MEDICAID

Billing Guidance for Healthy Blue Providers

November 2023

BlueCross BlueShield of North Carolina | HealthyBlue

Agenda

- About Us, Medicaid
- Availity Essentials:
  - Life cycle of a claim
  - Claims submission, requirement, and reimbursement
  - Common denial reasons
  - Common overpayment reasons
  - Prior authorization
- Vendors
- Tobacco cessation
- Guidance for rural health clinics/federally qualified health clinics (RHCs/FQHCs)
- 340B guidance
- Guidance for skilled nursing facilities
- Physician Administered Drug Program
- Vaccines for Children
- Newborn claims
- Electronic claims attachments
- High dollar claims reviews
- Q&A

About us

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

Visit **healthybluenc.com** to learn more!

Medicaid terms and systems

- **Division of Health Benefits (DHB):** Division within the North Carolina Department of Health and Human Services (NC DHHS) that governs the Medicaid and NC Health Choice programs
- **NCTracks:** Multi-payer Medicaid Management Information System. All credentialing and changes to provider data is completed through NCTracks.
- **Standard plan:** NC DHHS transitioned most Medicaid beneficiaries on standard plans to Medicaid managed care on July 1, 2021.
- **Tailored plan:** Medicaid plan for members who have significant mental health needs, severe substance use disorders, intellectual/developmental disabilities (I/DDs) or traumatic brain injuries (TBIs). Auto-enrollment began August 15, 2022, and the plan is scheduled to go live April 1, 2023.
- **Division of Social Services (DSS):** Works to prevent abuse, neglect, dependency, and exploitation of vulnerable individuals, children, and their families.

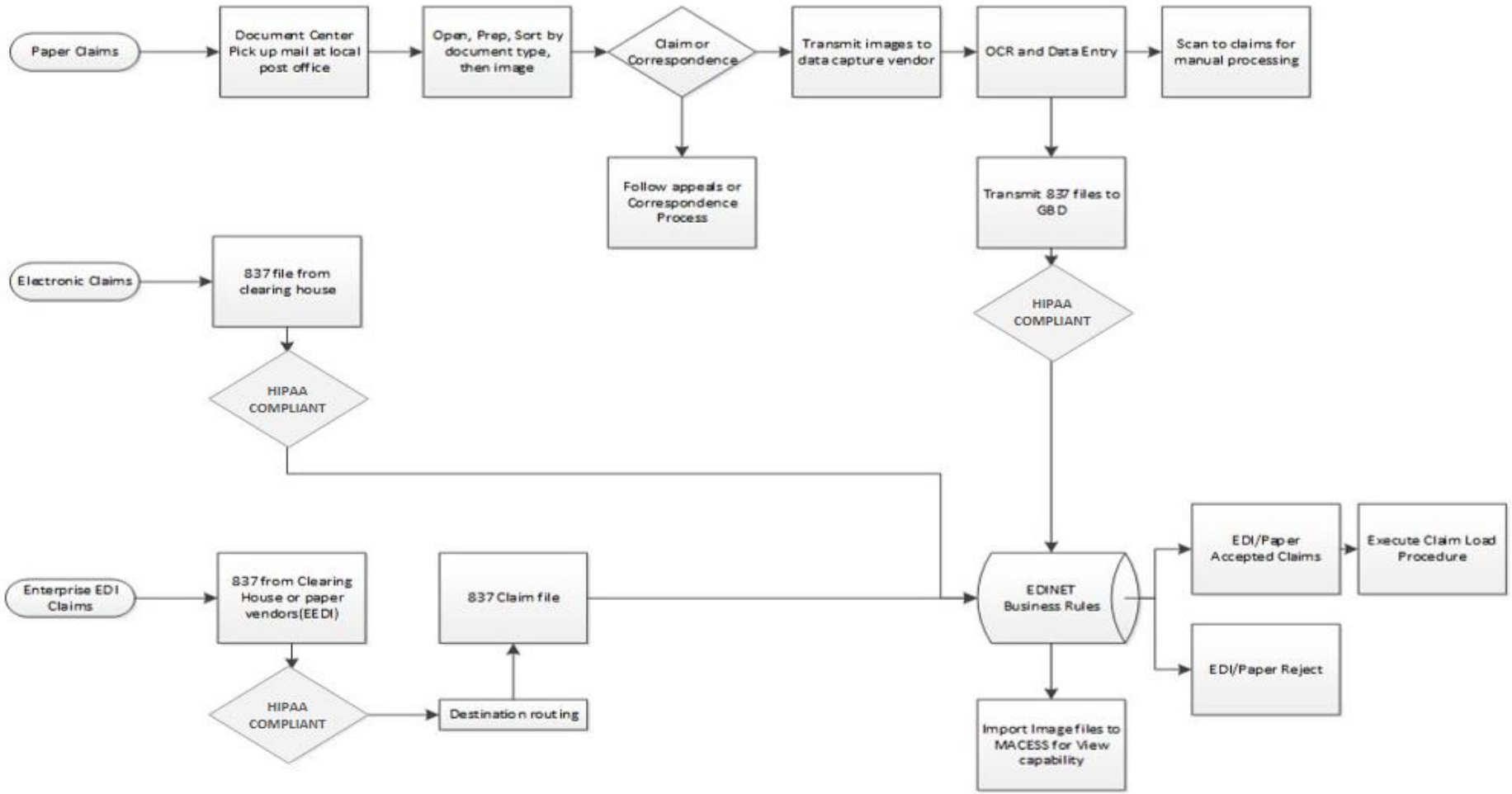
Availity Essentials

- **Availity Essentials** (Availity.com) is used by Healthy Blue providers to securely access patient information such as eligibility, benefits, claim status, authorizations, and other proprietary information. If you have questions about Availity registration or navigation or questions on an Availity application, contact Availity Client Services at **800-282-4548** (Monday through Friday from 8 a.m. to 8 p.m.) or submit a support ticket via Availity (Availity.com/contact-us). If you have questions or need assistance with any other item, contact Healthy Blue Provider Services at **844-594-5072**.
- Find these tools on Availity:
  - Claims submission
  - Claims status inquiry and claim dispute
  - Clear Claims Connection™
  - Authorizations
  - Precertification lookup tool
  - Eligibility and benefits inquiry
  - Registration for provider online reporting
  - Patient360

Availity Essentials (cont.)

- If you are new to Availity:
  - You can register with Availity at **Availity.com**.
  - You will need to name an administrator to grant you access to system functions needed for your role.
- If you already use Availity Essentials:
  - No additional registration is needed.
  - The Healthy Blue icon will be an available option from the **Payer Spaces** drop-down menu.
  - You can find out who your Availity Essentials administrator is by:
    - Selecting the **My Account** mention option listed in the top right of the *Availity Essentials* home page.
    - Selecting the **Organization(s)** menu option.
    - Selecting the **Open My Administrators** link.
    - Selecting **Your Organization**.

Life cycle of a claim



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Claim submission

- Options to submit claims:
  - Electronic claim submission
  - Paper claim submission
- Submit electronic claims through electronic data interchange (EDI) using your existing clearinghouse. The clearinghouse must be able to connect to Availity.
- Providers must submit claims within 365 calendar days:
  - From the date of discharge for inpatient services
  - From the date of service for outpatient services
- Because of the importance of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and the collection of data related to these services, we encourage providers to submit EPSDT claims as soon as possible.

Paper claim submission

- When submitting paper claims, providers must complete the *UB-04* or *CMS-1500* claim form on the original claim form with typed information or computer printed in large dark font.
- The paper claim submission address is:

  Blue Cross NC | Healthy Blue

  Claims Department

  P.O. Box 61010

  Virginia Beach, VA 23466

Electronic claim submission and EFT

- Electronic claim submission will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance Strategic National Implementation Process (SNIP) levels.
- Provider and member data will be verified against state reference data for accuracy and active status. Be sure to validate this data in advance of claims submission. This validation will apply to all provider data submitted including atypical and out-of-state providers.
- EnrollSafe replaced CAQH Enrollhub as the electronic funds transfer (EFT) enrollment website on November 1, 2021, for Healthy Blue providers with Blue Cross NC.
- Providers who are registered Availity users can enroll to receive electronic remittance advice (ERA) files from several payers. The ERAs display payment information for all claims, whether submitted electronically or via paper.

Common denial reasons

- Submitted after timely filing limit
- Disallow — not allowed under the provider's contract
- Serum available at no cost through Vaccines for Children (VFC)
- Duplicate claim
- Not a covered service
- PEGA — *Explanation of Benefits* (*EOB*) required from primary carrier
- Incidental to a current procedure
- Not separately reimbursable
- Preauthorization not obtained
- No Medicaid number and/or disclosure form

Also check the **Known Issues List** each Friday on the Healthy Blue provider website home page: provider.healthybluenc.com

Prior authorization

- What is a prior authorization (PA)?
  - A PA, sometimes referred to as a pre-authorization or pre-certification, is a Healthy Blue requirement. A provider must obtain approval from the member's plan before it will cover the costs of certain medicines, medical devices, or procedures.
- How to submit a PA request:
  - The **preferred** way to submit and manage PA requests is by using the interactive care reviewer (ICR) on Availity Essentials.
  - Providers can call Healthy Blue Provider Services at **844-594-5072** to start a PA request including an **urgent** authorization request.
  - Use the PA fax number (**855-817-5788)** if you would like to fax a paper request:
    - For behavioral health inpatient, fax to **844-439-3574**.
    - For behavioral health outpatient, fax to **844-429-9636**.

Common overpayment reasons

Listed here are common overpayment reasons for providers. Providers are encouraged to reference the Healthy Blue billing guide for additional information for each reason:

- Anesthesia modifier AA
- Duplicate professional/independent lab claims
- Global obstetrics (OB) procedures overpayments
- Initial versus subsequent hospital Evaluation/Management (E/M) codes
- Multiple surgery reduction professional

Vision and non-emergency medical transportation vendors

- **EyeMed** provides vision services for Healthy Blue members, including:
  - Routine vision services.
  - Dispensing feed.
  - Medical and surgical services.
  - **Note:** EyeMed will **not** be administering routine eyeglasses. Eyewear will continue to be ordered directly from Correction Enterprises.

- **Modivcare** provides non-emergency medical transportation (NEMT) services:
  - NEMT requests do not require prior authorization.
  - Minimum two-day notice is required except in the case of life-sustaining treatments, such as dialysis, chemotherapy, or discharge from the hospital.
  - All questions regarding reservations and ride assistance should be directed to Modivcare by contacting them at **855-397-3602**.

Prior authorization (cont.)

- How are the authorizations sent to the providers?
  - Approvals are auto-generated, sent electronically, and mailed out.
  - The utilization management manual letter team sends out a denial notification via fax, which is followed up by a denial letter in the mail.
  - If the PA request is reduced, Utilization Management (UM) auto-generates an approval letter for the approved portion and follow the manual letter process for reduced portion.
- What information is displayed on the authorization? Does it specify the CPT® codes the provider requested?
  - If the CPT code is submitted correctly, UM can see the code on the request.
  - UM utilizes the service group for the CPT code and lists it on the approval.
  - Patient360 allows the user to see the CPT code and other details on the request.

Electronic visit verification vendor

- **CareBridge** is our electronic visit verification (EVV) vendor who improves processes that enable the care for Healthy Blue members who receive home and community-based services:
  - EVV is the electronic verification process for Medicaid home- and community-based services (HBCS) performed in a member's home or in the community.
  - EVV captures six items in real time: date, location, start and end time, service provided, caregiver providing service, and member receiving service.
  - EVV is required for CPT® code 99509 with a HA or HB modifier. If the provider agency provides these services to Medicaid members, then they will need to use an EVV platform.
  - EVV is required for specific state-mandated home health revenue codes for taxonomy 251E00000X.
  - Providers can use an alternate EVV platform; however, they must make sure their EVV system or vendor completes the integration activities with CareBridge.

Guidance for RHCs and FQHCs

- RHC and FQHC core services are clinical services. Clinical services are not listed as services that require copayments.
- To locate RHC/FQHC core services, please refer to *Clinical Coverage Policy 1D-4* or the Healthy Blue provider manual.
- RHCs and FQHCs may bill their core service code, HCPCS code T1015, including HI and SC modifiers when appropriate.
- Refer to *Clinical Coverage Policy No: 1D-4 Attachment A* to bill for core services.
- If services are provided on the same day, please review *Clinical Coverage Policy No:1D-4 Attachment B.*

Utilization service review vendor

- Carelon Medical Benefits Management, Inc.* provides a review of diagnostic imaging, cardiology, musculoskeletal, and rehabilitation services for Healthy Blue members:
  - Carelon Medical Benefits Management will follow the clinical hierarchy established by Blue Cross NC for medical necessity determination. It will determine medical necessity using an objective, evidence-based process when existing guidance does not provide sufficient clinical detail.
  - Three classifications of therapies fall under the coverage of Carelon; Rehabilitative, Habilitative, and Maintenance.
  - Detailed prior authorization requirements are available online at **Availity.com** through the **Precertification Lookup Tool** accessed under Payer Spaces | Applications or on the Healthy Blue website.
  - Providers are strongly encouraged to verify they have obtained prior authorization before scheduling and performing services.

Tobacco cessation

- The Healthy Blue plan collaborates and aligns with department guidance to include benefit coverage and educational campaigns for providers and members.
- The plan's objectives are to:
  - Increase member awareness of benefits through live, outbound calls, text/IVR messaging, and referrals from medical management staff.
  - Progress tobacco cessation clinical guidelines through network provider training and provider forums and develop tobacco-free policies for medical and behavioral campuses.
  - Support providers who provide tobacco cessation counseling.
  - Offer virtual tobacco cessation counseling through Optum Quit for Life® program.
  - Remove any barriers related to co-pays, prior authorizations, cost limits, etc.

Guidance for 340B drugs

- 340B participating providers must register with HRSA's Office of Pharmacy Affairs (OPA).
- The 340B drugs are reimbursable as part of the North Carolina Physician Administered Drug Program (PADP):
  - Covers primarily injectable drugs used in physician's offices or outpatient clinics
- Most drugs in the PADP catalog must have a manufacturer's rebate agreement with the Centers for Medicare & Medicaid Services (CMS):
  - Drugs purchased under the 340B program are excluded from the manufacturer's rebates.

Guidance for 340B drugs (cont.)

- When dispensing 340B drugs, providers must submit the actual purchased drug price, reflecting their acquisition cost.
- Medicaid cannot be billed the standard price for drugs purchased under the 340B program.
- The UD modifier must be appended on the drug detail to indicate a 340B-purchased drug.
- Maximum daily and monthly quantity limits apply and amounts exceeding these limits may be denied.
- All drugs and biologics, with their 11-digit National Drug Codes (NDCs) and corresponding procedure (HCPCS) codes, must be classified as CMS-covered outpatient drugs from a labeler/manufacturer participating in the Medicaid Drug Rebate Program (MDRP).

Guidance for skilled nursing facilities (SNF)

- Once Blue Cross NC reviews and approves the authorization for Healthy Blue members, follow this process to bill for skilled nursing services:
  - The SNF needs to request an authorization for services.
  - Once the entity reviews and approves, the authorization approval letter is sent to the provider.
  - The provider then sends the authorization approval letter to the local Department of Social Services (DSS) for the patient monthly liability (PML) to be reviewed.
- Once the local DSS reviews the PML and approves, Blue Cross NC is notified via the Healthy Blue enrollment file. Blue Cross NC can then process the Healthy Blue claims.

State guidance for PML

- For claims submitted prior to PML determination, the clean claim date can be no earlier than the date the PML has been received on the X12 834.
- Blue Cross NC is expected to pend nursing facility claims submitted prior to PML determination as unclean claims until the lesser of 90 calendar days of receipt of the claim **or** the PML is received via the 834 and the claim is otherwise considered to be clean by Blue Cross NC.
- If the PML is not received by Blue Cross NC within 90 calendar days of receipt of the claim, Blue Cross NC may deny the claim.
- If the PML is received within one year after the date of denial notice, Blue Cross NC is required to reopen and process the claim.

Physician Administered Drug Program

- The Physician Administered Drug Program (PADP) uses the following guidance regarding HCPCS/NDC crosswalk with regards to drugs and products covered under the medical pharmacy benefit:
  - Professional claim submission — Drugs are rebate-eligible and pay at the PADP fee schedule.
  - Outpatient dialysis claim submission — Claims must be billed with the dialysis taxonomy and must include a valid HCPCS code as well as a valid/active NDC. These claims are reimbursed at the dialysis center claims rate.
  - Outpatient hospital claim submission — Drugs must be rebate eligible and will be paid based on the PADP fee schedule.
  - Inpatient hospital claim submission — Rebates are not collected for inpatient drugs, and the PADP program is not applicable to inpatient claims.

Vaccines for Children

- Blue Cross NC allows for reimbursement of the administration fee for vaccines provided by the Vaccines for Children (VFC) Program.
- Medicaid providers who participate in the VFC program must comply with all reporting requirements and procedures.
- Although providers will only be reimbursed for the administration of the vaccine, the serum code(s) must be included on the claim to meet regulatory and HEDIS® reporting requirements.

Newborn claims

- Newborns **must** have their permanent assigned Medicaid ID prior to the provider billing for services.
- Newborn claims should not and cannot be billed under the mother's Medicaid ID number.
- Hospitals are required to submit the *Delivery Notification* form to the entity within 24 hours of delivery
- Newborn delivery does not require a prior authorization if the hospital stay is within the 48-hour delivery window for vaginal delivery or 96-hour delivery window for cesarean delivery.

Electronic claims attachments

- Blue Cross NC accepts electronic claim attachments via Availity Essentials or EDI 275 transaction.
- Attachment examples include:
  - Sterilization consent forms.
  - Hysterectomy statements.
  - Abortion statements.

High dollar claim reviews

- CERIS currently performs inpatient facility claim reviews for Healthy Blue members on behalf of Blue Cross NC.
- CERIS' line-item bill review process identifies errors, unrelated charges, and non-separately reimbursable charges on facility claims for inpatient services.
- Any in-network or out-of-network inpatient claim on a prepayment basis, billed at ≥ $250,000, with an outlier reimbursement that is ≥ $2,500 over the base diagnostic related groups (DRG) are eligible for these reviews.
- CERIS may request documentation, such as an itemized bill, to conduct the professional review. Once contacted, please submit requested information within seven calendar days.

Wrap up

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Questions & answers

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Thank you!

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Notes:

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.

https://provider.healthybluenc.com

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