Section 3. Medicaid Provider Information

Enrollment Procedure

Providers who wish to enroll with the N.C. Medicaid Program must complete and submit a Provider Enrollment Application for their specific provider type. The online Enrollment Application is available on the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

Processing the enrollment application includes credentialing reviews and background checks to ensure that the provider is in good standing. Processing times vary according to provider types.

Providers will be assigned a Medicaid provider number and will be notified by mail once the process has been completed.

Group Provider Enrollment Packets

Providers who wish to enroll with the N.C. Medicaid Program as a group must complete and submit a Provider Enrollment Application for their specific provider type categorized as "organization." Examples of group providers are dental offices and physician offices. **If services are being provided at multiple sites, each site is required to enroll to receive a separate group Medicaid Provider Number for each existing location.**

Individual Provider Enrollment Packets

Providers who wish to enroll with the N.C. Medicaid Program as an individual must complete and submit a Provider Enrollment Application for their specific provider type categorized as "individual." Examples of individual providers are dentists, physicians, and nurse practitioners. It is not necessary for individual providers to submit multiple Provider Enrollment Applications if providing services at multiple locations. **Individual provider numbers are able to link to each group provider number where services are rendered.**

Provider Enrollment and Re-enrollment Fee

Session Law 2009-451 mandated DMA to begin collecting a $100 enrollment fee from providers upon initial enrollment with the N.C. Medicaid Program and at 3-year intervals when the provider is re-credentialed. This process will begin on September 1, 2009, and will apply to Provider Enrollment Applications received on or after that date.

Qualifications for Enrollment

The general requirements for provider enrollment are as follows.

Licensure

Providers must be licensed, accredited, endorsed, and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but most providers must complete an application and a North Carolina participation agreement. All providers are responsible for maintaining the required licensure, endorsement, and accreditation specific to their provider type to remain qualified as N.C. Medicaid providers. For detailed information regarding specific requirements for each provider type, refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp or contact the EVC Call Center at 1-866-844-1113.

Note: The Piedmont Cardinal Health Plan (PCHP) is responsible for enrolling behavioral health providers in the PCHP provider network.

Service Location

Services must be provided at a site within the State of North Carolina or, for some services, within 40 miles of the North Carolina border.

Out-of-state providers are eligible for enrollment only under the following conditions:

1. for reimbursement of services rendered to N.C. Medicaid recipients in response to an emergency or if travel back to the State would endanger the health of the recipient as determined by Medicaid's fiscal agent
2. for reimbursement of prior-approved non-emergency services
3. for reimbursement of medical equipment and devices that are not available through an enrolled provider located within the State of North Carolina or in the 40-mile border area.

Refer to the out-of-state zip code list on the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp for a list of zip codes that are within the 40-mile border area.

Provider Agreements

Providers sign participation agreements with DMA. These agreements contain general requirements for all providers as well as specific requirements for each service type.

All providers are responsible for ensuring that information on file with the N.C. Medicaid program for their practice or facility remains up to date. Refer to **Reporting Provider Changes** in this section of the billing guide for information on reporting changes in provider status to the N.C. Medicaid program.

Attestation Letter

Beginning in September 2007 and annually thereafter, DMA will notify providers who received $5 million or more in Medicaid payments during the last federal fiscal year that they must submit a Letter of Attestation to show that they are in compliance with the Deficit Reduction Act of 2005 (DRA). This minimum amount may have been paid to one N.C. Medicaid provider number or to multiple provider numbers associated with the same tax identification number. Each Medicaid provider who receives a notification must sign and submit the Letter of Attestation to EDS within 30 days of the date of notification. Additional copies of the Letter of Attestation may be printed from the website for False Claims Act Education, http://www.ncdhhs.gov/dma/fca/. A separate Letter of Attestation must be submitted for each Medicaid provider number.

Re-verification and Re-credentialing Requirements

The N.C. Medicaid Program is required to re-credential each enrolled provider every three years to verify that the provider continues to meet the conditions of participation for enrollment as a Medicaid provider. This process includes criminal background checks and queries of practitioner databases, such as the DHHS Penalty Tracking Database and the Office of Inspector General Medicare Exclusions Database. This requirement applies to all enrolled providers.

Providers will be notified in advance of the re-credentialing process and will be asked to complete a verification packet, which will be used to update information currently on file for the provider. Providers will be instructed to return the completed packet to CSC.

To implement this new requirement, in June, 2009, CSC began a process to verify information and credential currently enrolled Medicaid providers who have not previously been credentialed.

The N.C. Medicaid Program is also required, where applicable, to verify that a provider continues to meet accreditation requirements for participation. The source verification process will occur on the expiration of the provider's license, certification, and/or endorsement.

Tax Information

N.C. Medicaid must have proper tax information on file for all providers to ensure that 1099 MISC forms are correctly issued to providers and that the correct tax information is provided to the IRS.

Independent practitioners such as physicians, dentists, nurse practitioners, etc., are assigned individual attending Medicaid provider numbers. Most often, these numbers are linked to the provider's Social Security Number. When an independent practitioner provides services in a group setting, the group provider number is indicated on the claim form along with the individual provider number. The claim will pay to the group number and report to the group tax identification number. **Individual providers should not link their individual provider numbers to group tax identification numbers.**

The last page of the Remittance and Status Report (RA) indicates the provider tax name and number (FEIN) that Medicaid has on file. Review the RA throughout the year to ensure that the correct provider number information is on file with EDS. The tax information needed for a group practice is as follows:

- Group tax name and group tax number
- Attending Medicaid provider numbers in the group

Providers may also verify the tax information by calling EDS Provider Services at 1-800-688-6696 or 919-851-8888.

Refer to **How to Report a Change** in this section for information on submitting corrected tax information to the Medicaid program.

Conditions of Participation

Civil Rights Act

Providers must comply with Title VI of the Civil Rights Act of 1964, which states "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving Federal financial assistance."

Rehabilitation and Disabilities Acts

In addition to the laws specifically pertaining to Medicaid, providers must comply with the following requirements:

- **Section 504 of the Rehabilitation Act of 1973**, as amended, which states, "No otherwise qualified handicapped individual in the United States shall solely by reason of his handicap, be excluded from participation in, be denied the benefit of, or be subject to discrimination under any program or activity receiving Federal financial assistance."
- **The Age Discrimination Act of 1975,** as amended, which states, "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance."
- **The Americans with Disabilities Act of 1990**, which prohibits exclusion from participation in, or denial of, services because the agency's facilities are not accessible to individuals with a disability.

Disclosure of Medicaid Information

The provider must comply with the requirements of the Social Security Act and federal regulation concerning the following:

- The disclosure of ownership and control information by providers (other than an individual practitioner)
- The disclosure of any felony convictions by a provider or any owners
- The disclosure of any disciplinary action taken against business or professional licensees by a provider
- The disclosure of any denial of enrollment, suspension, or exclusion from Medicare or Medicaid in any state; or employment by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state
- The disclosure of any suspended payments from Medicare or Medicaid in any state; or employment by a corporation, business, or professional association that ever had any suspended payments from Medicare or Medicaid in any state

Medical Record Documentation

As a condition of participation, Medicaid providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program. Records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements. Copies of records must be furnished to Medicaid or its agents upon request. HIPAA does not prohibit the release of records to Medicaid. Record documentation is used by DMA to determine medical necessity and to verify that services were billed correctly.

The following principles of documentation are adopted from Medicare policy:

1. The medical record must be complete and legible.
2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessment; clinical impression or diagnosis; services delivered; plan for care, including drugs and dosage prescribed or administered; and legible signature of the observer.
3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.
4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.
5. The patient's progress, including response to and change in treatment, must be documented. Reasons for diagnostic revision must be documented.
6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.
7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

Payment in Full

With the exception of authorized copayments by recipients, the provider must agree to accept the amount paid for Medicaid-covered services as payment in full. This requirement is in accordance with the rules and regulations for reimbursement promulgated by the Secretary of DHHS and by the State of North Carolina and established under the Medicaid program.

Provider Responsibilities

Verifying Recipient Eligibility

Providers are responsible for verifying Medicaid eligibility when a recipient presents for services. Refer to **Verifying Eligibility** in **Section 2, Recipient Eligibility, and Appendix F, Verifying Eligibility,** for additional information.

Missed Appointments

Missed appointments are considered by the Centers for Medicare and Medicaid Services (CMS) to be part of the provider's overall cost of doing business and, therefore, prohibits Medicaid providers from billing a Medicaid recipient for a missed appointment.

Prior Approval

A provider may not bill a Medicaid recipient for time spent on obtaining prior approval, when required, for a Medicaid-covered service. This is considered by CMS to be part of the provider's overall cost of doing business and, therefore, prohibits Medicaid providers from billing a Medicaid recipient for obtaining prior approval.

Accepting a Medicaid Recipient

In accordance with 10A NCAC 22J.0106, a provider may choose whether to accept a patient as a Medicaid patient. However, Medicaid providers must be consistent with their policies and procedures when accepting or refusing Medicaid recipients. Providers may not discriminate against a Medicaid recipients based on the recipient’s race, religion, national origin, color, or handicap.

Agreeing to provide services to a Medicaid recipient and submission of a claim to the N.C. Medicaid Program for payment constitutes agreement to accept the Medicaid payment (in addition to any authorized copayment or third-party payment) as payment in full.

A provider may refuse to accept a Medicaid recipient and bill the recipient as private pay only if the provider informs the recipient prior to rendering the service, either orally or in writing, that the service will not be billed to Medicaid and that the recipient will be responsible for payment.

Billing the Recipient

Providers may not bill a recipient for

- the difference between the provider’s charges and the Medicaid payment in addition to co-payment and third-party payment.
- any service covered by the Medicaid program unless the provider has specifically informed the recipient that Medicaid will not be billed, and the recipient understands and agrees to accept liability for payment.
- any service covered by the Medicaid program for which the provider is denied payment because the provider failed to follow program regulations including, but not limited to, errors on claims, late submission, lack of prior approval, failure to bill third-party resources, etc.

When a non-covered service is requested by a recipient, the provider must inform the recipient either orally or in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to rendering the service.

A provider may also bill a Medicaid recipient for the following:

- Payments for services that are made to the recipient and not the provider by either commercial insurance or Medicare
- Services not covered by Medicare if the recipient has Medicare-AID (MQB-Q) coverage Allowable Medicaid deductibles or copayments*
- Unduplicated prescriptions in excess of 11 per month unless recipient is locked in to their pharmacy of record*
- Visits in excess of the legislative annual visit limit for provider visits for the state fiscal year (July 1–June 30) (See **Section 2, Recipient Eligibility**)*
- The recipient's loss of eligibility for Medicaid as defined in 10A NCAC 21B
- Part D copay

*Under federal EPSDT law, some limits and restrictions do not apply to recipients under the age of 21. See **Section 2, Recipient Eligibility** and **Section 6, Prior Approval,** for more information.

Third-Party Liability

State and federal regulations for third-party liability (TPL) require responsible third-party insurance carriers to pay for medical services prior to a provider's submitting a claim to Medicaid. Providers are required to seek payment from third-party insurance carriers when they know of their existence. A third-party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, automobile, or other liability carriers. DMA's third party recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both cost avoidance and recovery methods. Refer to **Section 7, Third-Party Insurance,** for additional information.

Overpayments

The PI Section of DMA conducts regular post-payment reviews in an ongoing effort to

- Determine a statistical payment accuracy rate for claims submitted by providers and paid by Medicaid
- Ensure that Medicaid payments are made only for services that are covered under Medicaid policy
- Verify that coding on Medicaid claims correctly reflects the services that were provided
- Ensure that third-party carriers were billed before Medicaid was billed and that providers reported any such payments from third parties on claims filed for Medicaid payment

When overpayments are identified, providers are given written information about the errors that includes the total identified overpayment, procedures for repayment to Medicaid, and procedures for disputing Program Integrity's findings.

Contacting Medicaid

An alphabetical list of contact information including addresses and phone numbers is available on DMA's website at http://www.ncdhhs.gov/dma/provider/provcontacts.htm.

An index of topics of interest to providers with links to web pages within DMA's website and to the websites of our vendors is also available online at http://www.ncdhhs.gov/dma/provider/topicsa-z.htm.

Provider Forms

All forms, except those listed in the table below, can be obtained from DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm or by calling EDS at 1-800-688-6696 or1-919-851-8888.

Name of Form	How to Obtain the Form
ADA Dental Claim Form	Call ADA at 1-800-947-4746
Certificate of Medical Necessity and Prior Approval Form (for DME and O&P)	Call EDS at 1-800-688-6696 or 1-919-851-8888
CMS-1500 Claim Form	Available in most Office Supply Stores
Prior Approval for Psychiatric Inpatient Services	Call Value Options at 1-888-510-1150
Sterilization Consent Form	Call EDS at 1-800-688-6696 or 1-919-851-8888
UB-04 Claim Form	Available in most Office Supply Stores
Visual Aids Prior Approval Form (372-017 or 372-017A)	Call EDS at 1-800-688-6696 or 1-919-851-8888

Fee Schedule Requests

There is no charge for fee schedules or reimbursement plans requested from DMA. The information that is provided is to be used only for internal analysis. Providers must bill their usual and customary charges. Requests for fee schedules and reimbursement plans must be made on the **Fee Schedule Request Form** and mailed to the address listed on the form. The **Fee Schedule Request Form** may also be faxed to DMA's Finance Management section at 919-715-2209. Telephone requests are not accepted.

Many of the fee schedules are also available on DMA's website at http://www.ncdhhs.gov/dma/fee/.

Reporting Provider Changes

What Changes Must Be Reported

Providers are responsible for notifying Medicaid when any of the following information related to their business or practice changes:

- National Provider Identifier (NPI)
- Billing and site addresses
- Contact information, including phone number, fax number, and e-mail addresses
- Individual name changes
- Group name changes
- Adding or deleting a service
- Adding a site
- Adding or deleting a group member
- Tax name and number changes
- Changes of ownership
- CLIA renewals
- Bed capacity changes
- Voluntary termination

As required by 10A NCAC 22N.0202, providers licensed under NCGS 122C or 131D shall notify DMA in writing within 30 business days when:

- The legal name of any person with ownership interest in the facility is changed
- An new individual acquires ownership interest in the facility; notification must include the new owner's legal name and Social Security Number
- An individual withdraws his or her ownership interest in the facility; notification must include the name of the departing owner

The provider shall hold DMA harmless for payment of claims to the enrolled provider prior to execution of an agreement under new ownership or name.

Managed care providers [Community Care of North Carolina/Carolina ACCESS (CCNC/CA), ACCESS II/III, and Piedmont Cardinal Health Plan (PCHP)] must also report changes in daytime or after-hours telephone numbers, counties served, enrollment restrictions, etc. CCNC/CA providers must report Medicaid provider number changes immediately to ensure that CCNC/CA management fees are paid correctly.

Failure to report changes in provider status may result in suspension of the Medicaid provider number and a delay in providers' receipt of claims reimbursement. In addition, providers may be liable for taxes on income not received by their business.

How to Report a Change

The following changes must be reported to CSC using the **Medicaid Provider Change Form:**

- NPI
- Billing addresses
- Contact information, including phone number, fax number, and e-mail addresses
- Individual name changes
- Adding or deleting a group member
- CLIA renewals
- Bed capacity changes
- Voluntary termination
- Site addresses

Refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html for a copy of the **Medicaid Provider Change Form** and a detailed list of supporting documentation that is required for some changes.

The following changes must be reported to CSC by completing and submitting a new Provider Enrollment Application:

- Group name changes
- Adding a service
- Adding a site
- Tax name and number changes
- Changes of ownership or ownership interest

The online Enrollment Application is available on the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

Voluntary Termination

All providers who decide to terminate their participation in the N.C. Medicaid program must notify CSC in writing. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator. The notification must be submitted with a completed **Medicaid Provider Change Form.** Mail the notification and the **Medicaid Provider Change Form** to

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

Note: Managed care providers must also notify DMA's Managed Care section of their decision to terminate. Refer to **Section 4, Managed Care Provider Information,** for additional information.

Termination of Inactive Providers

If an enrolled Medicaid provider does not bill Medicaid for 12 months, DMA will send notice of termination of the Medicaid provider number. These notices are sent to the current mailing address listed in the provider's file. A provider who wishes to remain enrolled as a Medicaid provider will have two weeks to respond with a justification. Once terminated, providers must complete a new application and agreement to re-enroll and may have a lapse in eligibility as Medicaid providers.

Payment Suspension

Any correspondence, including RAs and checks, that cannot be delivered due to an incorrect billing address in the provider's file, all claims for the provider number are suspended and the subsequent RAs and checks are no longer printed. Automatic deposits cannot be processed for suspended claims.

Once a suspension has been placed on the provider number, the provider has 90 days to submit an address change. After 90 days, if the address has not been corrected, suspended claims will be denied and the provider number will be terminated.

Licensure Revocation or Suspension

Any provider or facility whose license is revoked or suspended is not eligible for participation in the N.C. Medicaid program. Providers whose licenses are revoked or suspended should notify DMA immediately.

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested in writing by the provider or the facility. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

Providers who receive one or more sanctions from CMS may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under CMS sanctions. CMS will notify DMA of providers who are sanctioned. Any provider who is sanctioned should notify DMA immediately.

Program Integrity Reviews

Determining Areas for Review

PI reviews are initiated for a variety of reasons. The following are examples of reviews conducted by PI.

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections.
- PI uses a Fraud and Abuse Detection System (FADS), which consists of two software products called HealthSPOTLIGHT and OmniAlert.
    - HealthSPOTLIGHT uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraudulent claims and abuse.
    - OmniAlert is PI's client server Surveillance and Utilization Review System (SURS). OmniAlert is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
    - Additional features such as claims imaging, the claims data warehouse, and ad hoc query tools, along with FADS software, also make detection and investigation faster.
    - Special ad hoc DRIVE computer reports are available to target specific issues such as procedure codes, duplications of services, etc.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.
- PI staff also conduct a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.
- EDS refers to PI any questionable services identified during claims processing.

Provider Responsibilities in a Program Integrity Review

PI reviews may be conducted in person or by mail. Visits to providers and their clients may be unannounced (this is a routine procedure). Providers should adhere to the following steps when a review has been initiated.

- PI will request medical and/or financial records either by mail or in person. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. Providers must maintain records for five years in accordance with the recordkeeping provisions of the provider participation agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
    - If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS, as this could result in a duplication of your refund. Also, do NOT request that EDS adjust for the amount or items identified, as this could result in duplicate recoupment.

- o If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DHHS Hearing Unit at the address on the letter and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Request for Reconsideration

Informal Hearings—A provider who disagrees with a DMA decision may have the right to an informal hearing. If applicable, the provider will be notified of the right to an informal hearing, conducted in Raleigh. The DHHS Hearing Office will notify the provider of the date, time, and location.

Informal Paper Reconsideration Review—Providers may instead send any additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Formal Hearings—If the provider is not satisfied with the outcome of the informal hearing, the provider may have the right to request a formal hearing. If applicable, the provider will be notified of the procedure to request a formal hearing (as well as the time limitations to submit the request) with the Office of Administrative Hearings (OAH). Once the request is received, OAH will contact the provider regarding scheduling.

Miscellaneous

- For assistance or information, please call EDS at 1-800-688-6696 or 919-851-8888.
- It is the provider's responsibility to maintain the medical coverage policies and Medicaid bulletins and to ensure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to and follow these Medicaid guidelines.

Self-Referral Federal Regulation

For Medicaid payments, the omnibus Budget Reconciliation Act of 1993 (OBRA 1993) prohibits self-referral by a physician to designated health services in which the physician has certain ownership or compensation agreements. Designated health services include the following:

- Clinical laboratory services
- Outpatient drugs
- Durable medical equipment
- Parenteral and enteral nutrition equipment and supplies
- Comprehensive outpatient rehabilitation facility services
- Contact lenses
- Physical and occupational therapy services
- Home infusion therapy services
- Prosthetic and orthotic devices
- Eyeglasses
- Radiation therapy services
- Inpatient and outpatient hospital services
- Radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services)
- Hearing aids

- Home dialysis
- Home health services
- Ambulance services

If post-payment review determines that inappropriate payments were made due to the provider's failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in Section 1877 of the Social Security Act.

Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive (for example, a living will or health care power of attorney).

NCGS 122C-71–122C-77, "An Act to Establish Advance Instruction for Mental Health Treatment," became effective January 1, 1998. The law provides a method for an individual to exercise the right to consent to or refuse mental health treatment if the individual later becomes "incapable" (that is, lacks the capacity or ability to make and communicate mental health treatment decisions). The advance instruction becomes effective when delivered to the individual's physician or mental health treatment provider, who then makes it part of the individual medical record. In conjunction with an advisory panel, DMA has developed *Medical Care Decisions and Advance Directives: What You Should Know,* the required summary of state law concerning patients' rights that must be distributed by providers.

The brochure is available in both a 4-page condensed format and a 16-page expanded format. If providers choose to alter the document graphically, they may not change or delete text, or the order of the paragraphs. A provider-published pamphlet must include the N.C. DHHS logo and production statement on the last page brochure. A print-ready copy can be found on DMA's website at http://www.ncdhhs.gov/dma/medicaid/rights.htm.

Provider Information—Frequently Asked Questions

1. **What are the requirements for enrollment in the N.C. Medicaid program?**

   Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application and agreement and provide verification of licensure, if applicable. Refer to the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp for specific credentialing requirements.

2. **Where can I get an enrollment application?**

   Applications for enrollment as a Medicaid provider are available from the NC Tracks website (http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp). Mail the completed application to:

   N.C. Medicaid Provider Enrollment
   CSC
   PO Box 300020
   Raleigh NC 27622-8020

3. **How do I enroll as a managed care provider?**

   Applications for participation as a CCNC/CA provider are available from the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

   - To enroll as an ACCESS II/III provider, contact the Office of Rural Health and Community Care at 919-715-7625.
   - To enroll as a PCHP provider, contact Piedmont Provider Relations at 1-800-958-5596.

   For additional information, contact EVC Call Center at 1-866-844-1113 or the managed care consultant for your county.

4. **How are group provider numbers assigned?**

   Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. A group practice that has multiple sites could have a separate provider number for each site. Individual provider numbers can be linked to one or more of the sites. Groups must notify the EVC Call Center a when an individual practitioner is added to or deleted from their group practice.

5. **When can I begin billing for services that I have rendered to Medicaid recipients?**

   Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, be assigned a provider number, and agree to certain conditions of participation before payment can be made for services rendered to Medicaid recipients. The effective date on the participation agreement is the earliest date a provider may begin billing for services.

6. **How often do I have to re-enroll as a Medicaid provider?**

   Enrollment periods vary according to service types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting the EVC Call Center at 1-866-844-1113.

   All providers are responsible for maintaining the required licensure and accreditation specific to their provider types to remain qualified as N.C. Medicaid providers.

   All providers are responsible for ensuring that their service and facility information on file with N.C. Medicaid remains up to date.

7. **Is it necessary for a physician who already has a Medicaid provider number to notify DMA if s/he transfers to a new practice?**

   Yes. While re-enrollment is not necessary, the physician must notify DMA that s/he is no longer linked to the old group practice and ask to be linked to the new group practice. The new group must complete the **Medicaid Provider Change Form** located on the NC Tracks website. A physician will usually keep the same individual provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician's individual provider number is active.

8. **Are we required to apply for a new provider number if our group merges with another group and our group tax ID number changes?**

   Yes. A provider must apply for a new group provider number, but the provider's individual provider number will remain the same. If you are merging groups but will still have separate locations, each office site must apply for a new group provider number.

9. **Are individual providers required to apply for a new provider number if there is a change to the tax ID number?**

   No. But, providers must notify the Medicaid program of the tax ID number changes.

10. **If I have an individual provider number and I leave a group practice, do I need to change my tax ID number to the new group's tax ID number?**

    No. An individual provider number belongs to the individual provider. The provider's Social Security Number or the FEIN tax number should not be changed when an individual provider leaves a group practice.

11. **How do I contact the Medicaid program to report changes to my provider status?**

    The **Medicaid Provider Change Form** is located on the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.. Refer to **How to Report a Change** in this section for information on reporting changes in your provider status to the Medicaid program.

12. **I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. How do I report this change?**

    Changes must be reported to the EVC Call Center using the **Medicaid Provider Change Form** on the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html.

    If the Medicaid provider number that is changing is also your CCNC/CA provider number, DMA Provider Services must be alerted as soon as possible to ensure that the CCNC/CA management fee is paid correctly and to prevent claim denials.

13. **If our practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, whom do I contact when there is a change in our practice's provider number?**

    CCNC/CA provider must report all change to the EVC Call Center using the **Medicaid Provider Change Form** on the NC Tracks website at http://www.nctracks.nc.gov/provider/cis.html. When reporting a change in ownership, CCNC/CA providers must submit a new Carolina ACCESS enrollment application package. All providers must report changes to the EVC Call Center using the **Medicaid Provider Change Form**.

14. **My organization participates with the Medicaid program as an administrative entity for ACCESS II/III. Whom do I contact when there is a change in our provider status?**

    Report changes to the Office of Rural Health and Community Care at 919-715-1453 or 919-715-7628.

15. **I am currently enrolled as a Community Alternatives Program (CAP) provider. How do I amend my enrollment to include additional services?**

    CAP providers who are currently enrolled in the Medicaid program must complete Provider Enrollment Application and provide verification of appropriate licensure and certification to the EVC Call Center at the address below. The online Enrollment Application is available on the NC Tracks website at http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

16. My specialty is listed incorrectly. How do I correct it?

Requests to change a provider's specialty must be submitted in writing to the EVC Call Center at the address below. Requests must be written on letterhead and include the provider number and the correct specialty.

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

17. How do I terminate my enrollment as a Medicaid provider?

All providers who decide to terminate their participation in the N.C. Medicaid program must notify the EVC Call Center in writing. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator. The notification must be submitted with a completed **Medicaid Provider Change Form.** Mail the notification and the **Medicaid Provider Change Form** to

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

18. How do I terminate my enrollment as a Managed Care provider?

Managed Care providers (CCNC/CA and ACCESS II/III) must notify the EVC Call Center, in writing, of their decision to terminate their participation in the managed care program, and must do so at least 30 days in advance of the effective date. Notification must be sent by registered mail, with return receipt requested, to

N.C. Medicaid Provider Enrollment
CSC
PO Box 300020
Raleigh NC 27622-8020

19. My practice has opened another location. Can I use their current group number?

No. A "group" is defined as an affiliation of individual providers in a group practice (for example, a dental practice) or a service agency that employs or contracts with staff to provide services (for example, a home health agency). Group providers with multiple site locations are required to enroll each site and bill for the group with the Medicaid provider number assigned to that site. (Please note that groups enrolled to provide CAP services are exempt from the requirement to enroll each site separately.)

20. I am currently enrolled with Medicaid as a provider of behavioral health services and my service area includes the PCHP catchment area. Do I need to enroll with PCHP in order to be reimbursed for services provided to PCHP recipient?

Yes. Contact the PCHP Provider Relations Department at 1-800-958-5596.