Claims Adjudication in NCTracks

During the design and development of any new MMIS claims adjudication system, there are opportunities to revisit internal business processes and calculation methods regarding claims payment. During the design and development of NCTracks, the new N.C. Department of Health and Human Services (DHHS) multi-payer system, a number of internal processes were identified that can now be standardized and refined. The standardization and refinement of these business processes does not mean that DHHS has modified its clinical or reimbursement policies that were approved and published previously to the provider community. NCTracks has provided the ability to refine how the system utilizes these business processes for calculating the payment amounts and applying the policies.

The best way to communicate these opportunities for standardization and refinement of these business processes is to give some examples as follows:

Example 1—NCTracks reimbursement rates will not be rounded to the nearly whole dollar.

The implementation of NCTracks will enable the use of the exact rates established by the Department without any rounding of rates.

Example 2—Payment logic for claims indicating there is Medicare and Insurance coverage/payment.

With the implementation of NCTracks, and in those instances where the billing claim formats are the same for Medicare and Medicaid, NCTracks will accept the Medicare crossover claim and will process the Medicaid portion in accordance with Medicaid rules. For Professional claims, Medicaid will no longer use the estimated percentage table, but process using the coordination of benefits claim data.

For those providers whose Medicaid claim formats are not the same as Medicare formats, they will need to continue filing Medicaid secondary claims. It is the future intent of DHB to change billing formats to match Medicare formats. This improvement will allow NCTracks to process all crossover claims and reduce provider burden.

For claims that indicate third party insurance coverage, DHHS will utilize a standard calculation for determining the payment. This payment methodology takes into account payment difference between cost share (co-pay/deductible/co-insurance) versus Medicaid-allowed amount minus the primary payer payment and select the lower amount. In legacy systems there are multiple payment calculation methods for various claims.

Example 3—Inpatient DRG calculation utilizes admission date for eligibility determination.

The DHB-approved reimbursement policy is to use the admission date for eligibility determination. Under the legacy system, the recipient eligibility was determined on date of discharge date. NCTracks utilizes the “admit date of service” for eligibility determination. With the implementation of NCTracks, the State has the capability to process claims in a multi-payer environment. To accommodate this, one of the improvements will be using the admission date as the determination as to which payer benefit plan the claim will adjudicate under. Thus, for hospital DRG claims in which the payment is all-inclusive of the hospital admission through discharge, the benefit to providers is that they will know which benefit plan rules will apply.

Besides the policy examples cited above, providers will notice other differences between legacy systems and NCTracks. Many of these new system requirements will cause claims to deny, so providers should become familiar with them.

Example 4—Taxonomy and service address can deny claims.

NCTracks relies on taxonomy codes to properly assign service location, claim type and to price the claim. Submitted claims with service codes that do not correlate to provider taxonomy and location on file will deny. NCTracks incorporates new EOBs to ensure the submitted taxonomy codes are on file for the provider and are valid for the service being billed.

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Claims Adjudication and NCTracks, cont.

Accurate information on where services are rendered is vital to ensuring claims process correctly in NCTracks. NCTracks uses this 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 fail.

Providers can review their active taxonomy codes on file for service locations, based on NPI or EIN, in the online look-up feature at *http://ncmmis.ncdhhs.gov/taxonomy.asp*. In case of discrepancies or omissions, providers must wait until NCTracks goes live July 1 to make corrections online at *www.nctracks.nc.gov*. Changes to a provider's taxonomy must be verified, which can take up to a week. While the change is pending, providers could have claims denied. To prevent this, providers should use the Enrollment "Status and Management" button in the secure NCTracks Provider Portal to ensure the changes have been accepted before submitting claims. (See the eLearning CBT courses on "Provider Records" and "Updating Provider Data" in SkillPort via *NCTracks Training*.)

Example 5—Rendering providers must have a non-group enrollment and taxonomy.

N.C. DHHS policies require many services to be provided by actively enrolled service providers. For DHHS claims, the submitted rendering provider cannot be defined exclusively as a group within NCTracks. Therefore in NCTracks, rendering providers must be enrolled with at least one non-group based taxonomy code.

In cases where claims are submitted in NCTracks with rendering providers that are either not active or enrolled only as a group, these claims can deny. Hospitals, local health departments and federally qualified health centers (FQHCs) are the providers most likely to be affected by this.

In NCTracks, rendering providers must also be enrolled with the rendering taxonomy code being submitted on the claim. Claims will fail if the submitted rendering taxonomy code is either not active or not on file in NCTracks.

Example 6—Validate recipient identification numbers.

Claims submitted with incorrect or incomplete recipient identification numbers will be denied. Providers should validate the full recipient identification number (9 numeric digits and 1 alphabetic character) for all recipients before submitting claims to NCTracks.

Example 7—Accommodation rates allocation.

Inpatient hospitals will notice that NCTracks allocates the accommodation rate days across all accommodation lines for DRG transfers. This does not affect overall reimbursement.

Example 8—Replaced TCN field for Replacements and Voids.

Providers should enter data in the Replaced TCN field only if the claim is a replacement of a void claim. NCTracks checks this field on all claims, so if the Replaced TCN field is populated for an original claim, the claim will be denied.

Example 9—Pharmacy providers must list Place of Service.

NCTracks requires the Place of Service field to be populated on all NCPDP claim submissions. Pharmacy claims will fail without the Place of Service field populated.

Example 10—Pharmacy Diagnosis Codes - no decimals allowed.

NCTracks does not allow a decimal point in this field and it will cause a claim to fail. To avoid denial, enter diagnosis codes without any decimal or special characters in the required field.