Back Porch Chat: Medicaid Managed Care Launch Edition with:

August 19, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here:

<Enter Link Here>

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Logistics for today's webinar

Question during the live webinar

Technical assistance

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AGENDA

01 Updates on Hot Topics

02 Data Overview: Call Center, NEMT, & Claims

03 Common Claims Issues & PA Denial Reason

04 Questions from the Field

05 Q&A

Audience Response Question 1

Regarding contracting, which of the following is true for your organization to the best of your knowledge?

A. We are fully contracted with all plans and are done.

B. We have contracted with everyone we plan to contract with and are done.

C. There are others we want to contract with but have not yet.

D. There are others we want to contract with but are having trouble getting the PHPs to respond.

E. We have a VERY long way to go. It may be hopeless.

Audience Response Question 2

If you are not fully contracted with <u>every</u> plan, how do you think going Out of Network will impact your office and the beneficiaries you care for? Choose all that apply.

A. Wait, we will be out of network???

B. We will decline to schedule or see patients from certain plans until they change plans.

C. We will see patients from certain plans urgently but ask that they change plans before they return.

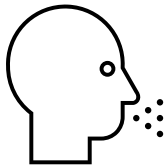
D. We will see everyone and do our best to get paid.

E. Our staff stands ready to help members change plans.

F. I am not worried about my office, but I am worried about difficulty accessing hospital services in my community.

Procedures for Prior Authorization of Palivizumab (Synagis®) for Respiratory Syncytial Virus Season 2021-2022

Coverage season begins Aug. 15, 2021



The clinical criteria used by NC Medicaid for the 2021-2022 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the *American Academy of Pediatrics (AAP): 2021 – 2024 Report of the Committee on Infectious Diseases, 32nd Edition.* This guidance for Synagis use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription. Providers are encouraged to review the AAP guidance.

Extended Coverage Season

Normally a late fall/winter season, due to atypically high levels of circulating RSV, **the Synagis coverage season will start Aug. 15, 2021, and last through March 31, 2022**. Up to eight monthly doses can be covered. RSV activity will be closely monitored during the eight-month timeframe to determine if the season length should be adjusted.

- The June 2021 Centers for Disease Control and Prevention (CDC) health advisory notice to notify clinicians and caregivers about increased interseasonal RSV activity across parts of the Southern United States.
- The North Carolina Division of Public Health (DPH) Epidemiology sections has reported a substantial uptick in the number of RSV cases throughout the state at levels almost to the height of the typical RSV season.

For more information about RSV, please reference the RSV Medicaid Bulletin:

Procedures for Prior Authorization of Palivizumab (Synagis®) for Respiratory Syncytial Virus Season 2021-2022

Audience Response Question 3

What would make the biggest impact on increasing COVID vaccination rates in your community? (Choose All that Apply)

A. Financial incentives for patients

B. Financial incentives for providers

C. Off-hours vaccine availability (clinics in evenings and weekends)

D. Coordinating information sessions with faith- and community-based local organizations

E. Mass media outreach/advertisements

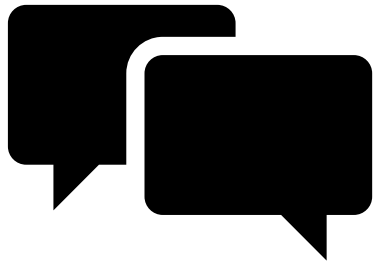
Update on Vaccination Counseling Code Reimbursement 99401

NC Medicaid recognizes the importance of vaccinating Medicaid beneficiaries for COVID-19. We also understand the additional administrative responsibilities this places on Medicaid providers due to providing the vaccine in your offices and the additional time it takes for counseling and informed consent, as well as post-vaccine observation. NC Medicaid reimburses for the provision of the vaccine at the same rate as Medicare and is creating an additional payment to encourage access to vaccines during the Public Health Emergency (PHE).

Effective June 22, 2021, CPT 99401: Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual, up to 15 minutes has been added to counsel Medicaid beneficiaries regarding the benefits of receiving the COVID-19 vaccine.

CPT 99401 can be billed at only one visit for each beneficiary per day, but there are not quantity limits for the number of times this education can be provided to an individual beneficiary. Counseling may be provided in person, via live audio/video (telehealth) or telephonically. Additionally, this service can be billed by multiple providers and can be billed multiple times on different days. Providers must bill CPT 99401 with a CR modifier to indicate a PHE code. There is no requirement for a specific diagnosis code. The following coding criteria will apply:

Requires 25 modifier if in addition to OV E&M, if applicable
Requires CR and GT modifiers if provided via telehealth
Requires CR and KX modifiers if provided telephonically



For more information, please reference the special bulletin:

Update on Vaccination Counseling Code Reimbursement

Audience Response Question 4

How has the surge in COVID infections over August impacted your practice? (Choose All that Apply)

A. We are overwhelmed with sick visits.

B. We are having trouble staffing because of sick staff members.

C. Our volumes are way down because no one is coming in.

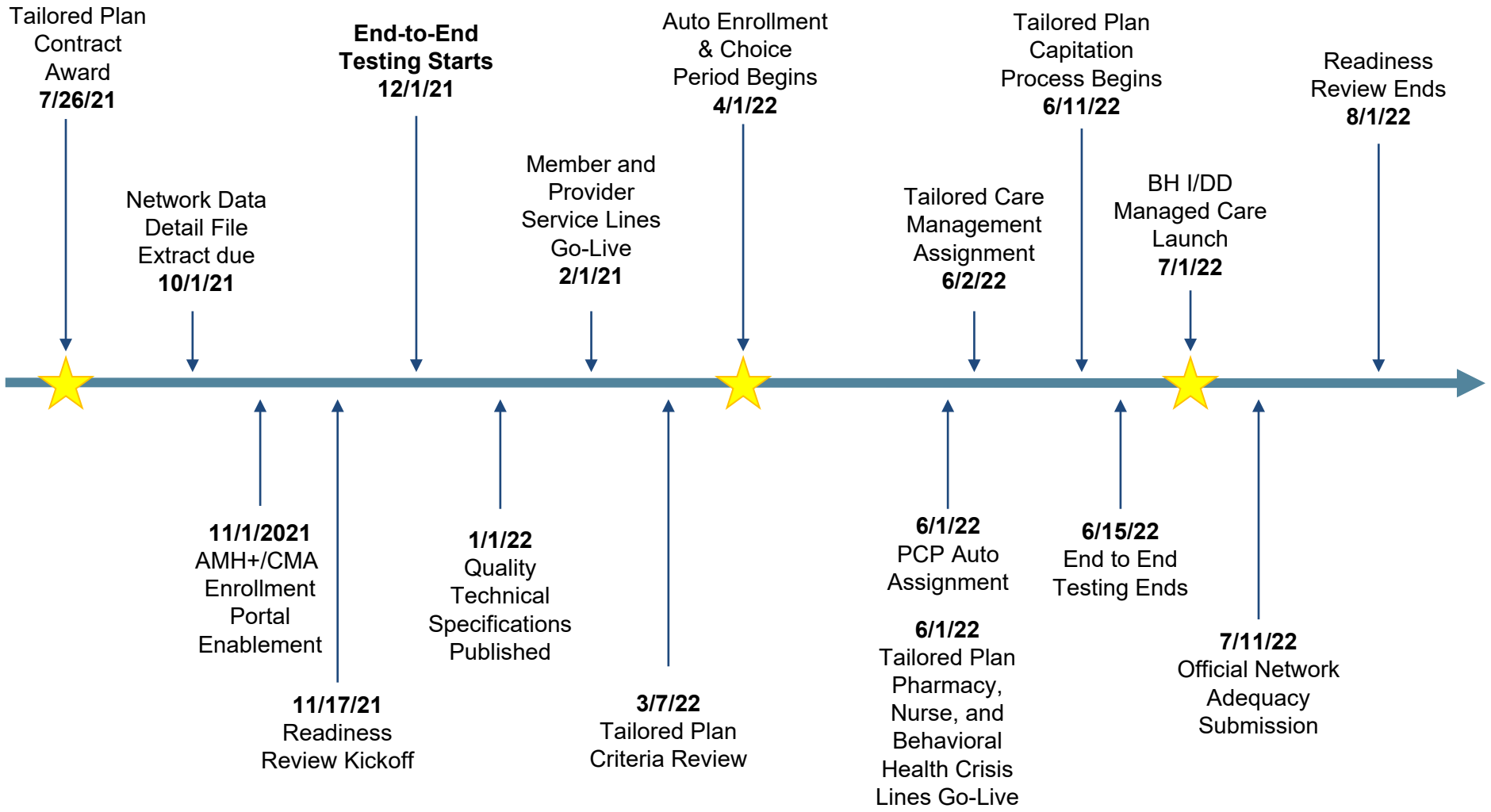
D. We are shifting back to virtual and telehealth services now.

E. We are thinking about shifting back to virtual and telehealth services soon.

F. None of the above apply.

TP Key Milestone Timeline

THE TAILORED PLAN HAS AN EXPEDITIED TIMELINE AND LEVERAGES PROCESSES FROM THE STANDARD PLAN IMPLEMENTATION.



Health Plan Office Hours for Providers

	AmeriHealth Caritas	Carolina Complete	Healthy Blue	United Healthcare	WellCare
When	Every Wednesday at 5:00 – 6:00 p.m. EST	Every 2nd and 3rd week of the month on Tuesday and Thursday at 4:00 – 5:00 p.m. EST	Every Tuesday at 11:00 a.m. – 12:00 p.m. EST and every Thursday 1:00 – 2:00 p.m. EST	Every Tuesday at 10:00 a.m. and Thursday at 2:00 p.m. EST	Every Thursday at 4:00 p.m. – 5:00 p.m. EST
Duration	Until September 8, 2021	Until April 2022	Until September 2, 2021	Until September 30, 2021	Until September 16, 2021
Format	Zoom meeting. Respond to Provider questions with question-and-answer period.	Zoom meeting. Questions submitted in advance to NCCH_Claims_NetworkOperations@carolinacompletehealth.com.	WebEx meeting. Providers can submit questions in advance to nc_provider_training@healthybluenc.com a minimum of 2 business days prior. There will also be a chat box during session.	Microsoft Teams meeting. Details on digital tools, best practices with question-and-answer period.	Zoom meeting. Question-and-answer session
Registration	Register at: https://www.amerihealthcaritasnc.com/provider/training-and-education/provider-training.aspx From there, click on claims and billing office hours to register and submit questions	Provider must submit email for link to Zoom meeting to NCCH_Claims_NetworkOperations@carolinacompletehealth.com	Register through the PDF at: https://provider.healthybluenc.com/docs/gpp/HBNC_HBTC_OfficeHours.pdf?v=202108112057	No Registration required. Access sessions through the PDF at: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/UHCCP-NC-Provider-Overview-Tuesdays.pdf	No Registration required. Access sessions at: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Training/Medicaid-Training

Electronic Payment Enrollment Process

- Your banking information from NCTracks did **not** transfer to the health plan(s).

- Please refer to the Managed Care Claims and Prior Authorization Submission: Frequently Asked Questions - Part 2 Fact sheet for specific guidance from each health plan to enroll to use electronic funds transfers for payments.

- All PHPs should offer a **free** electronic funds transfer option, and enrolling will result in faster payment.

Guidance For Providers Experiencing Payment Issues

- PHPs follow prompt payment requirements as defined in § 58-3-225

- Providers experiencing payment issues due to claim denials or delayed payments at transition should use contact information in the Guidance for Providers Experiencing Payment Issues bulletin

- If providers are unable to resolve the payment issues, they should contact the provider ombudsman at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 866-304-7062

Audience Response Question 5

In what way can PHPs best support providers with the rising rates of COVID infections? (Choose all that apply)

A. Support members with social resources – e.g., food, in home care

B. Reduce administrative burden (Prior Authorization, etc.)

C. Office Supports (PPE, telehealth capability, etc.)

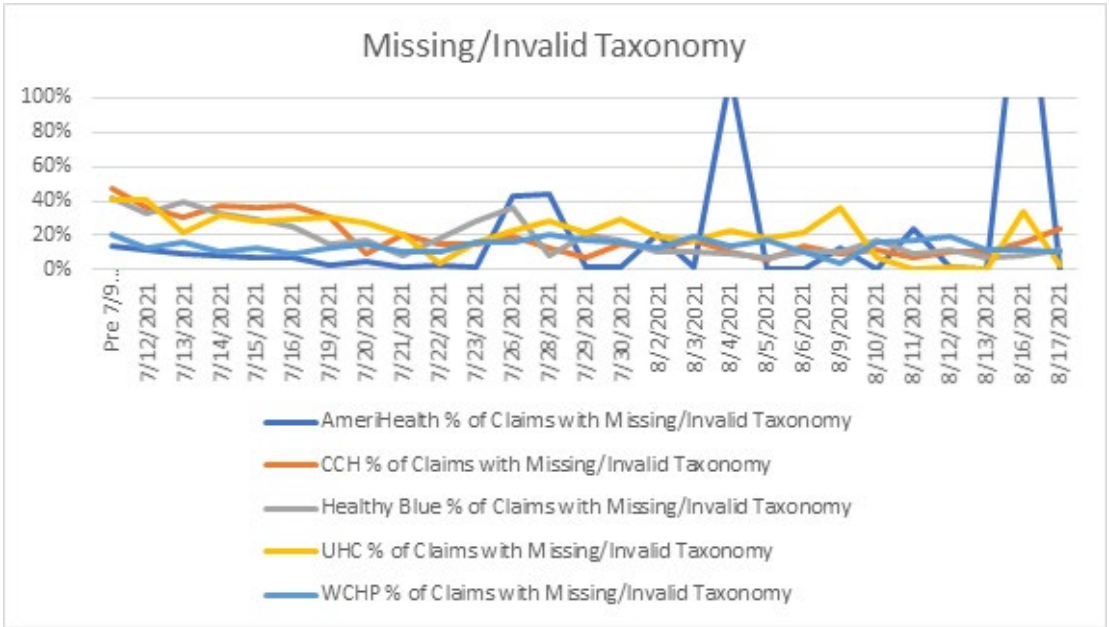
D. Supporting vaccine efforts

E. Clinical Best Practice updates

Adding Billing, Rendering and Attending Provider Taxonomy to Professional and Institutional EDI Claims

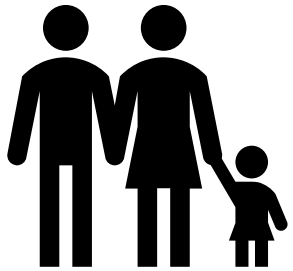
Health plans have identified a common billing error of providers submitting professional and institutional EDI claims (ASC X12 837-P and ASC X12 837-I) with missing or invalid billing provider, rendering provider and attending provider taxonomy codes.

When billing NC Medicaid Direct claims, providers may have directed clearinghouses to append billing provider, rendering provider, or attending provider taxonomy codes to the claims. This process may not have been established for NC Medicaid Managed Care claims being submitted to the prepaid health plans (PHPs), causing these claims to deny for missing or invalid taxonomies.



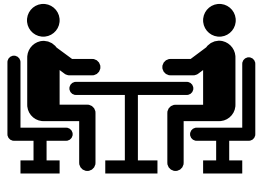
For more information, please refer to the Special Bulletin, **Adding Billing, Rendering and Attending Provider Taxonomy to Professional and Institutional EDI Claims**

What's the Bottom Line?

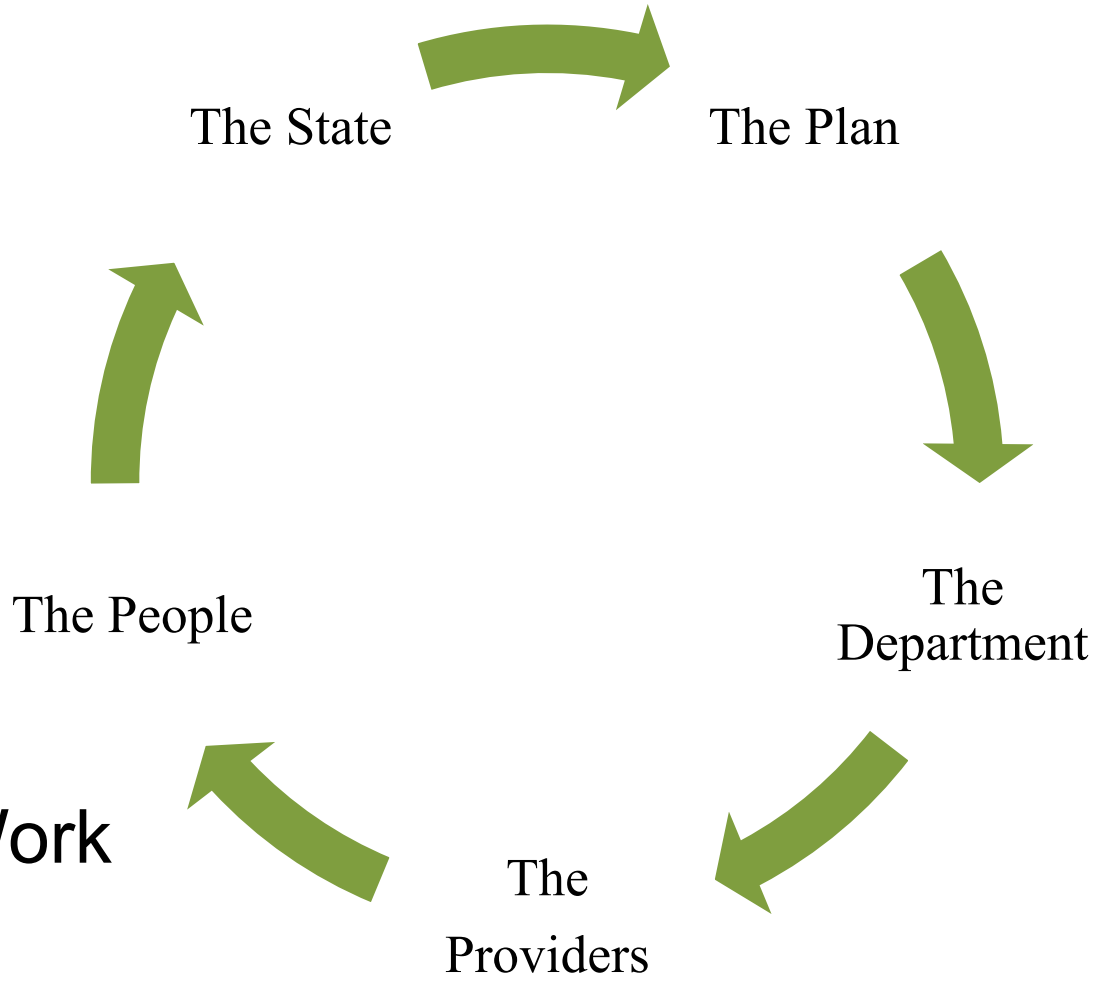


Members Have Access

Providers Get Paid



Collaborative Spirit of Work



Managed Care Flexibilities Extensions

- **Out-of-Network Provider Payment and Prior Authorization Flexibility: These have now been extended until Nov 30th, 2021**
  - For the first 60 days after Launch (Aug. 30, 2021), the health plan will pay claims and authorize services for Medicaid-enrolled out-of-network providers equal to that of in-network providers until end of episode of care or for 60 days, whichever is less (extended transition periods may apply for circumstances covered in N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).).
  - Between July 1 and Aug. 30, 2021, medically necessary services that normally require prior authorization will still be reimbursed at 100% of the NC Medicaid fee-for-service rate for both in- and out-of-network providers. To ensure that providers fully understand each PHP's prior authorization requirements during the transition, the PHPs will still process and pay for these services if:
    - a provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
    - a provider submits for retroactive prior authorizations.

This exception does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period.

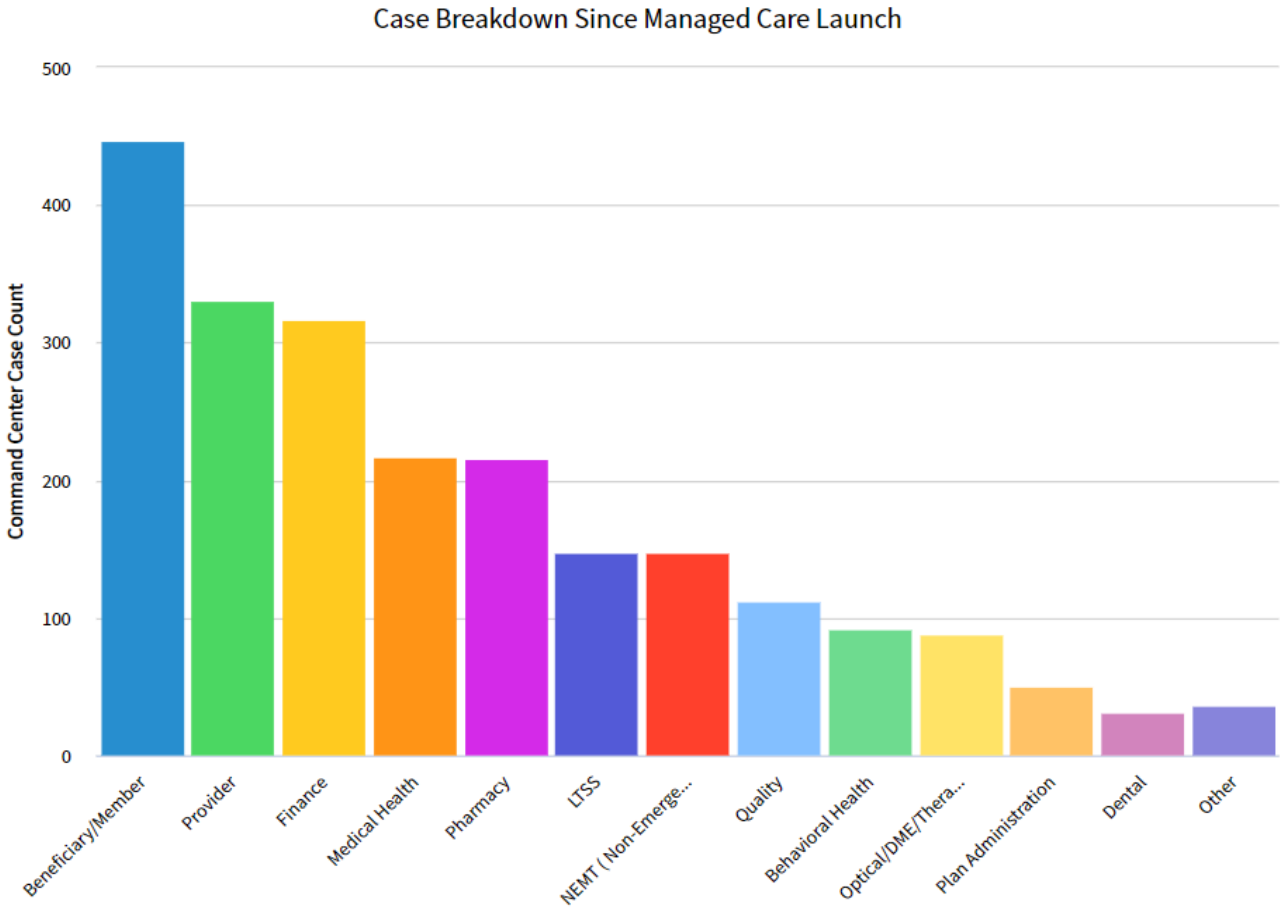
- **End of beneficiary choice period to change PHP**
  - Beneficiaries have 90 days after the effective date of initial enrollment to change their health plan for any reason. In year one, most beneficiaries will have until Sept. 30, 2021, to change their health plan for any reason. In addition, beneficiaries shall be allowed to change their health plan with cause at any time.

- **End of beneficiary choice period to change PCP**
  - Members shall be allowed to change their AMH/PCP with cause at any time. In year one, most beneficiaries will have until Aug. 1, 2021 to change their PCP/AMH for any reason. – **This has now been extended until Nov 30th, 2021**

Commitment to Transparency

Medicaid Help Center

Weeks of July 1st - August 16th



Inquiry Category	Command Center Case Count	Percentage of Count
Beneficiary/Member	447	19.99%
Provider	331	14.8%
Finance	317	14.18%
Medical Health	217	9.7%
Pharmacy	216	9.66%
LTSS	148	6.62%
NEMT (Non-Emergency Medical Transportation)	148	6.62%
Quality	112	5.01%
Behavioral Health	92	4.11%
Optical/DME/Therapies	89	3.98%
Plan Administration	51	2.28%
Dental	31	1.39%
Other	37	1.65%
Total	**2,236**	**100%**

What Our Call Centers are Hearing from Members

Week of August 2nd- August 8th

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	2,771	99%	0%
Healthy Blue	5,647	85%	1%
Carolina Complete	3,028	99%	1%
United	4,902	81%	1%
WellCare	4,486	99%	0%
Enrollment Broker	6,228	100% in 3m	0%
Medicaid Contact Center (MCC)	4,005	95%	0%

Top Call Center Reasons		
EB	1	Changing Enrollments
	2	Health Plan Questions
	3	Medicaid Questions
Health Plans	1	PCP Changes
	2	Benefits Questions
	3	Demographics Changes
	4	Find a Provider
	5	ID Card Requests

What Our Call Centers are Hearing from Providers

Week of August 2nd- August 8th

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	1,558	99%	0%
Healthy Blue	3,752	85%	1%
Carolina Complete	1,172	95%	1%
United	2,012	87%	1%
WellCare	2,342	98%	1%
Provider Ombudsman	86	88%	2%

Top Call Center Reasons		
Health Plans	1	Claims/ Reimbursement
	2	Benefits and Eligibility
	3	Authorization Status
	4	Demographics Changes
	5	Provider Network Status
	6	Provider Enrollments

Non-Emergency Medical Transportation (NEMT)

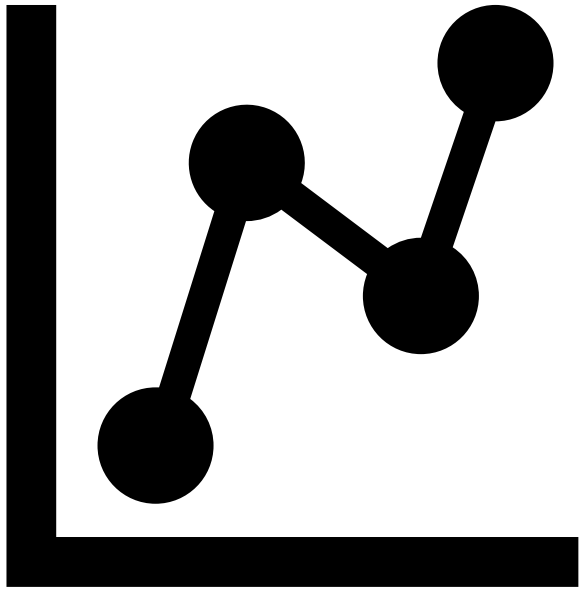
Number of Trips Completed Per Month

PHP	Member Enrollment*	July	August (to 8/10)
AMHC	304,938	3,311	1,406
BCBS	418,260	5,580	2,193
CCHE	215,418	2,194	890
UNHC	360,748	4,632	1,859
WCHP	344,967	2,953	1,522
Total	**1,644,331**	**18,670**	**7,870**

*Data as of 8/17

Claims Surveillance

- DHHS and PHPs monitor claim status through metrics weekly and take action when trends are identified
- Claim data reviewed includes:
  - Claims paid vs. denied
  - EDI claim rejections
  - Pended claims
  - Common claim denial reasons
- Plan to share metrics publicly in the near future
  - By PHP
  - Over Time



FROM THE HEALTH PLAN CMOs
What are your most common Claims and Prior Authorization Denials? What clues can you give the field to get more claims paid and services approved first time around?

WellCare of North Carolina

Most Common Claims Denials Issues

1. Missing billing or rendering taxonomy on claims
2. Missing modifiers
3. Missing or incorrect NDC number

Dr. Eugenie Komives
WellCare (WCHP)
Eugenie.Komives@wellcare.com

Most Common PA Denials Reasons

1. Lack of clinical Information
2. Inpatient level of care
3. Incorrect service requested

*** **Providers can contact their provider relations representative for assistance with claim questions at NCProviderRelations@wellcare.com**

United Healthcare Community Plan of North Carolina

Dr. Michelle Bucknor
UnitedHealthCare (UNHC)
michelle_bucknor@uhc.com

Most Common Claims Denials Issues

1. Missing taxonomy
2. Duplicate claim submission
3. Submission of a claim with date of service prior to Group's Effective date

Most Common PA Denials Reasons

1. Service request does not meet medical necessity criteria
2. Lack of necessary clinical information to support clinical review
3. Requests for Out of State services

Healthy Blue

Dr. Michael Ogden
Healthy Blue (BCBS)
michael.ogden@healthybluenc.com

Most Common/Important Claims Denials Issues

1. NPI/Taxonomy mismatch from NCTracks info
2. No PA present (PA requirements may be different than in Medicaid Direct)

Most Common PA Denials/Delay Reasons

1. Providers submitting multiple requests and late (or no) notification for inpatient
2. Requests for Non-covered codes (exceptions: EPSDT and 440.70)
3. Medical necessity not documented according to criteria

Carolina Complete Health

Dr. William Lawrence Jr.
Carolina Complete Health (CCHE)
William.W.Lawrence@carolinacompletehealth.com

Most Common Claims Denials Issues

1. Taxonomy mismatch or missing
2. Service or Service/ Modifier Combo not on fee schedule
3. Billing NPI not on Medicaid File

Most Common PA Denials Reasons

1. Inpatient New and Concurrent Reviews
2. Pharmaceutical Prior Authorizations
3. Lumbar Spine Imaging

AmeriHealth Caritas of North Carolina

Dr. George Cheely
AmeriHealth Caritas (AMHC)
gcheely@amerihealthcaritasnc.com

Most Common Claims Denials Issues

1. Missing or invalid taxonomy codes
2. Primary carrier should be billed first (Medicaid is the last to pay, except for EPSDT)
3. Duplicate claims

Most Common PA Denials Reasons

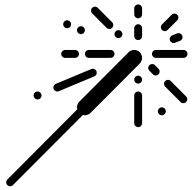
1. Does not meet medical necessity criteria
2. No or insufficient clinical information
3. Non-specific, Standard Request Pharmacy PA form submitted for drugs with a State-required specific form

Your Voice Matters

Inappropriate Fees on Electronic Fund Transfers

Requiring PA for seizure medications

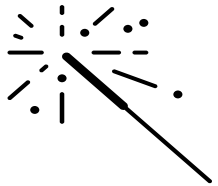
Paying 99401 Vaccine Counseling appropriately



Paying for Dental Varnish for certain Ages

Networks not Using NC Tracks data for Provider Enrollments

Requiring PA for Inhaled Medications



Following NC Medicaid Rate Tables for FQHCs

Removing Barriers for Dental GA Services

Responding to the early RSV season

Questions From The Field

We have a PHP stating that our credentialing information in their system is from data provided by NCTracks in 2019, not from 2021 when we initiated and signed a contract. Why would they have 2019 in their system?
Everyday we run into family members (usually children) who have been assigned to different managed plans, many of which have no idea. We even have encountered a set of twins that have different plans. Is the state going back and auditing how their algorithm assigned members? If not is there a better way for providers to assist patients when they do not understand how to request a change?
Why are the PHPs not following Medicaid guidelines as far as authorizing therapy treatments for 6 months? Some are authorizing only 3 months and not 6. Thank you!
Are Plans supposed to cover each code in the same way as Medicaid? In other words, if a claim is submitted appropriately and coded as it would have been for Medicaid in June, should each Plan begin paying that same claim coded the same way in July? Thank you!
We are having trouble with Managed Care plans covering Birth Control methods, especially Depo. We are receiving "Drug manufacturer labeler is not allowed for rebate". Are the Managed Care plans not supposed to cover the same CPT/ICD-10s as Medicaid?
We are currently not receiving full PPS rate as an FQHC from any of the PHP's. When we attach the T1015 line item to claims we receive denials stating that they do not recognize that code and the fact that it is not a part of the fee schedule. We are not receiving reimbursement for telehealth visits. Can you provide guidance?
Could each Managed Medicaid Plan verify what revenue code is to be billed for skilled nursing facility room and board? Also, if a plan is only paying 90% of the Medicaid rate and we have a contract with the company, how do we get this corrected?
I am a homecare provider and trying to navigate this new Managed Care system with billing for Personal Care Patients. We were able to submit claims through NC Tracks on Personal Care patients (PCS) for a week previously, and we were compensated on that claim the following week. With this Managed Care Plan, we submit our claims now, and the payout is several weeks later. For a small agency, this is extremely difficult to maintain payroll. How can this Managed Care Plan be more effective with the compensation regarding turn-around time?

Healthy Opportunities Pilots Webinar: Human Service Organizations

Join us on Tuesday, Aug. 31, 2021, from 9:30-11:00 a.m. ET for a webinar on North Carolina's Healthy Opportunities Pilots.

This webinar will provide an overview of the Pilot program, with a focus on the essential roles and responsibilities of human services organizations that will provide Pilot services to eligible Medicaid members. The webinar will also highlight important upcoming implementation milestones and next steps. The session will be geared towards human services organizations that are interested in providing Pilot services but is open to the public. There will be time reserved at the end for Q&A.

The Pilots offer the unprecedented opportunity to evaluate the impact of providing evidence-based, non-medical interventions to a subset of high-risk eligible Medicaid members in select regions of the state. The federal government has authorized up to $650 million in state and federal Medicaid funding to cover the cost of providing select Pilot services related to housing, food, transportation and interpersonal safety that directly impact the health outcomes and health care costs of Medicaid members.

Register to attend the webinar here. More information about the Healthy Opportunities Pilots is available at: https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

Next Up September Back Porch Chat

- All Things Behavioral Health
- Tailored Plan Preview

NC DHHS

NCDHHS Announces Medicaid Managed Care Regional ...

At launch, Behavioral Health I/DD Tailored Plans will operate regionally, offering robust care management to approximately 200,000 ...

3 weeks ago

The Richmond Observer

NCDHHS announces Medicaid Managed Care Regional ...

At launch, Behavioral Health I/DD Tailored Plans will operate ... Projected County Alignments at Tailored Plan Launch for July 1, 2022.

3 weeks ago

Watauga Democrat

Vaya Health awarded new 'whole-person' health plan by ...

The Vaya Health Behavioral Health I/DD Tailored Plan is expected to launch July 1, 2022. As part of the statewide shift to Medicaid managed ...

1 week ago

WWAY

Trillium Health Resources awarded Tailored Plan contract by ...

Tailored Plans are designed for individuals with significant behavioral health ... "While we are still about one year from the launch date, ...

3 weeks ago


QUESTIONS?

APPENDIX

WellCare of North Carolina

Most Common Claims Denials Issues & Guidance

1. Missing Billing or Rendering Taxonomy on claims
   - Taxonomies must match what is in NC Tracks. Please ensure that NC Tracks is up to date with both Rendering and Billing Provider NPI/Taxonomy Information. Claims are rejected for incorrect or missing taxonomies.

2. Missing Modifiers
   - The modifier necessary to process the claim correctly is either missing, incomplete, or invalid for the specific procedure and diagnosis indicated on the claim form. WellCare follows NC DHHS clinical coverage policies. In the absence of a policy WellCare follows CMS guidance.

3. Missing or Incorrect NDC number
   - NDC number is required for drug codes. The appropriate NDC from the prescription drug list is required to be submitted for reimbursement.

*** **Providers can contact their provider relations representative for assistance with claim questions at NCProviderRelations@wellcare.com**

WellCare of North Carolina

Most Common PA Denials Reasons & Guidance

1. Lack of Clinical Information: Submission of clinical information at the time of auth request is ideal. If unable to do so, please respond timely to a request for additional information or if needed, peer to peer. Unfortunately, if we do not have the needed clinical and we hit the end of our turnaround time we need to issue a denial.

2. Inpatient level of care: We pay for observation up to 30 hours without an authorization. For inpatient stays, we will review against MCG criteria. If the member can be treated in 24-30 hours and is not severely ill, in many cases observation is appropriate.

3. Incorrect service requested: Examples – PCS vs. HHA or PDN vs. SN, etc. How long are the services required? Long or short term? LTSS (PCA/PDN) or intermittent (HHA, SN).

United Healthcare Community Plan of North Carolina

Most Common Claims Denials Issues

1. Missing taxonomy
   - Providers should work with their clearinghouses to ensure that the same processes are followed when submitting claims to NC Medicaid Direct and the PHPs.
   - To facilitate timely adjudication, providers should include the billing provider taxonomy and, when applicable, the rendering provider taxonomy and attending provider taxonomy on claims before sending them to a clearinghouse.

2. Duplicate claim submission

3. Claim submission with date of service prior to Group's Effective date

https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home.html

United Healthcare Community Plan of North Carolina

Most Common PA Denials Reasons

1. Service request does not meet medical necessity criteria
   - Medical Necessity is aimed at promoting care that is medically appropriate and proven effective based on published clinical evidence
   - Medical necessity criteria may be found in our Medical Policies
     - Community Plan of North Carolina Medical Policies and Coverage Determination Guidelines | UHCprovider.com

2. Lack of necessary clinical information to support clinical review
   - Clinical information should be provided to support the services meeting medical necessity criteria

3. Requests for Out of State services

https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-prior-auth.html

Carolina Complete Health

Billing provider taxonomy required

Claims must be submitted exactly as registered with the state for claims to pass provider validation edits . Please verify that the Rendering Taxonomy, Billing Taxonomy, and Attending Taxonomy (for institutional claims) are completed fields and align with what is in NCTracks.

For further assistance, please reach out to your Provider Engagement Coordinator or the Provider Relations and Support Team.

Carolina Complete Health

Service or service modifier combo not found on fee schedule

CPT CODE	DESCRIPTION
99173	Screening test of visual acuity, quantitative, bilateral
36416	Collection of capillary blood specimen (e.g., finger, heel, ear stick)
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory
99177	Instrument-based ocular screening (egg, photo screening, automated-refraction), bilateral; with on-site analysis
3008F	Body Mass Index (BMI), documented (PV)

Codes that are inherently bundled into other services may deny with this reason. That includes things like documentation of BMI and standard visual acuity assessments, which are appropriate services to perform and record, but not paid additionally.

If you are seeing that descriptor frequently, we can have you work directly with Provider Engagement Coordinator or the Provider Relations and Support Team to better understand the specifics for your practice.

Healthy Blue

Most Common/Important Claims Denials Issues

1. NPI/Taxonomy mismatch from NCTracks info
2. No PA present (PA requirements may be different than in Medicaid Direct)

Most Common PA Denials/Delay Reasons

1. Providers submitting multiple requests and late (or no) notification for inpatient
2. Requests for Non-covered codes (exceptions: EPSDT and 440.70)
3. Medical necessity not documented according to criteria
   https://provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup

For more information, please refer to the Provider Billing Pearls and the Claims Reject Avoidance documents

Healthy Blue

Most Common Claims Denials Issues & Guidance

1. Missing code
    - If the code is not on the claim, the claim will deny with the explanation code e02 – Delivery diagnoses incomplete without report of pregnancy weeks of gestation. You may resubmit the claim with the appropriate Z3A code. Healthy Blue's provider manual requires this information as part of the delivery notification. The clinical information required is outlined as follows:
        - Indicate whether a live birth
        - Newborn's birth weight
        - Gestational age at birth
        - Apgar scores
        - Disposition at birth
        - Type of delivery: vaginal or Cesarean
        - If a Cesarean: the reason the Cesarean was required
        - Date of birth
        - Gender
        - Single/multi birth
        - Gravida/para/ab for mother
        - EDC and if neonatal intensive care unit (NICU) admission was required

AmeriHealth Caritas NC

Most Common Claims Denials Issues & Guidance

1. Missing or invalid taxonomy codes
   - Double-check codes listed match NCTracks and are entered in the appropriate fields
2. Primary carrier should be billed first (Medicaid is the last to pay except for EPSDT)
   - Ensure office staff check with patients about additional insurance and bill accordingly
3. Duplicate claims
   - Check claim status via NaviNet (https://www.navinet.navimedix.com/) or your Account Executive

Most Common PA Denials Reasons

Medical

1. Does not meet medical necessity criteria
   - ACNC typically follows the criteria in the NC DHHS Clinical Policies—check our reference materials (https://www.amerihealthcaritasnc.com/provider/resources/clinical/resources.aspx)
   - InterQual criteria will be available via the Transparency feature on NaviNet (https://www.navinet.navimedix.com/) in the near future or from our UM team (**1-833-900-2262)**
2. No or insufficient clinical information
   - Recent records documenting criteria are best, call our UM team when in doubt (**1-833-900-2262)**

Pharmacy

1. Does not meet medical necessity criteria
   - ACNC follows the criteria in the NC DHHS Pharmacy Services Clinical Coverage Policies—https://medicaid.ncdhhs.gov/pharmacy-services-clinical-coverage-policies
2. No or insufficient clinical information
   - Recent records documenting criteria are best, call PerformRx Provider Services with questions (**1-866-885-1406)**
3. Non-Specific, Standard Request PA form submitted
   - Double-check the medication matches the form with specific questions about the State's required criteria (https://www.amerihealthcaritasnc.com/provider/resources/pharmacy-prior-auth.aspx)

Additional Pharmacy Prior Authorization Tips: AmeriHealth Caritas NC

If a provider has a question about which Pharmacy PA form to submit, please call PerformRx. **PerformRx Provider Call Center 1-866-885-1406** during normal business hours

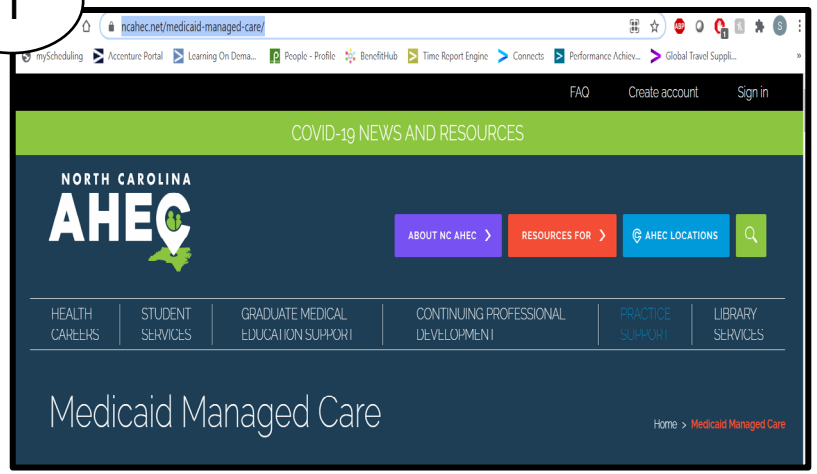
- If you have questions after business hours (Sunday and holidays) call Member Services at **1-855-375-8811 (TTY 1-866-206-6421)**
- **Find ACNC Pharmacy PA forms here:** https://www.amerihealthcaritasnc.com/provider/resources/pharmacy-prior-auth.aspx

ePrescribing and ePA are both live in NC, and allow providers to submit PA requests via EHR

- ***Prescribers can answer ePA questions and can submit electronically***
- ***The request comes into PerformPA for manual review and providers will receive a response through the ePA platform***

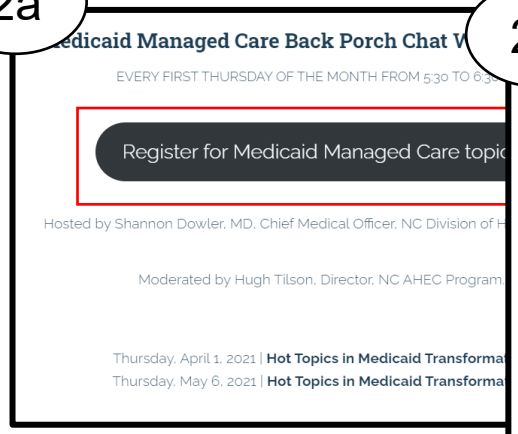
How To Sign up for the Back Porch Chat Webinar Series

1

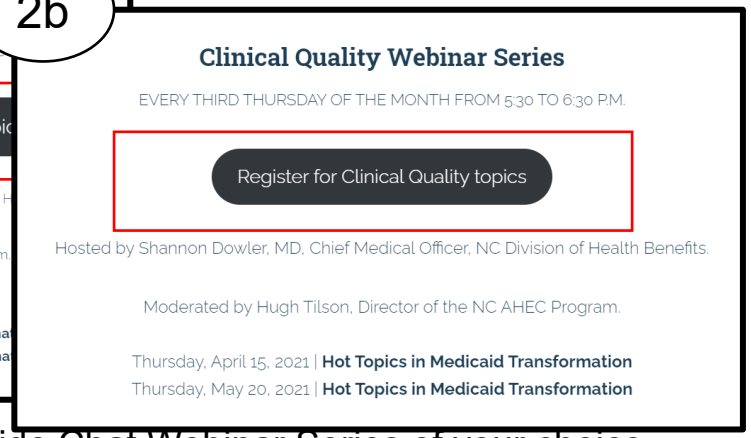


1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



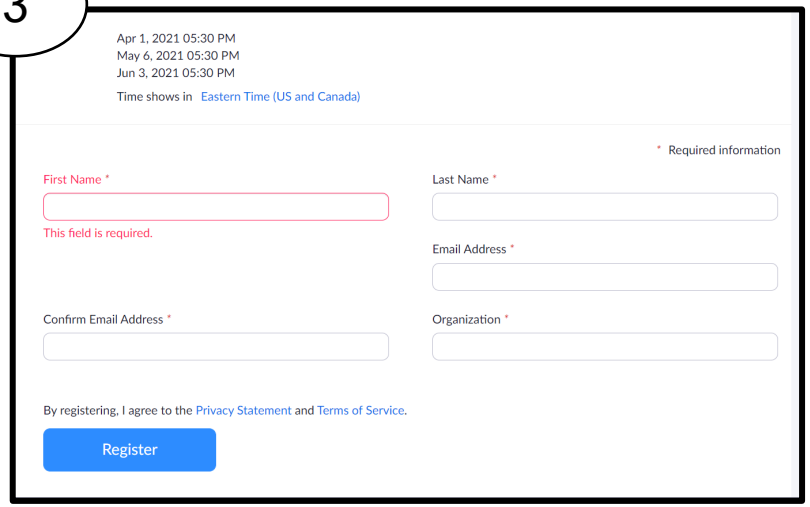
2b



2. Scroll down to the Fireside Chat Webinar Series of your choice

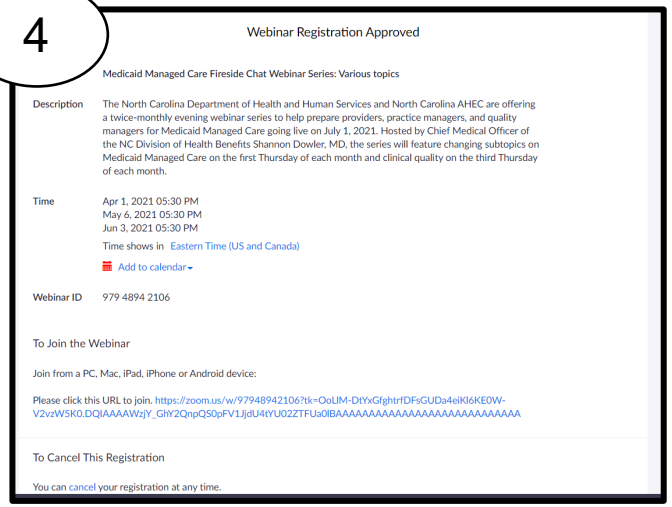
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.

Provider Resources

- NC Medicaid Managed Care Website
  - medicaid.ncdhhs.gov
  - Includes County and Provider Playbooks
  - Fact Sheets
  - Day One Quick Reference Guide
- NC Medicaid Help Center
  - medicaid.ncdhhs.gov/helpcenter
- Practice Support
  - ncahec.net/medicaid-managed-care
  - NC Managed Care Hot Topics Webinar Series, hosted by Dr. Dowler on the first and third Thursday of the month
- Regular Medicaid Bulletins
  - medicaid.ncdhhs.gov/providers/medicaid-bulletin

What should Providers do if they have issues?

1

Check in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan

If you still have questions, call the NCTracks Call Center: 800-688-6696

2

Connect with the Health Plan (PHP) for coverage, benefits, and payment questions.

You can find a list of health plan contact information at health-plan-contacts-and-resources
Also, please refer to the Day One Provider Quick Reference Guide for more information on how to contact PHPs

3

Consult with the Provider Ombudsman on unresolved problems or concerns.

Call 866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov

Day 1 Quick Reference Guide

VERIFICATION OF ELIGIBILITY AND PLAN

- **NCTracks:** Providers will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal
- **Real Time Eligibility Verification Method**
  a. Log into the NCTracks Provider Portal: https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP
  b. Follow the Eligibility > Inquiry navigation
  c. Populate the requested provider, recipient and time period information
- **NCTracks Call Center:** 800-688-6696

PROVIDER PORTAL / PROVIDER SERVICES

- **AmeriHealth Caritas**: https://navinet.navimedix.com / Provider Services: 888-738-0004
- **Carolina Complete**: https://network.carolinacompletehealth.com / Provider Services: 833-552-3876
- **Healthy Blue**: https://provider.healthybluenc.com or https://www.availity.com / Provider Services: 844-594-5072
- **United Healthcare**: https://www.uhcprovider.com / Provider Services: 800-638-3302
- **WellCare**: https://provider.wellcare.com / Provider Services: 866-799-5318
- **NC Medicaid Provider Playbook**: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

PRIOR AUTHORIZATIONS

- **AmeriHealth Caritas: Online**: Provider Portal / **Phone**: 833-900-2262 / **Pharmacy**: 866-885-1406
- **Carolina Complete: Online**: Provider Portal / **Phone:** 833-552-3876 / **Pharmacy:** 833-585-4309
- **Healthy Blue: Online**: Provider Portal / **Phone:** 844-594-5072 / **Pharmacy**: 844-594-5072
- **United Healthcare: Online:** UHCProvider.com / **Pharmacy: Phone:**855-258-1593 **Online**: CoverMyMeds: https://www.covermymeds.com/main/prior-authorization-forms/optumrx/; SureScripts: https://providerportal.surescripts.net/ProviderPortal/optum/login; Pharmacy Resources and Physician Administered Drugs: UHCprovider.com
- **WellCare: Online**: Provider Portal / **Phone:** 866-799-5318 / **Pharmacy**: Fax: 800-678-3189 **or** SureScripts: https://providerportal.surescripts.net/providerportal/

Day 1 Quick Reference Guide

CLAIMS

- **AmeriHealth Caritas: Online**: https://navinet.navimedix.com / **Phone**: 888-738-0004
- **Healthy Blue: Online:** www.availity.com / **Phone**: 844-594-5072
- **Carolina Complete: Online**: https://network.carolinacompletehealth.com
- **United Healthcare: Online**: https://www.uhcprovider.com / **Phone**: 800-638-3302
- **WellCare: Online**: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims / **Phone:** 866-799-5318

Two Claims Submission Fact Sheets are available on the Provider Playbook at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care that address filing managed care claims.

NON-EMERGENCY MEDICAL TRANSPORTATION & NON-EMERGENCY AMBULANCE TRANSPORTATION

- **AmeriHealth Caritas, Carolina Complete, Healthy Blue, United Healthcare:**

ModivCare Health Care Provider Line: 855-397-3606 / ModivCare Transportation Provider Line: 855-397-3604

- **WellCare**: One Call Health Care Provider Line: 877-598-7602 / One Call Transportation Provider Line: 877-598-7640

If you are helping a member arrange transportation, call the PHP Member Services line on the member's Medicaid ID card.

PROVIDER OMBUDSMAN

Medicaid Managed Care Provider Ombudsman: **Phone:** 866-304-7062 / **Online:** Medicaid.ProviderOmbudsman@dhhs.nc.gov

HEALTH PLAN QUICK REFERENCE GUIDE LOCATION

- AmeriHealth Caritas: https://www.amerihealthcaritasnc.com/assets/pdf/provider/provider-reference-guide.pdf
- Carolina Complete: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHNCurrent-PDF-QRG-Form.pdf
- Healthy Blue: https://provider.healthybluenc.com/docs/gpp/NC_CAID_QuickReferenceGuide.pdf
- United Healthcare: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/NC-Medicaid-QRG.pdf
- WellCare: https://www.wellcare.com/North-Carolina/Providers/Medicaid