**CSRA**

**a General Dynamics Information Technology, Inc. company**

# NCMMIS
# Provider Claims and Billing Assistance Guide

**PREPARED FOR:**

North Carolina Department of
Health and Human Services

DHHS MES VMU

**WPDT**
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**SUBMITTED BY:**

CSRA
a General Dynamics Information
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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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North Carolina Medicaid Management
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# Revision History

| Version | Date | Description of Changes |
|---------|------|------------------------|
| W7.3.1F | April 24, 2024 | Updated for CSr 2742. |
| W7.2.3F | December 22, 2023 | Finalized work product |
| W7.2.3 | December 21, 2023 | Addressed State review comments. |
| W7.2.2 | November 09, 2023 | Addressed State review comments. |
| W7.2.1 | October 02, 2023 | Revised per State request. |
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| W7.1.2 | May 06, 2021 | Revised and published. |
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| WPDT 03 | Sept 13, 2013 | Third draft |
| WPDT 02 | July 14, 2013 | Second draft |
| WPDT 01 | July 01, 2013 | Initial draft |

# Provider Claims and Billing Assistance Guide

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# List of Exhibits

# 1. NC Medicaid and Managed Care

In 2015, the NC General Assembly enacted Session Law 2015-245, which directed the Department of Health and Human Services (DHHS) to transition Medicaid from fee-for-service to Managed Care. Under the fee-for-service model, DHHS reimbursed physicians and health care providers based on the number of services provided or the number of procedures ordered. This model will now be known as NC Medicaid Direct. Only a small percentage of people remained in Medicaid Direct. Under Managed Care, the State contracted with insurance companies, called Health Plans. These insurance companies will be paid a capitated rate, which is a pre-determined set rate per person to provide health care services. This model is known as NC Medicaid Managed Care.

In addition, DHHS is contracted with the Cherokee Indian Hospital Authority (CIHA) to support the Eastern Band of Cherokee Indians (EBCI) in addressing the health needs of American Indian/Alaskan Native Medicaid beneficiaries. This new delivery system, the EBCI Tribal Option, manages the health care for North Carolina's Tribal Medicaid beneficiaries primarily in Cherokee, Graham, Haywood, Jackson, and Swain counties.

In July 2021, the North Carolina Department of Health and Human Services (NC DHHS) implemented NC Medicaid Managed Care which allowed beneficiaries opportunity to choose a health plan and get care through a health plan's network of doctors. There are five Prepaid Health Plans (PHPs), the Eastern band of Cherokee Indians (EBCI) Tribal Option, and fee-for-service known as NC Medicaid Direct that will render care through the health plan's network of doctors and health professionals. Under NC Medicaid Managed Care, providers submit claims to the Health Plan with whom the beneficiary is enrolled. The Health Plan will then pay providers. Providers are encouraged to explore contracting options with each Health Plan.

The NCTracks Provider Portal serves as the conduit for training, determining claim status, retrieving Remittance Statements, and other functions essential to effectively managing business with NC DHHS for NC Medicaid Direct recipients.

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# 2. Who's Who

## 2.1 CMS

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

## 2.2 NC DHHS

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

## 2.3 DHB

The mission of the Division of Health Benefits is to provide access to high quality, medically necessary healthcare for eligible North Carolina residents through cost-effective purchasing of healthcare services and products. DHB administers the NC Medicaid program by:

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

## 2.4 DPH

The Division of Public Health (DPH) promotes disease prevention, health services, and health promotion programs that protect communities from communicable diseases, epidemics, and contaminated food and water. DPH programs include:

- Child Service Coordination
- Children with Special Diet Needs
- Coronavirus Disease 2019 (COVID-19) Response in North Carolina

- Early Hearing Detection and Intervention Services (Newborn hearing screening and follow-up)
- Newborn Home Visit Services
- Pediatric Health Care: Exams and Treatment for Children
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

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

## 2.5 ORH

The North Carolina Office of Rural Health (ORH) supports equitable access to health in rural and underserved communities. To achieve its mission, ORH works collaboratively to provide funding, training, and technical assistance for high quality, innovative, accessible, cost-effective services that support the maintenance and growth of the State's safety net and rural communities.

The ORH assists underserved communities by improving access, quality, and cost-effectiveness of healthcare. ORH administers over 300 contracts designed to expand access to high-quality healthcare for rural and underserved populations, allowing ORH to return over 88% of its budget directly to North Carolina communities. In addition, ORH provides in-depth technical assistance to North Carolina's healthcare safety net system.

## 2.6 DMH/DD/SAS

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

Per the [North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services webpage](#), the Commission established the Rules Committee as well as the Advisory Committee to carry out its two primary functions: rulemaking and serving in an advisory capacity to the Secretary of the NC DHHS. Committee membership consists of current members of the Commission who are appointed to the committees by the Chair of the Commission. The Division works closely with the NC Division of State Operated Healthcare Facilities, which manages all mental health, developmental disability, and substance abuse facilities. For more information on DMH/DD/SAS, please see the [division webpage](#).

## 2.7 COUNTY DSS

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

- Determining beneficiary eligibility for NC Medicaid program
- Enrolling beneficiaries in Fee-For-Service (FFS) managed care plans
- Maintaining all beneficiary eligibility files

## 2.8 PCG

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

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# 3. NCTracks Provider Portal

The NCTracks Provider web portal is designed with ease of use and productivity in mind. Providers have the capability through the portal to manage aspects of their business within the NCTracks system. The enhanced functionality allows providers to more efficiently manage changes, update records, add services to a location, participate in electronic communications and listservs, as well as manage affiliations to billers, groups, and organizations. The functionality allows for the automation of the Prior Approval (PA) process, checking beneficiary eligibility, Checkwrite information, Remittance Statements, etc. The majority of the automation accessible by the provider allows for real-time processing and information retrieval. The portal serves to enhance providers' access, productivity, and management of their information, and expedite business processes.

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

Providers are able to establish and manage staff access to their records, use electronic signature capabilities, and upload documentation electronically.

**Note**: Providers must have an NCID to access the Secure Provider Portal. Please see Section 4.1 North Carolina Identity Management (NCID) for information on how to obtain an NCID.

## 3.1 SECURE PROVIDER PORTAL MESSAGE CENTER

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

## 3.2 PROVIDER PORTAL FUNCTIONS

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

- Perform provider enrollment and maintenance functions
- Inquire on beneficiary eligibility and enrollment[1]
- Submit original claims, claim adjustments, and PA requests[1]
- Review claims payment and status information[1]
- Access PA requests[1]
- Access State-approved forms

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

- Access provider training information including provider workshop registration, training materials, training evaluation forms, bulletins, broadcast e-mails, and supporting documentation for training
- Register to receive notifications and/or facilitate communications appropriate to each DHHS division and Health Plan supported by NCTracks

## 3.3 WHY USE THE PROVIDER PORTAL?

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

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

## 3.4 PROVIDER PORTAL SIGNUP

How to access the Provider Portal:

1. To register, go to https://www.nctracks.nc.gov/content/public/providers/getting-started.html and follow the steps to access NCTracks Currently Enrolled Provider (CEP) Registration.
2. Complete the registration form and select **Save**.
3. An e-mail notification is sent to providers and their networks. A network representative will contact providers or their designees to complete their registration.

## 3.5 TAXONOMY

NCTracks uses the NPI, the Healthcare Provider Taxonomy Code (HCPTC), and the service location in the processing of claims. Taxonomy codes for the specified provider reporting levels (attending, rendering, service facility, etc.) are required on all claim types except pharmacy (although pharmacy providers select taxonomy codes in the Provider Enrollment/Re-enrollment process for their provider records).

### 3.5.1 Healthcare Provider Taxonomy Code Set (HCPTC)

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

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

### 3.5.2 Healthcare Provider Taxonomy Codes (HCPTC) and NCTracks

The Healthcare Provider Taxonomy Codes and code descriptions that healthcare providers select when applying for NPIs may or may not be the same as the categorization used by DHHS in enrollment and credentialing activities. Many DHHS providers submit taxonomy codes on claims today. It is important that providers use the appropriate taxonomy code from their provider records based on the service rendered and location.

Providers may have more than one taxonomy code per location. **New** DHHS providers who enroll designate their taxonomy during the enrollment process, using a drop-down list based on the Division-specified provider enrollment, licensing, and credentialing guidelines. **Existing** providers are able to view and/or update their taxonomy codes using the Manage Change process in the NCTracks Provider Portal. Providers are encouraged to verify their taxonomy codes and locations at https://npiregistry.cms.hhs.gov/. This page allows providers to enter their NPI and view the taxonomy codes and locations currently on record for that NPI. Providers can change their taxonomy codes through the Enrollment function in the NCTracks Provider Portal. In case of discrepancies or omissions, providers must make corrections online at https://www.nctracks.nc.gov/content/public/providers.html. Changes to a provider's taxonomy must be verified. While a change is pending, providers could have claims denied. To prevent this, providers should use the enrollment **Status and Management** screen in the secure NCTracks Provider Portal to ensure the changes have been accepted before submitting claims. (See the How to View and Update Taxonomy Job Aid on the NCTracks User Guides & Fact Sheets page.)

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

Taxonomy Errors: If the provider is not actively enrolled in a taxonomy on the Date of Service, please submit an MCR with the provider taxonomy that should be added and include the effective date for that taxonomy. Please ensure the provider affiliation accurately reflects any affiliates on the date of service and the correct affiliate NPI. Once these steps are complete and the provider's taxonomy and affiliation are properly updated, please resubmit the claim for reprocessing.

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

Both the group/billing provider and the rendering provider have their own taxonomy codes, which should be reflected on the claim (unless the provider's specific provider billing guide instructs them otherwise; some exceptions that may use a group taxonomy code assigned to the rendering provider include DMH, Durable Medical Equipment [DME], Non-Emergency Medical Transportation [NEMT], DD, and SAS).

Providers submitting batch/X12 claims electronically (not via the web portal) should indicate the rendering/attending provider location. Taxonomy codes are required on all claim types except pharmacy Point-of-Sale (POS) claims.

### 3.5.3 Location and Healthcare Provider Taxonomy Codes (HCPTC) and NCTracks

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

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

The NPI Final Rule stipulates that only entities who meet the definition of "healthcare providers" found at 45 CFR 160.103 are eligible for NPIs. There are a number of entities who do not meet this definition who are therefore not eligible for NPIs, but whose services are payable by NCTracks. The NPI Final Rule refers to these entities as "atypical service providers" because the services they render are not "healthcare" services. Examples are NEMT services and physical alterations to living quarters for the purpose of accommodating disabilities. Atypical providers use a system-generated provider identification number to file claims and not an NPI.

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# 4. Provider Provisioning

## 4.1 NORTH CAROLINA IDENTITY MANAGEMENT (NCID)

Access to the NCTracks Provider Portal requires an NCID. Providers who already have an NCID can use it to access NCTracks. To obtain an NCID, go to https://ncid.nc.gov and select the "Register" link.

Users who have an NCID but have forgotten the password can go to https://ncid.nc.gov and select the Forgot Password link. NCID registration and passwords are controlled by the NC Office of Information Technology Services (ITS).

An NCID is required to complete the Currently Enrolled Provider (CEP) Registration, to register for training, and to access the secure NCTracks Provider Portal. Providers must obtain an NCID for their Office Administrator (OA) and additional NCIDs for staff who intend to access NCTracks.

## 4.2 USER ACCESS

OAs (owners or managing employees) can control the access that each member of their provider organization has to information in the NCTracks Provider Portal, by granting role-based access to NCTracks features based on user job responsibilities. Access settings are controlled per NCID; therefore, each person who will access the NCTracks Provider Portal must have their own NCID. Sharing NCIDs is not advised for security reasons and because it is a single login system (performing multiple actions under one NCID logs out that NCID).

OAs can designate one or more User Administrators to administer ongoing system access. OAs (or User Administrators) can then grant staff members access to the portal, as desired. OAs and User Administrators are encouraged to complete the OA training available in SkillPort, the NCTracks Learning Management System (LMS).

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# 5. Provider Enrollment

## 5.1 ENROLLMENT APPLICATION

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

All applications, including applications for a new practice location, are screened and assigned a categorical risk level of limited, moderate, or high. Provider types and specialties that fall into the moderate- and high-risk categories may be subject to a pre-enrollment site visit, unless a screening and site visit has been successfully completed by Medicare or another state agency, as well as fingerprinting and payment of the Federal Fee. Senate Bill 496 §108C-3 further defines provider types that fall into each category. If a provider fits within more than one risk level, the highest level of screening is applicable (42CFR 455.450, NC Session Law 2011-399, NCGS 108C-(3)). Providers can also find their taxonomy enrollment requirements in the Provider Permission Matrix available under **Quick Links** on the NCTracks Provider Enrollment page.

Providers billing Medicaid for children ages 0 – 3 must still enroll directly with NCTracks, as children these ages are not covered by the LME-MCO (Managed Care Organization) waiver at this time.

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

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

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

### 5.1.4 Other Enrollment Requirements
In accordance with Sections 6401(a), 10603 and Section 1866(j) of the Affordable Care Act (ACA), prior to initially being enrolled, all providers are required to attend trainings and some providers are required to undergo screenings (depending on risk level and state and federal requirements) as designated by the NC DHHS in accordance with NCGS § 108C-9, including, but not limited to, the following.

- How to avoid common billing errors
- Audit procedures, including explanation of the process used to extrapolate audit results
- How to identify beneficiary fraud

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

### 5.1.5 Provider Enrollment and Re-enrollment Fees

In accordance with Section 1866(j) (2) (C) (i) (I) of the ACA, an Application Fee is required from providers and suppliers who are newly enrolling, revalidating, or establishing a new practice location, or in response to a CMS revalidation request. Depending on provider risk level, a Federal Fee may be required as well. The Federal Fee changes yearly; fee amounts by year may be found under **Quick Links** on the NCTracks Provider Enrollment page by selecting the "Federal Fees & NC Enrollment Fees by Year" link.

Session Law 2011-145 Section 10.31(f) (3) mandates that DHB collect a $100 NC Application Fee from providers upon initial enrollment with the Medicaid program and at 5-year intervals when the provider is re-credentialed (re-verification).

Initial enrollment is defined as an enrollment by a provider who has never enrolled to participate in the Medicaid program. Re-verification is the process that providers must complete every 5 years to remain active Medicaid providers.

The $100 NC Application Fee is required for:

- New initial Enrollment applications when the provider applies for NC Medicaid. (**Note**: This requirement does not include Out-of-State [OOS] Lite providers.)
- Re-verification applications when the provider is active in NC Medicaid.
- Applications that are abandoned, withdrawn, or denied, upon re-submission of the application.
- OOS Lite provider requests to become a full provider.

The $100 NC Application Fee is never required for Re-enrollment applications.

More information on enrollment and re-enrollment fees can be found on the NCTracks Federal Fee and NC Application Fee FAQs page.

### 5.2 PAYMENT OF PROVIDER FEES

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

Providers should make every effort to remit payment promptly. Applications are not processed if payment is not received. If payment is not received within 30 days of the date of the application, the application is abandoned, and the applicant is required to reapply. Payment of the Federal Fee is an automated part of the enrollment process. Providers have the option to submit payment directly after completion of the application. If payment is not submitted, the application shows in a Payment Pending status. The application is not processed until payment is submitted.

## 5.3 QUALIFICATIONS FOR ENROLLMENT

The general requirements for provider enrollment are as follows.

### 5.3.1 Licensure, Accreditation, Endorsement, and Certification

Providers must be licensed, accredited, endorsed, and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but ALL providers must complete an application and an NC DHHS Provider Administrative Participation Agreement. All providers are responsible for maintaining the required licensure, endorsement, and accreditation specific to their provider type to remain qualified and are required to notify NC DHHS immediately if a change in status occurs. For detailed information regarding specific requirements for each provider type, refer to the Provider Permission Matrix under **Quick Links** on the NCTracks Provider Enrollment page.

**Note**: Behavioral Health MCOs that operate under the DMH/DD/SAS Plan waiver are responsible for enrolling behavioral health providers in their respective provider networks.

### 5.3.2 Service Location

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

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

OOS providers are required to adhere to all North Carolina rules, regulations, laws, and statutes governing healthcare delivery under the North Carolina Medicaid program. OOS providers are also required to sign the NC DHHS Out of State Lite Provider Participation Agreement during enrollment, which can be found at https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/terms-and-conditions/NC-DHHS-Out-of-State-Lite-Provider-Participation-Agreement.html.

For a list of ZIP Codes that are within the 40-mile border area, refer to the **North Carolina Border ZIP Codes** list on the NCTracks website at https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information/zip-codes.html. Providers should be affiliated with each location and organization where they render services.

### 5.3.3 Re-verification Requirements

Each enrolled provider is required to be re-verified every 5 years to confirm that they continue to meet the conditions of participation for enrollment as a Medicaid provider.

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

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

In 1998, CCNC was created using the existing CA infrastructure and established 14 community networks that created local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid beneficiaries. These 14 regional networks covered all 100 North Carolina counties. Each network has an administrative entity that contracts with DHB. North Carolina continues to operate the original CA PCCM program; however, in 2019, the 14 regional networks were restructured into six regional networks. Each network has an administrative entity that contracts with DHB. Most primary care providers (PCPs) are now members of a regional network.

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

The networks provide population health management by:

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

The networks provide disease management by:

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

Currently, the six CCNC regional networks include more than 6,000 physicians across North Carolina.

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

## 6.1 CCNC/CA PROVIDER PARTICIPATION AND ENROLLMENT

## 6.1.1 Requirements for Participation in Primary Care Case Management (PCCM) Program

DHB and NCTracks work together to recruit and enroll PCPs into the CCNC/CA program. NCTracks is responsible for processing the applications and enrolling providers into the program. DHB is responsible for establishing PCP participation requirements, assisting providers in carrying out CCNC/CA policies and procedures, and recruiting providers into the program.

For more information, please visit https://medicaid.ncdhhs.gov/providers/programs-and-services/community-care-north-carolinacarolina-access-ccncca.

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

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

**Note**: The following instructions on how to enroll in CCNC, as well as information on how to update or terminate CCNC enrollment, are available in the most up-to-date form in SkillPort in the Job Aid *PRV242 Changing or Terminating CCNC_CA Enrollment*.



**Exhibit 6-1. CCNC/CA Provider Enrollment**

| Step | Action |
|---|---|
| 1 | Select the **radio button** next to the desired location.<br>**Note**: Applications for CCNC/CA **must** be completed for each service location. |
| 2 | Select the **Edit Location** button to continue. |
| 3 | Select **Yes** to the question "**Do you want to apply for CCNC/CA for this location?**". |

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| Step | Action |
|------|--------|
| 4 | Select the radio button for **Same as Authorized Individual** or **Other** in the **CCNC/CA Contact Person** section.<br>**Note**: When **Same as Authorized Individual** is selected, the information is populated with the authorized individual's name. When **Other** is selected, the user must complete the required fields. |
| 5 | Select the **Save Location** button (if applicable). **Note**: All service locations must have a status of Complete in the **Form Status** field. If Incomplete displays for any location, the user must edit the location and complete all required fields. |
| 6 | Select the **Next** button to continue. |

### 6.1.2 Advanced Medical Home and CA Participation

As per the NC DHHS [Advanced Medical Home (AMH) webpage](), "DHHS developed the Advanced Medical Home (AMH) program as the primary vehicle for delivering care management as the state transitions to Medicaid managed care. The AMH program builds on the Carolina ACCESS program."

The AMH program requires Prepaid Health Plans (PHPs) to delegate certain care management functions to AMHs at the local level. In order to provide these care management functions, AMHs may work with their affiliated healthcare system or make an arrangement with an entity called a Clinically Integrated Network, a Care Management vendor, or other population health entity. To ensure that beneficiaries across the state are receiving high-quality care management, DHHS developed standards for AMHs and will be responsible for initially certifying that practices meet AMH criteria.

For more information about the AMH program and enrollment starting with CA, please see the NC DHHS [Advanced Medical Home (AMH) webpage]().

### 6.2 BENEFICIARY ENROLLMENT IN CCNC/CA

The county DSS is responsible for enrolling FFS beneficiaries with a CCNC/CA medical home as part of Medicaid Managed Care (more information about Health Plans can be found [here]()). Enrollment requirements are based on the beneficiary's Medicaid program aid category and classification of eligibility.

**Beneficiaries in any of the mandatory categories that receive Medicare have optional enrollment.**

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

Enrollment considerations:

- In areas that do not have access to CCNC/CA PCPs for all potential enrollees, efforts are made to preserve existing provider-patient relationships.
- Beneficiaries whose third-party insurance is a Health Maintenance Organization (HMO) or who have Tri-Care may be exempted from CA if their PCP does not participate with CCNC/CA.
- At the discretion of the county DSS and the provider, beneficiaries may choose a provider whose CA agreement does not include their county of residence in the provider's service

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

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

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

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

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

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

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

- Providers must inform beneficiaries of their right to choose any CCNC/CA PCP who is accepting new beneficiaries, and their right to change PCPs at any time pursuant to processing deadlines.
- Enrollment is optional for some beneficiaries, including pregnant women and Medicare beneficiaries. Providers must inform optional beneficiaries of their right to disenroll in the program at any time in the future. Optional beneficiaries may discuss enrollment options by contacting their local DSS. For a listing of all the county DSS offices, refer to www.ncdhhs.gov/dss/local/.
- Complete the enrollment form and it send to the CCNC/CA contact at the DSS in the county where the beneficiary resides. The form can be found on the DHB website at https://medicaid.ncdhhs.gov/providers/programs-and-services/community-care-north-carolinacarolina-access-ccncca.
- Provide the Medicaid beneficiary with a CCNC/CA Member handbook. A copy of the handbook is available on the DHB website at https://medicaid.ncdhhs.gov/providers/programs-and-services/community-care-north-carolinacarolina-access-ccncca.

Providers with questions regarding enrolling beneficiaries can contact their county DSS Regional Consultant.

## 6.4 MEMBER IDENTIFICATION

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

The following table identifies mandatory, optional, and ineligible beneficiaries by program aid category.

| Mandatory | Optional | Ineligible |
|---|---|---|
| AAF/Work First – Cash Assistance with Medicaid | MPW – Medicaid for Pregnant Women | MQB and RRF/MRF |
| MIC (N) and MIC (1) – Medicaid for Infants and Children | HSF – State Foster Home Fund | Beneficiaries in Deductible status |
| MAABD – Medicaid for the Aged, Blind or Disabled (Without Medicare) | IAS – Medicaid with IV-E Adoption Subsidy and Foster Care | Community Alternatives Program (CAP) cases with a monthly deductible |
| MAF – Medicaid for Families | End Stage Renal Disease Patients | Aliens eligible for Emergency Medicaid only |
| SAD – Special Assistance for the Disabled (Without Medicare) | SSI beneficiaries under age 19 | Nursing Facility residents (does not include ICF-I/DD [Intermediate Care Facilities for those with intellectual and developmental disabilities]) |
| SAA – Special Assistance for the Aged (Without Medicare) | Native Americans (members of a federally recognized tribe) | MAF-D – Family Planning Waiver |
| Native Americans | • SAA – Special Assistance for the Aged (With Medicare)<br>• SAD – Special Assistance for the Disabled (With Medicare)<br>Benefit Diversion Cases | MAF-W – Breast and Cervical Cancer Medicaid |

## 6.4.1 Beneficiary Education

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

It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CCNC/CA PCPs are expected to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly Carolina ACCESS Provider Enrollment Report.

Providers should inform each enrollee about the following:

- The availability of medical advice 24 hours a day, 7 days a week, and the preferred method for contacting the PCP

- The enrollee's responsibility to bring his/her MID card to each appointment

- The need to contact the PCP for a referral before going to any other doctor

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- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for enrollees from the county DSS
- Copayment requirements

### 6.4.2 Process for Referring a CCNC/CA Beneficiary to Another Provider

Coordination of care protocol is a required component of CCNC/CA. The CCNC/CA provider should promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the beneficiary's medical record. However, a CCNC/CA payment authorization number is not required for claims processing.

- Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. Referrals for routine follow-up care after discharge from a hospital must be made to the PCP. Referrals to a specialist for follow-up care after discharge from a hospital do not require PCP authorization but should be coordinated through the PCP's office.
- If surgery is recommended, CCNC/CA PCPs are required to refer beneficiaries for a second opinion at the request of beneficiaries.
- If beneficiaries disagree with their PCP's decision regarding referrals for specialty services or other care, the beneficiaries should be advised of their option to choose a different CCNC/CA PCP.
- All referrals should be documented in the beneficiary's medical record.

### 6.4.3 Pregnancy Care Management and Care Coordination for Children

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

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

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

# 7. Verifying Beneficiary Eligibility

## 7.1 VERIFYING ELIGIBILITY

A beneficiary's eligibility status may change from month to month if financial and household circumstances change. For this reason, **providers are required to verify a Medicaid beneficiary's eligibility each time a service is rendered.**

### 7.1.1 Verification Methods

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

- NCTracks Provider Portal
- Automated Voice Response System (AVRS)
- Electronic Data Interchange (EDI) (batch)

## 7.2 VERIFYING BENEFICIARY ELIGIBILITY USING THE NCTRACKS PORTAL

Online eligibility verification through NCTracks allows access to the Health Plans and benefits for which the recipient qualifies. NCTracks also offers a secure Recipient Portal where recipients can check their eligibility status with Medicaid, DPH, and ORH.

For example, a beneficiary may be enrolled in a specific North Carolina Medicaid program, such as Medicaid for Infants and Children (MIC) or Medicaid for Adults with Disabilities (MAD). The program abbreviations can be identified in the *NCTracks Benefit Plans Mapped to DHB Eligibility Coverage Codes* document on the NCTracks Provider Policies, Manuals, Guidelines and Forms page. A provider verifying beneficiary eligibility can view the Health Plan in which the beneficiary is enrolled (Medicaid, Public Health, Mental Health, or Rural Health). Beneath the Health Plan is a list of benefits the recipient is eligible to receive.

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

When conducting a DHB eligibility inquiry, providers can verify beneficiary eligibility up to 36 months prior to the current month of the inquiry in NCTracks. Past this time period, providers must contact the DHB Claims Analysis Unit.

When conducting a DPH eligibility inquiry, the dates of service may be back as far as 36 months prior to the current month and up to 12 months beyond the current month.

**Recipient Eligibility Response on the Provider Portal**

A section, called "Time Limit Override," is located at the bottom of the Provider Eligibility Response page on the Provider Portal. Up to three time limit override spans will be returned, and the information returned will include the "From Dates of Service," "To Dates of Service," and "Date By Which Claims Must Be Filed." If there are more than three time limit override information spans, the segment will include a message to contact the NC Medicaid Contact Center.

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**Exhibit 7-1. Verify Recipient Screen**

| Step | Action |
|------|--------|
| 1 | Base Information: Select the **Account**, **Group**, and **NPI/Atypical ID**. |
| 2 | Recipient Information: Enter recipient data using one of the following combinations:<br>• Recipient ID<br>• Recipient ID, Last Name, and Date of Birth<br>• Recipient ID, First Name, and Last Name<br>• First Name, Last Name, and Date of Birth<br>• Date of Birth and Social Security Number |
| 3 | Date of Service: Enter **From** date or use the calendar icon to select a date. |
| 4 | Date of Service: Enter **To** date or use the calendar icon to select a date. |
| 5 | Optional: Select **Service Type** and select **Add**. |
| 6 | Select the **Check Eligibility** button to display search results. |

### 7.2.1 Individual Eligibility Response

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

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

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

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**Exhibit 7-2. Provider Eligibility Response Screen (1 of 3)**

| Section | Description |
|---------|-------------|
| 1 | **Search Criteria** displays the search criteria used for the results. This section includes Recipient ID, Dates of Inquiry, Verified On (date and time), and Tracking #. |

| Section | Description |
|---|---|
| 2 | **About the Recipient** displays recipient demographic information. This section includes Name, Date of Birth, Gender, Recipient ID, Tribal Member, Tribal Services Received, and Last Well-Child Check. Last Well-Child Check displays the month, date, and year of the last well-child checkup the recipient received.<br><br>**Note**: A 'Y' value in the **Tribal Member** field indicates that the recipient is a member of a federally recognized Native American tribe. An 'N' value indicates that the recipient is not a member of a federally recognized Native American tribe.<br><br>A 'Y' value in the **Tribal Services Received** field identifies a tribal member who has been treated or referred by an Indian Health Services (IHS)/tribal provider. An 'N' value identifies a tribal member who has NOT been treated or referred by an IHS/tribal provider. No value, blank, or spaces in this field indicates that the recipient is not a member of a federally recognized Native American tribe. |
| 3 | **Coverage Details** displays information for each calendar month within the dates of inquiry. To change inquiry dates, the user must select the appropriate date span from the **Period Selection** drop-down menu. |
| 4 | The **Administrative County Code** displays.<br><br>Below the Administrative County Code, users will see the message:<br>**"Beneficiary is enrolled in Managed Care and is not eligible for Medicaid claims payment. Please contact the Prepaid Health Plan (PHP) listed below under Managing Entity for information."**<br><br>Next, the first **Health Plan** displays. This is the county that determines eligibility<br><br>**Note**: When the future month is returned on an eligibility request, the disclaimer message displays under the Admin County Code section of the request. |
| 5 | **Health Plan** – Displays eligibility information for the period requested for the following Health Plans: Medicaid, Public Health, and Rural Health. Each Health Plan section includes Benefit Plan, Category of Eligibility, Dates of Enrollment, Managing Entity, the Address of the Managing Entity, the Recipient's Residential County Code, the Managing Entity Phone Number, and the Managing Entity's After Hours Phone Number.<br><br>The **Managing Entity** field displays an agency or other entity that manages and administers the Benefit Plan.<br><br>**Primary Care Provider** displays Primary Care Provider, Daytime Phone Number, Address, and After Hours Phone Number, the Network Entity, and their Daytime Phone Number. |
| 6 | **Indian Health Services Eligible** displays the details of the recipient's IHS eligibility data. If the IHS Eligible indicator displays 'Y', this means the recipient is not a tribal member but is eligible to receive services at an IHS facility. If the IHS Eligible indicator displays 'N', this means the recipient is not a tribal member and is not eligible to receive services at an IHS facility. |
| 7 | **Cost Sharing Balance – Threshold to Current Date** includes a statement that the cost-sharing information is valid as of <the date of inquiry>, the Tracking Period (State fiscal year), Out-of-Pocket (OOP) Max, and Amount Applied to OOP. This information is provided only when the recipient is enrolled in a benefit plan that requires recipient cost sharing, such as enrollment fees, premium payments, and co-pays, and that has an OOP maximum (the threshold). |
| 8 | **Hospice Information** displays Yes or No to indicate whether the beneficiary has elected to use the hospice benefit or not. If the hospice period covers any part of the calendar month selected, the information is provided. |

**9** **RECIPIENT MONTHLY LIABILITY**

This Monthly Liability Information is valid as of 06/16/2021

Date Segments: -

Monthly Liability:                                                    Liability Balance:

?

**10** **MEDICARE INFORMATION**

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

Part C Eligibility

Group Health Org :                                              Plan Name :

Coverage Type :

Part D Eligibility

Group Health Org :                                              Plan Name :

Coverage Type :

?

**11** **OTHER INSURANCE**

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

?

**12** **PHARMACY LOCK-IN**

| Lock-in Type | Provider Type | Provider Name | Provider Phone # | Begin Date | End Date |
|---|---|---|---|---|---|

Information regarding these services is provided for informational purposes only and is not a guarantee of payment. Service counts are based on paid claims as of the date of inquiry. Payment for services is subject to criteria and limitations documented in the applicable policy manual. Please refer to your NC Provider Claims and Billing Assistance Guide or call the CSRA Call Center at 1-800-688-6696.

**Exhibit 7-3. Provider Eligibility Response Screen (2 of 3)**

| Section | Description |
|---|---|
| 9 | **Recipient Monthly Liability** displays the recipient's monthly liability totals and balance. This section contains Monthly Liability valid through date, Date Segments, Monthly Liability, and Liability Balance. |
| 10 | **Medicare Information** displays the recipient's Medicare insurance information. This section contains Medicare #, Part A Eligible, and Part B Eligible. In addition, this section displays Part C & D Eligibility details, Group Health Org, Coverage Type, and Plan Name. |
| 11 | **Other Insurance** displays information regarding insurance policies, when the recipient has insurance coverage other than Medicare. This section contains Type, Company Name, Company Address, Company Phone, Policyholder, Policy #, Group Policy #, and Coverage Dates. |
| 12 | **Pharmacy Lock-In** displays the Lock-In Type, Provider Type, Provider Name, Provider Phone Number, Begin Date of the lock-in period, and End Date of the lock-in period. |

?

**13** **MEDICAID SERVICE LIMITS**

| Service Type | Allowed Amount / $ | Time Period | Available Amount / $ | Message (restriction) | Previous Date of Service |
|---|---|---|---|---|---|

?

**14** **SICKLE CELL SERVICE LIMITS**

| Service Type | Allowed Amount / $ | Time Period | Available Amount / $ | Message (restriction) | Previous Date of Service |
|---|---|---|---|---|---|

?

**15** **INFANT/TODDLER SERVICE LIMITS**

| Service Type | Allowed Amount / $ | Time Period | Available Amount / $ | Message (restriction) | Previous Date of Service |
|---|---|---|---|---|---|

?

**16** **ADAP SERVICE LIMITS**

| Service Type | Allowed Amount / $ | Time Period | Available Amount / $ | Message (restriction) | Previous Date of Service |
|---|---|---|---|---|---|

?

**17** **TRANSFER OF ASSETS SANCTION**

| Date Range | Message |
|---|---|

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**Exhibit 7-4. Provider Eligibility Response Screen (3 of 3)**

| Section | Description |
|---|---|
| 13 | **Medicaid Service Limits** displays information about the recipient's service limits. This section contains Service Type, Allowed Amount/$, Time Period, Available Amount, Message (restriction), and Previous Date of Service. |
| 14 | **Sickle Cell Service Limits** displays information about Sickle Cell service limits. This section contains Service Type, Allowed Amount/$, Time Period, Available Amount, Message (restriction), and Previous Date of Service. |
| 15 | **Infant/Toddler Service Limits** displays information about Infant/Toddler service limits. This section contains Service Type, Allowed Amount/$, Time Period, Available Amount, Message (restriction), and Previous Date of Service. |
| 16 | **ADAP Service Limits** displays information about AIDS Drug Assistance Program (ADAP) service limits. This section contains Service Type, Allowed Amount/$, Time Period, Available Amount, Message (restriction), and Previous Date of Service. |
| 17 | **Transfer of Assets Sanction** displays information about asset transfers for the recipient. This section contains Date Range and Message. |

# 8. Prior Approval

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

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

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

## 8.1 GENERAL REQUESTS FOR PRIOR APPROVAL

PA forms are used to assist in the review of medical necessity for requested services. Providers submitting PA requests in writing are strongly encouraged to use forms published by the service-specific Utilization Review (UR) contractor. However, UR contractors consider all relevant information that is submitted, regardless of whether it is included on a particular form. To access PA forms, contact the service-specific UR contractor.

All PA requests can be submitted electronically via the Provider Portal, including FL2, Hospice Reporting, Transplant, and Visual Aid PA requests. The Provider Portal is designed with drop-down menus wherever possible so the user can select the entry, thus reducing errors and delays from additional information requests. In addition, the request is immediately placed in the queue for review.

- The Provider Portal allows users to view real-time status of PA requests regardless of which vendor made the decision. Denial letters with appeal rights are sent when applicable.

- The system is designed to allow for many of the drug classes that require PA to be automatically approved by the system. The user receives a PA number and the status of the request.

- All DHB Medical (Medicaid) PA requests (DME, Visual Aid, Hearing Aid, Surgery, etc.) are required to have a taxonomy code and location for the requesting, billing, and rendering providers. The system validates the taxonomy code against what is on the provider file for that service location and determines if the taxonomy code is valid for the service requested. Providers are strongly encouraged to use the NCTracks Provider Portal to submit PA requests. Manual processing requirements for the old forms are likely to cause delays.

- AVRS inquiry has been replaced with web-based inquiry. Much of the functionality needed to find a PA record in the AVRS has been removed, and replaced by more robust functionality in the Provider Portal. In addition, Dental Benefit Limitations and Refraction Confirmation can be performed in the Provider Portal.

- Once a PA has been issued, it must be used within the time limit specified by the PA **OR** within 365 days, whichever time period is less.

Providers are encouraged to review their Clinical Coverage Policies and criteria to determine whether PA is required for a specific service/drug/device and, if so, what guidelines apply.

Providers may also find more information on the NC DHHS PA webpage.

# 9. Submitting Claims

## 9.1 BILLING CLAIMS ELECTRONICALLY

- The NCTracks Provider Portal claim submission system is an electronic option to submit claims into NCTracks. It converts the claim into X12 format for Professional (CMS-1500/837P), Institutional (UB-04/837I), and Dental (ADA 2019/837D) claim forms.

### 9.1.1 Time Limits for Filing Claims

All Medicaid claims, except hospital inpatient and nursing facility claims, must be received by NCTracks within 365 days of the DOS 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 DOS** on the claim. If a claim was filed within the 365-day time period, providers have 18 months from the last Remittance Statement date to refile the claim.

### 9.1.2 Billing Professional (CMS-1500/837P) Claims

The following are examples of provider types that submit professional claims:

| | |
|---|---|
| Allopathic & Osteopathic physicians | Local education agencies |
| Ambulance providers | Local Management Entities |
| Ambulatory surgery centers | Maternity Care Coordination/Child Services Coordination services |
| Certified registered nurse anesthetists | |
| Children's Development Services Agencies | Non-Emergency Medical Transportation (NEMT) providers |
| Chiropractors | |
| Clinical pharmacist practitioners | Nurse midwives |
| Community Alternatives Program services | Nurse practitioners |
| Critical Access Behavioral Health Agencies | Ophthalmologists |
| Dietary & Nutritional Services | Optical supply dealers |
| Direct-enrolled independent behavioral health practitioners | Optometrists |
| | Orthotics and prosthetics suppliers |
| DME suppliers | Outpatient behavioral health services provided by Community Intervention Services Agencies |
| Federally qualified health centers | |
| Free-standing birthing centers | Personal care services |
| Health departments | Physicians |
| Hearing aid dealers | Planned Parenthood (non-medical doctor) organization |
| HIV case management services | |
| Home infusion therapy services | Podiatrists |
| Independent diagnostic testing facilities | Portable X-ray services |
| Independent laboratories | Private duty nursing services |
| Independent practitioners | Rural health clinics |

### *9.1.2.1 Creating a Professional Claim in NCTracks*

**Note**: The following instructions are available in the most up-to-date form in SkillPort under the title *CLM 221 Submitting a Professional Claim Participant User Guide*.

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**Exhibit 9-1. Creating a Professional Claim**

| Step | Action |
|------|--------|
| 1 | Hover over the **Claims** menu. |
| 2 | Select **Create Professional Claim**. The **Verify Patient** screen displays. |

## 9.1.3 Billing Institutional (UB-04/837I) Claims

The following provider types submit Institutional claims:

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

### 9.1.3.1 Creating an Institutional Claim in NCTracks

**Note**: These instructions are available in the most up-to-date form in SkillPort under the title *CLM 241 Submitting an Institutional Claim Participant User Guide*.
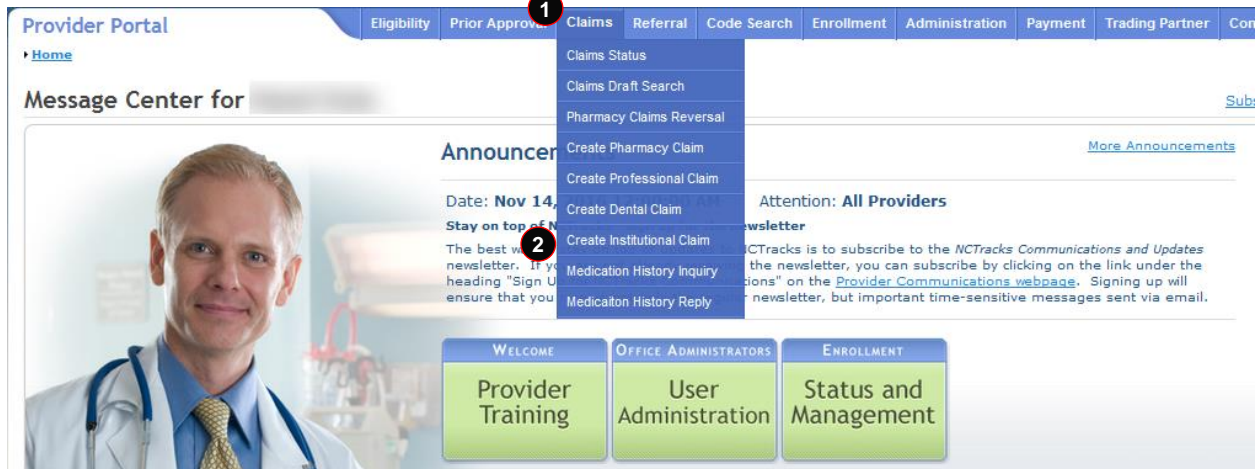
**Exhibit 9-2. Creating an Institutional Claim**

| Step | Action |
|------|--------|
| 1 | Hover over the **Claims** menu. |
| 2 | Select **Create Institutional Claim**. The **Verify Patient** screen displays. |

The **Claim Information** tab on the **Create Institutional Claim** screen allows users to enter general information about an institutional claim. This webpage contains a number of collapsible/expandable sections. Normal default behavior displays the sections collapsed. Sections expand or collapse when providers select **Yes** or **No** for entering information for the sections.

## 9.1.4 Billing Dental (ADA 2019/837D) Claims

The following provider types submit Dental claims:

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

### 9.1.4.1 Creating a Dental Claim in NCTracks

**Note**: These instructions are available in the most up-to-date form in SkillPort under the title *CLM321 Submitting a Dental/Orthodontic Claim Participant User Guide*.

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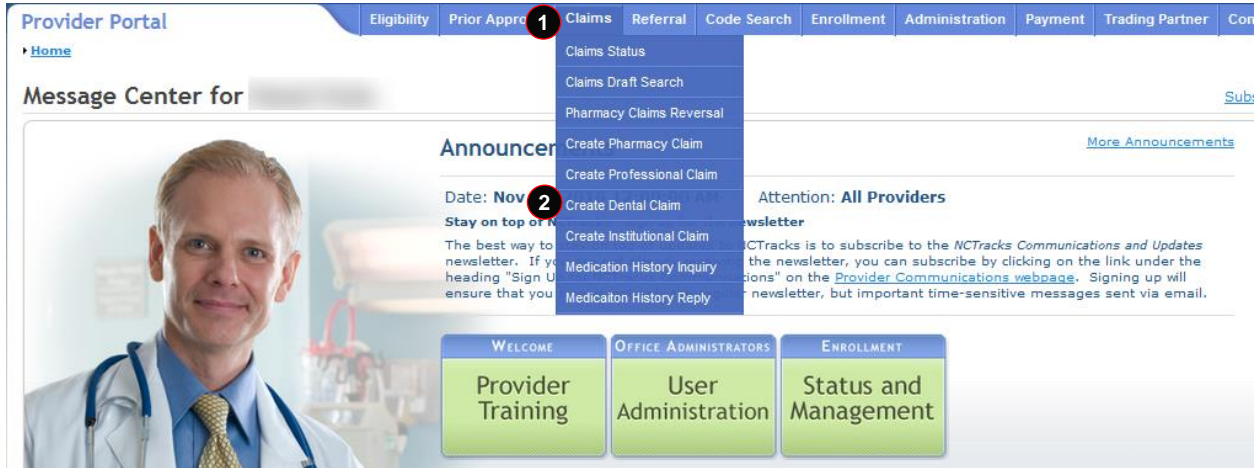
**Exhibit 9-3. Creating a Dental Claim**

| Step | Action |
|------|--------|
| 1 | Hover over the **Claims** menu. |
| 2 | Select **Create Dental Claim**. |

## 9.1.5 Creating a Pharmacy Claim in NCTracks

**Note**: These instructions are available in the most up-to-date form in SkillPort under the title *CLM 231 Submitting a Pharmacy Claim Participant User Guide*.
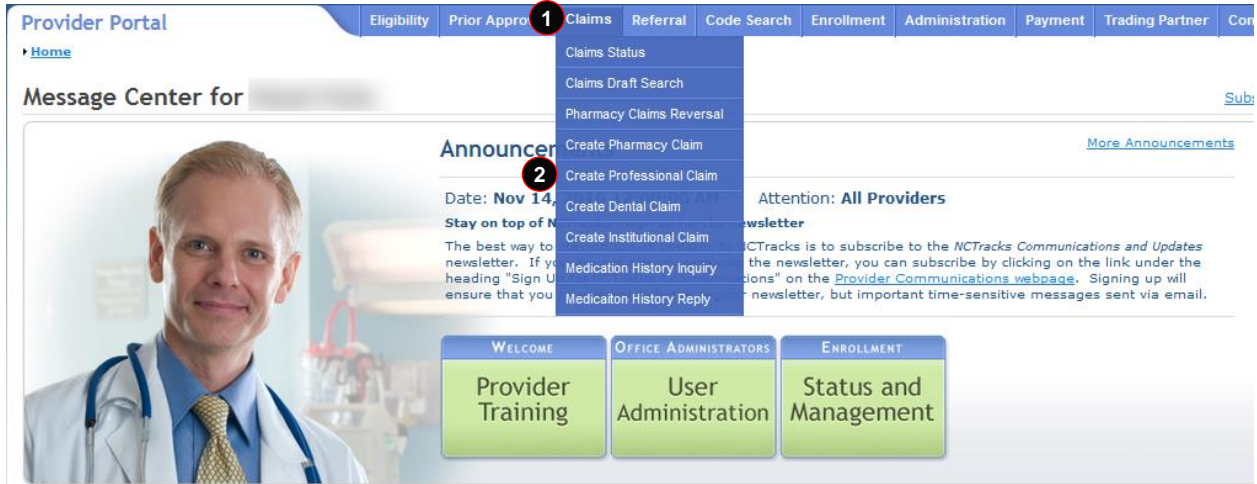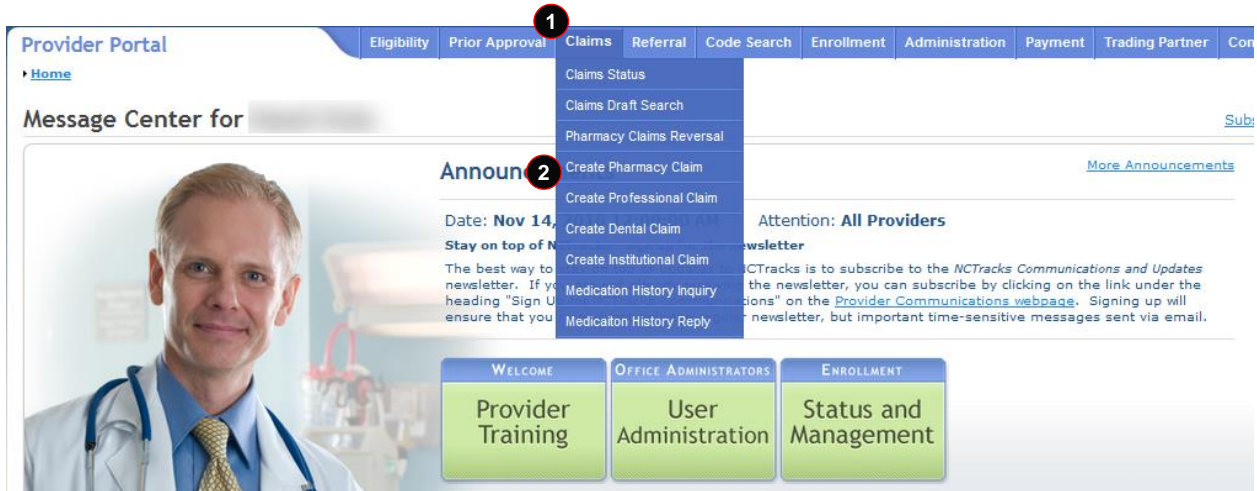


**Exhibit 9-4. Creating a Pharmacy Claim**

| Step | Action |
|------|--------|
| 1 | Hover over the **Claims** menu. |
| 2 | Select **Create Pharmacy Claim. The Verify Patient** screen displays. |

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## 9.1.6 Creating a Pharmacy Claim Reversal in NCTracks

**Note**: These instructions are available in the most up-to-date form in SkillPort under the title *CLM 231 Submitting a Pharmacy Claim Participant User Guide*.

A pharmacy claim reversal is used to reverse a claim previously entered in NCTracks. To reverse a claim, the provider needs to know the claim pharmacy's NPI number and the Prescription Number, National Drug Code (NDC), and Date Dispensed.
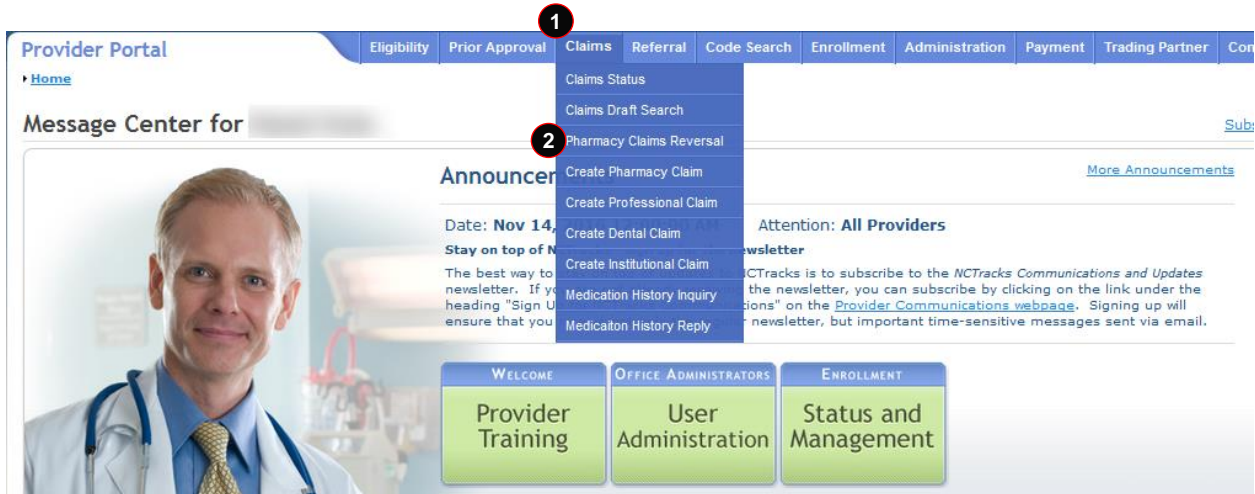
**Exhibit 9-5. Creating a Pharmacy Claim Reversal**

| Step | Action |
|------|--------|
| 1 | Hover over the **Claims** menu. |
| 2 | Select **Pharmacy Claims Reversal**. The **Create Pharmacy Reversal** screen displays. |
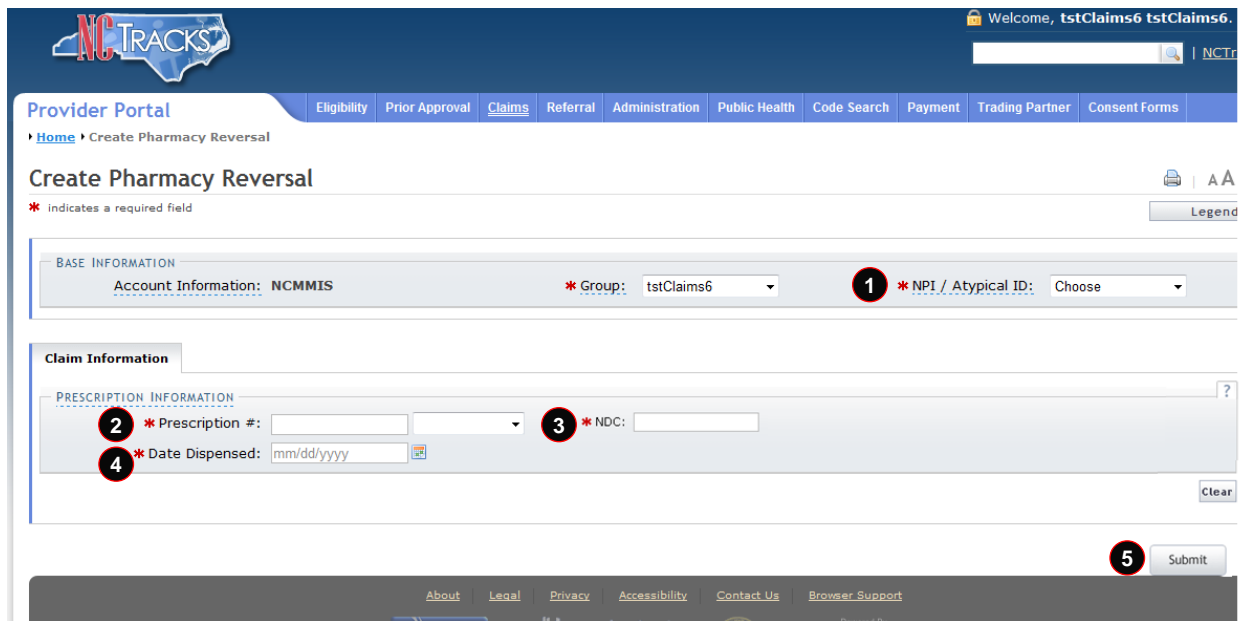
**Exhibit 9-6. Create Pharmacy Reversal Screen**

| Step | Action |
|------|--------|
| 1 | NPI/Atypical ID: Select the Pharmacy **NPI #**. |
| 2 | Prescription #: **123456789** |
| 3 | National Drug Code: **00186502082 – NEXIUM DR 20 MG CAPSULE** |
| 4 | Date Dispensed: **2/11/2021**. |
| 5 | Select the **Submit** button. |

### 9.1.7 Submitting Payments from Other Payers and Line Items

The **Other Payers** screen allows the user to enter information for third-party payers on a claim. When **Yes** is selected for the question "Would you like to add All Other Payers?", the **All Other Payers** section expands. All third-party insurance policies active for the service date and applicable to the service must be entered. The **All Other Payers** section has three required fields: **Name**, **Date Paid**, and **Paid Amount**. Other Payer Medicare and/or private insurance details should be populated at the detail line level.

If applicable, the user can add more than one payer by selecting the **Add** button. The **Clear** button clears the current entry information. To delete a payer, select the **Remove Service Line** button in the last column. **Exhibit 9-7** shows how **All Other Payer** line item and **Editing Row #1** details are added. In this example, there are no other payers assigned. Selecting **No** for the question "Would you like to add All Other Payers?" collapses the **All Other Payers** section. Selecting the **Next** button advances to the **Service(s)** screen. Please note that all fields marked with an asterisk (*) are required.



**Exhibit 9-7. Other Payers Screen**

| Step | Action |
|------|--------|
| 1 | Would you like to add All Other Payers? Select **Yes**. The **All Other Payers** section expands. |
| 2 | Other Payer Name: **Medicare** (Other Payer Medicare and/or private insurance details should be populated at the detail line level). |
| 3 | Complete **Editing Row #1**. |
| 4 | Complete all fields marked with an asterisk (*). |
| 5 | Select the **Save Other Payer** button. |

**Note**: These instructions are available in the most up-to-date form in the Participant User Guide for the corresponding claim type in SkillPort.

## 9.1.8 Transmitting Attachments and Submitting the Claim

The following instructions show how to attach documentation to the portal claim such as Admittance Summary, Certifications, Diagnosis Report, Discharge Summary, Explanation of Benefits (EOB), physician's orders, etc. (these are examples and are not applicable to all claims). The provider can enter up to nine attachments.

After selecting the Attachment Type, use Transmission Codes to represent the method of delivery: Electronic, E-mail, File Transfer, Mail, or On Request.
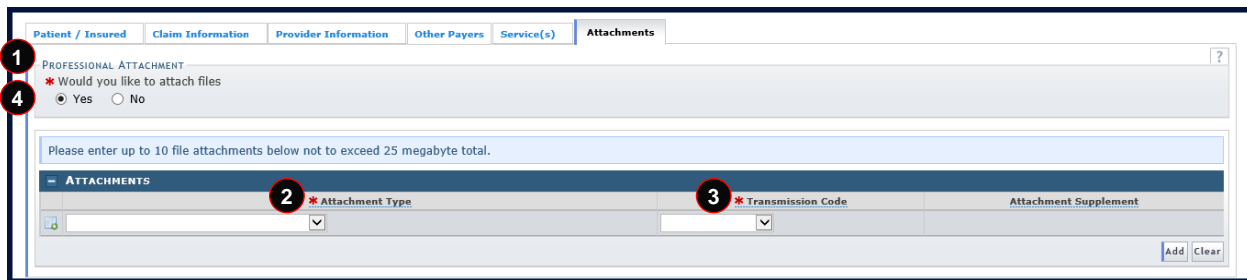


**Exhibit 9-8. Attachments Screen**

| Step | Action |
|------|--------|
| 1 | Would you like to attach files? Select **Yes**. The **Attachments** section expands. |
| 2 | Select the attachment type from the **Attachment Type** drop-down list. |
| 3 | Select the method of delivery from the **Transmission Code** drop-down list:<br>• Select **Electronic** (the preferred method) to electronically attach the documents. Selecting this option allows the provider to browse to his/her desktop for the documents and attach them.<br>• Select **Mail** to mail the documents. When this option is selected, the mailing address to be used will populate in the **Attachment Supplement** column.<br>• Select **On Req** if the provider plans to make the supplemental information available upon request. |
| 4 | Would you like to attach files? Select **No** (to collapse the **Attachments** section). |

**Note**: These instructions are available in the most up-to-date form in the Participant User Guide for the corresponding claim type in SkillPort. Refer also to the How to Add an Attachment to a Claim Job Aid.

### 9.1.8.1 Submitting the Completed Claim

The Submit option becomes available once the **Attachments** page is active. If the user selects the **Submit** button and any errors are found, an **Error Summary** dialog displays. Correct the errors and select **Submit** again to resubmit the claim.

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| Patient / Insured | Claim Information | Provider Information | Other Payers | Service(s) | **Attachments** |

PROFESSIONAL ATTACHMENT
**1** ✱ Would you like to attach files
   ○ Yes  ● No

《 Previous

**2** Submit

Save Draft  Copy  Cancel

**Exhibit 9-9. Submit Claim**

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

**Note**: These instructions are available in the most up-to-date form in the Participant User Guide for the corresponding claim type in SkillPort.

## 9.2 NC MEDICAID IMPLEMENTATION OF THE NATIONAL CORRECT CODING INITIATIVE

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

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

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

NCCI edits are updated quarterly. For more information on NCCI, refer to the DHB website at https://medicaid.ncdhhs.gov/documents/ncci-additional-information. Refer also to the *Understanding NCCI Edits Job Aid* located under the **Claims Submission** section on the NCTracks User Guides & Fact Sheets page.

Providers are reminded that:

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

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## 9.2.1 Additional Correct Coding Edits Implementation

DHB has implemented correct coding guidelines and edits nationally sourced by organizations such as CMS and the American Medical Association (AMA). These edits identify any inconsistencies with CPT, AMA, CMS, and/or DHB policies and deny the claim line.

For example, the edits ensure that:

- The appropriate procedure code is utilized based on age and gender of the patient.
- If a procedure code is submitted that requires a primary procedure code, DHB verifies that the primary procedure code has been submitted.
- Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS; for example, certain procedure codes are not permitted to be performed outside of an inpatient setting.
- Obstetric services including antepartum care, delivery, and postpartum care are billed appropriately according to CMS guidelines and DHB policy.
- The appropriate Evaluation and Management (E&M) codes are utilized for new patients and established patients.
- Certain services related to surgical procedures are included in the payment of the global surgery package; these services include E&M and related surgical procedures performed by the same physician for the same patient.
- Duplicate services are not submitted for the same provider, same patient for the same DOS.

## 9.3 TRADING PARTNER AGREEMENTS

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

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

Trading partner registration, which includes electronic signature of the TPA and generation of the Transaction Supplier Number (TSN), is an online process. Clearinghouses, service bureaus, Trading Partners, billing agents, and other entities that intend to exchange electronic transactions with NCTracks must sign the TPA and be enrolled into NCTracks. Providers who are not enrolled in NCTracks cannot enroll as Trading Partners until they have been registered and credentialed with NCTracks. Visit https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html for more information.

The NCTracks website contains links to all forms and related information for enrollment as a Trading Partner. Refer to https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html for additional information and a variety of useful quick links such as Frequently Asked Questions (FAQs), enrollment instructions, and NCTracks HIPAA Companion Guides.

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Note that all entities should obtain an NCID before enrolling into NCTracks.

NCID Registration: https://ncid.nc.gov. Contact information and instructions for enrolling as a NCTracks Trading Partner, obtaining technical assistance, initiating and maintaining connectivity, sending and receiving files, testing, and other related information is listed below.

**NCTracks Support Services Contact Information**
Phone: 1-800-688-6696
E-mail: NCTracksprovider@nctracks.com
Website: https://www.nctracks.nc.gov/content/public/providers.html

**EDI Technical Assistance**
Phone: 1-800-688-6696
E-mail: NCMMIS_EDI_Support@csra.com
Website: http://www.nctracks.nc.gov/provider/index.html
Companion Guides: https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html

**Provider/Trading Partner Enrollment**
Phone: 1-800-688-6696
E-mail: NCTracksprovider@nctracks.com
https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html

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

## 9.4 BILLING WITH SOFTWARE OBTAINED FROM A CONTRACTOR

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

After verifying that the contractor has tested their software with NCTracks, the provider must complete a TPA located on the DHB website at https://medicaid.ncdhhs.gov/medicaid/your-rights. Once the TPA is processed, providers may begin billing immediately.

## 9.5 BILLING WITH SOFTWARE WRITTEN BY PROVIDER'S OFFICE OR COMPANY

Facilities and providers may develop their own software for electronic claims filing. This software must comply with the electronic standards as adopted under HIPAA. HIPAA Transaction Implementation Guides may be obtained from Washington Publishing Company at www.wpc-edi.com. In addition, NC Medicaid Companion Guides, designed for use in conjunction with HIPAA Transaction Implementation Guides, may be found at https://www.nctracks.nc.gov/content/public/providers/provider-trading-partners.html.

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# 10. Claim Forms and Resolution

North Carolina Medicaid requires providers to submit claims electronically, either as a batch X12 837 transaction or through the NCTracks Provider Portal. Electronic submission allows claims to be processed more efficiently and accurately, and allows instant status tracking in real time.

## 10.1 PHARMACY CLAIMS

All pharmacy claims may be submitted electronically including DPH pharmacy claims. Providers may also submit pharmacy claims directly to NCTracks via the Provider Portal if preferred, although POS transmissions are the most efficient method for pharmacy claim submissions.

## 10.2 PROCESSING CLAIMS WITHOUT A SIGNATURE

Providers who file claims electronically are **not** required to provide a signature. Provider signatures are required only if there is no signature on file on their provider record for the paper claim forms.

Forms that must be signed must contain the provider's original signature; stamped signatures are not accepted. Providers are encouraged to review the current Clinical Coverage Policy that applies to them for other specific requirements.

## 10.3 TIME LIMIT OVERRIDES

Since DHB and NCTracks must follow all federal regulations to override the billing time limit, requests for time limit overrides must document that the original was submitted within the initial 365-day time period. Providers should submit time limit override requests electronically for efficient processing. Examples of acceptable documentation for time limit overrides include:

- Dated correspondence from DHB or NCTracks about the specific claim received that is within 365 days of the DOS.
- An explanation of Medicare benefits or other third-party insurance benefits dated within 180 days from the date of Medicare or other third-party payment or denial.
- A copy of the Remittance Statement showing that the claim is pending or denied; the denial must be for reasons other than time limit.

The billing date on the claim or a copy of an office ledger is not acceptable documentation. The date that the claim was submitted does not verify that the claim was received by NCTracks within the 365-day time limit. Providers may also submit via the batch claims process and use the EOB cover sheet as an attachment.

A delay reason code must be used and attachments must be provided when submitting an electronic timely filing override. Providers should use delay reason code 7 if they are requesting an override based on delay of processing from another payer, or delay reason code 9 if they are requesting an override based on documentation from an NCTracks Remittance Statement and a rejected/denied claim.

Providers must also keep the claim timely (active) within 18 months of the last denied claim (unless the last claim denied for time limit, in which case it cannot be overridden), or within 180 days of receiving an EOB from Medicare or another payer.

For instructions for submitting time limit overrides, refer to the Job Aid "How to Submit Claim Adjustments and Time Limit and Medicare Overrides," located under the **Claims Submission** section on the NCTracks User Guides & Fact Sheets page.

If the claim is a crossover from Medicare or any other third-party commercial insurance, regardless of the DOS on the claim, the provider has 180 days from the EOB date listed on the EOB 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.

# 11. Claim Details and Options Post-Submittal

## 11.1 TRANSACTION CONTROL NUMBER (TCN)

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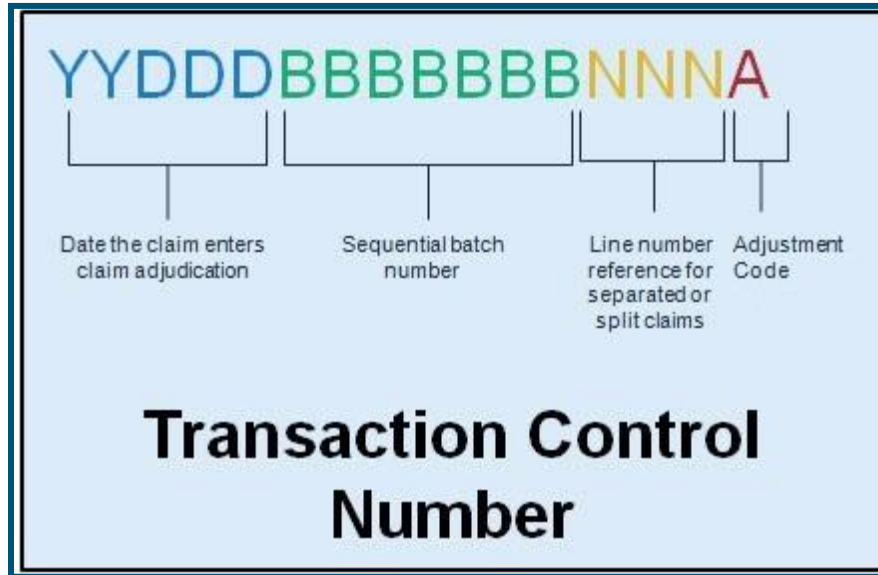


**Exhibit 11-1. Transaction Control Number**

## 11.2 CLAIM ADJUSTMENTS

Adjustment of claims (void or replacement) should be submitted electronically through an X12 837 transaction or through the NCTracks Provider Portal. Attachments can be sent through the claims attachment process or uploaded to the Provider Portal.

Other scenarios where an adjustment may be automatically initiated by the system include retro-eligibility for Medicaid. Mass Adjustments support the Fiscal Agent's (FA's) ability to perform adjustments on a mass selection of claims, e.g., a rate change to a procedure that is applied retroactively. The claim criteria are entered in the adjustment request where the claims are selected and set up for adjustment processing. The mass adjustments workflow supports batch processing of adjustment requests or real-time processing to accommodate situations where the FA must perform a provider-initiated adjustment on behalf of the provider.

## 11.3 CLAIM STATUS AND CLAIM COPY

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

The **Claim Status Request** screen is used to search for the status of a claim. To display this screen, select the **Claims Status** option from the **Claims** menu in the NCTracks Provider Portal. The **Claim Status Request** screen has three sections: **Base Information**, **Claim Search**, and **Claims (Results)**. The required fields are **Dates of Service** (From and To) and **Recipient ID**. Use more search fields to return a quicker and more accurate response. All required fields are denoted by a red asterisk (*).

**Note**: These instructions are available in the most up-to-date form in SkillPort.
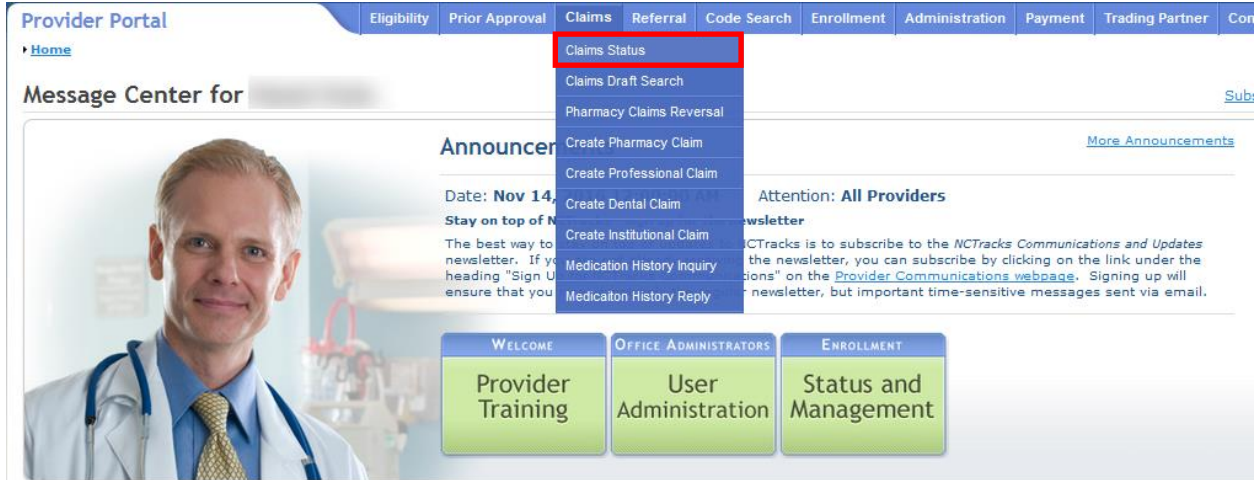


**Exhibit 11-2. Claims Status Menu Option**
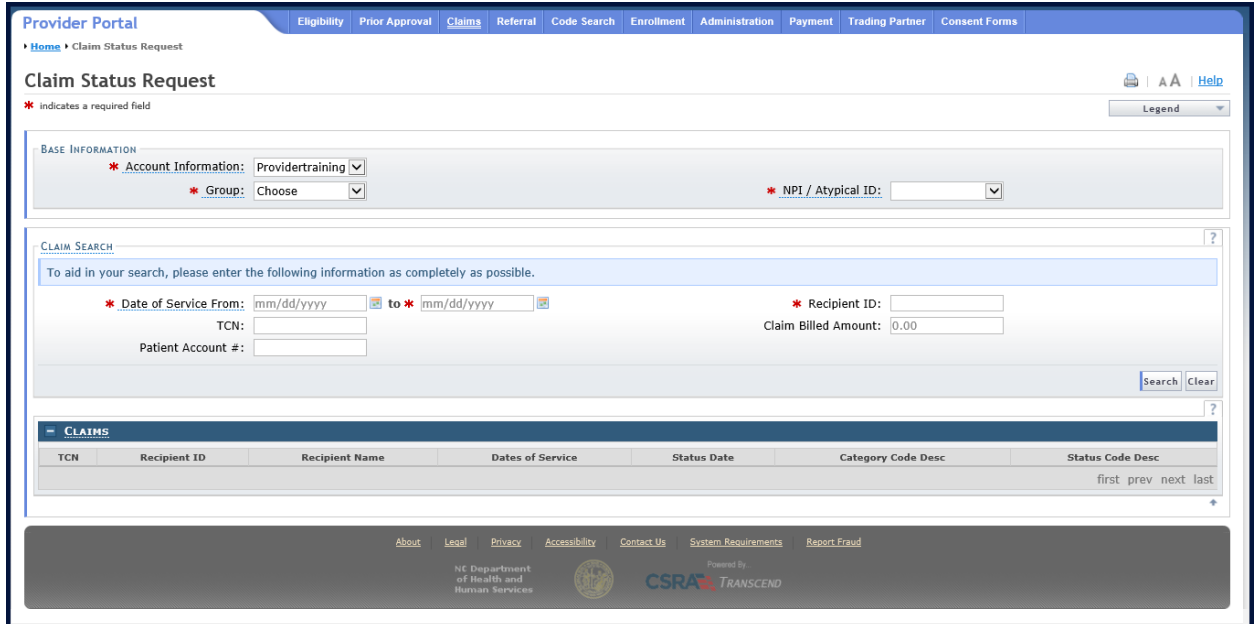


**Exhibit 11-3. Claim Status Request Screen**

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**Exhibit 11-4. Claim Status Request Result**

## 11.4 RESUBMITTING A CLAIM THROUGH THE PROVIDER PORTAL

The claim resubmission process starts with the provider searching for the original claim that was previously adjudicated. If the original claim resulted in a denial, the provider can submit a new claim using the original claim. A denied claim cannot be used to submit an adjustment. Only paid original claims are eligible for adjustments.

The provider has the option to enter a claim completely from scratch, with the adjustment indicators noted in the Claim Frequency Type Code and Original Claim Reference Number.

**Exhibit 11-5. Claims Draft Search Screen**

### 11.4.1 Claim Information Tab on Create Claim Screen

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

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**Exhibit 11-6. Claim Information Tab**

## 11.4.2 Attachments Tab on Create Claim Screen

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



**Exhibit 11-7. Create Professional Claim Screen Attachments**

After selecting Yes, the attachment type is selected in the drop-down list under the heading Attachments. The submitter will add the attachments and submit the claim for electronic processing.

## 11.5 HEALTH CHECK CLAIM DETAILS

Health Check claim details are reported on the Professional Claims Layout section of the Remittance Statement. Procedure Code, Description, Total Units, Total Billed, Total Allowed, Paid amounts, and EOB code are reported in the Professional Claim section of the Remittance Statement.

There is a separate Remittance Statement section for Health Check fees, which includes:

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

For changes and updates to coverage criteria, billing information, and other program requirements, refer to the NC Medicaid general and special bulletins links under **Quick Links** in NCTracks.

https://www.nctracks.nc.gov/content/public/providers/provider-communications.html

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# 12. Resolving Denied Claims

EOBs are codes used by Medicaid to explain how a claim processed and sometimes provide action that needs to be taken to correct a claim. They are found on the Remittance Statement. The following are commonly received EOBs, their descriptions, and suggested resolutions. Although the suggested resolutions are for common denial cases, each claim may present a unique processing scenario. For further information or claim research, contact NCTracks for claim-specific analysis.

| Edit | EOB | EOB Description | Possible Resolution |
|------|-----|-----------------|---------------------|
| 00259 | 00094 | An insurance primary to Medicaid is suspected. Please resubmit with primary insurance information documented on the Medicaid claim. | Bill charges to primary insurance prior to billing Medicaid. |
| 00358 | 05203 | Service represented by this procedure code/modifier combination is not covered as billed. | This is a non-covered service as billed; please review combination of procedure code and modifier. |
| 00431 | 02310 | Procedure code is not covered or not on file for dates of service. | This is a non-covered procedure on the date of service. |
| 00433 | 02312 | Revenue code is not covered for dates of service. | This is non-covered on the date of service. |
| 00701 | 04701 | Missing billing taxonomy code. | No taxonomy submitted for the billing provider. |
| 01100 | 01723 | Drug not on PDL. Pharmacy PA required. | Obtain PA when billing for this drug. |
| 01162 | 07062 | Dispense brand name drug. Generic drug is non-preferred. | Dispense brand name drug. |
| 01760 | 01760 | Claim indicates Medicare is prior payer but no Medicare allowable amount is indicated for this detail. | Please include Medicare payment information on claim. |
| 02601 | 02601 | Procedure not covered under the Family Planning Waiver. | This is a non-covered service for waiver program. |
| 04531 | 04531 | Billing provider taxonomy is invalid for service location. | Correct the taxonomy code and resubmit the claim if necessary. |
| 07011 | 03102 | The taxonomy code for the billing provider is missing or invalid. | Provider submitting taxonomy code not appropriate for claim being billed. |
| 07012 | 03100 | The taxonomy code for the rendering provider is missing or invalid. | Correct or add the taxonomy code and resubmit the claim if necessary. |
| 07013 | 03101 | The taxonomy code for the attending provider is missing or invalid. | Correct or add the taxonomy code and resubmit the claim if necessary. |
| 08599 | 08599 | The benefit plan is not matching provider or beneficiary eligibility or the service covered. | Verify the provider is appropriate for the recipient's benefit plan and resubmit the claim if necessary. |
| 09932 | 00905 | Drug not covered under rebate agreement. | Submit a drug covered under a rebate agreement. |
| 09933 | 00009 | Service not covered by the Medicaid program; pharmacy: see non-covered items under scope of services in manual. | Submit a drug covered by the beneficiary's benefit plan. |
| 13630 | 00498 | Exact duplicate-same provider/procedure/billed amount/date of service, dental. | This claim was duplicate of prior claim. Informational. |
| 34410 | 05400 | Exact duplicate-same Rend Prov/PCode/Internal Modifier/DOS/Mod/Bill Amt/different TCN. | This claim was duplicate of prior claim. Informational. |

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| Edit | EOB | EOB Description | Possible Resolution |
|------|-----|-----------------|---------------------|
| 49560 | 02492 | Drug dispensed is a therapeutic duplication of prior claim. | Submit an appropriate DUR response. |
| 49570 | 02493 | Drug dispensed is an early refill (overuse alert). | Submit an appropriate DUR response or resubmit when the refill is no longer early. |

## 12.1 CCI/MUE DENIALS

EOBs have been created to indicate a claim that was denied for a CCI/MUE or other National Correct Coding Initiative (NCCI) edit. Providers have the ability to view the denials via the North Carolina Electronic Claims Submission (NCECS) Web Tool, which provides a detailed explanation of why an edit was invoked and the supporting industry (CMS, AMA, etc.) standards justifying the denial.

Providers must determine if the denied claim can be resubmitted to Medicaid for reconsideration by accessing the following link from the CMS website: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html.

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

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

If the NCCI edit responsible for a CCI denial has a modifier indicator of '0', the claim cannot be corrected and resubmitted as a new day claim. Refer to Section 12.1.2, Appealing a CCI/MUE Denial for additional information.

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

### 12.1.1 MUE Denials

Providers must determine the allowed units of service by viewing the appropriate MUE table from the CMS website at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

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

### 12.1.2 Appealing a CCI/MUE Denial

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

DHHS Hearing Office
2501 Mail Service Center
Raleigh, North Carolina, 27699-2501

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[OR SUBMIT VIA FACSIMILE AT 919-882-1179]**Requesting a reconsideration of a CCI/MUE denial is not equivalent to the adjustment process.**

## 12.2 PROVIDER CLAIMS REVIEW PROCESS

Providers are encouraged to exhaust all claim corrective measures before requesting an appeal. After all other avenues have been pursued, if necessary, providers may initiate an appeal. The purpose of the regulations contained in 10A NCAC 22J .0101-.0104 is to specify the rights of providers to appeal reimbursement rates, payment denials, disallowances, payment adjustments and cost settlement disallowances and adjustments.

- The process to appeal a claim denial is summarized below. Please note that provider appeals for actions taken by program integrity and appeals about reimbursement rates, disallowances, cost settlement disallowances, and adjustments are excluded from the process below. These actions should be appealed to the DHHS Hearing Office or the DHB Finance Management Section as instructed in the appeal letter. A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement and adjustments and within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances, and payment adjustment means that all administrative actions necessary to have a claim paid correctly have been taken by the provider and DHB or the fiscal agent has issued a final adjudication.

- The Remittance Advice (RA) serves as notice of appeal rights. If no request is received within the respective 30- or 60-day periods, the State agency's action shall become final.

- A request for reconsideration review must be in writing, signed by the provider, and contain the provider's name, address, provider number, and telephone number. The request must state the specific dissatisfaction with the DHB action and explain all efforts made to have the claim(s) pay. Additionally, the redacted Remittance Statement showing the claim denial, medical records, and any other information the provider wishes to submit to support medical necessity for the service or that the claim denied incorrectly should be submitted with the provider claims denial reconsideration review request.

- Reconsideration review requests should be mailed to DHHS HEARING OFFICE at the DHB address (listed in Section 12.1.2).

- Following the review, DHB shall render a decision in writing and send it by certified mail to the provider. The decision shall be made within 30 calendar days or such additional time thereafter as specified in writing during the 30-day period.

- If the provider disagrees with the reconsideration review decision, he may request a contested case hearing at the Office of Administrative Hearings in accordance with G.S. § 150B-23.

- Once a final overpayment or final erroneous payment is determined to exist by DHB, action is taken immediately to recover such overpayment or erroneous payment. If the provider's appeal is successful, repayment is made to the provider.

## 12.2.1 Provider Claims Review Process/Reconsideration Review Requests

Providers can request a departmental claims review if an adjustment has been processed and denied. The department will consider the request and determine if the claim denied incorrectly or if the provider can make corrections or present additional information. If the department determines the claim was denied correctly, a final notification denial letter will be issued which will include appeal rights to the provider denial reconsideration review process.

Providers may submit a letter requesting review of claims denied to DHB via Fax at the following number:

984-204-6792

This is the preferred method of submission.

If that option is not available, providers may submit the letter to the following address:

Division of Health Benefits
Due Process / Appeals Unit
2501 Mail Service Center Raleigh, NC 27699-2501

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# 13. Remittance Statement

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

Providers have access to electronic views of their Remittance Statements via the NCTracks Secure Provider Portal. Providers are also able to inquire online regarding payment status from multiple payers (DHB, DMH/DD/SAS, and DPH).

NCTracks produces Remittance Statements in two formats: (1) PDF version of the paper layouts; or (2) electronic Remittance Statements using the HIPAA approved EDI 835 transaction set. Providers can select their preferred Remittance Statement notification method.

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

NCTracks gives the provider access to the Remittance Statements via the following:

- Provider message screen
- E-mail notification
- Report2Web
- Paper form

Remittance Statement notifications are posted to the Provider Portal Message Center Inbox. The provider can select a hyperlink to open an electronic version of the printed Remittance Statement.

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

**Note**: These instructions are available in the most up-to-date form in SkillPort under the title *PRV574 Using the Provider Message Center*.

Inbox

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

**Exhibit 13-1. Provider Message Center Inbox**

## 13.1 REMITTANCE STATEMENT SECTIONS AND SUBSECTIONS

The Remittance Statement is composed of information identified by subject headings. Each major subject heading is further divided into subsections depending on provider type or claim type. All Remittance Statements have the same basic data flow and layout. The Remittance Statements are sorted by the following criteria:

- Claim type
  - Professional
  - Dental
  - Institutional
  - Pharmacy
- Claim status
- Claim document type (encounter and FFS claims)
- Recipient Last Name and First Name

Summary totals are reported at the end of:

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

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

### 13.1.1 Remittance Statement Layouts

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

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

The Dental Remittance Statement contains the remittance layout for Dental claims.

The Pharmacy Remittance Statement contains the remittance layout for Pharmacy claims.

## 13.1.2 Paper Remittance Layout
The following layouts are used to display the claim and financial transaction information (based on the claim type) on paper remittances:

- Provider Notification
- Provider Summout
- Payment Header
- Professional Remittance
- Dental Remittance
- Institutional Remittance
- Pharmacy Remittance
- Financial Transactions Remittance
- Accounts Receivable Remittance
- Management Fees Remittance

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

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

- Recipient Name
- Recipient ID
- Original TCN
- Transaction Control Number
- Dates Of Service
- Claim Service Begin and End Date
- Days/Units
- Quantity or Units Submitted
- Total Billed
- Claim Charge Amount
- Non Allowed
- Tot Allowed
- PYBLE Cutback charge
- Other Charges
- Paid Amount

- Claim Reimbursement Amount
- HIC (Medicare Health Insurance Claim number)
- Patient Account Number and Medical Record Number

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

## 13.1.4 Denied Original Claims Page

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

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

The next section designates the following:

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

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NCTRACKS
REMITTANCE STATEMENT

PROCESS DATE:
PROCESS TIME: 03:03:43:00
PAGE:          3
CHECKWRITE DATE:
DENTAL
PROV ID:
REMITTANCE NO:

DENTAL         DENIED ORIGINAL    CLAIMS

| RECIPIENT NAME | TCN | DATES OF | DAYS/UNITS | NON ALLOWED | PYBLE CUTBACK | TPL AMT | PAID |
| RECIPIENT ID | ORIGINAL TCN | SERVICE | TOTAL BILLED | TOT ALLOWED | PYBLE CHARGES | OTHER CHARGES | AMOUNT |
| | | | 0.000 | 709.00 | 0.00 | 0.00 | 0.00 |
| | | | 709.00 | 0.00 | 0.00 | 0.00 | |

MEDICARE ID :          PATIENT ACCOUNT NUMBER :              MEDICAL RECORD NUMBER :
DED :         0.00  PAT LIAB :         0.00  COPAY :          0.00
EOB :
INTERNAL EDIT :
REMARK CODE : N255
ADJUSTMENT REASON CODE : 16

**Exhibit 13-2. Denied Original Claims Page of Remittance Statement**

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

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

- Top left: provider name and address
- Center: NC DHHS and Remittance Statement
- Top right: process date and time, page number, Checkwrite date, remittance type, provider ID, and remittance number

## 13.1.5 Summout Page

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

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



**Exhibit 13-3. Summout Page of Remittance Statement**

## 13.1.6 Payment Header Page

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

If there is a payment, a Payment Header page is generated instead of the Summout page. This Remittance Statement contains only a Denied Original Claim. A Summout is not generated for providers receiving electronic remittances. Providers receiving paper remittances always receive a Summout, EFT header, or paper check along with their remittance.

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


                    NC

                                        PAYMENT HEADER


PAYER :    1   PAYER NAME: DMA              PAYMENT NUMBER : 000000000000     PAYMENT AMOUNT :      $1,673.40

TOTAL ASSOCIATED AMOUNT :      $1,673.40
```

**Exhibit 13-4. Payment Header Page of Remittance Statement**

## 13.1.7 Summary Page

The Summary page Remittance lists the following information:

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

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

                                        SUMMARY PAGE

PROVIDER :            TOTALS

              TOTAL PAID ORIGINAL           1,673.40        NUMBER OF CLAIMS      5
              TOTAL PAID ADJUSTMENTS             .00        NUMBER OF CLAIMS      0
              TOTAL PAID VOIDS                   .00        NUMBER OF CLAIMS      0
              NET TOTAL PAID              1,673.40          NUMBER OF CLAIMS      5

              TOTAL DENIED ORIGINAL            .00          NUMBER OF CLAIMS      0
              TOTAL DENIED ADJUSTMENTS         .00          NUMBER OF CLAIMS      0
              NET TOTAL DENIED                 .00          NUMBER OF CLAIMS      0

              NET TOTAL PENDED                 .00          NUMBER OF CLAIMS      0

TOTALS BY BENEFIT PLAN
                  BENEFIT            BENEFIT              CURRENT          YTD
                  PLAN               GROUPING             PAID            PAID
                  NUMBER             DESCRIPTION          AMOUNT          AMOUNT

                                     MEDICAID             1,673.40        1,673.40
```

**Exhibit 13-5. Summary Page of Remittance Statement**

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# 14. Provider Training

## 14.1 PROVIDER TRAINING AND WORKSHOP ENROLLMENT

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

NCTracks provider CBT courses can be taken at any time and provide important information about how to use the NCTracks system. There are also recorded webinars, participant guides, and job aids that can be downloaded for future reference, using SkillPort, the NCTracks LMS.

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

## 14.2 SKILLPORT

SkillPort is the LMS for NCTracks. Providers can use SkillPort to register for ILT courses, whether they plan to attend in person or remotely (via webinar). SkillPort is also used to access eLearning (CBT) courses. Providers can access SkillPort from within the NCTracks Provider Portal.

### 14.2.1 How to Access and Register for Training in SkillPort

NCTracks provider training is accessed through the Secure Provider Portal, which requires an NCID. Users who already have an NCID can select the NCTracks Training Login button to access the secure NCTracks Provider Portal. Users who need an NCID can select the button for NCID Self Service or navigate to the NCID website at https://ncid.nc.gov and register.

**Note**: User NCIDs must be provisioned to access SkillPort. If you are unsure whether your NCID is provisioned for training, please contact your OA.

Once provisioned to access SkillPort, the user may navigate there and register for courses. The following training types are available:

- **CBTs (Computer-Based Training):** Computerized courses the provider can go through at any time to learn about a specific subject.
- **ILTs (Instructor-Led Training):** Live courses led by training instructors. Courses may be on-site or remote via WebEx (live web conference where the provider shares their screen), and the form of the course is specified by folder in SkillPort. *Please note that these courses are not listed in the chart below, as they are offered at specific times and should be registered for in SkillPort.
- **PUGs (Participant User Guides):** PUGs are Participant User Guides that provide guidance on how to use a system as a whole, often with steps for that system or program overall. They help the reader gain understanding and comprehend basic use of a complex system. (Example: a PUG about how to file a claim)
- **JAs (Job Aids):** Job Aids are read-through, task-specific instructions. They walk the user through an action step-by-step to complete a task. They are excellent references if the user is not able to attend a class. (Example: How to Add or Change a Billing Agent and Other Claim Submission Options in NCTracks)

PUGs, Job Aids, reference documents, and CBT modules can be used at any time. ILT modules are live trainings and therefore only available when announced. Occasionally, a PowerPoint slide deck from an ILT is uploaded if available, but the course information is usually only available at the time and date the live class is held.

**Note**: Based on the seating availability at each training venue, it is mandatory that users register for each session that they plan on attending. If more than one person from a provider's office or association plans on attending, they must register separately under their own NCIDs.

A list of courses available is provided in Appendix C. However, for the most up-to-date content, please check SkillPort.

For more information on how to register for training and what classes to take, please see the following user guides on the NCTracks Provider Training page:

- How to Register for Training in SkillPort
- How to Access Online Training Sessions
- NCTracks Provider Training – What Courses Should I Take?

**Top recommended provider resources in SkillPort include:**

| CRN | Course Title |
| --- | --- |
| CLM 281PUG | Submitting a Professional Claim |
| CLM 323 | Adding an Attachment to a Claim |
| PA 341PUG | Prior Approval Medical |
| PRV 111PUG | Provider Web Portal Applications Participant Guide |
| PRV 551JA | Change Office Administrator Application Process |
| PRV 573 | Re-credentialing |
| PRV 589 | Fingerprinting Application Required Process |
| PRV 591 | Provider Permission Matrix Instructions |
| PRV 596 | OPR Provider Enrollment |
| PRV 671 | How to Complete the Re-Credentialing – Re-verifications |
| RCP 181PUG | Recipient Eligibility Verification |

# Appendix A. Resources

Please visit https://www.nctracks.nc.gov/content/public/providers.html and look under **Quick Links** on the right to find the following:

- Up-to-date contact information for NCTracks (NCTracks Contact Information document)
- Checkwrite schedules
- AVRS Features Job Aid
- NCTracks Issues List

**NCTracks acronyms:** https://www.nctracks.nc.gov/content/public/providers/faq-main-page/nctracks-glossary-of-terms.html

**NCTracks Regional Provider Relations Representatives**

NCTracks has Regional Provider Relations Representatives, serving all regions of the state of North Carolina. Provider Relations Representatives can assist with reoccurring problems with claims, enrollment, PA, issue resolution, and more. They offer individualized, one-on-one support via web meetings or phone calls. Provider site visits, web meetings, or calls can also be requested online using the NCTracks Provider Portal. Select the "Contact Us" link found at the bottom of every webpage, complete the form, select the Subject "Request a Site Visit" from the drop-down list, and select **Send**. A Provider Relations Representative will be in contact to schedule a site visit or call.

**Note**: During the COVID-19 pandemic, all site visits are suspended for the health and protection of NCTracks personnel and providers. Updates on resumption of site visits will be provided as available via announcements on the NCTracks Providers page.

**Community Care of North Carolina/Carolina ACCESS Provider Information**

To find your local Community Care coordinator by county, please e-mail CCNCSupport@communitycarenc.org or call 1-877-566-0943.

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

| Department Name | Contact Information | Reason for Referral |
|---|---|---|
| DHHS Customer Service Center | Phone: 1-800-662-7030 | An information and referral line to help citizens receive information and referral on human service agencies in government, nonprofit agencies, and support groups. |
| Clinical Policy (DHB) | https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies<br>Phone: 919-855-4260<br>Fax: 919-733-2796 | Caller is a provider seeking information on number of beneficiaries they can service (policy service limitations, reimbursement rates, etc.). |
| Clinical Policy (DMH/DD/SAS) | https://www.ncdhhs.gov/divisions/mhddsas<br>Phone: 984-236-5300 / 855-262-1946<br>E-mail: dmh.advocacy@dhhs.nc.gov | |
| County Department of Social Services (DSS) | https://www.ncdhhs.gov/divisions/social-services/local-dss-directory | Caller is a Medicaid beneficiary seeking the name of their case worker. Use the hyperlink to look up the caller's county and provide the correct number. |
| Division of Health Service Regulation (DHSR) | https://info.ncdhhs.gov/dhsr/<br><br>Acute and Home Care Licensure and Certification:<br>Phone: 919-855-4620<br>https://info.ncdhhs.gov/dhsr/ahc/index.html<br><br>Adult Care Licensure:<br>Phone: 919-855-3765<br>https://info.ncdhhs.gov/dhsr/acls/index.html<br><br>Mental Health Licensure and Certification:<br>Phone: 919-855-3795<br>https://info.ncdhhs.gov/dhsr/mhlcs/mhpage.html<br><br>Nursing Home Licensure and Certification:<br>Phone: 919-855-4520<br>https://info.ncdhhs.gov/dhsr/nhlcs/index.html | Caller has questions about licensure requirements for a specialty regulated by DHSR. |
| Financial Management (DHB) | NC Medicaid Fee Schedules:<br>https://medicaid.ncdhhs.gov/providers/fee-schedules<br><br>Rate Setting:<br>Phone: 919-527-7699<br>Fax: 919-831-1811 | Caller is questioning the reimbursement amount for a service.<br>**Note**: If the caller is from a hospital, they need to contact Hospital Rate Setting. |
| Financial Management (DMH/DD/SAS) | Hospital Rate Setting:<br>Phone: 919-527-7699<br>Fax: 919-831-1811<br><br>Providers that are contracted with LME/MCOs should contact the appropriate LME/MCO using the contact information provided at https://www.ncdhhs.gov/providers/lme-mco-directory. | |
| | | |

**Additional Contacts:**

| Department Name | Contact Information | Reason for Referral |
|---|---|---|
| Health Check Program | Health Check/EPSDT (DHB Clinical Policy) Phone: 919-855-4260<br><br>Health Check Coordination https://www.ncdhhs.gov/assistance/childrens-services/health-check | Obtain information about EPSDT policy and procedures for EPSDT services. |
| Hearing and Appeals | Medicaid recipients https://medicaid.ncdhhs.gov/medicaid/your-rights | Information for provider to provide if recipient is denied benefits. |
| Medicare | Phone: 1-800-Medicare (633-4227) http://www.medicare.gov/default.aspx<br><br>Office of Inspector General https://oig.hhs.gov/about-oig/contact-us/ | Provider has questions regarding an OIG sanction on his/her account. |
| Program Integrity – Reporting Fraud and Complaints | Recipients: https://medicaid.ncdhhs.gov/contact<br><br>Providers: https://medicaid.ncdhhs.gov/get-involved/report-fraud-waste-or-abuse/complaint-form<br>**Note**: All callers (providers and recipients) should be encouraged to complete this confidential online complaint form. | Provider wants to report any type of fraud, waste, or abuse, or has a complaint about Medicaid or DHB. |
| Provider Contacts | https://medicaid.ncdhhs.gov/providers/programs-services | Provider is seeking contact information for various Medicaid departments. |

## Appendix C. SkillPort Training Materials

This list is current as of February 2021. For additional courses, please navigate to SkillPort.

| CRN | Course Title | Learning Asset | Overview/Learning Objectives |
|---|---|---|---|
| CLM 171 | How to File a Pharmacy Claim | eLearning | • Submit pharmacy prescription drug claims via the NCTracks Provider Portal:<br>  − Select a claim submission method<br>  − Create a pharmacy prescription drug claim<br>  − Save a draft claim and retrieve using Claims Draft Search<br>  − Submit a claim and view results of claim submission<br>  − Submit a pharmacy claim reversal |
| CLM 181 | How to File a Professional Claim | eLearning | • Submit professional claims via the NCTracks Provider Portal:<br>  − Select a claim submission method<br>  − Create a professional claim<br>  − Save a draft claim and retrieve using Claims Draft Search<br>  − Submit a claim and view results of claim submission |
| CLM 191 | How to File a Dental Claim | eLearning | • Submit dental claims via the NCTracks Provider Portal:<br>  − Select a claim submission method<br>  − Create a dental claim<br>  − Save a draft claim and retrieve using Claims Draft Search<br>  − Submit a claim and view results of claim submission |
| CLM 201 | How to File an Institutional Claim | eLearning | • Submit institutional claims using the NCTracks Provider Portal:<br>  − Select a claim submission method<br>  − Create an institutional claim<br>  − Save a draft claim and retrieve using Claims Draft Search<br>  − Submit a claim and view results of claim submission |
| CLM 211 | How to Read Your Remittance Advice | eLearning | • Understand how to read/interpret a Remittance Statement |
| CLM 241 | Submitting an Institutional Claim | PUG | • Create an institutional claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |
| CLM 271 | Submitting an Institutional Claim | ILT | • Create an institutional claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |
| CLM 281 | Submitting a Professional Claim | ILT | • Create a professional claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |

| CRN | Course Title | Learning Asset | Overview/Learning Objectives |
|---|---|---|---|
| CLM 281PUG | Submitting a Professional Claim | PUG | • Create a professional claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |
| CLM 291 | Submitting a Dental Claim | ILT | • Create a dental claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |
| CLM 291PUG | Submitting a Dental Claim | PUG | • Create a dental claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission |
| CLM 311 | Submitting a Long Term Care Claim | eLearning | • Create an institutional LTC claim |
| CLM 321 | Submitting a Dental/Orthodontic Claim | PUG | • Create a dental/orthodontic claim via the NCTracks Provider Portal<br>• Save a draft claim<br>• Submit a dental/orthodontic claim<br>• Search for the status of a claim and copy the claim details to a new claim, allowing for the resubmission of the claim<br>• Void a previous claim<br>• Replace a previous claim |
| CLM 322 | Submitting a Professional Claim Non-Emergency Medical Transportation Providers | ILT | • Understand claims terminology<br>• Understand the PA process<br>• Create a professional claim via NCTracks<br>• Save a draft claim and retrieve using Claims Draft Search<br>• Submit a claim and view results of claim submission<br>• Search for the status of a claim and copy the claim details to a new claim, allowing for the resubmission of the claim<br>• Resubmit a claim<br>• Void prior claim or replacement prior claims<br>• Read/interpret a Remittance Statement<br>• Submit a PA inquiry |
| CLM 323 | Adding an Attachment to a Claim | JA | • Add attachments to a claim in the NCTracks Secure Provider Portal and by mail such as Admittance Summary, Medical Records, Ambulance Trip Ticket, Certifications, Diagnosis Report, Invoice, Discharge Summary, EOB, physician's orders, etc. |
| CLM 323 | Add Attachment to a Claim | JA | • Add attachments to a claim in the NCTracks Secure Provider Portal and by mail |

| CRN | Course Title | Learning Asset | Overview/Learning Objectives |
|---|---|---|---|
| CLM 402 | Submitting a Time Limit Override Request Using NCTracks | ILT | • Indicate Time Limit Override request using the Delay Reason field on a claim<br>• Understand the Delay Reason Code<br>• Attach an EOB document to a claim<br>• Submit a claim |
| GEN 100 | Helpful Hints for Dental Prior Approval and Claims Submission | ILT | • Identify the available methods of PA submission<br>• Identify how to upload documents when submitting PA via NCTracks or to existing PA<br>• Identify the most common errors when completing American Dental Association (ADA) form<br>• Identify common errors that require requests for PA additional information<br>• Identify the common mistakes when submitting claims |
| GEN 102 | ICD System Changes for Provider | eLearning | • Identify the NCTracks system changes as they relate to ICD-9 and ICD-10 in institutional, pharmacy, professional, and dental claim types<br>• Navigate through entering a PA request for ICD-10 for medical and dental PA types |
| GEN 111 | NCTracks Overview – Provider Portal (Provider) | eLearning | • Navigate to the public Provider Portal on NCTracks<br>• Navigate to the Secure Provider Portal<br>• Access messages, links to online resource, and news feeds<br>• Select the appropriate icon or drop-down menu option for commonly performed tasks |
| GEN 171 | AVRS Features | JA | • Understand available features of the NCTracks AVRS |
| GEN 181 | Contact Guide | JA | • Provides the reason for referral and contact information for each relevant department |
| GEN 201 | Provider Adjustment, Time Limit & Medicare Override | JA | • Perform adjustments on a claim document. The claims adjustment process gives providers an opportunity to request a review or correct a previously processed claim that has either paid or denied. |
| PA 261 | Prior Approval Requests and Inquiry | eLearning | • Enter a PA request<br>• Inquire on an existing PA request |
| PA 331 | Prior Approval Institutional | ILT | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs, and Managed Care Referrals and Overrides |
| PA 331PUG | Prior Approval Institutional | PUG | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs, and Managed Care Referrals and Overrides |

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| PA 105 | Pharmacy Prior Approval Inquiry | JA | • Conduct inquiries on PAs where the provider is listed as the submitting, billing, and/or rendering provider<br>• View PAs completed by MedSolutions, Carolinas Center for Medical Excellence (CCME), and other vendors in NCTracks |
| PA 341 | Prior Approval Medical | ILT | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs, and Managed Care Referrals and Overrides |
| PA 341PUG | Prior Approval Medical | PUG | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs, and Managed Care Referrals and Overrides |
| PA 351 | Prior Approval Dental | ILT | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs and Managed Care Referrals and Overrides |
| PA 351PUG | Prior Approval Dental | PUG | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs and Managed Care Referrals and Overrides |
| PA 361 | Long Term Care Prior Approval Request | eLearning | • Submit an LTC PA request using the FL2 form<br>• Inquire on a PA status |
| PA 371 | Prior Approval Dental/Orthodontic | PUG | • Submit dental PA requests<br>• Inquire about dental PA requests |
| PA 151 | Pharm PA Short Long acting Prefer/Non prefer drugs | JA | • Identify the NCTracks system changes involving PA for Short-Acting and Long-Acting Opioid Analgesics |
| PA 374 | Dental, Optical, Physician Fluoride Varnish, and Durable Medical Equipment (DME) and Orthotic and Prosthetic (O&P) Service Inquiry Training | ILT | • Submit an Eyeglass Confirmation service request<br>• Submit a Refraction Confirmation service request<br>• Submit a Dental Benefit Limitation service request<br>• Submit a Physician Fluoride Varnish Limitation service request<br>• Submit a DME/O&P Service History request |
| PA 375 | Dental, Optical, Durable Medical Equipment (DME), Physician Fluoride Varnish and Orthotic and Prosthetic (O&P) Prior Approval Service Inquiry | eLearning | • Submit an Eyeglass Confirmation service request<br>• Submit a Refraction Confirmation service request<br>• Submit a Dental Benefit Limitation service request<br>• Submit a Fluoride Varnish Limitation service request<br>• Submit a DME/O&P Service History request |
| PA 333 | Prior Approval: Private Duty Nursing | JA | • Submit PA requests for services, products, and/or procedures electronically using the PA Entry screen in the Provider Portal |
| PA 342 | Prior Approval: Hearing Aid | JA | • Submit PA requests for hearing aids |

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| PA151PUG | Prior Approvals and Managed Care Referrals & Overrides Participant User Guide | PUG | • Submit PAs and Managed Care Referrals electronically<br>• Conduct electronic inquiries about PAs and Managed Care Referrals and Overrides |
| PA372 | PA for Medicaid for Pregnant Women (MPW) Chiropractic and Podiatry Services | ILT | • Understand the changes to the process for referrals and PA for MPW chiropractic and podiatry services<br>• Enter PA requests in NCTracks<br>• Search for PA requests in NCTracks |
| PA 373 | Dental, Optical, Durable Medical Equipment (DME), Physician Fluoride Varnish and Orthotic and Prosthetic (O&P) Prior Approval Service Inquiry Provider | JA | • Submit an Eyeglass Confirmation service request<br>• Submit a Refraction Confirmation service request<br>• Submit a Dental Benefit Limitation service request<br>• Submit a Fluoride Varnish Limitation service request<br>• Submit a DME/O&P Service History request |
| PA 380 | CAP Respite Service History | JA | • Access PA entry functions<br>• CAP Respite Service History<br>• Inquiry messages<br>• Inquiry messages for Authorized/Paid Units and Procedure Code H0045 Dates |
| PA151JA | Pharmacy Provider Prior Approval Short-Acting and Long-Acting Preferred and Non-Preferred Drugs | JA | • Identify the NCTracks system changes involving PA for Short-Acting and Long-Acting Opioid Analgesics |
| PA600 | Pharm PA SC DPH | ILT | • Electronically submit and inquire about Pharmacy PA requests for DPH Sickle Cell recipients |
| CO101 | ORH COVID-19 Testing Claims Submission | JA | • Access Provider Portal in NCTracks<br>• Access Uninsured NC Residents COVID-19 Related Services Payment Request Page<br>• Create ORH COVID-19 claim<br>• Access ORH COVID-19 Claim Search Page<br>• Access ORH COVID-19 Claim Details Page |
| HIE 101 | NC Health Information Exchange (HIE) Network Status and Hardship | JA | • Understand how NCTracks allows OAs to view a provider's HIE Network status and the process to request a hardship extension |
| PRV111 | Rendering/Attending Provider Changes | JA | • Understand the NCTracks system changes regarding rendering/attending providers and CCNC/CA |
| PRV111 | Provider Web Portal Applications | PUG | • Understand the Provider Enrollment Application processes<br>• Navigate to the NCTracks Provider Portal and complete Provider Enrollment, MCR, Re-enrollment, Re-verification, and Maintain Eligibility processes<br>• Track and submit applications using the Status and Management page |

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|-----|-------------|----------------|------------------------------|
| PR145 | Enrollment Process for Behavioral Health Providers | JA | • Understand the NCTracks system changes to the Provider Enrollment Process for behavioral health providers. Effective July 1, 2017, Medicaid behavioral health providers requesting an initial enrollment through LME-MCOs must be directed to NCTracks. |
| PR402 | Four Schools Batch Enrollment Process | JA | • Upload batch enrollment files, check the status of a batch enrollment file, and complete the batch enrollment file (Four Schools: Duke University, University of North Carolina [UNC], East Carolina [ECU], and Wake Forest University) |
| PR451 | Processing DME Claims with PAs, Using Local W Codes | JA | • Correctly process claims when submitting multi-line PA requests with multiple state/local "W" codes |
| PR374 | PRV374 Submitting An Optical (Eyeglasses and Refraction) Service Inquiry | ILT | • Submit an Eyeglass Confirmation service request<br>• Submit a Refraction Confirmation service request |
| PR3741 | Submitting Dental Benefit Limitation Inquiry | ILT | • Submit a Dental Benefit Limitation service request |
| PR3742 | Submitting Physician Fluoride Varnish Service Inquiry | ILT | • Submit a Physician Fluoride Varnish Limitation service request |
| PR381PUG | Professional Claims Participant User Guide – DPH | PUG | • Create a professional claim<br>• Save a draft claim and retrieve using Claims Draft Search<br>• View results of a claim submission |
| PR551JA | Change Office Administrator Application Process | JA | • Change the OA associated with a provider's record (NPI/Atypical ID) |
| PR411 | Provider Records – Functions and Impacts | eLearning | • Discern the structure of provider records<br>• Identify the functions and impacts of provider records |
| PR461PUG | Provider User Provisioning – Participant Guide | PUG | • Establish an OA<br>• Access and navigate the User Administration section of the Secure Provider Portal<br>• Add, maintain, and delete provider groups<br>• Add, maintain, and delete users<br>• Disable, enable, and reset users' Electronic Signature PINs |
| PR481PUG | Pharmacy Prior Approval Participant User Guide | PUG | • Submit PAs electronically<br>• Upload PA attachments<br>• Submit real-time PA inquiries (adjudication status, units allowed and used, and dollars allowed and used) |
| PR501 | Office Admin Functions | eLearning | • Understand the functions of an OA<br>• Add, maintain, and delete Provider Groups<br>• Add, maintain, and delete User Administrators and General Users<br>• Understand functions of the User Administrator and the General User<br>• Reset an Electronic Signature PIN |

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| PR511 | Updating Provider Data (Provider) | eLearning | • Access and navigate through the MCR screens<br>• Add and update provider information on the MCR screens |
| PR531 | Provider Web Portal Applications | ILT | • Understand the Provider Enrollment Application processes<br>• Navigate to the NCTracks Provider Portal and complete the Provider Enrollment, MCR, Re-enrollment, Re-verification, and Maintain Eligibility applications<br>• Track and submit applications using the Status and Management page |
| PR531PUG | Provider Web Portal Applications | PUG | • Understand the Provider Enrollment Application processes<br>• Navigate to the NCTracks Provider Portal and complete the Provider Enrollment, MCR, Re-enrollment, Re-verification, and Maintain Eligibility applications<br>• Track and submit applications using the Status and Management page |
| PR560 | Create and Submit a Prior Approval for Home Health using Electronic Physician Signature | JA | • Submit PA request/electronic signature for Requesting Provider and Prescribing Provider user roles |
| PR561 | Change Office Administrator Application Process | JA | • Change the OA associated with a provider's record (NPI/Atypical ID) |
| PR564 | Assign the Enrollment Specialist User Role and Assign/Reassign Applications. | JA | • Assign the ES role to a user |
| PR565 | Upload Supporting Documents to Various Applications | JA | • Understand the process for uploading documents for a provider enrollment application (initial Enrollment, Re-enrollment, MCR, Maintain Eligibility, or Re-verification) |
| PR562 | Enrollment Specialist | PUG | • Understand the Enrollment Specialist User Role<br>• Navigate the NCTracks Provider Portal to complete a Provider Enrollment, MCR, Re-enrollment, Re-verification, or Maintain Eligibility application<br>• Assign completed applications to the OA |
| PR563 | Abbreviated Manage Change Request | PUG | • Update EFT information<br>• Add/update Affiliations<br>• Add/update Method of Claim and Electronic Transactions and/or Billing Agent<br>• Complete multiple changes or review the authorized user's complete provider record |
| PR569 | Create and Submit a Prior Approval (PA) for DME using Electronic Physician Signature | JA | • Understand the step-by-step process for the PA request/Electronic signature for Requesting Provider and Prescribing Provider user roles |
| PR573 | Re-credentialing | JA | • Understand the purpose and requirements for provider Re-credentialing<br>• Understand the steps for completing the Re-credentialing/Re-verification processes through NCTracks |
| PR574 | Provider Message Center | JA | • Access the Nursing Facility Rate and Patient Roster letters in the Provider Message Center Inbox |
| PR577 | Submitting an Ambulance Claim for Providers | JA | • Submit a professional or institutional claim (ambulance providers) |

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|---|---|---|---|
| PR575 | Provider Message Center Inbox – WebEx | ILT | • Navigate within the Provider Message Center<br>• Search for and retrieve messages |
| PR578 | Enrollment Process for Therapeutic Foster Care Providers | JA | • Complete an enrollment application within NCTracks (Therapeutic Foster Care providers) |
| PR581 | Enrolled Practitioner Search | JA | • Access and use the Enrolled Practitioner Search feature of NCTracks |
| PR579 | Submitting an Ambulance Claim for Providers – WebEx | ILT | • Create a professional or institutional claim<br>• Submit a professional or institutional claim and view results of claim submission |
| PR580 | How to Add/Update Credentials for Providers | ILT | • Add/update provider accreditation, certification, or license |
| PR582 | Provider Web Portal Applications – NEMT | ILT | • Understand the Provider Enrollment Application process for NEMT providers<br>• Navigate to the NCTracks Provider Portal and understand how to complete initial Enrollment, Re-enrollment, Re-verification, Abbreviated MCR, MCR, and Maintain Eligibility application processes |
| PR583 | County DSS NEMT – Enrollment, Payment Authorization Submission, and Prior Approval Inquiry | ILT | • Enroll as a Billing Agent to allow for the submission of Payment Authorization batches<br>• Update the Method of Claims Submission on an existing provider record to allow for the submission of Payment Authorization batches<br>• Create Payment Authorization batches<br>• Upload Payment Authorization batches<br>• Search for NEMT PAs |
| PR584 | Helpful Hints for Dental Prior Approval And Claims Submission | ILT | • Identify the available methods of PA submission<br>• Identify how to upload documents when submitting PAs via NCTracks or to existing PA<br>• Identify the most common errors when completing ADA form<br>• Identify common errors that require requests for PA additional information<br>• Identify the common mistakes when submitting claims |
| PR584_PDF | Helpful Hints for Dental Prior Approval And Claims Submission | ILT slides in a PDF format | • Identify the available methods of PA submission<br>• Identify how to upload documents when submitting PAs via NCTracks or to existing Prior Approval<br>• Identify the most common errors when completing ADA form<br>• Identify common errors that require requests for PA additional information<br>• Identify the common mistakes when submitting claims |
| PR589 | Fingerprinting Application Required Process | JA | • Understand how to complete the Fingerprinting Required application process in NCTracks |
| PR591 | Provider Permission Matrix Instructions | JA | • Understand how to use the Provider Permission Matrix spreadsheet to identify provider enrollment requirements |

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| PRV586 | Traumatic Brain Injury Waiver | ILT | • Define the Traumatic Brain Injury (TBI) Waiver<br>• Identify the TBI Benefit Plan in Recipient Eligibility<br>• Understand the TBI encounter claims received from the LMEs/MCOs |
| PR587 | Helpful Hints for Orthodontic Prior Approval Submission | ILT | • Identify the available methods of PA submission<br>• Identify how to upload documents when submitting PA requests via NCTracks and how to upload documents to existing PA requests<br>• Identify the most common errors when completing ADA form<br>• Identify common errors that require requests for PA additional information<br>• Request payment for orthodontic records<br>• Submit PA requests for orthodontic treatment requiring orthognathic surgery<br>• Use the Orthodontic PA attachment forms |
| PR593 | Hospice Rate Changes | JA | • Understand the two-tier rate calculation and End of Life Service Intensity Add-on (SIA) payments |
| PR598 | Pharmacy Prior Approval Requirements for Nucala | JA | • Submit initial PA requests and reauthorization requests for Nucala |
| PR594 | Other Payer Detail on Claim | ILT | • Submit a professional claim via the NCTracks Provider Portal and include Other Payer detail |
| PR595 | OOS Provider Enrollment | PUG | • Understand how to enroll as an OOS provider |
| PR596 | OPR Provider Enrollment | PUG | • Submit an OPR Lite Enrollment application<br>• Convert from an OPR Lite provider to an OPR Full provider with an MCR |
| PR599 | Pharmacy Prior Approval Requirements for Epinephrine Auto Injectors | JA | • Submit PA requests for Preferred and Non-Preferred Epinephrine Auto Injectors |
| PR599 | Pharm PA Requirement – Epi Injectors | JA | • Submit PA requests for Preferred and Non-Preferred Epinephrine Auto Injectors |
| FSPRV604 | Changes to Individual Provider Application Process for Four Schools | ILT | • Identify how NCTracks captures and stores work history (including work history gaps), education history, and current malpractice insurance information<br>• Understand requirements for individual enrolling providers to submit ALL board certification data, answer Exclusion Sanction questions, and sign provider agreement |
| PRV604 | Changes to Individual Provider Application Process | ILT | • Identify how NCTracks captures and stores work history (including work history gaps), education history, and current malpractice insurance information:<br>• Understand requirements for individual enrolling providers to submit ALL board certification data, answer Exclusion Sanction questions, and sign provider agreement |
| PR603 | Advanced Medical Home Tier Attestation | JA | • Complete the AMH Tier Attestation process in NCTracks |

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| PR651 | How to Add or Update Electronic Funds Transfer (EFT) Information in NCTracks | JA | • Add or update EFT information in NCTracks |
| PR661 | How to Change the Physical Address in NCTracks | JA | • Change a provider's physical address using the MCR process in NCTracks |
| PR662 | How to Change the Correspondence Address in NCTracks | JA | • Change a provider's correspondence address using the MCR process in NCTracks |
| PR671 | How to Complete the Re-Credentialing – Re-verifications | JA | • Understand the steps for completing the re-credentialing process (otherwise known as re-verification) in NCTracks |
| PR681 | How to Add or Change a Billing Agent and Other Claim Submission | JA | • Add or change a billing agent and use other claim submission options in NCTracks |
| PR691 | How to View or Update Provider Taxonomy | JA | • View and change taxonomy codes for provider profiles |
| PR701 | Unable to Enter EIN – Receive the Error Message – Enter 9 or Fewer Characters | JA | • Understand/resolve the error message 'You must enter text with 9 or fewer characters' when entering provider EIN in NCTracks |
| PR911 | Review and Implement DME Claims Processing | ILT | • Process a DME Professional claim<br>• Edit and resubmit a claim<br>• Request a Time Limit Override |
| PR911PUG | Review and Implement DME Claims Processing Participant User Guide | PUG | • Process a DME Professional claim<br>• Edit and resubmit a claim<br>• Request a Time Limit Override |
| PR912 | Provider Web Portal Applications – NEMT | PUG | • Understand the Provider Enrollment Application processes<br>• Navigate to the NCTracks Provider Portal and complete the Provider Enrollment and MCR application processes<br>• Track and submit applications using the Status and Management page |
| PR702 | Request to Back-Date Enrollment Effective Dates | JA | • Submit a request to back-date all Health Plans, service locations, taxonomy codes, and services (if applicable) to the same date<br>• Submit a request to back-date one Health Plan, service location, taxonomy code, or service (if applicable)<br>• Understand back-dating approval or denial notification |
| PR703 | Sub Disaster Relief ProEnroll App | JA | • Access the NCTracks Provider Portal to complete and submit a Disaster Relief abbreviated enrollment application |
| PR602 | Advanced Medical Home Tier Attestation | ILT | • Define AMH<br>• Understand AMH tier assignments<br>• Complete the AMH Tier Attestation process in NCTracks |
| PR711 | How to Add Billing and Rendering Provider Taxonomy Information to a Claim | JA | • Resolve the edit code 07011 INVLD BILLING PROTAXON CODE |
| PR721 | How to Indicate Other Payer Details or an Override on a Claim in NCTracks and Batch Submissions | JA | • Indicate "Other Payer" details on a professional claim in NCTracks |

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| PRV241 | Applying For and Maintaining CCNC_CA Enrollment | JA | • Enroll and maintain participation in CCNC/CA within NCTracks |
| PRV242 | Changing or Terminating CCNC_CA Enrollment | JA | • Change or terminate participation in CCNC/CA within NCTracks by completing an MCR |
| RCP 131 | Viewing Recipient Information | eLearning | • Access recipient eligibility information via the Provider Portal<br>• Review and verify recipient eligibility information on the Provider Eligibility Response screen |
| RCP 161 | Recipient Eligibility & Verification (Medical) | ILT | • Submit consent forms and access status<br>• Perform inquiries for recipient eligibility and navigate to eligibility responses<br>• Upload files for batch eligibility inquiries and navigate to response screens |
| RCP 181 | Recipient Eligibility Verification | ILT | • Submit an individual recipient eligibility inquiry<br>• Submit a batch eligibility inquiry<br>• View an eligibility response |
| RCP 181 | Recipient Eligibility Verification – Provider – WebEx | ILT | • Verify a recipient's Identity, Current eligibility, Health Plan, Benefit Plan, Service Type and Co-pay, Category of Eligibility, County Code |
| PR912 | Provider Web Portal Apps NEMT | PUG | • Understand the Provider Enrollment Application processes<br>• Navigate to the NCTracks Provider Portal and complete the Provider Enrollment and MCR provider application processes<br>• Track and submit applications using the Status and Management page |
| RCP 281 | Recipient Eligibility Verification Participant User Guide (DPH Providers) | PUG | • Submit an individual recipient eligibility inquiry<br>• Submit a batch eligibility inquiry<br>• View an eligibility response |
| RCP 301 | PHP Eligibility/Enrollment for Providers | JA | • Review the Managed Care (MC) plan information for a beneficiary |
| RFR 171 | Pharmacy Coverage Inquiry | eLearning | • Verify whether a drug/product is covered, by NC DHHS Payer, Benefit Plan, or DOS (pharmacy providers) |
| RFR 181 | Pharmacy Drug Type Forms | JA | • Understand changes in the NC Medicaid Preferred Drug List (PDL) including:<br>  – Addition of PA drug type forms for Juxtapid, Crinone, Off Label Antipsychotic Safety Monitoring in Children through Age 17 (AKIDS), and Adult Safety with Antipsychotic Prescribing (ASAP)<br>  – Removal of stand-alone drug type forms for Lyrica, Lamictal, and Topamax<br>• Access and accurately complete the Juxtapid, Crinone, AKIDS, and ASAP drug type forms<br>• Access the Non-Preferred drug type form |

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| RFR 182 | Discontinued Drug Class Forms | JA | • Understand changes in the NC Medicaid PDL including:<br>  – Discontinuation of the AKIDS and ASAP drug class paper forms<br>  – Rejection/return of AKIDS and ASAP records submitted from Infina as errors |
| RFR 183 | A+KIDS Drug Type Forms | JA | • Understand changes in the NC Medicaid PA criteria including discontinuation of the A+KIDS) drug class paper forms<br>• Access A+KIDS drug type forms via the NCTracks Secure Provider Portal<br>• Submit A+KIDS PA requests via the NCTracks Secure Provider Portal |
| RFR 184 | ASAP Drug Type Forms | JA | • Access ASAP drug type forms via the NCTracks Secure Provider Portal |
| RFR 185 | Hepatitis C Agents Pharmacy Prior Approval (PA) Request | JA | • Access the NCTracks Secure Provider Portal to submit Hepatitis C Agents Pharmacy PA requests for Sovaldi, Olysio, Harvoni, and Viekira Pak |
| RFR187 | PA Criteria for Relistor and Gattex Drug Class | JA | • Identify the PA criteria for the drug class for the Selective Constipation Agents (SCAs) Peripherally Acting drug Relistor for initial coverage and reauthorization and the PA criteria for Gattex for initial coverage and reauthorization |
| PR3743 | Submitting Durable Medical Equipment (DME)/Orthotic and Prosthetic Service History Inquiry | ILT | • Submit service inquiries for DME/O&P service history using the NCTracks Provider Portal |