NC Medicaid	Community Alternatives Program for Children CAP/C Waiver approval period: 3/01/2023-2/28/2028	Standard Operating Procedure (SOP)	Community Alternatives Program Home and Community-Based Services Willing Qualified Provider Enrollment
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Standard Operating Procedure

Where to find this information in the policy:

- Community Alternatives Program for Children 3K-1; Section 6.0
  https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

The federal citation that allows the 1915(c) Home and Community-Based Services (HCBS) Waiver is:
42 CFR §441.302

1. **Purpose -** The State Medicaid Agency (SMA) has to make sure that people get CAP HCBS services from qualified and willing providers. The SMA is responsible for keeping the CAP participants' health, safety and well-being.

2. **Scope** – In North Carolina, providers can offer different types of HCBS services through the CAP waiver. They must follow the rules for each service they want to offer. To add a service code, they need to fill out a Managed Change Request (MCR) in the NCTracks Portal.

   To apply to be an NC Medicaid Provider or make a Managed Change Request visit the NCTracks provider portal. Use the following link:
   Providers - Providers (nc.gov)

   Table 1 below lists the 23 approved HCBS.

Table 1 – CAP/C HCBS Services

CAP/C HCBS	Procedure Code	Taxonomy Code
Assistive Technology	T2029	332B00000X
CAP In-home Aide Services	S5125 & S5125 UN	253Z00000X
Case Management Services	T1016	251B00000X
Care Advisor Services	T2041	251B00000X
Community Transition Services	T2038	251B00000X and/or 332B00000X
Community Integration Services	T2033	251B00000X and/or 332B00000X
Congregate Services	S9122 TG & S9122 TF	253Z00000X and/or 251J00000X
Coordinated Caregiving Services	G9003 & G9004	253Z00000X and/or 251J00000X and/or 251B00000X
	G9012	251J00000X
Home Mobility and Adaptative Services	S5165	332B00000X
Financial Management Services	T2040	171M00000X
Individual Goods and Services	T2025	171M00000X and/or 332B00000X
Medical Supply	E0070	332B00000X

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Non-Medical Transportation	A0090	251B00000X and/or 171M00000X
Nutritional Services	H2010	251B00000X and/or 171M00000X
Participants Goods and Services	T2025	251B00000X and/or 332B00000X
Pediatric Nurse Aide Services	T1019	251J00000X
Attendant Nurse Care	T2026	251J00000X and/or 171M00000X
Personal Assistance Services	T2027 and T2027 TF	171M00000X
Pest Eradication	T5999	251B00000X and/or 171M00000X
Respite – Institutional	H0045	385H00000X
Respite – In Home	S5150, T1004 and T1005	253Z00000X, 251J00000X and/or 171M00000X
Training, Education and Consultative services	S5111	251B00000X
Vehicle Modification	T2039	332B00000X and/or 171M00000X

- CAP WQP Prior Approval Enrollment Packet Desktop Tool, and

QP_2023.pdf

3. Abbreviations of commonly used terms

AA – Administrative Authority
CD - Consumer direction
CAP – Community Alternatives Program
DHSR – Department of Health Services Regulation
DSP – Direct service provider
FM – Financial management
FMS - Financial management services
HCBS – Home and Community-Based Services
HSW – Health, safety, and well-being
MDT – Multidisciplinary treatment
OPR - Ordering, Prescribing or Referring Provider
PCSP – Person-centered service plan
POC – Plan of care
SMA – State Medicaid Agency
SP – Service Plan
WQP - Willing Qualified Provider

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4. Definition of terms:

Willing Qualified Provider (WQP) – An organization that:

- Meets the requirements.
  - These come from NC Medicaid.
- Follows the requirements.
  - These come from NC Medicaid.
- Meets the minimum qualifications.
  - These are listed in section 6.0 of the CAP Clinical Coverage Policy.
- Follows the rules.
  - These are listed in the CAP Clinical Coverage Policy.

The ordering, prescribing, rendering, and referring specifically for CAP:

- Ordering and prescribing is the physician.
- Rendering is the provider.
- Referring is the CAP case management entity.

5. Responsibilities - The SMA makes sure that all providers are qualified to give CAP HCBD services. They do this by checking the following:

a. Service providers have the right licenses and certifications. These are required by regulatory agencies and checked when they apply and regularly after that.
b. Direct service providers follow policy standards before giving services. This is checked regularly.
c. Providers who don't need licenses or certifications are still checked to make sure they meet program requirements. This is done every three months.
d. WQP make sure that the SP is monitoring health, safety, and well-being. This is done during an MDT meeting every three months.
e. Direct service providers provide services as described in the service plan. This happens when approved and includes:
   - Types of services.
   - Scope of services.
   - Amount of services.
   - Duration of services.
   - Frequency of services.
f. Participants get services that are:
   - In the least restrictive environment,
   - Free from seclusion,
   - Free from restraint,
   - Free from restrictive interventions that are not ordered by a doctor.
   - These checks happen every day.

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g. That participants are given the freedom to choose WQP to perform their approved CAP HCBS. These providers must be free of conflict. This is done at first enrollment, annually, and as needed.

6. **Measure** - Each WQP will meet the minimum qualifications and requirements to render CAP services. Table 2 below shows the requirements for each service.

Table 2 – Willing Qualified Provider Requirements

Type of HCBS Provider	Qualifications	Authorization Requirements	HSW Requirement
Case Management Entity	Have at least 3 years of CM or LTSS experience. Have the appropriate staff to participant ratio. Have financial stability. Have connection to the service area. Have automated systems. Have qualified staff. Have a designated office location. Have written policies and procedures. Have an active NPI.	Be an NC Medicaid enrolled provider. Have approval by NC Medicaid to take on the role of CME. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Make monthly case management contacts. These include: • Monthly contacts with the participant. • 4 quarterly contacts with the participant. • 4 MDT meetings. • Managing HSW.
Coordinated Caregiving	Have 3 years of experience providing	Be an NC Medicaid enrolled provider.	Set a schedule of visits to give support,

	services to the target population. Have the ability to create a care plan. It must include opportunities for 8 hours of training each year. Have access to professionals such as OTs, PTs, and nurses. They help with the training and education of the caregiver. Have a connection to the service area. Have financial stability. Have qualified staff. Have automated systems. Have written policies and procedures. Have an active NPI.	Use the appropriate taxonomy code for high or low acuity. If not licensed as a home health agency by DHSR obtain an atypical provider taxonomy. Designation by NC Medicaid to act in this capacity. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	guidance, and training. Take part in quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.
CAP In-Home Aide I Services	Have all of the licenses and certifications that are required. The	Be an NC Medicaid enrolled provider.	Take part in the quarterly MDT meetings.

	requirements are set by the NC Department of Health Services Regulations. Have a restraint and seclusion free policy. Have an active NPI.	Have a Managed Change Request that includes the case management and in-home supportive services codes. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.
Equipment, Home and Vehicle Modification and Assistive Technology	Have all of the licenses and certifications that are required. The requirements are set by the NC Department of Health Services Regulations. The CME has checked and confirmed that they can provide the item or service. The item or service will be good quality. It will meet the need that it is intended for. The item or service is not provided through the CAP/C waiver or the	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management and in-home supportive services codes. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

	Medicaid State Plan. The participant or LRP does not have the resources to obtain the goods or services. Have a business or retail license. Have an active NPI.		
Financial Management Services	Have 3 years of experience providing services to the target population. Have financial stability. Have a business license for NC. Have automated systems. Have written policies and procedures. Meet the requirements set by: • The IRS. • The CAP/C Clinical Coverage Policy.	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

Goods and Services	The CME has checked and confirmed that they can provide the item or service. The item or service will be good quality. It will meet the need that it is intended for. The item or service is not provided through the CAP/C waiver or the Medicaid State Plan. The participant or LRP does not have the resources to obtain the goods or services. The item or service is needed to avoid a move to an institution. Have a business or retail license. Have an active NPI.	Have a completed comprehensive multidisciplinary declaration of need assessment that states the participant's needs. Have a copy of the physician's order, when applicable. Have a recommendation by a professional that states need(s). Have the estimated life expectancy of the equipment. Have the length of time the participant is expected to use the good or service. Have an invoice from the supplier that shows: • The date the equipment, supply, adaptation, or modification was provided to the participant, and • The cost, with related charges	Items or services that are needed that will help the participant: • Stay in the community. • To be able to do ADLs or IADLs. • Decrease their need for personal assistance services or other services paid for by Medicaid. Each good and service must be related to a need. The need must be based on the assessment and listed in the SP.

		and maintained in e-CAP. Complete Medicaid enrollment training and annual training courses. Consumer Directed goods and services must be: • clearly linked to an assessed need, and • Established in the service plan.	
Personal Assistance Services	Pass a background check. Show the required skills. CPR certified as required. Complete beneficiary-specific competencies. Sign the Employer/Employee Agreement.	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.
Personal Emergency Response System (PERS)	Provide a response for emergencies.	Be an NC Medicaid enrolled provider. Have a Managed Change Request that	Take part in the quarterly MDT meetings when applicable.

		includes the case management code. Acceptance of Service Authorization in e-CAP.	Report critical incidents. Report PERS calls immediately. Respond to complaints made by the participant. This must be done within 5 business days.
Respite	Pass a background check. Institutional respite services must be provided in a Medicaid certified nursing facility or a hospital with swing beds under 10A NCAC 13D. In-home respite must be a licensed by the State of North Carolina in accordance with 10A NCAC 13J.1107 if a personal care aid they must be listed on the Nurse Aide Registry according to G.S. 131E-256. Comply with EVV requirements section	Be a Medicaid enrolled provider Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

	12006 1903(l) of the 21st Century Cures Act.		
Pediatric Nurse Aide	Must be at least 18 years or older. Pass a background check. Be CPR certified Complete beneficiary-specific competencies. Comply with 10A NCAC Chapter 13 Subchapter J. Comply with North Carolina Health Services Regulation in the management of this service. Comply with EVV requirements section 12006 1903(l) of the 21st Century Cures Act. If provided by a spouse, parent, child or sibling, meet all of the above and the beneficiary is 18	Be a Medicaid enrolled provider Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

	years or older. Any employment cannot negatively impact the provision of services; nor supersede the identified care needs of the CAP/C beneficiary.		
Specialized Medical Supplies	Have all of the licenses and certifications that are required. The requirements are set by the NC Department of Health Services Regulations. The CME has checked and confirmed that they can provide the item or service. The item or service will be good quality. It will meet the need that it is intended for. Have a business or retail license. Have an active NPI. The item or service is not provided through the CAP/C	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management and medical supplies codes. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings when applicable. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

	waiver or the Medicaid State Plan. The participant or LRP does not have the resources to obtain the goods or services.		
Transition and Integration Services	Have a business or retail license.	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings when applicable. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.
Training, Education and Consultative Services	Have a business or retail license. Complete Medicaid enrollment training and annual training courses.	Be an NC Medicaid enrolled provider. Have a Managed Change Request that includes the case management code. Acceptance of Service Authorization in e-CAP. Complete Medicaid enrollment training and annual training courses.	Take part in the quarterly MDT meetings when applicable. Report critical incidents. Respond to complaints made by the participant. This must be done within 5 business days.

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7. **Procedure** – An application to be an NC Medicaid provider must be made and approved. A Managed Change Request must be made. These are both done through the NCTracks portal. The Managed Change Request adds the CAP taxonomies and procedure codes to the Medicaid provider application profile. This must be done to provide services and receive payment. Please refer to table 1 for the 23 HCBS codes.

   3 of the CAP services require an additional application step. They are:
   - Case Management/Care Advisement Services,
   - Coordinated Caregiving, and
   - Financial Management Services.

   The additional step for the 3 services is to submit a CAP enrollment packet for prior approval. Case Management/Care Advisement, Coordinated Caregiving and Financial Management Services providers must have prior approval before being able to provide CAP services.
   - This is done after applying to be an NC Medicaid provider through NCTracks.
   - The enrollment packet is sent to the CAP unit at NC Medicaid.
     - There are templates for the packet. These are available through the following links:
       - Case management and Care Advisement Provider Application Packet Template
       - Coordinated Caregiving Provider Application Template
       - Financial Management Services Provider Application Packet Template
     - Once the application has been approved:
       - A letter is sent.
       - This letter states the effective and start date granted by NC Medicaid CAP unit.
       - Having the approval letter is called receiving prior approval.
   - A Managed Change Request is made in NCTracks.
     - The prior approval letter and taxonomy code are required for this.

   To request to be a CAP willing provider of case management, coordinated caregiving or financial management services:
   - An application packet must be submitted to the CAP unit. This can be done by fax or mail. Fax is the preferred method.
     - Fax information to:
       - Attention CAP Unit at NC Medicaid
         1 + (919) 715–0052
     - Mail information to:
       - Attention CAP Unit at NC Medicaid
         2501 Mail Service Center,
         Raleigh, NC 27699-2501
   - The application packet will be reviewed within 90 calendar days of being received. This review confirms the minimum qualifications have been met.

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- A CAP willing provider response notice letter will be provided. This letter will be provided by the 95th calendar day from when the packet was received.
- Requests for case management services are approved based on the needs of the service area that is being applied to.
- Get help while you collect the supporting documentation.
    - For support:
        - Email: **floriece.davis-jones@dhhs.nc.gov**
    - For questions about the CAP program:
        - Email: **heather.smith@dhhs.nc.gov** **or** **kia.mckenzie@dhhs.nc.gov**, or
        - Call the general CAP line: 919-855-4340.

Each WQP will meet the minimum qualifications and requirements to render CAP services. The enrollment packet will show this by the documentation listed in column 3 of table 3 below.

Table 3 – CAP Enrollment Packet Requirements

HCBS Type	Required Qualifications & Requirements	Supporting Documentation
Case Management and Care Advisement	Be enrolled as an NC Medicaid provider.	An approved NC Medicaid Provider Approval Letter.
	Have 3 years of HCBS experience. This experience must be progressive and consistent.	Written explanation of: 1. The types of HCBS that have been provided and how those services were provided. 2. The number of years of providing those HCBS services. 3. The locations those service(s) were provided. 4. The number of people served by the services provided. 5. The number of years working directly with people 0 through 20 with chronic and severe physical disabilities. 6. The number of waiver participants wishing to serve. 7. References for previous service.
	Have connection to the service area.	Written account of: 1. The physical address of the central office. 2. The farthest distance to waiver participants' zip codes from the central office and home-based offices.

		3. The number of years serving the catchment area.
	Have financial stability.	A solvency statement.
	Have written policies and procedures.	Agency policies on the following topics: • The acceptance of referrals. • The conduction of assessments. • The creation and approval of person-centered service plans (PCSP). • The monitoring of health, safety, and well-being • The performance of home visits. • The Management of critical incidents. • Knowing the signs of fraud, waste and abuse and when to make a report. • Providing services without the use of seclusion, restraint, and restrictive procedures. • Rendering services that are free from conflict. • The Advisory Board. • The Marketing strategy. • The Communication plan.
	Have qualified staff.	Written account of: 1. The number of and discipline of professional and supportive staff. 2. The qualification of each staff. 3. The timeframe to conduct background checks on job candidates and action taken. 4. A sign off that currently hired staff have passed a background check.
	Have and create systems for automated programs now and in the future.	A written explanation of: 1. The description of the virtual office. 2. The cyber security. 3. The HIPAA requirements.

		4. The safeguarding of PII/PHI and ePHI.
HCBS Type	**Required Qualifications & Requirements**	**Supporting Documentation**
Coordinated Caregiving	Be enrolled as an NC Medicaid provider.	1. An approved NC Medicaid Provider Approval Letter; and 2. Licensure for Home Care or Nursing Care provider as outlined by NCDHSR; OR Approved Enrollment as Atypical Provider in NC.
	Have 3 years of experience delivering HCBS. This experience must be as a Home Health Agency. Services must have been provided to: • Children 0 through 20 years old, and • Caregivers.	Written explanation of: 1. The types of HCBS that have been provided and how those services were provided. 2. The number of years of providing those HCBS services. 3. The locations those service(s) were provided. 4. The number of people served by the services provided. 5. The number of years working directly with people 0 through 20 with chronic and severe physical disabilities. 6. The number of waiver participants wishing to serve. 7. References for previous service.
	Have connection to the service area.	Written account of: 1. The physical address of the central office. 2. The farthest distance to waiver participants' zip codes from the central office and home-based offices. 3. The number of years serving the catchment area. 4. The access to RNs. LPNs, behavioral support, and allied support professionals.
	Have financial stability.	A solvency statement.
	Have written policies and procedures.	Agency policies on the following topics: • The acceptance of referrals.

		• The assessment of the care needs of the waiver participant and their caregiver. • The creation and carrying out the care plan. • The monitoring of the health, safety, and well-being of waiver participants to decide how much support the caregiver needs. • The conducting of home visits. • The management of critical incidents. • Knowing the signs of fraud, waste and abuse and when to make a report. • Providing services without the use of seclusion, restraint, and restrictive procedures unless physician ordered. • Rendering services that are free from conflict. • The details of a training plan and coaching techniques for the waiver participant and caregiver. This includes the type and frequency of the training. • The marketing strategy. • The communication plan.
	Have qualified staff.	A written account of: 1. The number of professionals and supportive staff on staff or who are PRN. 2. The qualifications of each staff member. 3. The timeframe to conduct background check on job candidates and action taken. 4. A sign off that currently hired staff passed a background check.

	Have and create systems for automated programs now and in the future.	A written explanation of: 1. The description of the virtual office. 2. The cyber security. 3. The HIPAA requirements. 4. The safeguarding of PII/PHI and ePHI.
HCBS Type	**Required Qualifications & Requirements**	**Supporting Documentation**
Financial Management services	Be enrolled as an NC Medicaid provider.	1. An approved NC Medicaid Provider Approval Letter; and 2. Approved Enrollment as Atypical Provider in NC.
	Have 3 years of experience with records management. This includes processes for: • Developing, • Implementing, and • Maintaining.	Written explanation and copies of documents showing: 1. The number of years' experience providing FMS through both the Agency with Choice and Fiscal and Employer Agent.
	Be approved to do business in the State of North Carolina.	Written explanation and copies of documents showing: 1. Internal Revenue Services (IRS) ability to do business in North Carolina.
	Have financial stability.	A solvency statement.
	Have written policies and Procedures.	Agency policies on the following topics: • The acceptance of referrals. • Enrollment in CD. • The filing of IRS required documents. • Compliance with department of Labor Laws. • The conduction of background checks and confirmation of hire-ability. • Supporting the EOR to ensure that they create a payrate that is within budget. • Employer/employee agreements. • The offer of training and coaching to help individuals to direct care.

		• The management critical incidents. • Knowing signs of fraud, waste and abuse and when to make a report. • Making sure approved service hours were provided without the use of seclusion, restraint, and restrictive procedures unless a physician ordered. • Providing services that are free from conflict. • Payroll. • Customer service.
	Have and create systems for automated programs now and in the future.	A written explanation of: 1. The description of the virtual office. 2. The cyber security. 3. The HIPAA requirements. 4. The safeguarding of PII/PHI and ePHI.

Reimbursement methodology for case management, care advisement, financial management and coordinated caregiving:

- Case management:
  - Is a monthly flat rate.
  - May be claimed by the last day of each month services are provided and correctly documented.
- Care advisement:
  - Is a monthly flat rate.
  - May be claimed by the last day of each month services are provided and correctly documented.
- Financial management:
  - Is a monthly flat rate.
  - May be claimed by the last day of each month services are provided and correctly documented.
- Coordinated caregiving
  - Is a daily rate.
  - May be claimed weekly when services are provided and correctly documented.

The documentation requirements for reimbursement are listed below in table 3.

Table 4 – Reimbursement Requirements for Services Requiring Prior Authorization

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HCBS	Documentation Requirement for Reimbursement
Case management and Care Advisement	1. Completion of monthly and quarterly monitoring tasks. 2. Case notes that list all completed case management tasks. 3. Fill out critical incident reports (CIR) as needed. Be sure to include a root cause analysis (RCA). 4. Completion of Individual Risk Agreements, when applicable. 5. Complete initial, annual and COS assessments. 6. Complete the first and annual Person-Centered Services Plan. 7. Completion of revisions to the POC. 8. Linking, referring, and following up.
Financial Management	1. Upload all documents in the e-CAP system. This will confirm your enrollment in CD. 2. Complete monthly expense reports.
Coordinated Caregiving	1. Complete monthly supervision tasks. 2. Progress notes that record the services provided. 3. Meet the needs of CAP/C participants and caregivers. 4. Fill out critical incident reports (IR) as needed. Be sure to include a root cause analysis (RCA). 5. Be part of annual and COS assessments. 6. Be part of the yearly services plan meeting. 7. Send monthly updates to the CAP case manager. Give updates on the CAP/C participant's and caregiver progress. 8. Be part of MDT meetings. 9. Talk to the CAP/C participant and their caregiver when needed.

Ordering, Prescribing or Referring (OPR) Providers:

- Must have an NPI.
    - The ordering and referring NPI that is submitted on claims must be for an individual provider.
        - Ordering claim types include:
            - Home Infusion Therapy,
            - Independent Diagnostic Treatment Facilities/Portable X-ray,

        - Exception:
            - Modifier 26. When billing for only the professional component an ordering NPI is not required.
    - Private Duty Nursing,
    - Independent Labs/X-rays,
        - Exception:
            - Modifier 26. When billing for only the professional component an ordering NPI is not required.
    - Community Alternatives Program Services,
    - Immunizing Pharmacist,
    - Radiological Procedures,
        - Exception:
            - Modifier 26. When billing for only the professional component an ordering NPI is not required.
    - Durable Medical Equipment (DME),
    - Children's Developmental Services Agencies (CDSA).
        - Exceptions apply to the billing codes:
            - H0031,
            - H0036 (and modifiers HI, HM, HQ, TL),
            - T1017 modifier HI, and
            - T1023.
- Referring claim types include:
    - Home Infusion Therapy,
    - Specialized Therapy – outpatient and independent practitioners,
    - Hospice,
    - Home Health,
    - Private Duty Nursing,
    - Outpatient Hospital Clinics – dialysis facilities,
    - Community Alternatives Program Services.
- An operating NPI is required when an operating room revenue code is submitted.
- A service facility NPI is required on Hospice claims when the member lives in a nursing facility.

- Must be enrolled in NC Medicaid.
    - NCTracks has an application for providers who do not intend to render or bill services to NC Medicaid.
    - Providers who render, attend and bill services to NC Medicaid must be fully enrolled to receive payment.
- Providing services in another state:
    - The out-of-state provider(s) must be enrolled with NC Medicaid as an OPR provider.

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Billing providers should:

- Check that the enrollment of individuals before services are provided. This can be done through the “Enrolled Practitioner Search” on NCTracks provider portal.