

OPC Finance Communication Bulletin
Replacement Claims/Void Claims
Revised 3/30/2011

To: OPC Community of Network Providers
From: Karen Strum, OPC Billing and Reimbursement Manager
Date: March 30, 2011
RE: Process for Replacement/Void Claims

Submission of Replacement Claims:

Providers may submit replacement claims for originally **paid** claims in order to correct the payment amount. Billing days for a replacement claim is **60 days** from the service date. Replacement claims submitted past 60 days from the service date will be denied for exceeding billing days and cannot be resubmitted.

- **Instructions for claims submitted through Provider Direct**

The replacement claim should include all the correct services as rendered.

- In Box 22 on the **CMS1500**, key 10 and the original claim number found on the RA where the claim was paid as the reference number.

- In Box 4 on the **UB04**, use 7 as the 4th digit which will indicate “replacement of prior claim”. You will reference the original claim number in box 64A (Document Control Number).

- **Instructions for claims submitted via an 837 transaction set**
Include all the correct services as rendered.

- In Loop 2300 – Claim segment / 5th element (CLM05-03), 7 (code for resubmission) should be submitted along with a REF segment with “F8” as reference code identifier & the claim # found on the RA as the reference number. Here is an example:

CLM*0131930001*500***11::7*Y*A*Y*Y***02*****N~REF*F8*111111~

Once the replacement claim has been received, your original claim will deny and its payment is sent back to IPRS or Medicaid. The replacement claim will be processed according to all OPC billing guidelines.

Submission of Voided Claims:

Void claims are submitted when an original **paid** claim was billed in error and the entire payment needs to be returned to IPRS or Medicaid. Payment for all services listed on the original claim form will be refunded to IPRS or Medicaid. Billing days for a void claim is **60 days** from the service date.

- **Instructions for claims submitted through Provider Direct**

- In Box 22 on the **CMS1500**, key 12 and the original claim number found on the RA where the claim was paid as the reference number.

- In Box 4 on the **UB04** use 8 as the 4th digit which will indicate “reversal of prior claim”. You will reference the original claim number in box 64A (Document Control Number).

- **Instructions for claims submitted via an 837 transaction set**

- In Loop 2300 – Claim segment / 5th element (CLM05-03), 8 (code for reversal) should be submitted along with a REF segment with “F8” as reference code identifier & the claim # found on the RA as the reference number.

Here is an example:

CLM*0131930001*500***11::8*Y*A*Y*Y***02*****N~REF*F8*111111~

Voided claim will be reverted from our system and the original claim payment will be recouped and returned to IPRS or Medicaid.

If you have any questions regarding a replacement or void claim please contact me at 919-913-4064 or kstrum@opc-mhc.org.

Medicaid Alert - Provider Frequently Asked Questions for NCHC Changes to the Medicaid Benchmark Benefit Plan

1. What are the major exceptions to the NCHC transition to benefits coverage equivalent to Medicaid?

- No long-term care
- No non-emergency medical transportation
- No Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (but well-child visits and immunizations)
- Dental services provided on a restricted basis
- No screening for and special provision for children with special health care needs (absorbed into Medicaid Benchmark).

2. What are the administrative changes that will take place?

- New claims processing contracts (effective Oct. 1, 2011).
- Six-month run-out period contract amendment with BCBS (effective Oct. 1, 2011).
- Clinical coverage policies are being adopted, amended or terminated as the program transitions to provide Medicaid-equivalent coverage.
- Working with the Attorney General's Office to develop Health Choice rules for the NC Administrative Code.
- Revising NCHC ID cards and Recipient Handbook.
- Creating a Health Choice-specific Medicaid Billing Guide section 12.
- Training DMA staff and outreach contractors about Health Choice Program transitions, policies, and procedures.

3. What new claims processing changes will be in contracts?

- Effective with dates of service on and after Oct. 1, 2011, medical and pharmacy claims will be processed by DMA's fiscal agent, HP Enterprise Services.
- Providers must file all claims for dates of service on or before Sept. 30, 2011, with BCBS by Feb. 29, 2012.
- Any provider who is not currently a Medicaid-enrolled provider and wants to provide care to NCHC recipients must complete the Medicaid Provider enrollment application at www.nctracks.nc.gov. CSC, DMA's enrollment, verification and credentialing vendor, is available at 866-844-1113 to assist providers who want to enroll in NC Medicaid.

4. What changes can providers expect in the Remittance Reports (RA)?

- For claims which have been processed by the MMIS+, the Provider will receive a RA on which both Medicaid and SCHIP claims are displayed. SCHIP and Medicaid claims will be identified by the “SCHIP” or “NCXIX” payer which is displayed on the RA.
- Also, the provider will receive only one electronic payment. The provider will NOT receive a separate electronic payment - one for Health Choice and one for Medicaid claims.

5. What is the run-out period with Blue Cross & Blue Shield to process claims and issues for NCHC?

- DMA’s contract with BCBS as fiscal agent will end as of Sept. 30, 2011. The run-out period is a contract amendment so BCBS can provide claims processing services from Oct. 1, 2011 to March 31, 2012.
- Providers must file claims for DOS on or before Sept. 30, 2011, will send those to BCBS.
- Prior authorizations for dates of service on or after Oct. 1, 2011, must be requested through the new vendor, HP Enterprise Services.
- Prior authorizations for dates of service beginning prior to Sept. 30, 2011, but ending on or after Oct. 1, 2011, must be split and submitted to both vendors (BCBS for dates of service on or before Sept. 30 only).

6. Is the Medicaid Billing Guide being revised to reflect program changes?

- The fall 2011 *Basic Medicaid Billing Guide* update will include a new section 12 specific to Health Choice. It will cover:

7. Will NCHC recipients receive revised ID cards or a new Handbook?

- NCHC recipients will get new ID cards effective Oct. 1, 2011. Current recipients will receive new cards in September.
- Cards will include assigned PCP name and contact information.
- Recipient IDs will be Medicaid ID numbers; no more BCBS ID numbers.
- ID card is *not* proof of eligibility; provider must verify.
- New joint Medicaid-NCHC Handbooks to be distributed in October. Handbooks will reflect benefits/program changes.

8. Why are the co-payments changing?

The co-payment changes were legislated by the North Carolina General Assembly. Not all families will have a change in their co-payment amount. Families should review their child’s current NCHC ID card and the notice they received in the mail to determine if the co-payment changes apply to them.

9. Who should I contact with questions about the co-payment changes?

For questions about any changes to co-payments, contact the DHHS Customer Care Service Center at 1-800-662-7030.

10. Will providers know about the new co-payment amounts?

NCHC providers have been notified of the changes in co-payments effective in the September Medicaid Bulletin. However, it is important that families take their child's current NCHC ID card along with any notices they received, so that the provider knows what co-payments apply to them.

11. How will override procedures work for NCHC in the CCNC/CA?

- Overrides will mirror the policy and procedures for Medicaid recipients enrolled in CCNC/CA.
- That means an override request for past dates of service (after 10/1) should be submitted to HP on the override request form that is posted on the web.
- Overrides are usually granted when a course of treatment was begun before enrolling in CCNC/CA, but it is not an automatic override and each situation is reviewed separately.
- Continuity of care is important. For current or future dates of service, the provider contacts DMA override coordinator to request the override.
- A provider requesting an override must contact the PCP for authorization before an override will be approved (unless this is the first time for enrollment of course).
- Most PCPs are already enrolled in Medicaid and in CCNC so these situations would probably be few.
- If a child is not established with their PCP within the first 3 months of enrollment, an override will be granted.
- If the child is not established during that time period the request will be reviewed on an individual basis.

12. What has changed in the NCHC optical coverage?

- NCHC covers a routine eye exam once every 12 months.

13. When can a NCHC child get eyeglasses?

- NCHC covers eyeglasses (frame and lenses) once every 12 months.
- NCHC covers medically necessary contact lenses and back-up eyeglasses once every 12 months.

13. Who should families contact with any questions about a child's eligibility?

Families should call their county DSS caseworker or the DHHS Customer Service Center at 1-800-662-7030.

What are some resources we can refer recipient and providers to for assistance with NCHC issues:

- **Clinical Coverage Policies**

<http://www.ncdhhs.gov/dma/hcmp/index.htm>

- **What's New in DMA**

For updates on transition changes and enrollment information

<http://www.ncdhhs.gov/dma/provider/index.htm>

- **NC Healthy Start Foundation**

For NCHC application and eligibility information

www.NCHealthyStart.org

- **Fee Schedules**

What NCHC pays

<http://www.ncdhhs.gov/dma/fee/index.htm>

- **Children with Special Health Care Needs Help Line - For information on children with severe disabilities and needs**

1-800-737-3028

- **Health Choice Review Request and authorization Representative Forms**

<http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm>

- **Basic Medicaid Billing Guide**

<http://www.ncdhhs.gov/dma/basicmed/>

• **2011 Health Choice Handbook (“A Consumer’s Guide to NC Health Care Coverage Programs for Families and Children”)**

<http://www.ncdhhs.gov/dma/healthchoice/NCHChandbook2011.pdf>

- **DMA *What’s New* on the DMA Website**

For updates and the latest changes within Medicaid and NCHC

<http://www.ncdhhs.gov/dma>



Traumatic Brain Injury 101

Offered by:
OPC/LME

For Providers Serving Orange, Person, and Chatham Counties

October 7th

9:30 a.m. – 11:30 a.m.

Location: OPC Administrative Offices
100 Europa Drive, Suite 490, Chapel Hill, NC 27517

This training is designed to help providers understand Traumatic Brain Injury basics including causes, common characteristics, need for services, statistics, physiological effects of brain injury, working with individuals with brain injury, available resources, challenges that survivors face when accessing resources, and pending and current legislation associated with brain injury services.

Presenter: **Shawn Chase, CBIS**
Training Coordinator
Brain Injury Association of North Carolina

To register with OPC/LME please submit the attached registration form to Vickie Hussey at vhussey@opc-mhc.org or by fax 919-913-4038. **Participants will be limited to 25, and will be registered on a first-come, first-served basis.**

OPC

Area Program

Administrative Offices
100 Europa Drive, Ste. 490
Chapel Hill, NC 27517

Phone: 919-913-4053

Fax: 919-913-4038

Provider Training Registration Form

Topic of Training: Traumatic Brain Injuries 101
Date/Time of Training: October 7, 2011 / 9:30 am – 11:30 am
Cost of Training (if applicable): FREE
<i>If the training requires a fee, please send a check to address below or bring with you to the training</i>

Your Agency Name:		
Representative(s) Attending: <i>If more than one representative attends, please plan to carpool due to limited parking.</i>	E-mail Address: <i>Please provide email address for each representative so that we can send a registration confirmation.</i>	Phone number: <i>Please provide best number to reach you in case of a cancellation.</i>

Please return this form by:

Email (preferred): vhussey@opc-mhc.org

Mail: Attn: Vickie Hussey, 100 Europa Drive, Ste. 490, Chapel Hill NC 27517

Fax: 919-913-4038



**MASTER AGING PLAN
COMMUNITY KICK-OFF MEETING**

WED, OCT. 5

1 - 5 pm

**Seymour Center
2551 Homestead Rd * Chapel Hill, NC**

**COME TO THE MAP
COMMUNITY KICK-OFF EVENT!**

YOUR INPUT IS NEEDED!

Orange County Department on Aging is gearing up to create the **2012-17 Master Aging Plan (MAP)** to improve services and programs provided to older adults and their families.

LEARN MORE. GET INVOLVED. JOIN A WORK GROUP.

Refreshments Provided!

To help us plan, please call (919) 968-2070 to let us know you're coming!

In observance of National Mental Illness Awareness Week

The Family Advocacy Network (FAN)
a program of Mental Health America of the Triangle
In co-sponsorship with NAMI-Orange and Joshs' Hope Foundation, Inc.
presents

“Family Mental Health Forum”

Saturday, October 8th

9:30am to 12noon

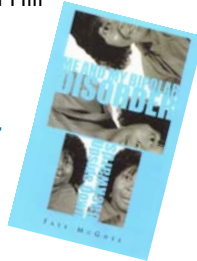
Orange United Methodist Church
1220 Martin Luther King Jr. Blvd. ♦ Chapel Hill



Keynote Speaker

Faye McGhee, RN, author

“Me and My Bipolar Disorder”



“Understanding Childhood Mental Illness”

Facilitated by Aimee Vandemark, PBCN Program Coordinator at MHAT

Family and Consumer Panel

*Facilitated by Donna Carrington, FAN Parent Advisory Council
and Joanna Bowen, NAMI-Orange*

Registration deadline: Wednesday, October 5th

To register, email georgia@mhatriangle.org
or call Georgia Gamcsik at 919-942-8083



Co-sponsored by



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