

Section 4. Managed Care Provider Information

Community Care of North Carolina—Carolina ACCESS

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) is a primary care case management (PCCM) program that provides managed care for North Carolina's Medicaid recipients. Health care is coordinated and managed by primary care providers (PCPs) who contract with DMA. Enrollment in CCNC/CA is mandatory for the majority of Medicaid recipients.

Historically, North Carolina has had two PCCM programs. The initial program, Carolina ACCESS, created an infrastructure of PCPs. Community Care of North Carolina further developed this infrastructure by creating networks of community medical and service providers. CCNC/CA is used to identify managed care as a united program that provides access to high-quality primary care.

In addition to receiving fee for service payment, primary care providers participating in CCNC/CA are paid a per member/per month management fee. An enhanced management fee is paid for each aged, blind, or disabled recipient enrolled with their practice. For more information about becoming a network provider or management fees, contact your regional managed care consultant (see page 4-27).

Carolina ACCESS

Initiated in 1991 as Medicaid's PCCM program, Carolina ACCESS was developed to provide Medicaid recipients with a medical home, which provides access to the public and private medical provider community. Enrolling recipients into a medical home reduces the need for recipients to seek primary care services and basic sick care services from hospital emergency departments. PCPs coordinate care for enrollees by providing and arranging care based on each enrollee's health care needs.

Community Care of North Carolina—ACCESS II/III

Community Care of North Carolina (<http://www.communitycarenc.com>), formerly known as ACCESS II/III, was initiated in 1998 as a community-based enhanced PCCM program, joining PCPs, hospitals, health departments, departments of social services (DSS), and other Medicaid providers into regional provider networks to manage the health care needs of Medicaid recipients. Each CCNC regional network employs care managers who assist in developing, implementing, and evaluating the care management strategies at each site. Care management strategies include

- **Population Stratification:** This is the application of a common series of measures to the enrolled population to describe the distribution and severity of illness, and the index of resource utilization, assigning member to "targeted groups/risk buckets" for purposes of program assignment.
- **Member Assignment:** The assignment of members falling within certain risk strata to case management, disease management and other preventive health programs.
- **Member Care Coordination:** The provision of structured interventions to targeted groups in order to ameliorate bio-psycho-social risk factors and provide ongoing monitoring of the effectiveness of the care coordination effort.

Currently, there are 14 CCNC regional networks that include more than 3,000 physicians across North Carolina.

CCNC is jointly administered by the Office of Rural and Community Care and DMA. The following is a list of the networks in CCNC:

ACCESSCare, Inc.
ACCESS II Care of Western North Carolina
ACCESS III of Lower Cape Fear
Carolina Collaborative Community Care
Carolina Community Health Partnership
Community Care of Wake/Johnston Counties
Community Care Partners of Greater Mecklenburg
Community Care Plan of Eastern Carolina
Community Health Partners
Northern Piedmont Community Care
Northwest Community Care Network
Partnership for Health Management
Sandhills Community Care Network
Southern Piedmont Community Care Plan

Networks are also paid a management fee based on the number of enrollees.

Recipient Enrollment

CCNC/CA is considered a higher level of benefit over regular Medicaid for recipients eligible to enroll. The county DSS is responsible for enrolling recipients. Based on the Medicaid program aid category of eligibility, recipients are either required to enroll, optional for enrollment, or not eligible to be enrolled. Enrollment is mandatory for the majority of Medicaid recipients.

Note: Recipients whose third-party insurance is an HMO or who have Tri-Care may be exempted from Carolina ACCESS if their PCP does not participate with CCNC/CA.

Medicaid recipients who enroll in CCNC/CA, whether as a requirement or an option, must select a medical home from the list of PCPs serving their county of residence. Recipients who do not choose a medical home may be assigned to a medical home by the county based on location, medical history, and other factors. Each family member may have a different medical home.

Enrollees may request to change their medical home at any time. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Enrollees are responsible for all copayments required by Medicaid. Refer to **Copayments in Section 2, Recipient Eligibility**, for additional information.

CCNC/CA enrollees are identified by information on their MID card. The name, address, and the daytime and after-hours telephone numbers of the medical home/primary care provider are listed on the MID card.

In order to maximize enrollment, providers who wish to enroll their patients may do so by following these procedures:

- Inform patients of their freedom to choose any CCNC/CA primary care provider who is accepting new patients.
- Complete the enrollment form and send to the Carolina ACCESS contact at the department of social services in the county in which the recipient resides. The form can be found on the DMA website at <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>.
- Provide the enrollee with a Carolina ACCESS Member Handbook. Handbooks can be obtained by contacting the DMA Managed Care Section at 919-855-4780.

Refer to **Verifying Eligibility in Section 2, Recipient Eligibility**, for information on verifying recipient eligibility.

Recipient Education

The county DSS is responsible for recipient education. Enrollees are provided with a Carolina ACCESS member handbook (available in English and Spanish) that informs them of the rights, responsibilities, and benefits of being a member. It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CCNC/CA PCPs are strongly encouraged to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly **Carolina ACCESS Provider Enrollment Report**. Refer to the examples of the reports at the end of this section.

Providers should inform each enrollee about the following:

- The availability of medical advice 24 hours a day, 7 days a week, and the preferred method for contacting the PCP
- The enrollee's responsibility to bring his/her Medicaid identification (MID) card to each appointment
- The need to contact the PCP for a referral before going to any other doctor
- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for enrollees from the county DSS
- Copayment requirements

DMA's customer service center is available to help all Medicaid recipients understand their health care benefits. Customer service representatives also help enrolled recipients understand the procedures for obtaining health care in a managed care program.

Provider Participation

Requirements for Participation

DMA Managed Care and CSC work together to recruit and enroll PCPs into the CCNC/CA program. CSC is responsible for processing the applications and enrolling providers into the program. DMA Managed Care is responsible for establishing PCP participation requirements, assisting providers in carrying out CCNC/CA policies and procedures, and recruiting providers into the program. Questions about the CCNC/CA program or requirements for participation can be answered by the regional managed care consultants (see the list at the end of this section) or by the staff at DMA Managed Care (919-855-4780).

DMA requires providers to complete and submit a signed application and agreement confirming their compliance with all participation requirements. The **CA Provider Enrollment Packet** is available on the NC Tracks website at <http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>. The application and the agreement must each contain the original signature of the authorized representative (or a participating provider). Applications may be pending for a maximum of 90 days from the date of receipt of the application. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time unless a sanction has been imposed upon the provider's participation by the Managed Care Section.

Every DSS is notified weekly of new CCNC/CA providers and changes in current CCNC/CA provider information. Providers are required to report any changes regarding their practice's status to DMA Provider Services. To report changes to the Medicaid program, CCNC/CA providers must submit a signed **Medicaid Provider Change Form** (refer to the NC Tracks website at <http://www.nctracks.nc.gov/provider/cis.html>).

To be approved as a CCNC/CA PCP, providers must meet the following requirements:

1. Accept N.C. Medicaid payment as payment in full, practice in the state of North Carolina or within 40 miles of the borders of North Carolina, and have an active N.C. Medicaid provider number (MPN) for use as the CCNC/CA provider number.
2. Have an active license for each provider in the practice. Each physician and doctor of osteopathy must also have an active individual MPN. Participating nurse practitioners and certified nurse midwives who have been issued individual MPNs must also disclose their individual provider numbers on the CCNC/CA provider application. The information on file for each individual MPN must be consistent with the information provided in the CCNC/CA application.
3. Be enrolled as one of the following Medicaid provider types:
 - Family medicine practitioners
 - Gynecologists
 - General practitioners
 - Internists
 - Nurse midwives
 - Nurse practitioners
 - Federally qualified health centers
 - Osteopaths
 - Health departments
 - Pediatricians
 - Rural health clinics
 - Obstetricians

Other provider types will be considered only if they meet the requirements found in the CA application and agreement.

Note: Physician assistants do not directly enroll in Medicaid at this time, but may participate in Carolina ACCESS through their supervising physician and enroll with Carolina ACCESS using the supervising physician's MPN. A rural health clinic or federally qualified health center served by only a physician assistant may enroll as a Carolina ACCESS provider using a rural health clinic/federally qualified health center group number.

4. **Enroll each CCNC/CA location with a separate, site-specific provider number.** (This helps with claims filing, referrals, management of reports, and accurate financial reporting to the IRS.) Practices operating as a group must enroll with a site-specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the N.C. Medicaid program, and must therefore be site specific. The CCNC/CA PCP's practice name, address, and daytime and after-hours telephone numbers are printed on the enrollee's MID card.

5. State on the initial application the maximum number of enrollees that will be accepted for the site and also any specific enrollment restrictions such as age or gender. Enrollment of Medicaid recipients is capped at 2,000 per participating provider (MD, DO, PA, NP, or CNM).
Note: Providers who do not accept Medicare will not have CCNC/CA enrollees who have Medicare coverage assigned to their practice.
6. List on the application all contiguous counties from which the practice will accept CCNC/CA enrollees. Since the provider must be accessible for primary care, these counties must include only the county in which the practice is located and the bordering counties. (DSS may enroll a recipient with a provider beyond the contiguous counties at their discretion and with the provider's agreement.)
7. Disclose on the application information regarding sanctions or termination by the Medicaid program or the Carolina ACCESS program. For complete information, refer to **Sanctions** in this section.
8. Establish and maintain hospital admitting privileges or enter into a formal agreement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. If the CCNC/CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the N.C. Medicaid program, then the **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement** (on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>) must be submitted to CSC to address this requirement for participation.
9. Have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week.
10. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. Refer to **24-Hour Coverage** in this section.
11. Make oral interpretation services available free of charge to each current and potential enrollee. This applies to all non-English languages.
12. Make primary care services available to enrollees and indicate these services on the application. These services must encompass all requirements for the specified ages. For example, a provider who wishes to enroll recipients ages 2 through 20 must agree to provide all components for each age category, 2 through 20.
Note: PCPs who request CCNC/CA participation for enrollees with Medicaid for Pregnant Women (MPW) benefits only are exempt from the preventive and ancillary services requirements.

Conditions of Participation

When a provider agrees to participate with CCNC/CA, she or he agrees to

- Develop patient–physician relationships
- Manage the health care needs of recipients
- Provide mandatory preventive services
- Establish protocols for referring enrollees for specialty care or urgent care (including situations when referral was not obtained prior to the service being rendered)
- Review and use recipient utilization, emergency room enrollment, and referral reports
- Follow standards of appointment availability

In addition to the conditions of participation for Medicaid providers (in **Section 3, Medicaid Provider Information**), CCNC/CA providers must comply with section 1932 (b)(7) of the Social Security Act, which states, “the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider’s license or certification under applicable State law solely on the basis of provider’s license or certification.”

Exceptions

Exceptions to a requirement for participation may be granted in cases in which it is determined that the benefits of a provider’s participation outweigh the provider’s inability to comply with this requirement. The provider shall submit a written request to DMA for consideration for exception for a specific agreement requirement. The request shall include the reasons for the contractor’s inability to comply with this agreement. The request shall be submitted at the time this agreement is submitted to the DMA Managed Care Program Operations Manager for consideration. Approval of the application constitutes acceptance of the request for exception.

Approved CCNC/CA providers who have a change in their office procedures that impacts their compliance with any participation requirement must report the change timely and request an exception as outlined above.

Sanctions

Failure to meet the terms outlined in the CCNC/CA provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly management/coordination fee may be withheld.
- The PCP may be referred to DMA Program Integrity (PI) for investigation of potential fraud or for quality-of-care issues.
- The PCP may be referred to the N.C. Medical Board.
- The PCP may be terminated from the CCNC/CA program.

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered; or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

Reasons for Sanctions

Sanctions against CCNC/CA providers may be imposed by DMA Provider Services for the following reasons:

1. Failure to enroll each site with a site-specific Medicaid Provider Number.
2. Fraudulent, misrepresentative, or erroneous billing practices, including unauthorized use of another PCP’s Carolina ACCESS referral number.
3. Failure to maintain after-hours coverage or to report a change in coverage arrangements to the Managed Care Consultant.
4. Failure to maintain hospital admission privileges or an approved admitting arrangement covering all enrollee ages.
5. Failure to cooperate with CCNC/CA program initiatives.

6. Failure to provide all preventive and ancillary EPSDT services or to properly refer for services for all ages impacted by EPSDT services.
7. Failure to meet any terms outlined in the CCNC/CA provider agreements.

Sanction Appeals

The PCP is notified by certified mail of the sanction and the right to appeal the sanction.

DMA must receive the PCP's request for a formal evidentiary hearing by the DHHS hearing office no later than 15 calendar days after the receipt of the sanction notice. The hearing provides an opportunity for all sides to be heard in an effort to resolve the issue. The sanctioned party may represent himself or herself, may designate a representative, or may enlist the services of an attorney. The findings are documented by the DHHS hearing office and presented to the DMA Director, who makes the final determination to uphold or rescind the sanction. The PCP is notified by certified mail of the Director's decision.

PCPs who are terminated from the CCNC/CA program—or who voluntarily withdraw to avoid a sanction—are not eligible to reapply for a minimum of one year, with a maximum time period to be determined by the Managed Care Section. The decision is predicated on the extent or severity of the contract violation necessitating the termination.

Terminations

The PCP's agreement to participate in the CCNC/CA program may be terminated by either the PCP or DMA, with cause, or by mutual consent, upon at least 30 days' written notice delivered by registered mail, return receipt requested. Termination will be effective on the first day of the month, pursuant to processing deadlines.

Provider Reports

The goals of the CCNC/CA program are to improve access to primary care and to provide a more effective and cost-efficient health care system. It is the responsibility of PCPs to manage the care of their enrollees. DMA provides four reports to assist PCPs with this goal. An example of each report is available at the end of this section.

Carolina ACCESS Reports Web Portal

PCPs may complete the Provider Confidential Information and Security Agreement (<http://www.ncdhhs.gov/dma/provenroll/ccncca.htm>) and return it to gain access to web-based versions of their Carolina ACCESS reports. Each approved user will receive login information via e-mail. This e-mail will include a link to the **DMA Information and Report System** (<http://reports.ncmedicaid.com>) where the user will have access to the following:

- Security Contact Administration
- On-line Training
- Access to View Reports
- Technical Support
- Additional Information (related sites)

Enrollment Report

DMA's Managed Care Section provides PCPs with a monthly **CA Provider Enrollment Report**. The report consists of three sections for both Carolina ACCESS enrollees and N.C. Health Choice enrollees, if applicable: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the managed care consultant or the county DSS. PCPs are expected to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported, until the change or error has been resolved and reported correctly. Refer to the end of this section for an example of the report.

Emergency Room Management Report

The **Emergency Room Management Report** lists the PCP's enrollees for whom emergency department services were paid during the month. It is very important to review this report to determine enrollees who are using the emergency department inappropriately and to develop strategies to redirect these enrollees to the appropriate setting. PCPs may need to evaluate their after-hours message or procedures or collaborate with an urgent care center to provide the most cost-effective after-hours care. PCPs are encouraged to contact enrollees who have visited the emergency department for follow-up care and medication management. All emergency room visits from any emergency department are included on this report, not just the local hospital. Refer to the end of this section for an example of the report.

Referral Report

DMA provides CCNC/CA PCPs with a monthly **Referral Report** containing information on where and when enrollees obtained services during the month. The report is available to PCPs on paper or diskette. Refer to the end of this section for an example of the report. Please refer any discrepancies to your Regional Managed Care Consultant (see list at the end of this section).

Quarterly Utilization Report

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost-effective primary care. An example of the report and instructions for using it are available at the end of this section.

Provider Requirements

Health Check Services/Early and Periodic Screening, Diagnosis, and Treatment Services

In the state of North Carolina, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are administered under the name Health Check, which is the Medicaid program for children. Refer to **Section 2, Recipient Eligibility**, for EPSDT policies.

CCNC/CA PCPs who accept enrollees under age 21 are required to provide Health Check preventive care screenings to Medicaid-eligible children. PCPs serving this population who do not provide Health Check screenings are required to pursue an agreement with the local health department to provide all Health Check screening components. (**Note:** There are certain public health departments that do not currently offer primary care services. Please contact your Managed Care Consultant to discuss alternatives.) PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer

to DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> for a copy of the **Health Check Agreement between Primary Care Provider and the Local Health Department**.

Refer to the *Health Check Billing Guide* on DMA's website at <http://www.ncdhhs.gov/dma/healthcheck/> for additional information.

Adult Preventive Annual Health Assessments

CCNC/CA PCPs are required to provide all of the components of an initial preventive annual health assessment and periodic assessments to adult enrollees aged 21 years and over. For more information, please refer to the latest edition of the *Pocket Guide to Clinical Preventive Services*, from the U.S. Preventive Services Task Force, at <http://www.ahrq.gov/clinic/uspstfix.htm>.

24-Hour Coverage

CCNC/CA requires PCPs to provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. There must be prompt (within 1 hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by the office staff during regular office hours.

Providers may not bill their Carolina ACCESS enrollees for after-hours consultations or for any other service that is part of their contractual agreement with DMA (refer to the Carolina ACCESS Provider Agreement).

PCPs must provide enrollees with an after-hours telephone number. The after-hours number may be the PCP's home telephone number. The after-hours telephone line must be listed on the enrollee's MID card. The after-hours telephone number must connect the enrollee to one of the following:

- An answering service that promptly contacts the PCP or the PCP-authorized medical practitioner
- A recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner
- A system that automatically transfers the call to another telephone line that is answered by a person who will promptly contact the PCP or PCP-authorized medical practitioner
- A call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital, available for review by DMA Managed Care section.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours, or is answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care, is **not acceptable**. It is **not acceptable** to refer enrollees to the PCP's home telephone if there is no system in place as outlined above to respond to calls. PCPs are **encouraged** to refer patients with urgent medical problems to an urgent care center.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- Emergency care—immediately upon presentation or notification
- Urgent care—within 24 hours of presentation or notification
- Routine sick care—within 3 days of presentation or notification
- Routine well care—within 90 days of presentation or notification (15 days if recipient is pregnant)

Emergency Conditions

An emergency medical condition is one in which the sudden onset of a medical condition, including emergency labor and delivery, manifests itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in

- serious jeopardy to the health of the individual or the health of a pregnant woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any body organ or part.

With regard to pregnant women having contractions, a situation is considered to be an emergency if

- there is inadequate time to effect a safe transfer to another hospital before delivery; or
- transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Conditions

An urgent medical condition is defined as a condition that, without medical attention and intervention within 12 to 24 hours, could seriously compromise the patient's condition and the possibility of a full recovery.

Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- Walk-ins—within 2 hours, or schedule an appointment within the standards of appointment availability
- Scheduled appointment—within 1 hour
- Life-threatening emergency—must be managed immediately

Hospital Admitting Privileges

CCNC/CA PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. An appropriate arrangement must be made to ensure access to care for all enrollees regardless of age. The **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement** fulfills this requirement for participation. It is a voluntary written agreement between the CCNC/CA PCP and the physician/group who is agreeing to accept the responsibility for admitting and coordinating medical care for the enrollee on behalf of the CCNC/CA PCP throughout the enrollee's inpatient stay. **This agreement must be completed by both parties.** The CCNC/CA PCP must submit the original form with his or her application for participation or when a change occurs regarding the

provider's admitting agreement. A copy of the admission agreement on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

The following arrangements are acceptable:

- A formal agreement may be made with a physician, a group practice, a hospital group, or a physician call group.
- The physician, group practice, or hospital group need not be a CCNC/CA provider, but must be enrolled with the N.C. Medicaid program.
- Admitting privileges or formal arrangements must be maintained at a hospital that is within 30 miles or 45 minutes' drive time from the PCP's office. If there is no hospital that meets these geographic criteria, the closest hospital to the CCNC/CA PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable. Exceptions may be granted in cases in which it is determined the benefits of a PCP's participation outweighs his or her inability to comply with the admitting privileges requirement. Failure to report a change in admitting privileges or with the formal agreement may result in sanctions.

Women, Infants, Children Special Supplemental Nutrition Program Referrals

Federal law mandates coordination between Medicaid managed care programs and the Women, Infants, Children (WIC) program. CCNC/CA PCPs are required to refer potentially eligible enrollees to the WIC program. Copies of the **WIC Exchange of Information Form for Women**, the **WIC Exchange of Information Form for Infants and Children**, and the **Medical Record Release for WIC Referral form** are available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

For more information, contact the local WIC agency at the county DSS or the Division of Maternal and Child Health at 1-800-FOR-BABY (1-800-367-2229).

Transfer of Medical Records

CCNC/CA PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request.

Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. In order to promote quality and continuity of care, a guideline for medical record keeping has been established by the CCNC/CA program and approved by the Physician Advisory Group. All CCNC/CA PCPs must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CCNC/CA PCPs. See **Section 3, Medicaid Provider Information**, for medical records standards that apply to all providers.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page or electronic file in the record contains the patient's name or patient's Medicaid identification number and the office/practice from which the page is coming.
2. All entries are dated.
3. The authors of all entries are identified.
4. The record is legible to someone other than the writer.

5. Medication allergies and adverse reactions, as well as the absence of allergies, are prominently noted and easily identifiable.
6. The patient's personal and biographical data—including age, sex, address, employer, home and work telephone numbers, and marital status—is recorded.
7. Medical history, including serious accidents, operations, and illnesses, is easily identified. For children, medical history includes prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization and administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded.
10. Response of patients aged 12 years and over to inquiries about smoking, alcohol, and other substance abuse at the routine visit.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Records of consultation and significantly abnormal labs and imaging results have an explicit notation of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with CCNC/CA.
14. Documentation of individual encounters provides adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test(s), therapies, and other prescribed regimen(s); follow-up care, referrals, and results thereof; and all other aspects of patient care, including ancillary services.

Referrals and Authorizations

Coordination of care is a required component of CCNC/CA. **Authorization for payment of services to another provider should be considered even when an enrollee has failed to establish a medical record with the PCP when medically necessary health care services are needed.** In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of **Exempt Services** in this section.) All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. Referral of an enrollee to a specialist may be made by telephone or in writing. The referral must include the number of visits being authorized and the extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation, or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP should be notified prior to the referral. The same authorization referral number must be used by both specialists. If the treating provider identifies a need for treatment for a diagnosis other than the original diagnosis, the patient must be referred back to the PCP for treatment or coordination of care.

Authorization is not required for services provided in an urgent care center billing with a hospital provider number. Referrals to a specialist for follow-up care after discharge from an urgent care center **do** require PCP authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals to a specialist for follow-up care after discharge from a hospital also require PCP authorization.

PCP authorization is not the same as prior approval (PA). Some services require **BOTH** PA and PCP authorization. Refer to **Section 6, Prior Approval**, for additional information about services requiring PA.

Referrals for a Second Opinion

CCNC/CA PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

Referral Documentation

All referrals must be documented in the enrollee's medical record. It is the PCP's responsibility to review the Referral Report for validity and accuracy and to report inappropriate use of their Carolina ACCESS referral number to the Managed Care Consultant. Refer to page 4-23 for an example of the report. (If the PCP does not have a medical record for the patient, document the referral on the referral log. PCPs are encouraged to keep a log of all referrals for ease in management of the Referral Report.)

Submitting Referral Claims

Claims submitted for reimbursement of a service authorized by a recipient's Carolina ACCESS PCP must include the PCP's referral authorization number. Prior to the implementation of NPIs, this referral authorization number was the PCP's Carolina ACCESS provider number. With the implementation of NPIs, the PCP's NPI number must now be used as the referral authorization number. Carolina ACCESS PCPs must provide their NPI when authorizing a service. Claims must be submitted with the Carolina ACCESS PCP's NPI number (unless the PCP is atypical) as the referral authorization number or the claim will be denied.

When billing for a service authorized by a recipient's Carolina ACCESS PCP, providers must include the PCP's NPI as the referral authorization number on the claim. A taxonomy is not required for the referral authorization NPI.

Refer to **Section 5, Submitting Claims to Medicaid**, for timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides, and referring provider information on a claim.

Exempt Services

Enrollees may obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance services
- At-risk case management
- Child care coordination
- Community Alternatives Program services
- Dental care

Note: CCNC/CA enrollees are instructed to contact their PCP for assistance in locating dental providers enrolled with the Medicaid program. A list of dental providers is available on DMA's website at <http://www.ncdhhs.gov/dma/dental/dentalprov.htm>. Recipients can also be referred to their county DSS (for a list of all the county DSS offices, please refer to <http://www.ncdhhs.gov/dss/local/>) or to the Office of Citizen Services, CARE-LINE Information and Referral, at 1-800-662-7030 or 919-855-4400 (English and Spanish). Area Health Check Coordinators also maintain a list of dentists that provide services to the under age 21 population. For a list of Health Check Coordinators, refer to <http://www.ncdhhs.gov/dma/provider/provcontacts.htm>.

- Developmental evaluations
- Emergency department services and inpatient hospital services when admitted from the emergency department. Physician services provided in the inpatient setting still require authorization from the PCP.
- Eye care services [limited to CPT codes 92002, 92004, 92012, and 92014 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]
- Family planning (including Norplant)
- Health department services
- Hearing aids (for recipients under the age of 21)
- HIV case management
- Hospice
- Independent and hospital lab services
- Maternity care coordination
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist
- Services performed in a psychiatric hospitals and psychiatric facilities (but see notes below)
- Services provided by schools and programs directly billed by the school
- Outpatient behavioral health services for adult recipients (aged 21 years and older) when performed by direct-enrolled providers.

Note: Psychiatric Services – ICD-9-CM diagnosis codes 290 through 319.99 are exempt for all providers except local management entities and psychiatrists. Local management entities and psychiatrist providers must adhere to Medicaid's service-specific policies (<http://www.ncdhhs.gov/dma/mp/>).

Outpatient psychiatric services must be referred for children under the age of 21 by a Medicaid-enrolled psychiatrist, the local management entity, or the PCP. A Carolina ACCESS override will not be given for outpatient mental health services provided to enrollees under age 21 when a referral is not obtained.

Although adult enrollees are not required to obtain authorizations from their PCPs for the services listed above, PA may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Section 6, Prior Approval**, for information on services requiring PA.

Override Requests

It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CCNC/CA enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers may request an override using the **Carolina ACCESS Override Request** form to obtain payment. Override requests will be considered only for extenuating circumstances beyond the control of the responsible parties that affected access to medical care. **Overrides will not be given for mental health services.**

Authorization for medically necessary services may be obtained from EDS by calling before the service is rendered (800-688-6696). If the service has already been provided, a written override request must be submitted to EDS on the Carolina ACCESS Override Request form within 6 months of the date of service. Written requests will be evaluated within 30 days of receipt. A copy of the Carolina ACCESS Override Request form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>. Forms that are incomplete or illegible when submitted will be returned.

Medical Exemption Requests

CCNC/CA was established on the premise that patient care is best served by care coordinated through a PCP. Enrollees may request a medical exemption from participation in CCNC/CA. Depending on the condition of the patient, the exemption may be made for a 6-month period or for the lifetime of the patient. Exemptions are granted for the following medical conditions:

- Terminal illness—the enrollee has a life expectancy of 6 months or less or is currently a hospice patient
- Major organ transplant—this would be considered for a permanent exemption
- Chemotherapy or radiation treatment—the enrollee is currently undergoing treatment

Note: This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than 6 months, the exemption must be requested after the initial 6-month time period during reapplication for Medicaid coverage.

- Diagnosis/Other—an enrollee may be granted an exemption if there is a specific diagnosis or other reason that the enrollee would not benefit from coordinated care through a PCP

Note: Supporting medical record documentation for this category may be requested for review prior to a determination decision.

- End-stage renal disease

The **Carolina ACCESS Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the DMA Managed Care Section at the address listed on the form. Recipients may also obtain the Medical Exemption Request form at their county DSS. A copy of the form is also available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

Patient Disenrollment

On occasion, it may be necessary to disenroll a CCNC/CA enrollee from a practice for good cause.* To disenroll a patient, PCPs must follow these procedures:

- Notify the CCNC/CA enrollee in writing of the disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days' notice. Advise the enrollee to contact his or her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.
- Fax a copy of the disenrollment letter to the Carolina ACCESS contact at the county DSS. In addition, a copy of the letter should be sent to the Regional Managed Care Consultant. (PCPs can check with the Managed Care Consultant to confirm the correct Carolina ACCESS Coordinator at the county DSS).

Note: Until a county DSS worker deletes the PCP's name, address, and telephone number from the recipient's MID card, the PCP must continue to provide services to the enrollee or authorize another provider to treat the enrollee.

***Good cause is defined as follows:**

- Behavior on the part of the recipient that is disruptive, unruly, abusive, or uncooperative to the extent that the provider's ability to serve the recipient or other affected recipients is seriously impaired
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment
- Fraudulent use of the MID card

Additionally, a CCNC/CA enrollee may be disenrolled for nonpayment of copayments or an outstanding balance if this is a standard operating procedure for the practice, it is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

Carolina ACCESS—Frequently Asked Questions

1. Is there a limit to the number of Carolina ACCESS patients that I can enroll for my practice?

PCPs may enroll up to a maximum of 2,000 CCNC/CA enrollees per physician or physician extender, unless otherwise approved by DMA.

2. May PCPs change the practice enrollment limit?

PCPs may change enrollment limits or restrictions by completing and submitting a **Medicaid Provider Change Form**.

3. How can providers verify that a patient is enrolled with Carolina ACCESS?

It is important to check the enrollee's eligibility at each visit. If there is no medical home listed on the card, the patient is not currently enrolled in CCNC/CA. If the patient is enrolled in CCNC/CA, the eligibility check will provide the name of the current medical home.

In addition to the verification methods listed in **Section 2, Recipient Eligibility**, enrollment can be verified by checking the current Carolina ACCESS Enrollment Report (PCPs only).

4. What should providers do if the patient does not bring his or her MID card to an appointment?

Verify the patient's enrollment by one of the methods listed in **Section 2, Recipient Eligibility**, or check the current Carolina ACCESS Enrollment Report. Alternatively, prior to rendering the service, the provider must inform the patient either orally or in writing that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

5. What if the medical home listed on the patient's MID card is incorrect?

Advise the patient to contact his or her caseworker or the Medicaid supervisor at the county DSS to request a change to another medical home. In most circumstances, the change takes a minimum of 30 days. Changes are typically effective the first day of the month following the change. If the recipient wants to change from his or her Carolina ACCESS provider to your practice, refer to **Recipient Enrollment** on page 4-2 for information regarding enrolling recipients at the PCP's office.

6. Are Carolina ACCESS enrollees responsible for copayments?

CCNC/CA enrollees are subject to the same copayment requirements as fee-for-service Medicaid recipients. Refer to **Copayments in Section 2, Recipient Eligibility**, for additional information.

7. Do all Medicaid-covered services require authorization from the primary care provider?

No. Some Medicaid-covered services are exempt from PCP authorization. See **Exempt Services** in this section.

8. What if a Carolina ACCESS enrollee needs health care that the assigned PCP practice cannot provide?

PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. Refer to **Carolina ACCESS Referrals and Authorizations** in this section for additional information on coordination of care.

9. What is the process for referring a patient to a specialist or to other health services?

A CCNC/CA enrollee may be referred to any specialist or to other health services enrolled with Medicaid. Your NPI number must be provided to the specialist or other health service provider as the authorization number. Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

10. What if the PCP practice receives a request for an authorization for a patient they have not seen yet?

PCPs are contractually required to provide services or authorize another provider to treat the enrollee. PCPs should develop referral or authorization protocols and ensure office staff are knowledgeable of the process. All referrals or authorizations must be documented in the enrollee's medical record. Appointments must be available according to the standards of appointment availability found in the contractual agreement.

11. What if a Carolina ACCESS enrollee self-refers to another practice?

Authorization from the PCP must be obtained before Medicaid will pay another provider to treat a CCNC/CA enrollee unless the service is exempt from authorization. You may contact (indicated by checking the enrollee's eligibility) and request authorization, but the PCP is not obligated to authorize the service.

12. Do Carolina ACCESS enrollees admitted through the emergency department require authorization from their primary care providers?

Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization**. Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

13. How should claims be filed when a PCP refers a Carolina ACCESS enrollee to another practice?

Refer to **Section 5, Submitting Claims to Medicaid**, for timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides, and referring provider information on a claim.

14. How do practices receive guidance with questions or obtain additional information?

DMA has established regional managed care consultants to assist managed care providers. Refer to the last page of this section for a list of consultants. If you are unable to reach the consultant, you may contact the DMA Managed Care program at 919-855-4780.

15. If I receive prior approval for a service, do I also have to have authorization from the recipient's PCP in order to be paid for my services?

Some services do require both prior approval and the PCP's authorization. Refer to the **Exempt Services** in this section for a list of services that do not require authorization from the PCP. Refer to **Section 6, Prior Approval**, for additional information about the prior approval processes.

Modified Sample of Carolina ACCESS Provider Enrollment Report, Section 1, New Enrollees

CA PROVIDER ENROLLMENT REPORT
SECTION 1
"New Enrollees"

PROVIDER NUMBER: 1234567	NC DEPT. OF HUMAN RESOURCES	PAGE NUMBER
PROVIDER NAME: DR. JOE PROVIDER	CAROLINA ACCESS	DATE RUN:
	PROVIDER ENROLLMENT REPORT	
	FOR THE MONTH OF: SEPTEMBER	
	ENROLLMENT STATUS: (NEW ENROLLEE)	
..... ELIGIBILITY DATES		
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX..... BIRTHDAY
		FROM TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M 08/08/98 09/01/03 11/30/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F 10/26/56 09/01/03 02/28/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M 11/02/73 09/01/03 12/31/03

Note: This section of the report lists all "New" Carolina ACCESS enrollees linked to your practice for the report month. Some of the clients listed in this section may be previous clients who were listed in the "Terminated" section of a previous report.

Carolina ACCESS primary care physicians are encouraged to use this section of the report to identify and contact all new enrollees by telephone or through a "welcome" letter as a way of establishing a medical record with your practice.

Modified Example of Carolina ACCESS Provider Enrollment Report, Section 2, Current Enrollees

<u>CA PROVIDER ENROLLMENT REPORT</u>		PAGE NUMBER
SECTION 2		DATE RUN:
"Current Enrollees"		
NC DEPT. OF HUMAN RESOURCES		
PROVIDER NUMBER: 1234567	CAROLINA ACCESS	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT	
	FOR THE MONTH OF: SEPTEMBER	
	ENROLLMENT STATUS: (CURRENT)	
..... ELIGIBILITY DATES		
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX..... BIRTHDAY
		FROM TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M 08/08/98 09/01/03 12/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F 10/26/56 09/01/03 10/31/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M 11/02/73 09/01/03 09/30/03

Note: This section of the report lists all Carolina ACCESS enrollees linked to your practice for the report month.

The eligibility "FROM" date listed for the client is always the current report month. The "TO" date will vary depending on each client's Medicaid certification period.

This section of the report can be used to verify **current month** eligibility if a client has not received their MID card for the current month or fails to bring the MID card to an appointment.

Modified Example of Carolina ACCESS Provider Enrollment Report, Section 3, Terminated Enrollees

<u>CA PROVIDER ENROLLMENT REPORT</u>		PAGE NUMBER
SECTION 3		DATE RUN:
"Terminated Enrollees"		
NC DEPT. OF HUMAN RESOURCES		
PROVIDER NUMBER: 1234567	CAROLINA ACCESS	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT	
FOR THE MONTH OF: SEPTEMBER		
ENROLLMENT STATUS: (TERMINATED)		
..... ELIGIBILITY DATES		
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX..... BIRTHDAY
		FROM TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC. 22231	M 08/08/98 09/01/00 08/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F 10/26/56 04/01/03 09/30/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M 11/02/73 06/01/03 09/30/03

Note: This section of the report lists all of the Carolina ACCESS enrollees "Terminated" from your practice for the report month.

The eligibility "FROM" date and "TO" date listed for the client will vary indicating that:

- The client is no longer eligible for Medicaid; or
- The client is eligible for Medicaid but has selected another CA PCP, or has been granted an exemption for this report month; or
- A change was made to the client's file but was not entered into the system in time to generate a link to the "New Enrollee" section of the report for this month.

Example of Emergency Room Management Report

REPORT: HMSR300N	DIVISION OF MEDICAL ASSISTANCE		PAGE: 1
FIN PAYER: NCX1X	PRIMARY CARE PROVIDER		DATE: 11/27/2003
	EMERGENCY ROOM MANAGEMENT REPORT		
	AS OF DATE: 11/27/2003		
	CLAIMS PAID DURING THE MONTH OF NOVEMBER 2003		
COUNTY: ALAMANCE	PCP: FUN FAMILY PRACTICE	PCP NUMBER: 1234567	
ENROLLEE NAME	MEDICAID NUMBER	PRIMARY REASON FOR VISIT	BILLING PROVIDER
	DIAG.		DOS
			TOS
			PAID AMOUNT
IDENTIFIED EMERGENCIES			
COOL JOE	F. 123456789M 7806	PYREXIA UNKNOWN ORIGIN	FUN HOSPITAL
SMALL SALLY	A. 987654321P 92310	CONTUSION OF FOREARM	CITY COUNTYHOSPITAL
			10/26/03 11 \$27.22
			10/18/03 14 \$99.73
		TOTAL PAID AMT	\$126.95
		TOTAL VISITS	2
OTHER ER CLAIMS			
DOE JANE	R. 123456798W 6929	DERMATITIS NOS	LOCAL URGENT CARE
			10/28/03 08 \$28.52
		TOTAL PAID AMT	\$28.52
		TOTAL VISITS	1
		AVERAGE PER VISIT	\$28.52
		TOTAL ER PAID AMT	\$155.47
		TOTAL ER VISITS	3

Instructions for Quarterly Utilization Report

This report gives the PCP a detailed representation of the utilization of services by recipients linked with the PCP's practice. These reports are based on claims that were paid during the quarter prior to the report date. This report can be a useful tool in assisting the provider with their internal utilization and quality management programs.

There are 14 service categories listed on the top portion of the report, with an explanation of each listed on the second page of the report. The 14 service categories are divided into 4 subcategories as follows:

1. **Current Quarter PCP**—PMPM (per member per month) is the cost for that quarter for each of the 14 service categories. The rate = units (claims) divided by quarterly enrollment x 1000. Rates and cost are reported per 1000 members.
2. **Current Quarter PCP Peer Group**—Average rate and cost for all practices in your specialty for the quarter in respective category.
3. **Quarter Average for PCP Peer Group**—Average rate and cost for PCP Peer group practices in respective categories.
4. **Quarterly Average**—Totals for the last four quarters in respective categories.

IF YOU HAVE ANY QUESTIONS REGARDING THE QUARTERLY UTILIZATION REPORT CONTACT YOUR REGIONAL MANAGED CARE CONSULTANT

Example of Quarterly Utilization Report

REPORT: HMSR4051 NORTH CAROLINA MMIS DATE: 04/20/2004
 CAROLINA ACCESS QUARTERLY UTILIZATION REPORT
 01/01/2004 - 03/31/2004

 OFFICE MANAGER: PLEASE DISTRIBUTE THIS

PRACTICE NAME: WE CURE WHAT AILS YOU MEDICAL OFFICE
 PROVIDER NUMBER: 8888888
 CA PCP TYPE: 001 - GPP/FAMILY PRACTICE
 COUNTY: 017 - CASWELL

REPORT TO ALL PHYSICIANS
 IN THE PRACTICE.

SERVICE CATEGORY	CURRENT QTR		CURRENT QTR		QUARTERLY AVE.		LAST 4 QUARTERS - PCP		LAST 4 QUARTERS - PCP	
	PCP	RATE	PCP	RATE	PCP	RATE	PCP	RATE	PCP	RATE
(1) PCP OFFICE SERVICES	256	\$14.01	292	\$15.63	232	\$13.52	48	\$8.30	48	\$8.30
(2) TOTAL URGENT CARE SERVICES	19	\$2.71	38	\$12.32	28	\$5.48	28	\$5.48	28	\$5.48
A. IDENTIFIED EMERGENCY	9	\$2.41	27	\$5.12	20	\$2.82	20	\$2.82	20	\$2.82
B. NON-EMERGENCY	809	\$35.16	1504	\$81.72	758	\$32.14	758	\$32.14	758	\$32.14
(3) PHARMACY	9	\$28.65	8	\$45.20	3	\$10.21	3	\$10.21	3	\$10.21
(4) HOSPITAL INPATIENT	0	\$0.00	1	\$5.61	0	\$0.00	0	\$0.00	0	\$0.00
(5) INPATIENT MENTAL HEALTH	88	\$13.95	169	\$20.66	65	\$8.07	65	\$8.07	65	\$8.07
(6) SPECIALISTS/REFERRALS	84	\$2.84	70	\$2.51	85	\$2.63	85	\$2.63	85	\$2.63
(7) LABS	1	\$0.43	4	\$2.54	1	\$0.78	1	\$0.78	1	\$0.78
(8) X-RAYS	47	\$5.69	97	\$24.48	46	\$4.79	46	\$4.79	46	\$4.79
(9) MENTAL HEALTH OUTPATIENT	47	\$17.43	133	\$43.07	38	\$9.36	38	\$9.36	38	\$9.36
(10) OUTPATIENT/AMBULATORY										

PMPM CALCULATIONS	CURRENT QUARTER		PCP LAST 4 QTRS		LAST 4 QUARTERS	
	PCP	PMPM	PCP	PMPM	PCP	PMPM
(11) PRIMARY CARE PROVIDER	\$16.01	\$18.07	\$16.40	\$16.40	\$17.53	\$17.53
(12) ALL OTHER SERVICES	\$133.13	\$298.57	\$99.51	\$99.51	\$291.07	\$291.07
(13) TOTAL SERVICES	\$149.13	\$316.64	\$115.91	\$115.91	\$308.60	\$308.60

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: 51 AGES > 21: 20 AVERAGE TOTAL MONTHLY ENROLLMENT: 71

Example of Quarterly Utilization Report, continued

<p>(1) NUMBER AND ASSOCIATED \$ OF PCP OFFICE VISITS, INCLUDING OFFICE LABS/XRAYS AND HEALTH CHECKS</p> <p>(2) URGENT CARE VISITS AND ASSOCIATED \$ IDENTIFIED EMERGENCIES = DMA DEFINED EMERGENCY DIAGNOSES (10/99 BULLETIN)</p> <p>(3) PHARMACY SERVICES AND ASSOCIATED \$ FROM DRUG CLAIMS</p> <p>(4) HOSPITAL ADMISSIONS AND ASSOCIATED \$ (INCLUDING ANESTHESIA). MENTAL HEALTH AND INPATIENT PHYSICIAN CONSULTATIONS ARE NOT INCLUDED.</p> <p>(5) HOSPITAL ADMISSIONS AND ASSOCIATED \$ FOR MENTAL HEALTH</p> <p>(6) NUMBER AND ASSOCIATED \$ FOR REFERRAL SERVICES TO SPECIALISTS, OTHER OUTPATIENT PROVIDERS, AND INPATIENT PHYSICIAN CONSULTATIONS PCP REFERRAL # IS ON THE CLAIM. (THIS DOES NOT INCLUDE OT/PT/ST OR MENTAL HEALTH).</p> <p>(7) NUMBER AND ASSOCIATED \$ IDENTIFIED FOR LABORATORY PROCEDURE CODES, PATHOLOGY INCLUDED.</p> <p>(8) NUMBER AND ASSOCIATED \$ IDENTIFIED BY X-RAY PROCEDURE CODES. THERAPEUTIC RADIATION SERVICES NOT INCLUDED.</p> <p>(9) NUMBER AND ASSOCIATED \$ FOR OUTPATIENT SERVICES RELATED TO MENTAL HEALTH</p> <p>(10) NUMBER AND ASSOCIATED \$ FOR HOSPITAL OUTPATIENT SERVICES. THIS INCLUDES AMBULATORY, ANESTHESIA IN AN OUTPATIENT SETTING, HOME HEALTH, AND PT/OT/ST. E/R AND MENTAL HEALTH SERVICES NOT INCLUDED.</p> <p>(11) QUARTERLY AND ANNUAL PMPM FOR PCP SERVICES INCLUDING MANAGEMENT FEES FOR PCP AND PCP PEER GROUP</p> <p>(12) QUARTERLY AND ANNUAL PMPM FOR LINES 2-10 AND ALL NON-PCP SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP</p> <p>(13) QUARTERLY AND ANNUAL PMPM FOR ALL SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP</p> <p>(14) AVERAGE MONTHLY NUMBER OF RECIPIENTS LINKED WITH THIS PCP.</p>	<p>NOTE: THESE FIGURES ARE BASED ON CLAIMS PROCESSED FOR SERVICES PROVIDED DURING THE QUARTER REPORTED</p> <p>MEDICARE CROSSOVER CLAIMS AND ADJUSTMENTS NOT INCLUDED</p> <p>RATE = UNITS / QUARTERLY ENROLLMENT X 1000.</p>
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List of Regional Managed Care Consultants

Consultant's Name	Telephone Number	E-mail Address (Please do not send PHI via email)	Counties
Jerry Law	252-321-1806 Fax: 252-321-1876	Jerry.Law@ncmail.net	Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Martin, Nash, Northampton, Pasquotank, Perquimans, Pitt, Tyrell, Washington
Rosemary Long	910-738-7399 Fax: 910-738-7349	Rosemary.Long@ncmail.net	Bladen, Brunswick, Carteret, Columbus, Craven, Cumberland, Duplin, Jones, Lenoir, New Hanover, Onslow, Pamlico, Pender, Robeson, Sampson, Wayne
Tiffany Ferguson-Cline	704-636-9000 Fax: 704-636-9003	Tiffany.Ferguson-Cline@ncmail.net	Davidson, Davie, Forsyth, Guilford, Hoke, Montgomery, Moore, Randolph, Richmond, Rockingham, Scotland, Stokes, Surry, Wilkes, Yadkin
Christopher Lucas	919-855-4789 Fax: 919-715-5235	Christopher.Lucas@ncmail.net	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Harnett, Johnston, Lee, Orange, Person, Vance, Wake, Warren, Wilson
LaRhonda Cain	919-855-4791 Fax: 919-715-5235	LaRhonda.Cain@ncmail.net	Alexander, Alleghany, Anson, Ashe, Cabarrus, Caldwell, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union, Watauga
Melanie Whitener	828-304-2345 Fax: 828-304-2346	Melanie.Whitener@ncmail.net	Avery, Buncombe, Burke, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
DMA Managed Care Customer Services	919-855-4780 Fax: 919-715-5235		When the consultant is out of the office, assistance may be obtained by contacting Customer Services at DMA Managed Care

