hearing Aids
0014	Home Health
0015	Hospital Inpatient - General
0016	Hospital Outpatient - General
0017	Hospital Inpatient - MTL, SO < 21
0018	Hospital Inpatient - MTL, SO > 65
0019	Hospital Inpatient - Specialty
0020	LTC – Nursing Facilities

Term	Definition	
	0021	LTC – ICF MRC, SO
	0022	LTC – ICF Swing Beds
	0023	Lab and X-ray
	0024	Family Planning - Sterilization
	0025	HOSPTIAL Outpatient – MTL, SO > 65
	0026	Home Health – Indian Health
	0027	Physician
	0028	Chiropractic
	0029	Optical Supplies
	0030	Optical
	0031	Family Planning – Drugs
	0032	Prescribed Drugs
	0033	Health Check – Health Department
	0034	Health Check – Other Provider
	0035	LTC - SNF SO and NSO
	0036	NF - SNF Swing Beds
	0037	Family Planning – RURAL Health
	0038	Family Planning – Health Department
	0039	NF - INDIAN Health
	0040	Hospital Inpatient – INDIAN Health
	0041	Hospital Inpatient – MTL, NSO < 21
	0042	Hospital Outpatient – INDIAN Health
	0043	Hospital Outpatient – MTL, SO < 21
	0044	Hospital Outpatient – MTL, NSO
	0045	Hospital Outpatient – Specialty
	0046	Podiatry
	0047	LTC – ICF MRC, NSO
	0048	Ambulatory Surgical Center
	0049	Hospital Long Term RM Care
	0050	Hospital Outpatient – Emergency Room
	0051	Hospital Inpatient – General Crossovers
	0052	Hospital Outpatient – General Crossovers
	0053	Personal Care
	0054	Durable Medical Equipment
	0055	CAP – Disabled
	0056	CAP – Mentally Retarded
	0057	CAP – Children
	0058	Hospital Inpatient – MTL, NSO > 65
	0059	Home Infusion Therapy
	0060	Hospice
	0061	Health Check – Rural Health Center

Term	Definition	
	0062	Case Management – FSO
	0063	Local Education Agencies – FSO
	0064	DHS Immunizations
	0065	Clinics – FQHC, Core and Ambulatory
	0066	Family Planning – FQHC
	0067	Health Check – FQHC
	0068	Head Start
	0069	Case Management – NFP
	0070	Practitioner – Non Physician
	0071	NF – Head Level of Care
	0072	NF – Vent Level of Care
	0073	Other Ambulatory Services – INDIAN
	0074	Domiciliary Care – Transportation
	0075	ACH – PCS Basic
	0076	Domiciliary Care – Basis/Eating
	0077	Domiciliary Care – Basic/Toilet
	0078	HMO Premiums
	0079	Domiciliary Care – Basic/Eat/Toil
	0080	CAP – AIDS
	0081	Case Management – HIV
	0082	Carolina Alternative
	0083	ACH – PCS Enhanced
	0084	High Risk Intervention
	0085	CAP – Choice
	0086	Administrative Costs
	0087	EHR Incentive Payments
Centers for Medicare and Medicaid Services (CMS)	The CMS is an organization within the Department of Health and Human Services (DHHS), which has oversight responsibilities for the DHB program, including encounter reporting.	
Child	In this document, refers to children and adolescents ages 3 through 21, eligible for Medicaid and/or enrolled in a Managed Care waiver program.	
Children's Health Insurance Program (CHIP)	Passed as part of the BBA, the CHIP provides health insurance for children who come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance.	
Claim	A bill from a provider of a medical service or product that is assigned a unique identifier that is a claim reference number. A claim does not include an encounter form for which no payment is made.	
Claim Types	Claim types and their descriptions as defined by NCTracks are:	

Code	Long Description
A	MEDICARE PART A CROSSOVER (INPATIENT)
B	MEDICARE PART B CROSSOVER (PROFESSIONAL)
C	HEALTH DEPARTMENTS
D	DENTAL

Term	Definition	
	E	HEARING AID
	F	NURSING HOME
	G	HOSPICE
	H	HOME HEALTH
	I	INPATIENT
	K	PRIVATE DUTY NURSING
	L	INDEPENDENT LABORATORY / XRAY
	M	MANAGEMENT FEE
	N	ADULT CARE HOMES
	O	OUTPATIENT
	P	PROFESSIONAL
	Q	MENTAL HEALTH
	R	DRUG
	S	DURABLE MEDICAL EQUIPMENT
	T	AMBULANCE (PROFESSIONAL)
	U	MEDICARE PART B CROSSOVER UB (OUTPATIENT)
	V	CHILDRENS DEVELOPMENTAL SERVICES AGENCIES
	W	FINANCIAL CLAIM
	X	OPTICAL
	Y	UNDEFINED PROFESSIONAL
	Z	UNDEFINED INSTITUTIONAL
	0	LOCAL EDUCATION AGENCIES
	1	HOME INFUSION THERAPY
	2	THERAPY SERVICES
	3	INSTITUTIONAL AMBULANCE
	4	CAPITATION
	5	RURAL HLTH CLINIC / FEDERALLY QUALIFIED HLTH CNTR
	6	PERSONAL CARE SERVICES
	8	INDEP DIAG TESTING FACILITY / PORTABLE XRAY
Clean Claim	Claim submitted on an approved claim format, and containing complete and accurate information for all data fields required by the Contractor and DHB for final adjudication of the claim. If information that is not included on the claim form is necessary for adjudication of a claim, then such additional information shall be submitted as required in order for the claim to be considered “clean.”	
Complaints	An issue an enrollee or provider presents to the PIHP, either in written or oral form, which is subject to resolution by the Contractor, their designee, and/or DHB.	
Contractor	A PIHP participating in the State’s Managed Care program authorized under NC General Statutes Chapter 108D, Medicaid Managed Care for Behavioral Health Services.	

Term	Definition
Covered Services	Health care services that the Contractor shall provide to enrollees, including all services required by this contract and state and federal law, and all additional services described by the Contractor in its response to the Request for Proposal (RFP) for this contract.
Continuous Quality Improvement (CQI)	Methods to identify opportunities for improving organizational performance: identify causes of poor performance, design and test interventions, and implement demonstrably successful interventions system-wide.
Corrective Action Plan (CAP)	As data issues are discussed, PIHPs must incorporate action steps into a CAP. The CAP should include a listing of issues, responsible parties, and projected resolution dates.
Covered Services	Health care services provided to enrollees, which includes all services required under contract, state, and federal law, and all additional services described by the PIHP in response to the RFP for the contract.
GDIT EDI Support	GDIT is under contract with the State to provide MMIS services, including the acceptance of electronic encounter reporting through the GDIT EDI process from the PIHPs.
Denial of Services	Any determination made by the Contractor in response to a provider's request for approval to provide DHB-covered services of a specific duration and scope which: disapproves the request completely; approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; or disapproves provision of the requested service(s), but approves provision of an alternative service(s). An approval of a requested service, which includes a requirement for a concurrent review by the Contractor during the authorized period, does not constitute a denial.
Denied Claim	An adjudicated claim that does not result in a payment obligation to a provider.
Denied Encounter Correction File	An encounter file submitted by a PIHP to NCTracks containing encounter records that had previously been submitted and had failed the edits and audits process.
Denied Encounters	An encounter reported on the 835 file produced by NCTracks for PIHPs containing encounter records that failed NCTracks MMIS edits and audits process and have been denied.
Denied Service Line	A claim line accepted into the MMIS that does not pass MMIS edits.
Department of Medical Assistance (DHB)	The administration within the North Carolina Department of Health and Human Services responsible for administering all Medicaid services under Title XIX (Medicaid) for eligible recipients, including the Managed Care program and oversight of its managed care contractors.
Disenrollment	Action taken by DHB, or its vendor, to remove a beneficiary’s name from the monthly Enrollment Report following the DHB’s receipt of a determination that the beneficiary is no longer eligible for enrollment.
State	Refers to the State of North Carolina.
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)	DSM-5 is the 2013 update to the American Psychiatric Association's classification and diagnostic tool of mental health, alcohol, and drug abuse disorders to reflect coding effective October 1, 2014. This replaced the DSM-4 code book.

Term	Definition
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The pediatric component of the Medicaid program created and implemented by federal statute and regulations. This program establishes standards of care for children and adolescents under age 21, calling for regular screening and for the services needed to prevent, diagnose, correct, or ameliorate a physical or mental illness, including alcohol and drug abuse, or a condition identified through screening. Medicaid services for children are required as a matter of law to meet these standards, which may require that services outside traditional Medicaid benefits be provided when needed to treat such conditions.
Eligibility Period	A period of time during which a consumer is eligible to receive DHB benefits. An eligibility period is indicated by the eligibility start and end dates.
Eligibiity Verification	NCTracks Customer Service provides assistance to Medicaid eligibles in the selection of a health plan. The same Contractor will offer a 24-hour helpline to answer Medicaid recipients' questions about participating in their health plans.
Encounter	An encounter is defined as any health care service provided to a beneficiary, whether reimbursed through FFS or another method of compensation, which shall result in the creation of an encounter record to DHB. The information provided on these records represents the encounter provided by the PIHP.
Encounter Data	An encounter is defined as any health care service provided to a beneficiary. Encounters, whether reimbursed through capitation, FFS, or another method of compensation, shall result in the creation and submission of an encounter record to NCTracks. The information provided on these records represents the encounter data provided by the Contractor.
Encounter Edits	NCTracks system processing checks that evaluate submitted encounter data for syntax, format, data quality problems, and duplicate records.
Encounter Reporting Formats	Transaction standards mandate that health care claims and related transactions be processed using standard "EDI" format and content with encounter submissions effective February 2014. DHB requires the 837 transactions to be submitted in the provider-payer-to-payer COB format. The ANSI ASC X12N HIPAA standard transactions for electronic data interchange are: 837 (I and P) health claims.
Encounter Submission	The monthly processing of encounter data performed by NCTracks, which includes receipt of new and correction encounter files, encounter processing, and distribution of Adjudicated and Denied Correction 835 files to PIHPs.
Encounter Submission Requirements	The PIHP contract requires the PIHP to collect and submit service-specific encounter data in the appropriate 837 format. The PIHP shall submit to DHB an electronic record of every encounter between a network provider and an enrollee within 15 calendar days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later. The data shall include all services reimbursed by the PIHP. Adjustments to previous records that are deemed repairable denials by NCTracks are submitted in the next monthly cycle. Further, the PIHP contract requires the PIHP to submit encounters at least once per week, unless otherwise approved by DHB. In instances where a claim has been voided, the PIHP must submit the encounter void within 7 days.
Enrollee	A person eligible for North Carolina's Medicaid program who is enrolled in a Managed Care program contracted health plan.

Term	Definition
Enrollment	The process by which a beneficiary's entitlement to receive services from a PIHPare initiated.
External Quality Review (EQR)	A requirement under Title XIX of the Social Security Act, Section 1902(a), (30), (c) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with PIHPs, including the evaluation of quality outcomes, timeliness, and access to services.
Fee-For-Service (FFS)	Payment to providers on a per-service basis for health care services.
Fraud, Waste, and Abuse	An intentional deception, misrepresentation, or concealment of the facts made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or another person. It includes any act that constitutes fraud under applicable federal or state law.
Generally Accepted Accounting Principles (GAAP)	A technical term in financial accounting. It encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time. This includes not only broad guidelines of general application, but also detailed practices and procedures.
HIPAA	Health Insurance Portability and Accountability Act of 1996.
HIPAA Transaction	Transaction standards mandate that health care claims and related transactions be processed using standard "EDI" format and content with an effective date of October 16, 2003. The ANSI ASC X12N HIPAA standard transactions for electronic data interchange are: • 837 (I, P, and D) health claims. • 834 health plan enrollment and disenrollment. • 270/271 health plan eligibility. • 835 health care payment and remittance advice. • 820 health plan premium payments. • 276/277 referral certification and authorization.
Involuntary Disenrollment	The termination of membership of an enrollee under conditions permitted in this agreement.
Managed Care Eligibles	North Carolina residents who have been determined eligible for Medicaid in an eligibility category that requires them to participate in a Managed Care program by enrolling in a PIHP.
Medicaid Management Information System (MMIS)	Computerized or other system for collection, analysis, and reporting of information needed to support management activities. Currently the system is NCTracks, operated by GDIT.
Medicaid	A program established by Title XIX of the Social Security Act, which provides payment of medical expenses for eligible persons who meet income and/or other criteria.
Medicaid Managed Care Program	A program for the provision and management of specified Medicaid services through contracted PIHPs. Managed Care program was established pursuant to the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1992. North Carolina has operated a pre-paid program under its 1915(b)/(c) Waiver for Mental Health (MH), Developmental Disability (DD), and Substance Abuse (SA) Services starting with five counties expanding statewide in 2013.
NC FAST	North Carolina Families Accessing Services through Technology-NC FAST is the information system maintained by the State to verify Medicaid and Health Choice eligibility by NCTracks Call Center.

Term	Definition
Network	All contracted or employed providers in the health plans that are providing covered services to Medicaid recipients.
Network Provider	Mental Health, Intellectual and Developmental Disability, and Substance Abuse Services provider who is contracted with the Prepaid individual or organization selected and under contract with a specific contractor.
Non-repairable denials	Denials that cannot be corrected and resubmitted to NCTracks, such as duplicate encounter.
Original Transaction Control Number (TCN)	The TCN of the originally submitted claim. The original TCN must be submitted on claims when claim frequency type code value “7” (adjustment) or “8” (void/cancel of a prior claim) is submitted.
Out-of-Network Provider	A health, mental health, alcohol, or drug abuse individual or organization that does not have a written provider agreement with a Contractor and therefore, not included or identified as being in the Contractor’s network.

Term	Definition	
Patient Status Code	Used on an institutional claim to identify the status of a patient	
	Code	**Long Description**
	01	DISCHARGE / TRANSFER TO HOME/SELF CARE
	02	TRANSFER TO A DRG HOSPITAL
	03	DISCHARGE / TRANSFER TO SKILLED NURSING FACILITY
	04	DISCHARGE/TRANSFER TO INTER CARE FACILITY/HRF
	05	TRANSFERRED TO A CANCER CTR/CHILDREN HOSPITAL
	06	DISCHARGE TO HOME UNDER CARE OF HOME HEALTH ORG.
	07	LEFT AGAINST MEDICAL ADVICE
	09	ADMITTED TO INPATIENT HOSPITAL
	20	EXPIRED
	21	DISCHARGED / TRANSFERRED TO COURT / LAW ENFORCEMENT
	30	STILL A PATIENT/RESIDENT
	40	EXPIRED AT HOME
	41	EXPIRED AT MEDICAL FACILITY
	42	EXPIRED - PLACE UNKNOWN
	43	DISCHARGED TO FEDERAL HOSPITAL
	50	HOSPICE – HOME
	51	HOSPICE - MEDICAL FACILITY
	61	TRANSFER WITHIN FACILITY – MDCR SWING BED
	62	DISCHARGE/TRANSFER TO INPATIENT REHAB FACILITY
	63	DISCHARGE/TRANSFER TO MCARE LTC HOSPITAL
	64	DISCHARGE/TRANSFER TO SNF CERTIFIED UNDER MCAID
	65	DISCHARGE/TRANSFER TO PSYCHIATRIC HOSPITAL
	66	DISCHARGE/TRANSFER TO CRITICAL ACCESS HOSPITAL
	70	DISCHARGE/TRANSFER TO ANOTHER HEALTH CARE INST
Prepaid Inpatient Health Plan (PIHP)	A State-licensed risk-bearing entity, which combines delivery and financing of health care and which provides basic health services to enrolled recipients for a fixed, prepaid fee. PIHP is the term used to represent those plans participating in the 1915(b) and (c) Managed Care program.	

Term	Definition
Primary Care Physician (PCP)	A board-certified or board-eligible physician who has a contract with a managed care plan to provide necessary well care, diagnostic, and primary care services, and to manage covered benefits for enrollees in his or her caseload. A physician with a specialty of pediatrics, obstetrics/gynecology, internal medicine, family medicine, or any other specialty the Contractor designates from time to time, may serve as a PCP.
Prior Authorization	A determination made by a Contractor to approve or deny a provider's or enrollee's request for a service or course of treatment of a specific duration and scope to an enrollee prior to the provision of the service.
Provider	An individual or organization that delivers medical, dental, rehabilitation, or mental health services within the scope of their license.
Provider File	A monthly file produced by DHB for PIHPs with information regarding all DHB registered providers.
Quality Improvement	Methods to identify opportunities for improving organizational performance: identify causes of poor performance, design and test interventions, and implement demonstrably successful interventions system-wide.
Reference File	Claims code sets maintained by NCTracks on behalf of DHB that reflect the procedure and diagnosis codes approved for FFS recipients.
Repairable Denials	Encounter denials that are to be corrected and resubmitted to NCTracks.
Section 1915(b) Waiver	A statutory provision of Medicaid that allows a state to partially limit the freedom of choice by consumers of Medicaid-eligible services or that waives the requirements under Title XIX, the Medicaid Act, for state wideness of a plan or comparability of benefits.
Section 1915(c) Waiver	A statutory provision of Medicaid that allows a state to provide Home and Community Based Services (HCBS) to Medicaid-eligible consumers.
Supplemental Security Income (SSI)	A Medicaid category of assistance for blind or disabled individuals who are eligible for federal SSI benefits and Medicaid.
Supplemental Security Income (SSI)	A Medicaid category of assistance for blind or disabled individuals who are eligible for federal SSI benefits and Medicaid.
SSI-Related	A Medicaid category, which includes, but is not limited to, the same requirements as the corresponding category of SSI. Persons who receive Medicaid in SSI-related categories may include, but are not limited to, aged, blind, or disabled, and people determined to be medically needy.
Temporary Assistance for Needy Families (TANF)	Federally funded program that assists single-parent families with children who meet the categorical requirements for aid. TANF eligibles also qualify for Medicaid coverage.
Third Party Liability (TPL)	Insurance policy, or other form of coverage, with responsibility to pay as primary for certain health services for a Medicaid-eligible, in addition to Medicaid. Includes Medicare, commercial health insurance, worker's compensation, casualty, torts, and estates. These sources shall be used to offset the costs of Medicaid services.
Title XVIII (Medicare)	A federally-financed health insurance program administered by CMS, covering almost all Americans 65 years old and older and certain individuals under 65 who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts: (1) Part A covers inpatient hospital services, post-hospital care in skilled nursing facilities, and care in patients' homes, and (2) Part B covers primarily physician and other outpatient services.

Term	Definition
Trading Partner ID	A 10-digit ID number assigned by NCTracks for each submitter of encounter data. A Transmission Submitter may be a PIHP or a vendor under contract to a PIHP.
Transaction Control Number (TCN)	A unique 16-digit number assigned to each encounter record by NCTracks for tracking purposes.
Type of Service (TOS)	DHB's TOS is used for data analytics. The following is a complete list with the TOS description.

TOS	Medicaid TOS Description
29	LOCAL EDUCATION AGENCY (M-SCHIP FPR)
30	CASE MANAGEMENT (M-SCHIP FPR)
31	CLAIMS COST (M-SCHIP FPR)
32	FAMILY PLANNING (M-SCHIP FPR)
33	MENTAL HEALTH CLINICS (M-SCHIP FPR)
34	ICF GENERAL (M-SCHIP FPR)
35	SNF GENERAL (M-SCHIP FPR)
36	ACH-PCS (M-SCHIP FPR)
37	INDIAN HEALTH FACILITY (M-SCHIP FPR)
40	LOCAL EDUCATION AGENCIES (B&CC FPR)
41	TYPE SERVICE 41
42	CASE MANAGEMENT (B&CC FPR)
44	CLAIMS COST - B&CC FFP (B&CC FPR)
45	FAMILY PLANNING (B&CC FPR)
46	MENTAL HEALTH CLINICS (B&CC FPR)
47	ICF GENERAL (B&CC FPR)
48	SNF GENERAL (B&CC FPR)
49	ACH-PCS (B&CC FPR)
50	INDIAN HEALTH FACILITY (B&CC FPR)
56	HURRICANE RITA EVACUEES
57	KATRINA DISASTER RELIEF (100% FED)
58	REFUGEES 100% FEDERAL (FPR)
60	LOCAL EDUCATION AGENCIES (FPR)
61	DHS IMMUNIZATIONS (FPR)
62	CASE MANAGEMENT (FPR)
64	CLAIMS COST-REGULAR FFP (FPR)
65	FAMILY PLANNING (FPR)
66	MENTAL HEALTH CLINICS (FPR)
67	ICF-GENERAL (FPR)
68	SNF-GENERAL (FPR)
69	DOMICILIARY CARE PCS (FPR)
72	INDIAN HEALTH FAC PYMTS (FPR)

APPENDIX B

Data Certification Forms

Please Type or Print Clearly	
MEDICAID PIHP Name	**Name of Preparer/Title**
For The Period Ending **_____, 20____** **(Month & Date) (Yr)**	**Contact Phone Number/Email Address**

Medicaid DATA Certification Statement

On behalf of the above-named Medicaid Prepaid Inpatient Health Plan (PIHP), I attest, based on best knowledge, information and belief, that all data submitted to the North Carolina Department of Medical Assistance Administration (DHB) is accurate, complete, and true. This statement applies to all documents and data submitted by the PIHP to DHB, including, but not limited to, the following information: encounter data, other workbook or claims information, and financial information. I further attest that no material fact has been omitted from the data form and acknowledge that the information described below may directly affect the payments made to the PIHP that I represent. I understand that I may be prosecuted under applicable federal and State laws for any false claims, statements, documents, or concealment of a material fact. Additionally, I attest in accordance with 42 CFR §438.604 that the reports have been reviewed and found to be complete, accurate, and true to the best of my knowledge, information and belief and have been submitted in accordance with the PIHP contract with DHB.

I understand that any knowing and willful false statement or representation on this data submission form or attachment(s) may be subject to prosecution under applicable federal and State laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the PIHP contract.

File Type	File Name	Total Number of Records	Sum Charged Amount	Sum of Paid Amount

Date of Submission:_____

Please circle as appropriate. Original Submission? Y N Void? Y N Resubmission of Corrected or Voided Encounters? Y N

Signatures

This certification must be signed by the Chief Executive Officer **and** Chief Financial Officer , or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Office and/or Chief Financial Officer. Please check here if a delegated authority is certifying this submission. ☐

_____	_____	_____
Date	PIHP Chief Executive Officer/Delegate - Name & Title	Signature
_____	_____	_____
Date	PIHP Chief Financial Officer/Delegate - Name & Title	Signature

APPENDIX C

Frequently Asked Questions (FAQs)

What is HIPAA and how does it pertain to PIHPs?
The Administrative Simplification provisions of HIPAA, Title II, include requirements that national standards be established for electronic health care transactions. These standards are being adopted to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of EDI in health care. DHB has chosen to adopt these standards for PIHP encounter data reporting.

What is NCTracks and what is their role with PIHPs?
NCTracks provides functions and services to receive and send ANSI ASC X12N transactions on behalf of their clients, including DHB.

Is there more than one 837 format? Which should I use?
There are two HIPAA-compliant 837 transactions — Institutional and Professional services. The transactions PIHPs will use will depend upon the type of service being reported. Further instructions can be found in Section 2 of this Manual.

Whom do I contact if I have a question regarding the EDI Information Sheet or need technical assistance concerning electronic claim submission?

You may contact the GDIT EDI Support Monday through Friday, from 8 a.m. to 5 p.m. EST, at +1 800 688 6696. Their email is NCMMIS_EDI_Support@csgov.com.

Will DHB provide us with a paper or electronic remittance advice?
NCTracks will provide PIHPs with an electronic 835 Health Care Claim Payment/Remittance Advice.

Where can I find HIPAA code lists, including the Claim Adjustment Reason Codes and Remittance Remark Codes, which appear in the 835 Health Care Claim?
The Claim Adjustment Reason Codes provide the “explanation” for the positive or negative financial adjustments specific to particular claims or services that are referenced in the 835.

The Remittance Remark Codes are used in the 835 to relay informational messages that cannot be expressed with a Claim Adjustment Reason Code. These codes are all nationally mandated codes that must be used by payers in conjunction with the 835.

Payers may no longer use the proprietary codes that they used prior to HIPAA, even if the proprietary codes give better details about how a claim was adjudicated.

HIPAA code lists can be obtained on the Washington Publishing Company’s website at http://www.wpc-edi.com/products/code-lists/.

What is a Trading Partner ID?
The Transaction Supplier Number (TSN) is assigned to Trading Partners by GDIT for each submitter of encounter data. The PIHP is assigned this ID prior to testing. The TSN is obtained through the enrollment process on the NCTracks Provider Portal.

Why must PIHPs submit encounter data?
The reasons why PIHPs are required to submit encounter data are as follows:

- ***Contractual Requirements:*** The PIHP contract requires Contractor to collect and submit service-specific encounter data in the appropriate 837 format, or an alternative format, if approved by DHB. The data shall be submitted electronically within 15 days after the claim or capitation payment was paid. The data shall include all services reimbursed by the Contractor. Adjustments to previous records that are deemed repairable denials by NCTracks are submitted in the next cycle.
- ***Rate Setting:*** The BBA requires the use of base utilization and cost data that is derived from the Medicaid population in order to produce actuarially sound capitation rates. Rates are considered actuarially sound if they are appropriate for the covered Medicaid population and the services that are provided under the contract.
- ***Utilization Review and Clinical Quality Improvement:*** DHB's managed care plan is a Medicaid waiver program partially funded by CMS. Encounter data are analyzed and used by CMS and DHB to evaluate program effectiveness, monitor quality of care, utilization levels and patterns, access to care, and to evaluate PIHP performance. The utilization data from encounter records provides DHB with performance data and indicators. DHB will use this information to evaluate the performance of each contracted PIHP and to audit the validity and accuracy of the reported measures per contract.

APPENDIX D

Code Sets

The use of standard code sets will improve the effectiveness and efficiency of Medicaid, Federal, and other private health programs through system administration simplification and efficient electronic transmission of certain health information. *Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A *code set* includes the codes and the descriptors of the codes.

When conducting 837 transactions, DHB requires PIHPs to adhere to HIPAA standards governing Medical data code sets. Specifically, PIHPs must use the applicable medical data code sets described in §162.1002, as specified in the IGs that are valid at the time the health care is furnished. PIHPs are also required to use the non-medical data code sets, as described in the IGs, which are valid at the time the transaction is initiated.

DHB required PIHPs to adopt the following standards for Medical code sets:

- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting).
- ICD-10 effective October 1, 2015.
- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the American Psychiatric Association's (APA) classification and diagnostic tool published May 18, 2013, as maintained for the following conditions:
  - Diseases.
  - Injuries.
  - Impairments.
  - Other health problems and their manifestations.
  - Causes of injury, disease, impairment, or other health problems.

The combination of Healthcare Common Procedure Coding System (HCPCS) maintained by CMS and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. These services include, but are not limited to, the following:

- Physician services.
- Physical and occupational therapy services.
- Radiological procedures.
- Clinical laboratory tests.
- Other medical diagnostic procedures.

The National place of service (POS) for professional services valid in the NCTracks system are:

POS	Description
01	PHARMACY
03	SCHOOL
04	HOMELESS SHELTER
05	INDIAN HLTH SVCS FR-STND FCLTY
06	INDIAN HLTH SVCS PR-BSD FCLTY
POS	**Description**
07	TRIBAL 638 FRE-STNDNG FACILITY
08	TRIBAL 638 PROV BASED FACILITY
09	PRISON-CORRECTIONAL FACILITY
11	OFFICE
12	HOME
13	ASSISTED LIVING FACILITY
14	GROUP HOME
15	MOBILE UNIT
16	TEMPORARY LODGING
17	WALK IN RETAIL HEALTH CLINIC
20	URGENT CARE FACILITY
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	HOSPITAL EMERGENCY ROOM
24	AMBULATORY SURGICAL CENTER
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE - LAND
42	AMBULANCE - AIR OR WATER
49	INDEPENDENT CLINIC
50	FEDERALLY QUALIFIED HEALTH CENTER
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
57	NON-RES SUBST ABS TRTMNT FCLTY
60	MASS IMMUNIZATION
61	COMPREHENSIVE INPATIENT REHABILITATION FACILITY

62	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
65	END STAGE RENAL DISEASE TREATMENT FACILITY
71	STATE OR LOCAL PUBLIC HEALTH CLINIC
72	RURAL HEALTH CLINIC
81	INDEPENDENT LAB
98	UNASSIGNED
POS	**Description**
99	OTHER UNLISTED FACILITY

APPENDIX E

Websites

The following websites are provided as references for useful information, not only for managed care entities, but also for consumers, health care providers, health care organizations, and other impacted entities.

Website Address	Website Contents
http://www.hhs.gov/ocr/privacy/hipaa/administrative/	The Department of Health and Human Services website's Administrative Simplification provisions of HIPAA. This site contains downloadable versions of the proposed and final rules, general information about the administrative simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.hhs.gov/ocr/privacy/	A consumer-friendly shortened version of the Privacy Rule.
http://www.cms.gov	The CMS home page.
http://www.wedi.org/	The Workgroup for Electronic Data Interchange website. This site includes information on EDI in the health care industry, documents explaining the Privacy Rule, lists of conferences, and the availability of resources for standard transactions.
http://www.wpc-edi.com/hipaa/HIPAA_40.asp	The Washington Publishing Company website. This site contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards under HIPAA of 1996. These items may be downloaded for free.
http://www.ansi.org	The American National Standards Institute website that allows one to download ANSI documents. ANSI Procedures for the Development and Coordination of American National Standards and a copy of the ANSI Appeals Process may be downloaded for free.
http://www.x12.org	The Data Interchange Standards Association website. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.nucc.org	The National Uniform Claims Committee website. This site includes a data set identified by the NUCC for submitting non-institutional claims, encounters, and coordination of benefits. This site also includes information regarding purpose, membership, participants, and recommendations.
http://HL7.org	Information on Logical Observation Identifier Names and Codes (LOINC) — Health Level Seven (HL7). HL7 is being considered for requests for attachment information to support clinical practice and management of health services.
Federal Policy Guidance | Medicaid.gov	Access monthly newsletters published by CMS's Data and System Group within the Center for Medicaid and State Operations. It is a very good source of information for State Medicaid Director Letters.
http://DHB.ncdhhs.gov/documents	DHB web portal for bulletins, transmittals, news, etc.