

Claims and Enrollment Guide Fiscal Year 2026-2027

Alliance Health

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Introduction

Welcome to the Alliance Health Tailored Plan

Welcome to the Alliance Provider Network. As a member of our network, you join a select, progressive group of providers who are dedicated to providing quality care for the Individuals of publicly-funded mental health (MH), intellectual and developmental disabilities (I/DD) and substance use (SU) services in Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. As a provider, you represent our network to the people we serve, and join us in our mission to help people with disabilities and special needs improve the quality of their lives.

As a contracted provider with Alliance Health (Alliance), it is your responsibility to be familiar and comply with all federal and state laws, rules and regulations governing the provision of MH/I/DD/SA services and the processes outlined in this manual. Failure to comply with rules, regulations, and practices,including those outlined in this manual, may constitute a material breach of your contract with Alliance and could result in sanction or administrative action by Alliance, up to and including termination from the network. This manual documents information about Alliance including our purpose, mission, vision and core values, and describes our processes related to participating in the Provider Network including obtaining referrals and authorizations, submitting claims and resolving many issues or problems. We have also included a glossary of frequently used terms for your reference and links to necessary forms. Your compliance with the requirements of this manual will assist Alliance in providing you with timely service authorizations and claims reimbursement.

Please note that this manual will change over time in response to changes in Alliance practices, federal and state law, rules, regulations and Department of Health and Human Services (DHHS) directives. In order to ensure high quality care, Alliance reserves the right to adopt more restrictive processes, policies and procedures than are required by state and federal rules and regulations. Alliance will strive to provide thirty days' advance notice of any material changes to this manual.

Nothing in this manual is intended, or should be construed, to create any enforceable rights, expectations or cause of action against Alliance for any provider or individual. All timelines in this document refer to calendar days unless otherwise specified. A business or working day refers to a day on which Alliance is officially open for business. Alliance Health is a multi-county area authority/Local Management Entity (LME) established and operating in accordance with Chapter 122C of the North Carolina General Statutes. We are a political subdivision of the State of North Carolina and an agency of local government. Additionally, Alliance operates as a regional Prepaid Inpatient Health Plan (PIHP) on a capitated risk basis for behavioral health services. A PIHP is a type of Managed Care Organization (MCO) as described in 42 CFR Part 438. Capitation means that Alliance receives funding on a per-member-per-month (PMPM) basis, which covers both treatment services and administrative costs, for the entire Medicaid network population in the four Alliance counties. Capitation supports the type of creative flexibility necessary in an individual-driven system of care.

Alliance also receives a limited allocation from the North Carolina Department of Health and Human Services for State-funded MH/IDD/SA services, and some competitive grant funding. As an LME/MCO, Alliance is responsible for authorizing, managing, coordinating, facilitating and monitoring the provision of state, federal and Medicaid-funded MH/IDD/SA services in Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake counties. The LME/MCO model developed by the state uses a funding strategy that includes single management of all public funding resources through a local public system manager. Under this model, Alliance receives funding from multiple federal, state and county sources. The financing provides for coordination

and blending of funding resources, collaboration with out-of-system resources appropriate and accountable distribution of resources, and allocation of the most resources to the people with the greatest disabilities. Re-engineering the system away from unnecessary high-cost and institutional use to a community-based system requires that a single entity has the authority to manage the full continuum of care. This document will provide you with basic information regarding the member eligibility, member enrollment, and claims processes at Alliance Health.

Reminders:

- The Claims & Enrollment Guide should be used along with the Provider Operations Manual and Provider Contract, as well as material published on the DHB, DMH, NCTracks, and Alliance Health websites to guide your practices. Additionally, providers are encouraged to follow Alliance Health Provider Updates for timely notification of changes throughout the year.
- This document is posted on our website AllianceHealthPlan.org.
- The Alliance Claims System (ACS) is the information management system that will be used for processing member enrollments and updates and for processing service claims filed through Alliance Health.

Provider Training/Technical Assistance

The Claims and Enrollment team now offers a brand-new self paced e-learning course, which provides an overview of the claims filing and enrollment process at Alliance Health.

The Claims Department offers virtual sessions for individualized assistance with claims-related matters. These sessions are specifically designed for agency, organization, or company-related issues concerning claims submissions and denials. Please note that space is limited each week, and registration is required. Training announcements can be found within the Provider Updates: Provider Updates Archive - Alliance Health (AllianceHealthPlan.org)

Verifying Your Agency Details in the ACS System

It is critical to verify the details of your agency prior to submission of claims to ensure correct processing. The following instructions review tabs and tiles that are critical in your claims processing.

Claim Site Selection – 837 Files - When submitting claims electronically via 837 files, the address in the billing loop must reflect the site where services were rendered. This address, including zip+4, must match exactly as the site address appears in NC Tracks. Claims submitted with inaccurate information in this loop can result in incorrect site mapping and claim denials.

Base Provider Tab: From the main menu, choose Provider Details. Double click on provider name to expand the view. Select details to review contract information. Verify the tax ID, and the NPI number. The NPI number listed is what will be considered the "main" number for your agency. If you would like us to consider another number as the "main" number, please email us at: providernetwork@alliancehealthplan.org or you may call 919-651-8500 and choose option 4 – Provider Network.

Site Tab: On the second tab, the multiple sites for the agency are listed. Your agency may have sites that contain the license name or the street name. Click on the site name to expand the view. Verify the address and NPI number for each site. A site can have multiple NPI numbers. Note: That when you click on the different sites, the header information will change according to the site name.

Site Mapping Tab: It is important for the agency to verify the NPI numbers and taxonomies associated with each site. The taxonomies can be seen by clicking on a site and then clicking on Bill Type Specialty.

Contract Tab: This is a critical tab in that it will show what services are in your contract and at what location they can be provided. To verify the procedure codes, click on a contract to expand the Contract Details. It is important that your agency verify each procedure code to each site. Your billing will not process if you bill a service that is not linked to the right site on this tile.

If you experience any issues related to agency information in ACS or need changes, please email us at providernetwork@AllianceHealthPlan.org or you may call 919-651-8500 and choose option 4 – Provider Network.

Enrollment/Eligibility and Claims Submission Guidelines

- ACS has a web-based provider portal that allows providers to submit enrollments to the LME/MCO. Use this link for information regarding enrollment and updates: AllianceHealthPlan.org/providers/network/billing-and-claims/information/
- Enrollments are used to request state funding for members who do not have insurance. (Medicaid, Medicare, or private insurance)
- All enrollment requests must be submitted within 14 business days of the admission date or first date of service.
- Enrollments require a compatible diagnosis and NCTracks Benefit Plan to indicate the disability they are receiving services for.
- Medicaid recipients are automatically enrolled in ACS via an electronic file from NC Tracks according to their eligibility to receive BH services.
- Enrollments and client update requests are subject to review by Alliance's eligibility and enrollment staff.
- All requests are reviewed for completeness, eligibility, residency and household income.
- Client updates are used to add or update any information in a consumers record who has state insurance.
- Client Updates must be submitted within 14 calendar days of the submission date or expiration of the previous NC Tracks Benefit Plan.
- Please be advised, you cannot request state funding using a client update.
- Enrollments and client update requests are subject to review by Alliance's eligibility and enrollment staff.
- All requests are reviewed for completeness, eligibility, residency and household income

Claims Filing

Alliance Health is required by North Carolina and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider to ensure timely processing of claims.

Healthcare providers interested in participating in the Alliance Health Medicaid network or in providing services to members/recipients in the Alliance Health network must be enrolled in NC Tracks as a Medicaid provider. This applies to out-of-state providers as well. Claims for all services provided to Alliance Health members must be submitted by the provider who performed the services.

Alliance Health works with four specialized vendors to process claims for durable medical equipment, vision, pharmacy, and non-emergency medical transportation:

Service	Vendor Name	Provider Portal
Pharmacy	Navitus	Pharmacy Claim Filing
Vision	Avesis	Vision Provider Portal
NEMT	Modivcare	NEMT Provider Portal
DME	Northwood	DME Provider Portal

Submitting Claims via Manual Entry Into ACS Portal

Claims may be keyed directly into the ACS Provider Portal. This is a web-based portal that allows providers to submit claims to the LME/MCO. Within the portal, claims can be submitted via a CMS 1500/UB04. https://acs.AllianceHealthPlan.org/portallogin

UB-04 CLAIM:

To manually enter a claim, select the green Create button. The Claim Entry Form will appear. Before entering data, verify that the correct claim form type was selected by checking the displayed form title.

Provider Search	Select this button to search for both Active/Inactive providers currently entered in ACS and associated with the claim being entered. Search by Provider ID, Name, Status, Specialty, Org Type, or Zip Code. Click on the provider once located in the returned list, and the Select Provider button will become available to select. Repeat this process to change the provider.
Patient Search	Select this button to search for the Active/Inactive members associated with the claim and currently entered in ACS. Search by Patient ID, Last Name, First Name, Insurance #, SSN, DOB, or MRN#. Click on the member once found in the returned list, and the Select Patient button will become available to select. Repeat this process to change the member. If neither provider nor member is returned in the search, try adjusting the search parameters, and make sure that the provider exists in ACS.
Add Services	Select the Add button to enter all services associated with the claim. The Revenue Code, Revenue Code Description, Number of Units, Total Charges, and Non-Coverage Charges are required to enter a service. The HIPPS Code and Service Date can also be entered. Select Save. Repeat this process for each additional service. Once the user begins to key the revenue code, a list of codes is provided. Select the appropriate
Modify Services	Select the desired service from the list of entered services, then select the Modify button to make changes to the existing entry. Select Save.
Remove Services	Select the desired service from the list of entered services, then select the Remove button to delete the entry. ACS does not provide any warnings before deleting the service from the claim form. Note: If the member has a Patient Monthly Liability amount, or PML, this should be entered in the COB Amount field in box 24 on the CMS 1500. On the UB-04, it's entered in box 39a.
Add Previous Payer	Add previous payer information.

Bill Type	A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.
Print, Cancel, Save, or Submit	Print: Allows the user to save a copy of the claim form. Cancel: Allow the user to exit the form without saving. Save: Allows the un-submitted claim to remain in queue for 30 days. Submit: Submits the completed claim for processing.

CMS 1500 CLAIM:

Patient Search	Select this button to search for the Active/Inactive members associated with the claim and currently entered in ACS. Search by Patient ID, Last Name, First Name, Insurance #, SSN, DOB, or MRN#. Click on the member once found in the returned list, and the Select Patient button will become available to select. Repeat this process to change the member. Note: Once a claim is submitted, use Filter to search for the submitted claim. Once located, select the Copy button to create a template. This allows the user to copy, edit pertinent information like the date of service, and submit as a new claim.
Provider Search	Select this button to search for both Active/Inactive providers currently entered in ACS and associated with the claim being entered. Search by Provider ID, Name, Status, Specialty, Org Type, or Zip Code. Click on the provider once located in the returned list, and the Select Provider button will become available to select. Repeat this process to change the provider.
Add Services	Once the provider is located, select the Add button to enter services. Contracted services, taxonomy codes, NPI, and other service information relevant to the claim and will be entered here.
Modify Services	To modify service entry, select the desired service record, then modify to edit service information.
Remove Service	To remove a service, select the service then Remove to delete the record.
Print, Cancel, Save, or Submit	Print: Allows the user to save a copy of the claim form. Cancel: Allow the user to exit the form without saving. Save: Allows the un-submitted claim to remain in queue for 30 days. Submit: Submits the completed claim for processing.

Searching for an Existing Keyed Claim in ACS Provider Portal From the Finance Menu

Filter	Once the appropriate claim type is selected from the Finance menu, the user can search for existing claims in ACS by selecting the Filter button. A claim can be searched for by entering the Last Name, First Name, Status, User ID, Date Type, Start Date, End Date, My MCS Claim #, or Adjudication ID on the claim. Select the record of interest and it will turn blue and expand, revealing additional options. Please note that information about the member on the claim is displayed at the top of the page. Click on the blue triangle to expand. Select an individual claim record for additional information about that claim line or select the symbol to access additional information about all the claim records returned from the search.
View, Update, Copy, and Details	Once the appropriate claim type is selected, the user can search for existing claims in ACS by selecting the Filter button.
View	Select View to review a full "read only" copy of the CMS1500 or UB04 claim selected. A copy of the claim can also be printed from this location by selecting Print at the bottom of the form.
Update	Select Update to edit a Saved claim. Once completed, it can be saved once again or select Submit to process. The user can also print the claim or cancel without making any changes. Note: A claim must be in saved status to be updated. A claim will remain saved for 90 days.

Submitting Claims via Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) allows for faster, more efficient and cost-effective claim submission for providers and reduces administrative costs.

Electronic claim submissions to Alliance Health should follow the same process as other electronic commercial submissions. To initiate electronic claims:

- Utilize or inform your vendor to use the Alliance Health EDI Payer ID#: 23071.
- Submit the required Trading Partner Agreement (TPA) & Connectivity Form that will be used for submission of 837s. Providers will receive a TPA with their contract. The TPA can be used for both state and Medicaid claims. The agreement needs to be signed only once for the fiscal year. It will be in effect for the entire fiscal year or until the provider makes changes to addresses, contacts, etc. Additionally, the Alliance Notice of Change form must be completed and submitted to the Contracts Department when any change occurs.
- If you have completed testing for 837s and you do not see that your EDI Certified box is checked, please contact the Alliance EDI specialist for assistance. Claims submitted via an 837 will not be processed if the EDI Certified box is not checked. Please limit your first 837 file to no more than 5 to 10 claims.

Please refer to the 837 companion guides below for the appropriate formatting of your file.

837 Professional Companion Guide

837 Institutional Companion Guide

Invalid Electronic Claim Record Rejections/ Denials

All claim records sent to Alliance Health must first pass plan-specific edits as well as edits required by your EDI vendor prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Alliance Health. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 365 calendar days from the date of service for Medicaid claims and within 90 calendar days from the date of service for state claims. It is important that you review your claim status reports received from your EDI software vendor in order to identify rejections and re-submit these claims timely.

Electronic Billing Inquiries

If you would like to transmit claims electronically	Submit a Trading Partner Agreement and Connectivity Form here
If you have general EDI questions	Contact EDINotifications@AllianceHealthPlan.org
If you have questions about claims that are reported on the Remittance Advice	Contact Provider Network Helpdesk at 1-855-759-9700
If you need to know your provider NPI number	Contact Provider Network Helpdesk at 1-855-759-9700
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information or questions about changing or verifying provider information	Contact Provider Network Helpdesk at 1-855-759-9700
If you would like information on the 835 Remittance Advice	Contact your clearinghouse (if you use one) OR contact EDInotifications@AllianceHealthPlan.org
Check the status of your claim	Contact Provider Network Helpdesk at 1-855-759-9700

Submitting Claims via Paper/Mail

Out-of-Network Providers may submit paper claims to: Claims Department, 5200 W Paramount Parkway, Ste 200, Morrisville, NC 27560. Any required documentation for claims processing should accompany the paper claim.

Paper claims are not accepted from in-network providers unless prior approval is requested via the Paper Claims Request form prior to submission and the request is approved. If Alliance Health receives a paper claim for an in-network provider, the claim will be mailed back to sender.

General Billing Information

Denied Claims	Denied claims may **NOT** be replaced. Providers should make necessary changes and submit a fresh claim when appropriate. Replacement claims may only be submitted for claims with a prior payment on them.
NCCI Edits	Alliance Health applies National Correct Coding Initiative (NCCI) edits (provided by NC DHB) to claims. The NCCI contains two types of edits: (1) NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should never be reported together. There are some code pairs that should only be used together under certain conditions by using specific modifiers. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported; and (2) Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.
NPI/Taxonomy Updates	Current NPI/Taxonomy information must be on file and displayed in the ACS. It is the provider's responsibility to ensure that the information is accurate and updated. When updates occur after claims have processed, the provider is responsible for identifying impacted claims and making a request to claims@alliancehealthplan.org for reprocessing of claims. The request should include a complete list of claim headers impacted.
NCTracks Registration	Providers must be enrolled in NCTracks prior to contracting with Alliance. Providers are responsible for ensuring accurate and complete information is registered with NCTracks and that all registrations remain current. The provider and site detail registered in NCTracks must match information placed on claims.
Diagnoses	All submitted diagnoses on a claim must be valid. Certain services require a Diagnosis that is specific to the service being rendered. For those services, ACS will edit against the service and diagnosis compatibility.
Distinct Part Unit (DPU) Claims	When a member has a medically appropriate transfer from a medical/surgical bed to a psychiatric/rehabilitative distinct part unit within the same hospital or to a specialty hospital, the admission to the DPU or specialty hospital is recognized as a separate service which is eligible for reimbursement under the per diem methodology. As such, both providers would submit a claim- each indicating an admission and discharge date.
Non-Distinct Part Unit (Non-DPU) Claims	When a member has a transfer within a general hospital from acute care services to non-DPU psychiatric/rehabilitative services, the entire hospital stay shall be reimbursed under DRG methodology.

Rate Updates	Physical health rates following the DHB fee schedules will be updated in accordance with DHB direction. Behavioral health rates will be updated on a regular basis. When rates are updated, information will be available on our website. If rate updates are retroactive, impacted claims will be reprocessed to ensure proper payment.
Physician Assisted Drug Program (PADP) and SevenFact	PADP claims are processed and reimbursed using the Physician Administered Drug Program Fee Schedule. Codes that require National Drug Codes on claim: drug-related A-codes, Q-codes, S-codes, C-codes; J-codes; Immunization/ Vaccine codes. Claims for SevenFact should be submitted with published rate provider obtains from Myers and Stauffer (800-763-2278). As this is a variable rate, provider should check rate each time rendered. SevenFact claims will pend in ACS for up to 15 days while the M&S rate is updated/published, at which time the claim can be processed.
Payer-Initiated Adjustments	Alliance Health reserves the right to adjust any payment made following a review of the claim submission or other documentation of the services provided to ensure proper adjudication/payment. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided and/or if the claim submission does not pass the encounter business rules set by DHHS.
Checkwrite Schedule	Claims payment is currently administered based on a claims processing cutoff date. There is a minimum one week span between the claims processing cutoff date and the actual date that checks are administered. An electronic RA is made available online to Providers within three business days after the check processing. Alliance will abide by prompt payment guidelines and pay all approved claims within 30 days from approval. Alliance is using the established standardized checkwrite published on the Alliance website.
Required Documentation	Services requiring documentation must have documentation submitted with the claim for timely processing. See pended claim section for list of required documentation.
Vaccines for Children Program	The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated. The Center for Disease Control and Prevention purchases the vaccine at a discounted rate for distribution to registered VFC providers. Eligible children are entitled to receive those vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). VFC providers who administer the vaccines should submit a claim for the administration of the vaccine (billed at administration rate) and the vaccine (billed at $0). For eligible individuals ages 19 or 20, the EP modifier should be affixed to the administration code.

Interim Claims	Interim Claims (bill types 0112 and 0117) will be handled as follows: 1. Initial and subsequent/replacement claims are reimbursed only if the covered days span at least 61 calendar days for bill types 0112 and 0117 or claims will be denied. 2. All continuing interim 0113 or discharge 0114 claims must be submitted as replacement claims 0117 to the previous interim/replacement claim. 3. All replacement interim claims must be submitted within 180 days of the previous interim claim statement period through date, if not received within 180 days the of the statement period through date on the previous claim statement, all payments made for all claims for the hospital stay will be recouped. 4. After a recoupment is made according to this plan, a subsequent “admit through discharge” or interim claim for payment will be considered for normal processing and payment unless the timely filing requirements exceeded. 5. The final claim is required and shall be submitted with a Beneficiary Status of discharged, expired, or transferred using the appropriate UB beneficiary status code. 6. The initial interim claim is submitted with bill type 0112 and discharge status 30. 7. For claims reimbursed as DRG, replacement claims are needed. Perdiem claims do not have to do replacement claims.
Split Claims	Claims not payable by DRG will need to be split based on benefit plan year.
Attending NPI	Attending NPI and associated taxonomy code must be included on all institutional claims. Note that the attending provider does not need to be employed by the facility but is the individual who has responsibility for the medical care/treatment of the beneficiary. The attending provider must be enrolled in the NC Medicaid program. The attending NPI must be an individual NPI number. Organizational NPIs billed as attending will be denied.

Claims Filed to Alliance Health are Subject to the Following Procedures:

- Verification that provider has an approved request to send paper claims document on file (if submitted via paper claims).
- Verification that the services were provided by a participating provider or an enrolled out-of-network provider.
- Verification that an authorization has been given for services that require prior authorization by Alliance Health.
- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services for the time period in which services were provided.
- Verification that a provider is not excluded from participation in federal health care programs and/or under any of the exclusion lists that the state requires Alliance Health to monitor.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that coordination of benefits occurred, when applicable.
- When required data elements are missing or are invalid, claims may be rejected by Alliance for correction and re-submission.

Pended Claims

Hearing Aid Services (specific codes: G5014, V5050, V5060, V5130, V5264, V5267, V5274)	Claims pend to review invoice. If invoice is not attached or insufficient, denials may occur with denial reason: (1) Service requires invoice for processing.
Physician Assisted Drug Program (PADP)	Claims pend to validate invoices and apply manual pricing. If required documentation is insufficient, denials may occur with denial reason: Service requires invoice for processing.
Modifier 66	Claims appended with modifier 66 will pend to validate the number of surgeons that performed the surgery in order to make the accurate payment. Claims submitted without the required documentation may deny for reason: Documentation indicating all surgeons on modifier 66.
Therapeutic Abortion Services	Claims will pend for review of required documentation as a signed consent form is required. Claims with no consent form on file or with insufficient consent form on file may deny for denial reason: Abortion consent statement missing or incomplete. https://medicaid.ncdhhs.gov/providers/forms/reproductive-health-forms.
Sterilization Services	Claims will pend for review of required documentation as a signed consent form is required. Claims with no consent form on file or with insufficient consent form on file may deny for denial reason: Sterilization consent form missing or incomplete. https://medicaid.ncdhhs.gov/providers/forms/reproductive-health-forms.
Hysterectomy	Claims will pend for review of required documentation which is the Hysterectomy Statement Form. https://medicaid.ncdhhs.gov/providers/forms/reproductive-health-forms.
Child Medical Exam (CME)	Claims will pend for review of assessment documentation. Claims with no documentation or insufficient documentation may deny for reason: CME checklist missing or incomplete.
Unlisted Service Codes	• Unlisted service codes must be submitted with documentation to support the use of the unlisted code. • If documentation is not received with the claim, the claim will pend for 30 days. • If documentation is not received, the unlisted service will be denied for "Unlisted service - submit documentation for review of service justification," and the service will need to be resubmitted with documentation. • Documentation should be labeled in ACS as "Support data for claim". • The documentation should be uploaded with the unlisted CPT/HCPC in the document name. • The effective date of the documentation should be the date of service of the unlisted service.

Claims Processing and Payment Timelines

Alliance Health follows prompt pay guidelines which state that we have 18 days to process a clean claim and 30 days to pay an approved claim. **Alliance Health shall within 18 calendar days of receiving a medical claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.**

Claim Filing Deadlines

All claims submitted to Alliance Health should be clean claims.

Claims must be submitted to Alliance Health within the prescribed calendar days from the date services were rendered (or the date of discharge for inpatient admissions). Please allow for normal processing time before re-submitting a claim either through the EDI, ACS portal, or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim.

Medicaid	365 days from date of service
State	90 days from date of service

Claims are not considered received under timely filing guidelines if they are rejected for missing or invalid provider or member data.

Timely Filing Exceptions

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid by Alliance Health, we will be entitled to recover any funds up to the amount owed by the third-party payer. While this is a requirement in most cases, there are exceptions when providers are not required to bill the third party prior to Alliance Health.

The exceptions are claims related to:

- Prenatal care for a pregnant woman.
- Preventive pediatric services (including EPSDT) that are covered by the Medicaid program.
- Vocational Rehabilitation Services
- Division of Service for the Blind
- Division of Public Health “Purchase of Care” Program
- Sickle cell program
- Crime Victims Compensation Fund
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Veteran’s Benefits for state nursing home per diem payments
- Veteran’s Benefits, for emergency treatment provided to certain veterans in a non- Veteran’s Affairs (VA) facility
- Women, Infants and Children Program
- Older Americans Act Programs
- World Trade Center Health Program
- Grantees under Title V of the Social Security Act (Maternal and Child Block Grant)

Following reimbursement to the provider in these cost avoidance exception cases, Alliance Health shall actively seek reimbursement from responsible third parties.

Corrected Claims

Corrected claims (or “replacement” claims) may be submitted for **previously approved** claims. Denied claims may not be followed by corrected/replaced claims. Rather, a new claim should be generated.

A corrected Medicaid claim must be submitted within 365 days of the original date of service. The original claim number must be submitted, as indicated below.

A corrected state claim must be submitted within 90 calendar days of the original date of service. The original claim number must be submitted, as indicated below.

You can find the original claim number from the 835 ERA, the Remittance Advice or from the Download Queue in ACS.

If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values "7" for the replacement (correction) of a prior claim and "8" for the void of a prior claim. The value "6" should not be sent.

In addition, the submitter must also provide the original claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

Claim Inquiries

Providers may contact our provider support line for assistance with claims status or general questions. The provider support team can provide valuable information and answer many inquiries. For questions requiring claims processing or more detailed information, the provider support line team will create a ticket for claims analysts to respond to.

You can reach the provider support line by phone at 1-855-759-9700. For claims inquiries, you may also send an email with all relevant information to claims@AllianceHealthPlan.org.

If responses are not received in a timely manner or are not satisfactory to the providers, an escalation can be requested. Escalations can be sent to:

- **Tina Everett**, Director of Claims: teverett@AllianceHealthPlan.org
- **Belinda Davis**, Claims Supervisor: bdavis1@AllianceHealthPlan.org
- **Janelle Cook**, Claims Supervisor: jcook@AllianceHealthPlan.org

Provider Claim Reconsideration Requests

Alliance Health will allow claim reconsiderations on denied clean claims. A clean claim is one that can be processed without obtaining additional information from the provider or a third party and with no changes to the submitted claim. Notifications of claim denials are provided by the remittance advice (RA) or by other final notification of payment, payment denial, disallowance or payment adjustment. All providers must submit requests for reconsideration of claims denials within 30 calendar days of this final notification. Reconsideration requests will be reviewed and responded to within 30 calendar days. Requests can be sent to: claimsreconsiderations@AllianceHealthPlan.org. The request should include a list of claims requiring review and justification for the claims to be reviewed.

Refunds for Claims Overpayments or Errors

Alliance Health encourages providers to conduct regular self-audits to ensure accurate payment. Medicaid program funds that were improperly paid or overpaid must be returned within 60 days of identifying the overpayment. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make immediate arrangements to return the funds to Alliance Health or follow the DHHS protocols for returning improper payments or overpayment.

Provider self-audit instructions can be found here. Questions related to the provider self-audit process may be directed to compliance@AllianceHealthPlan.org.

Third Party Liability (TPL) Information Missing or Incomplete

Any information indicating a work-related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

Providers have the ability to upload copies of all EOBs, medical records, or required Documentation when manually entering secondary claims into the ACS Provider Portal. Additionally, providers have the option of submitting documentation electronically via 275 EDI file.

Instructions on how to upload EOB's – Upload the EOB within Patient Maintenance. Locate the patient, click on the row to expand and then click on the "Details" button to go into the details. On the Base Tab, there is an option for "Clinical Docs" which is where you will upload the EOB. Please choose the "Clinical Doc Type" as "EOB". The effective and end dates should be the dates of service included on the document not the date of the upload.

Alliance Health reviews third party liability (TPL/COB) information on a routine basis. Providers must report primary payments and denials to Alliance Health to avoid denied claims. A provider who has been paid by Alliance Health and subsequently receives reimbursement from a third party must repay Alliance Health the difference between the primary carrier's contractual obligation and the patient liability.

All secondary claims must be received within 365 days of the date of service.

Patient Monthly Liability (PML) Values

For services that have patient monthly liability applied, the provider must include the correct PML value on the first claim(s) submitted for the month. The PML value should be validated with NCTracks/DSS to ensure accurate claim submission.

A post-payment review is conducted on claims for which PML should be reflected. If the values are incorrect, the provider will be notified and provided an opportunity to submit a replacement claim by a given date. If the provider does not meet the timeline, the claim will be recouped. Corrected claims submitted outside the timely filing parameters identified may not be approved/paid. It is critical that providers maintain accurate up-to-date contact information so that all efforts can be made for Alliance Health to help providers meet correction timelines.

Early and Periodic Screening, Diagnostic, and Treatment EPSDT

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products or procedures for Medicaid beneficiaries under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Service limitations on scope, amount, duration, frequency, location of service and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Providers should indicate when a claim is submitted for services under EPSDT by checking the appropriate box on the claim form **or** by affixing relevant modifiers when applicable.

Important Billing Reminders:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator on inpatient UB-04 claims.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections, or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- When submitting secondary claims, the services billed on the claim form should exactly match the services and charges detailed on the accompanying primary EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- When the provider or facility has more than one NPI number or taxonomy number, use the NPI and taxonomy numbers that match the services submitted on the claim form. Imprecise use of NPI or taxonomy numbers may result in inaccurate payments or denials.
- When submitting electronically, the provider NPI and taxonomy number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI and taxonomy number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for resubmitting these claims.

- Any changes in a participating provider's name, address, NPI number, taxonomy number, or tax identification number(s) must be reported immediately. Contact your provider network relations specialist for assistance with updates.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims.

EVV Services

The 21st Century Cures Act requires states use an Electronic Visit Verification (EVV) system for personal care services that require an in-home visit and home health care services. Claims for these services must be submitted with EVV data for providers to be reimbursed. Should a provider not be EVV compliant, EVV claims will be denied.

The EVV Personal Care Service Code Matrix can be found at AllianceHealthPlan.org/document-library/59361/. Alliance has partnered with HHA Exchange to provide EVV systems setup and technical support to providers. Should you have questions around your agency's HHAeX Portal please email ncsupport@hhaexchange.com. If your agency is using a third-party vendor, please email edisupport@hhaexchange.com. Should your agency have claims issues related to EVV or in need of technical support from Alliance, please e-mail providerevv@AllianceHealthPlan.org

Remittance Advice (RA) Reports

If claims are manually entered into the ACS Provider Portal, the provider will need to access the Remittance Advice report for posting information.

RA reports will be available following every checkwrite date. Providers can select RAs by date range according to check date or claim processing date.

1. Using the menu, choose RA reports.
2. The user can search by a specific check number, check date or claim processing date. The RA will appear in the box below for the user to retrieve.
3. The user can choose a standard or expanded view. Expanded view is for institutional claim data.

How to read your RA: The RA is grouped by four adjudication decisions: approved claims, denied claims and sub-capitated claims, and then by recoupments (credit memos). From within each adjudication group, there are sub-groups broken down by funding source (state or Medicaid). From within the funding source grouping, it is then sub-grouped by consumer. Then lastly within the consumer grouping, claims are in order by date of service, with subtotals under each grouping.

Retrieval of 835 Response Files

Agencies submitting 837 files will be able to retrieve 835 files on checkwrite dates. The 835 files can be retrieved using the agency assigned secure FTP or via the provider portal using the instructions below. Using the menu, choose Download Queue. Files will be listed. The user may select the applicable file and click on Download.

Transactional Upload and Download Queue

The Transactional Upload Queue module allows you to upload files, such as 837 files which contain the claims you want the MCO to process, into their system. Click the Upload File button, choose the file from your local computer an click the Save button.

The Download Queue module allows you to download files your MCO has waiting for you. Files that will be available are:

- Response files (999, 824, 277)
- 835 files
- Current Client Dumps (Current_Client_) runs daily. This shows all clients for which the provider has submitted claims, has an authorization, has an enrolment, has an appointment, has a SAR, has a client update request, or is marked as the clinical home.
- Current Claims Dumps (Current_Claims_) runs daily. This shows all the claims inserted within the last year.

If 835s are not showing on your Download Queue, check your Provider Details module. On the Base tab, if your company does not have "Certified for EDI" checked **or** if it is checked but there is NOT a clearing house chosen, you will not receive 835s from the system.