North Carolina
Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention:

All Providers

Provider Enrollment Guidelines

Table of Contents

Medicaid Agency Roles

Division of Medical Assistance

The Division of Medical Assistance (DMA) is the state agency responsible for the administration of the N.C. Medicaid program. DMA is responsible for interpreting federal laws and regulations as they relate to the Medicaid program. DMA establishes medical policy and rates for the Medicaid program and maintains third party insurance files as well as coordinates any revisions to the recipient eligibility files.

DMA is responsible for enrolling all providers, except Medicare Qualified Beneficiary (MQB) providers, in the N.C. Medicaid program. MQB providers are enrolled by Electronic Data Systems (EDS). For physicians (chiropractors**,** dentists**,** optometrists**,** osteopaths, podiatrists, and medical doctors) the enrollment process begins with Blue Cross and Blue Shield of North Carolina (BCBSNC). DMA is also responsible for maintaining all information on file for the provider.

Division of Medical Assistance – Managed Care Programs

DMA has four managed care programs available for Medicaid recipients. The programs are Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting. Providers are updated through the Medicaid Bulletin of changes to the procedures and policies for the Managed Care Program.

A Medicaid Managed Care Representative (MCR) is located in each North Carolina county (except Mecklenburg County) and coordinates the managed care program in the county. MCRs provide:

- Follow-up education to recipients, providers, and county departments of social services (DSS) as necessary.
- Assistance with contract participation requirements, patient compliance, and provider enrollment issues.

Managed Care providers can obtain the name and telephone number of their MCR by calling DMA's Managed Care section at 919-857-4022. Questions regarding HMO Risk Contracting in Mecklenburg County may be directed to the DMA Managed Care section HMO consultants at 919-857-4022.

Carolina ACCESS

Carolina ACCESS (CA) is Medicaid's primary care case management program. CA is active in 99 counties and links Medicaid recipients with primary care providers (PCPs) who act as gatekeepers in providing and coordinating the recipients' health care. PCPs bill fee-for-service and are reimbursed based on the Medicaid fee schedule. They also receive a monthly fee ($3.00 each for the first 250 enrollees, and $2.50 for each additional enrollee) for coordinating the care of recipients enrolled with their practice.

Information on a recipient's Medicaid identification (MID) card identifies CA enrollees. "Carolina ACCESS Enrollee" appears on the card along with the name, address, daytime, and after-hours telephone numbers of the PCP.

CA recipients are responsible for all copayments required by Medicaid.

ACCESS II and ACCESS III

ACCESS II and ACCESS III are primary care programs designed to build upon the principles and infrastructure of the CA program. The programs promote a health care system that retains dollars in the local delivery of services, while assisting local providers in the development of organized managed care systems that coordinate a full continuum of care with processes to influence cost and quality of care.

ACCESS II and ACCESS III are sponsored by the Department of Health and Human Services. Program direction is provided by the Office of Research, Demonstrations, and Rural Health Development. Technical assistance is provided by the N.C. Foundation for Advanced Health Programs, Inc. with funding from the Kate B. Reynolds Health Care Trust.

The ACCESS II and ACCESS III demonstration sites (see table on page 3) are paid an additional $2.50 per member per month care management fee to develop and implement managed care strategies. These managed care strategies include:

- Risk assessment process – utilizing an "at-risk" screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by patients.
- Implementing disease management processes – including pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those patients at risk.
- Identifying high cost and high users – developing and implementing activities that impact utilization and cost.

The following table lists the administrative entities for ACCESS II and ACCESS III.

Enhanced Care Management Model	Community Care Network Model
AccessCare, Inc. ACCESS II Care of Western North Carolina (Buncombe) County CLECO (Cleveland County) Community Health Partners (Gaston County) Durham Community Health Network Guilford Access Partnership Surry County Health System	Cabarrus Community Care Plan Community Care Plan of Pitt County

ACCESS III, active in Pitt and Cabarrus counties, includes countywide plans that are community partnerships involving physicians, hospitals, health departments, departments of social services, and other community providers. Networks are assuming responsibility for managing the care of eligible Medicaid populations in the entire county.

HMO Risk Contracting

HMO Risk Contracting is a Medicaid managed care program whereby DMA contracts with three health maintenance organizations (HMOs) to operate in Davidson, Forsyth, Gaston, Guilford, Mecklenburg, and Rockingham counties to provide and coordinate medical services for certain Medicaid eligibles on a full-risk capitated basis.

The following Managed Care Plans participate in HMO Risk Contracting:

- United Healthcare of North Carolina (UHCNC)
- The Wellness Plan of North Carolina (TWP)
- Southcare/Coventry Health Care (SCHC)

DMA also contracts with Metrolina Comprehensive (MC), a Federally Qualified Health Center, in Mecklenburg County to provide an additional health plan option for Medicaid recipients on a fee-for-service basis.

The recipient's MID card shows the HMO's name, address, and telephone number. Enrolled recipients also receive a member identification card from the plan. HMO enrollment may also be verified through the Automated Voice Response (AVR) System. Newborns of HMO members are automatically enrolled and covered by the mother's plan, effective from the date of the child's birth.

The following table lists the available managed care plans in the participating counties.

	UHCNC	TWP	MC	SCHC
Davidson	Ö			
Forsyth	Ö			
Gaston		Ö		
Guilford	Ö			
Mecklenburg	Ö	Ö	Ö	Ö
Rockingham	Ö			

Division of Facility Services

The Division of Facility Services (DFS) is the state agency responsible for licensing the services listed below. To qualify for enrollment with the N.C. Medicaid program, providers who offer these services must be licensed by DFS. Some of these services require the provider to reapply for a license when there is a change in their provider status. Call DFS at 919-733-1610 for more information.

- Adult Care Homes
- Ambulance Services
- Ambulatory Surgical Centers
- Critical Access Hospitals
- Dialysis Centers
- Home Health Agencies
- Home Infusion Therapy
- Hospice
- In-State Hospitals
- Intermediate Care/Mental Retardation Facilities
- Level II-IV Residential Child Care Facilities
- Nursing Facilities
- Personal Care Services
- Portable X-Ray Suppliers
- Private Duty Nursing Services
- Psychiatric Residential Treatment Facilities
- Rural Health Clinics
- Home Care Services enrolled in the Community Alternative Programs

Contracted Agencies

Blue Cross and Blue Shield of North Carolina

Through a memorandum of understanding, Blue Cross and Blue Shield of North Carolina (BCBSNC) assists DMA with the enrollment of physicians (chiropractors, dentists, optometrists, osteopaths, medical doctors, and podiatrists) by verifying and processing the credentials submitted by physicians who apply for enrollment with the N.C. Medicaid program.

Electronic Data Systems

Electronic Data Systems (EDS) is the fiscal agent for the N.C. Medicaid program. EDS processes claims for approved Medicaid providers according to the policies and guidelines established by DMA. The EDS system of edits and audits are applied to the provider's claims for service.

DMA contracts with EDS to publish the monthly Medicaid Bulletin and maintain the provider mailing list. Each provider enrolled in the Medicaid program receives a free copy of the Medicaid Bulletin, which is mailed to the site address on file for the provider. Additional subscriptions may be purchased by calling EDS Provider Enrollment.

DMA also contracts with EDS to conduct training seminars for providers on Medicaid and Managed Care billing and policy issues. They supply providers with billing information, provider manuals, and other training materials. Each provider enrolled in the N.C. Medicaid program is entitled to one copy of the Medicaid provider manual for their provider type at no charge. Additional manuals may be purchased by calling EDS Provider Enrollment at 1-800-688-6696 or 919-851-8888.

EDS enrolls the following providers who offer services to Medicare Qualified Beneficiary (MQB) recipients:

- Comprehensive Outpatient Rehabilitation Facilities
- Occupational Therapists
- Licensed Psychologists
- Licensed Clinical Social Workers
- Speech Pathologists
- Artificial Eye Service Providers
- Physical Therapists

Provider Enrollment Requirements

General Information

Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Services must be provided at a site location within North Carolina or within 40 miles of the North Carolina border. Out-of-state providers beyond 40 miles of the North Carolina border may be enrolled in the N.C. Medicaid program for emergency or prior approved services. Enrollment requirements vary, but most providers must complete an application, provide verification of licensure – if applicable – and complete a N.C. Medicaid participation agreement.

Nonphysician providers sign participation agreements, which remain on file with the N.C. Medicaid program. These agreements contain general requirements for all providers as well as specific requirements for each provider type. Physicians signify their compliance with participation when they submit a claim for payment. Each claim constitutes an agreement for services provided under the claim. Refer to ***Credentialing Requirements for N.C. Medicaid Participation*** on page 9 to determine the specific requirements for each provider type.

Once a provider has enrolled with the N.C. Medicaid program, EDS supplies the provider with an information package including provider service manuals and Medicaid bulletins. Fee schedules can be obtained from DMA Financial Operations. Refer to page 44 for a copy of the Fee Schedule Request form.

The enrollment process takes approximately four to six weeks. However, the process can take longer if supporting documentation from other entities is required. Providers will receive written notification once the enrollment process has been completed.

Enrollment periods vary according to provider types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting DMA Provider Services at 919-857-4017.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to ***Reporting Changes in Provider Status*** on page 25 to determine the appropriate process for reporting changes in provider status to the N.C. Medicaid program.

Managed Care Provider Enrollment

Carolina ACCESS

As a gatekeeper to health care, the PCP plays a key role in achieving the dual goals of managed care – improved access to care and reduction of unnecessary costs. PCPs set their own enrollment limits, up to a maximum of 2,000 patients per physician or physician extender.

The following N.C. Medicaid provider types may participate as PCPs:

- Family Medicine
- General Practitioners
- Nurse Practitioners
- Physician Assistants
- Pediatricians
- Specialists*
- Obstetricians
- Gynecologists
- Internists
- Community Health Centers
- Health Clinics
- Hospital Outpatient Clinics
- Health Departments
- Rural Health Clinics

* In certain circumstances, a specialist willing to provide all primary care services may be enrolled as a PCP.

To participate with CA, N.C. Medicaid providers must sign a contract agreeing to:

1. Operate the office a minimum of 30 hours a week for patient care.
2. Provide or arrange for access to medical care for enrollees, 24 hours per day, 7 days per week. There must be prompt access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate.
3. Develop patient/physician relationships.
4. Manage the health care needs of enrollees.
5. Provide essential preventive services.
6. Provide after-hours coverage that does not automatically refer to the emergency room.
7. Maintain hospital admitting privileges or have a formal arrangement for admissions.
8. Authorize and arrange referrals when necessary.
9. Review monthly and quarterly utilization reports.

N.C. Medicaid PCPs interested in applying to become Carolina ACCESS PCPs should contact the local MCR for the county in which the practice is located or the nearest North Carolina county served for out-of-state providers. The MCR will send a CA application and agreement to the provider, assist the provider with contract participation requirements, patient compliance, and other Medicaid managed care questions. When the MCR receives the provider's completed application and agreement, they are reviewed for completeness and compliance with participation requirements. The MCR may contact the provider if there are any questions. The MCR then forwards the application and agreement to the DMA Managed Care section who will either approve or deny the application and notify the provider in writing.

ACCESS II and ACCESS III

At this time, only CA providers in the demonstration areas (see table on page 3) are eligible to become ACCESS II or ACCESS III providers. CA providers interested in becoming ACCESS II or ACCESS III providers should contact:

N.C. Office of Research, Demonstrations and Rural Health Development
311 Ashe Avenue
2009 Mail Service Center
Raleigh, 27699-2009
Phone: 919-733-2040
Fax: 919-733-8300

The N.C. Office of Research, Demonstrations, and Rural Health Development staff will notify the DMA Managed Care section of the effective date of enrollment into the ACCESS II or ACCESS III program.

HMO Risk Contracting

All PCPs and specialists serving the counties participating in HMO Risk Contracting or Health Care Connection (Mecklenburg County) are eligible to become members of the HMO network. Interested providers should contact one or more of the following HMOs to inquire about becoming a participating provider:

Southcare/Coventry Health Care of the Carolinas, Inc.
2815 Coliseum Centre Drive, Suite 550
Charlotte, NC 28217-4522
Phone: 704-357-1421
Fax: 704-329-7174

The Wellness Plan of N.C., Inc.
4601 Park Road, Suite 550
Charlotte, NC 28209-3239
Phone: 704-944-3893
Fax: 704-944-3900

United Healthcare of North Carolina, Inc.
3200 Northline Avenue, Suite 160
P.O. Box 26403
Greensboro, NC 27408
Phone: 336-851-8775
Fax: 336-851-8742

Physician Services Provider Enrollment

Medical doctors, optometrists, chiropractors, podiatrists, dentists, and osteopaths are enrolled with the N.C. Medicaid program through BCBSNC using BCBSNC's enrollment application. Once BCBSNC has verified the provider's credentials, the provider's information is forwarded to DMA where the enrollment process is completed. The application is usually processed and forwarded to DMA within 10 working days.

Out-of-State Provider Enrollment

The enrollment process for out-of-state providers beyond 40 miles of the North Carolina border begins when a Medicaid recipient is seen by the provider for emergency or prior approved services. Providers must call DMA Provider Services and request an enrollment application for the N.C. Medicaid Program. Providers return the completed application along with the claim and credentialing documents specific to their provider type to DMA Provider Services. (Refer to ***Credentialing Requirements for N.C. Medicaid Participation*** for more information.)

Medicare Qualified Beneficiary (MQB) Provider Enrollment

MQB is a Medicare-Aid program available to low-income Medicare beneficiaries who are not eligible for regular Medicaid coverage. According to the terms of the program, Medicaid pays the coinsurance or deductible for Medicare-covered services provided to eligible MQB recipients. Because claims filed with Medicare will automatically cross over to Medicaid for payment of the coinsurance and deductible, Medicare providers who bill for services to MQB recipients must also enroll with the N.C. Medicaid program.

The enrollment process for MQB providers begins when an MQB recipient is seen by the provider. The provider files the claim with Medicare and sends a copy of the claim and the Medicare explanation of Medicare benefits (EOMB) to EDS Provider Enrollment along with the provider's name, site address, billing address, tax identification number, and county of residence. Once EDS verifies that the recipient is an MQB, they assign an MQB provider number. EDS then notifies the MQB provider.

Credentialing Requirements for N.C. Medicaid Participation

Adult Care Homes

- Licensed by Division of Facility Services as a Family Care Home, Home for the Aged and Disabled, Group Home for Developmentally Disabled Adult, **OR** Group Home for Mentally Ill Adults under G.S. 131 D or G.S. 122C and 131E combination facilities

Ambulance – In-State

- Licensed by Division of Facility Services as an Ambulance Service

Ambulance – Out-of-State

- Licensed by state of practice
- UB-92 claim form for dates of service

Ambulatory Surgical Center – In-State/Border

- Licensed by Division of Facility Services as an Ambulatory Surgical Facility

Ambulatory Surgical Center – Out-of-State

- Letter of Certification as a Medicare provider from HCFA
- Medicare/Medicaid Certification and Transmittal form
- HCFA-1500 claim form for dates of service

At-Risk Case Management
Resident Evaluation Services

- Each county is certified by the Division of Social Services as a provider for each of these services

Birthing Centers – Border

- Letter of Certification of Good Standing in state of practice from Medicaid
- Letter of Certification from Commission for Accreditation of Free-Standing Birthing Centers
- Letter of Verification of enrollment as a Medicaid provider in state of practice from Medicaid
- Articles of Incorporation (if applicable)

Birthing Centers – In-State

- Letter of Certification from Commission for Accreditation of Free-Standing Birthing Centers
- Articles of Incorporation (if applicable)

Birthing Centers – Out-of-State

- Letter of Certification of Good Standing in state of practice from Medicaid
- Letter of Certification from Commission for Accreditation of Free-Standing Birthing Centers
- Letter of Verification of enrollment as a Medicaid provider in state of practice from Medicaid
- Articles of Incorporation (if applicable)
- HCFA-1500 claim form for dates of service

CAP/AIDS – Adult Day Health Care
CAP/DA – Adult Day Health Care
CAP/MR-DD – Adult Day Care
CAP/MR-DD – Adult Day Health Care

- Certified by Division of Aging

CAP/AIDS – Case Management

- Certified by the Division of Public Health's AIDS Care Unit

CAP/AIDS – Home Mobility Aids
CAP/AIDS – Waiver Supplies

- Certified by the Division of Public Health's AIDS Care Unit
- Enrolled as Medicaid provider for CAP/AIDS Case Management

CAP/AIDS – In-Home Aide Level II
CAP/AIDS – In-Home Aide Level III Personal Care
CAP/AIDS – In-Home Respite Care (Aide Level II)
CAP/C – In-Home Respite Care
CAP/C – Personal Care
CAP/DA – In-home Aide Level II
CAP/DA – In-home Aide Level III Personal Care
CAP/DA – In-home Respite Care

- Licensed by Division of Facility Services as a Home Care Service to provide In-Home Aide

CAP/AIDS – Institutional Respite Care
CAP/C – Institutional Respite Care
CAP/DA – Institutional Respite Care

- Enrolled as Medicaid provider for Nursing Facility or Hospital with beds at the level of care approved on the patient's FL2

CAP/AIDS – Personal Emergency Response System
CAP/DA – Personal Emergency Response System (Telephone Alert)
CAP/MR-DD – Personal Emergency Response System

- Provide 24/7 care
- Agency marketing materials (brochure)
- Sample contract describing services
- Copy of contract with monitoring service (if applicable)

CAP/AIDS – Preparation and Delivery of Meals

- Letter of approval from county department of social services **OR** Division of Aging
- Copy of most recent review by the county department of social services **OR** the Division of Aging

CAP/C – Case Management
CAP/C – Home Mobility Aids
CAP/C – Medicaid Medical Supplies
CAP/C – Waiver Supplies

- Designated as a Case Management Agency by Division of Medical Assistance

CAP/AIDS – In-Home Respite Care
CAP/C – Hourly Nursing

- Licensed by Division of Facility Services as a Home Care Service to provide Nursing Care

CAP/C – Institutional Respite Care

- Enrolled as Medicaid provider for Nursing Facility or Hospital

CAP/DA – Case Management
CAP/DA – Home Mobility Aids
CAP/DA – Medicaid Medical Supplies
CAP/DA – Waiver Supplies

- Designated as Lead Agency by Division of Medical Assistance

CAP/DA – Preparation and Delivery of Meals

- Letter of Approval from county department of social services **OR** Division of Aging

CAP/MR-DD – Augmentative Communication Devices
CAP/MR-DD – Case Management
CAP/MR-DD – Environmental Accessibility Adaptations
CAP/MR-DD – Medicaid Medical Supplies
CAP/MR-DD – Vehicle Adaptation
CAP/MR-DD – Waiver Supplies

- Approved by the Division of Mental Health, Developmental Disabilities, and Substance Abuse as an Area Mental Health program

CAP/MR-DD – Community Inclusion
CAP/MR-DD – Crisis Stabilization
CAP/MR-DD – Developmental Day Services
CAP/MR-DD – Family Training
CAP/MR-DD – Prevocational Services
CAP/MR-DD – Supported Employment
CAP/MR-DD – Supported Living

- Letter of Approval from Division of Mental Health, Developmental Disabilities, and Substance Abuse

CAP/MR-DD – In-Home Aide Level I

- Letter from provider stating that agency employs qualified staff per 10 NCAC 3L.1110
- Letter of Approval from Division of Mental Health, Developmental Disabilities, and Substance Abuse

CAP/MR-DD – Institutional Respite Care

- Approved as a State Mental Retardation Facility
- Notice of Approval from DMA for enrollment as an Medicaid ICF/MR provider

CAP/MR-DD – Noninstitutional Community-Based Respite Care

- Licensed by Division of Facility Services (if applicable)
- Letter of Approval from Division of Mental Health, Developmental Disabilities, and Substance Abuse

CAP/MR-DD – Noninstitutional Nursing-Based Respite Care
CAP/MR-DD – Personal Care

- Licensed by Division of Facility Services as a Home Care Service to provide In-Home Aide
- Letter of Approval from Division of Mental Health, Developmental Disabilities, and Substance Abuse

Chiropractors – In-State

- Licensed by State Board of Chiropractors

Clinical Nurse Specialist

- Licensed as Registered Nurse
- Certified by the American Nurses Credentialing Center as a Child and Adolescent Psychiatric Clinical Nurse Specialist

Critical Access Hospitals

- Licensed by Division of Facility Services as a Critical Access Hospital

CRNA

- Licensed as Registered Nurse
- Letter of Certification by Council on Certification of Nurse Anesthetists **OR** Council on Recertification of Nurse Anesthetists
- Letter of Approval for Medicare Part B from HCFA

Dentists – In-State

- Licensed by the State Board of Dental Examiners

Dialysis Centers

- Licensed by Division of Facility Services as a Dialysis Facility
- Letter of Certification as a Medicare provider from HCFA
- Medicare/Medicaid Certification and Transmittal form

DME – In-State/Border

- Certificate of Authority to operate in the State of North Carolina (if corporate office is located out-of-state)
- Articles of Incorporation (if applicable)
- Privilege License (if applicable)
- Medicare provider number

DME – Out-of-State

- Medicare/Medicaid Certification and Transmittal form
- HCFA-1500 claim form for dates of service

FQHC
Hospice
Portable X-ray
Rural Health Centers

- Letter of Certification as a Medicare provider from HCFA
- Medicare/Medicaid Certification and Transmittal form

Head Start
Public Schools

- Operated by N.C. Public School System

Health Departments
HMO

- Enrolled through a Memorandum of Understanding with the Division of Medical Assistance

Hearing Aid Dealers

- Licensed by State Board of Hearing Aid Dealers and Fitters

HIV Case Management

- Certified by Division of Public Health's AIDS Care Unit
- Articles of Incorporation (if applicable)

Home Health Agencies – In-State

- Licensed by Division of Facility Services as a Home Health Service
- Letter of Certification as a Medicare provider from HCFA

Home Health Agencies – Out-of-State

- Letter of Certification as a Medicare provider from HCFA
- Enrolled as Medicaid provider in state of practice

Home Infusion Therapy

- Licensed by Division of Facility Services as a Home Infusion Therapy Service
- Articles of Incorporation (if applicable)

Hospitals – In-State/Border
Hospitals – Psychiatric
Hospitals – Swing Bed

- Licensed by Division of Facility Services as a Hospital
- Letter of Certification as a Medicare provider from HCFA

Hospitals – Out-of-State

- Enrolled as Medicaid provider in state of practice
- UB-92 claim form for dates of service

ICF/MR

- Licensed by Division of Facility Services as a Mental Health Facility

IDTF Portable Ultrasound

- Registry of Diagnostic Medical Sonographers
- Cardiovascular Credentialing International
- American Registry of Radiological Technologists
- Letter of Approval for Medicare Part B from HCFA

Independent Free-Standing Labs – Border

- CLIA Certificate
- Letter of Certification of Good Standing in state of practice from Medicaid
- Letter of Verification for enrollment as a Medicaid provider in state of practice from Medicaid
- Articles of Incorporation (if applicable)

Independent Free-Standing Labs – In-state

- CLIA Certificate
- Articles of Incorporation (if applicable)

Independent Free-Standing Labs – Out-of-State

- CLIA Certificate
- Letter of Certification of Good Standing in state of practice from Medicaid
- Letter of Verification for enrollment as a Medicaid provider in state of practice from Medicaid
- Articles of Incorporation (if applicable)
- HCFA-1500 claim form for dates of service

Independent Practitioners

- Audiologists – Licensed by Board of Audiology Examiners
- Occupational Therapists – Licensed by Board of Occupational Therapy Examiners
- Physical Therapists – Licensed by Board of Physical Therapy Examiners
- Respiratory Therapists – Licensed by Board of Respiratory Therapy Examiners
- Speech Therapist – Licensed by Board of Speech Therapy Examiners

Licensed Clinical Social Workers

- Licensed as a Clinical Social Worker in state of practice
- Proof of masters degree in Social Work

Medical Doctors – In-State

- Licensed by State Board of Medical Examiners

Mental Health Centers

- Letter requesting enrollment

MQB

- HCFA-1500 claim form for dates of service

Nurse Midwife – In-State

- Licensed as Registered Nurse
- Authorization from N.C. Midwifery Joint Committee Licensing Board
- Authorization from American College of Nurse Midwives

Nurse Midwife – Out-of-State

- Licensed as Registered Nurse
- Authorization for Midwifery from state of practice licensing board
- Authorization from American College of Nurse Midwives
- Enrolled as Medicaid provider in state of practice

Nurse Practitioner – In-State

- Licensed as Registered Nurse
- Certified by Board of Medical Examiners
- Certified by Board of Nursing
- Certified by American Nurses Credentialing Center as a Child and Adolescent Psychiatric Nurse Practitioner **if** providing mental health services

Nurse Practitioner – Out-of-State

- Licensed as Registered Nurse
- Certified by Board of Medical Examiners
- Enrolled as Medicaid provider in state of practice
- Certified by American Nurses Credentialing Center as a Child and Adolescent Psychiatric Nurse Practitioner **if** providing mental health services

Nursing Facilities – Border
Nursing Facilities – Out-of-State

- Letter of Certification as a Medicare provider from HCFA
- Medicare/Medicaid Certification and Transmittal form
- Letter of Certification of Good Standing in state of practice from Medicaid
- Letter of Verification of enrollment as a Medicaid provider in state of practice from Medicaid

Nursing Facilities – In-State

- Licensed by Division of Facility Services as a Nursing Facility
- Letter of Certification as a Medicare provider from HCFA
- Medicare/Medicaid Certification and Transmittal form

Optical/Optician – In-State
Optometrists – In-State

- Licensed by State Board of Opticians

Optical/Optician – Out-of-State

- Licensed by Board of Opticians in state of practice
- Enrolled as Medicaid provider in state of practice

Osteopaths – In-State

- Licensed by State Board of Medical Examiners

Personal Care Service

- Licensed by Division of Facility Services as a Home Care Service to provide In-Home Aide
- Articles of Incorporation (if applicable)

Pharmacy

- Licensed by Board of Pharmacy
- Board of Pharmacy Dispensing Permit
- Privilege License (if applicable)

Physicians – Out-of-State (chiropractors, dentists, optometrists, osteopaths, medical doctors, and podiatrists)

- Licensed in state of practice
- CLIA certificate, where applicable
- DEA number
- HCFA-1500 claim form for dates of service

Planned Parenthood

- Certified by Affiliate Development and Evaluation Committee of Planned Parenthood Federation of America

Podiatrists – In-State

- Licensed by State Board of Podiatry Medical Examiners

Presumptive Eligibility

- List of staff attending training

Psychiatric Residential Treatment Facility

- Licensed by the Division of Facility Services as a Mental Health Facility

OR

- Licensed by the Division of Facility Services as a Hospital

AND

- Letter of Accreditation from Joint Commission on the Accreditation of Healthcare Organizations

OR

- Letter of Accreditation from Council on Accreditation of Services for Families and Children

OR

- Letter of Accreditation from Rehabilitation Accreditation Commission

Psychologists

- Licensed as Psychologist in state of practice

Private Duty Nursing

- Licensed by Division of Facility Services as a Home Care Service to provide Nursing Care
- Articles of Incorporation (if applicable)

Residential Child Care Facility (Level II, III, IV HRI-Residential)

- Licensed by the Division of Facility Services as a Mental Health Facility

AND

- Letter of Accreditation from Joint Commission on the Accreditation of Healthcare Organizations

OR

- Letter of Accreditation from Council on Accreditation of Services for Families and Children

OR

- Letter of Accreditation from Rehabilitation Accreditation Commission

OR

- Letter of Approval from the Division of Mental Health, Developmental Disabilities, and Substance Abuse

OR

- Letter of Approval from an Area Mental Health Program

OR

- Copy of an Area Mental Health Program contract for residential services

School-Based Health Centers

- Approved by Division of Women and Children's Health

Monitoring Medicaid Services

Providing Medicaid Services

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

Providers must agree to accept as payment in full the amounts paid by the N.C. Medicaid program for those claims submitted for payment under the program. (Refer to page 57 for a copy of N.C. Administrative Code, Title 10, Section 26K.0006.)

Program Integrity

DMA's Program Integrity (PI) section operates under federal and state laws and regulations that are both stringent and comprehensive. The state rules are found in the N.C. Administrative Code Title 10, Section 26G, and the federal rules are found in 42 CFR 455. Information regarding requirements resulting from these laws and rules are provided through provider manuals and monthly Medicaid bulletins issued by DMA through EDS.

It is PI's mission to ensure that:

- Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud;
- overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions;
- recipients' rights are protected and recipients receive quality care; and
- problems found are communicated to appropriate staff, providers or recipients **and** corrected through education or changes to the policy, procedure, or process, and monitored for corrective action.

Program Integrity Reviews

PI reviews are initiated for a variety of reasons. The following are some common examples. (This list is not all-inclusive.)

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections.
- PI uses a sophisticated Fraud and Abuse Detection System (FADS) which consists of two software products called SPOTLIGHT™ and OmniAlert™.
    1. SPOTLIGHT™ uses fraud and abuse pattern recognition software, algorithms, statistical analysis, fraud filters, queries, and neural net technology to identify fraud and abuse claims.

2. OmniAlert™ is PI's new client server Surveillance and Utilization Review System (SURS). OmniAlert™ is an on-demand, real-time product that makes comparisons of provider billings to determine aberrant billing patterns among peer groups.
3. Additional features such as claims imaging, the claims date warehouse, and ad hoc query tools along with SPOTLIGHT™ and OmniAlert™ also make detection and investigation faster.

- Special ad-hoc computer reports are run that target specific issues, procedure codes, duplications of services, etc.
- Identified billing errors and problems can be linked among similar provider groups and may generate additional investigations to determine their prevalence.
- Random sampling of all claim types are reviewed for possible fraud and abuse.
- EDS refers questionable services identified during claims processing to PI.

Provider Responsibilities with a Program Integrity Review

If notified that PI has initiated a review, a provider can ensure the review will be both positive and educational by adhering to the following steps:

- PI will request medical or financial records either by mail or in person. EDS, as the fiscal agent for DMA, may also request records. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.
- If you receive a recoupment letter from PI, review the information and details in the letter and chart. You have two options:

1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. (Send the check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to EDS as this could result in duplication of your recoupment.)
2. If you disagree with the overpayment decision by PI and want a reconsideration review, then return the enclosed hearing request form to the DMA Hearing unit (at the address on the letter) and indicate whether you request a personal hearing or a paper review. **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

   Personal hearings – Personal hearings are held in Raleigh. The Hearing unit will assign the date, time, and place. You will be notified in writing of the Hearing Officer's final decision after the personal hearing.

   Paper reviews – You may instead send additional relevant documentation to the Hearing unit for reconsideration. Your written material will then be evaluated and a final decision rendered.

Quality Management Program for Carolina ACCESS (CA), ACCESS II, and ACCESS III

In addition to DMA's Program Integrity reviews, monitoring for the Carolina ACCESS (CA), ACCESS II, and ACCESS III programs is accomplished by various methods including:

- **Complaint Process –** the complaint process is an important component of the CA Quality Management program. It is a mechanism that ensures that providers are meeting their contractual obligations and that enrollees have access to appropriate and timely care.
- **After-Hours Accessibility Study –** a process of assuring that enrollees have access to medical care and advice twenty-four hours a day, and to ensure contractual compliance.
- **Patient Satisfaction Survey –** a mechanism for collecting and analyzing information regarding enrollees' access to care and their experience with health care services.
- **Initial Provider Application Review –** a process to ensure that the provider meets minimum criteria for participation in the CA program.
- **Recredentialing Process –** every approved CA provider is contacted biennially to ensure that all requirements for participation in the CA program continue to be met, and to update information maintained on file and in databases.
- **Provider Satisfaction Survey –** a mechanism to solicit and analyze opinions from primary care providers on various program issues to identify potential areas for process improvement.
- **Utilization Monitoring –** a process to ensure that appropriate services are delivered to Medicaid recipients (e.g., Health Check and Adult Preventive Screening Services), and that incidences of over- or under-utilization and quality of care issues are identified and addressed in quality improvement activities. Analysis of paid claim and encounter data is also used to determine disease management opportunities and to identify questions to be addressed by focused care studies.

Quality Management Monitoring for HMOs

HMOs are required to establish and maintain an internal quality assurance system. A written description of quality assurance objectives, means of accomplishing these objectives, and a timetable are required. Focused care studies of health care services as designated by DMA and an annual Member Satisfaction Survey must be conducted by the Plans. HMOs are required to submit electronically 100 percent encounter data to EDS using the HCFA-1500 or UB-92 claim forms as well as Medicaid Health Plan Employer Data and Information Set (HEDIS) reports.

Prior Approval Procedures

Services Requiring Prior Approval

Many services covered by the N.C. Medicaid program require providers to obtain prior approval before the service is offered. Except in emergency situations, **all** services provided to N.C. Medicaid recipients by out-of-state providers must be approved prior to rendering the service. The following table lists services that require prior approval and the process for obtaining prior approval.

Service	Verbal Authorization	Written Authorization
CAP/DA	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	Follow up within 10 days of receiving verbal approval with a completed N.C. Medicaid Program Long Term Care Services form (FL2).
Dental Services		Complete an ADA Claim Form.
Durable Medical Equipment	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval for emergency repairs to orthotics or prosthetics only.	Complete a Certificate of medical Necessity and Prior Approval form (DMA-6022)
Eye Examinations And Refractions	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	
Hearing Aids		Complete a general Request for Prior Approval form (372-118).
Hospice	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	
Intermediate Care/Mental Retardation Services	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval, and fax a copy of N.C. Medicaid Program Mental Retardation Services form (MR2) to: 1-919-233-6834.	Follow up within 10 days of receiving verbal approval with a completed N.C. Medicaid Program Mental Retardation Services form (MR2).
Long-term Care	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	A N.C. Medicaid Long-term Care Services form (FL2) must be sent to the appropriate county DSS and received by EDS within 10 working days of the receipt of verbal approval.
Medicaid for Pregnant Women program recipients		Complete a general Request for Prior Approval form (372-118).
Out-of-State Elective Services		Complete a general Request for Prior Approval form (372-118).
Outpatient Psychiatric Services		Complete a Request for Prior Approval for Psychiatric Services form (372-016).
Private Duty Nursing	Call 1-919-857-4021 to receive verbal approval.	
Surgery	Call 1-800-688-6696 or 1-919-851-8888 to verify if surgery requires prior approval.	Complete a general Request for Prior Approval form (372-118).
Therapeutic Leave	Call 1-800-688-6696 or 1-919-851-8888 to receive verbal approval.	Follow up within 10 days of receiving verbal approval with a completed general Request for Prior Approval form (372-118).
Visual Aids		Complete a Request for Prior Approval for Visual Aids form (372-017).

Prior approval forms must be mailed to:

Prior Approval Unit
EDS
P.O. Box 31188
Raleigh, NC 27622

Managed Care Referrals

Carolina ACCESS

Carolina ACCESS (CA) primary care providers (PCPs) are expected to assure each enrollee's access to necessary health care by arranging for after hours coverage and by authorizing referrals for specialty care.

The process of referring a patient to a specialist is simplified in order to facilitate access to the most appropriate and cost effective care. Referrals can be made by telephone; written authorization is not required.

CA covers services provided in the Emergency Department and Urgent Care Centers 24 hours per day with PCP authorization when billed with a hospital provider number. Specialist referrals given for follow-up care after discharge from the Emergency Department or Urgent Care Center **do require PCP authorization**.

Hospital admissions through the Emergency Department do not require PCP authorization. However, the **physician component for inpatient services does require PCP authorization**.

Enrollees can receive the following services from any qualified provider who accepts Medicaid, subject to Medicaid coverage policies and limitations, without first obtaining authorization from their PCP:

- Ambulance services
- Anesthesiology
- At-risk case management
- CAP services
- Certified nurse anesthetist
- Child care coordination
- Dental
- Developmental evaluation centers
- Eye care services (limited to CPT codes 92002, 92004, 92012, 92014 and diagnosis codes related to conjunctivitis 370.3, 370.4, 372.0, 372.1, 372.2, 372.3)
- Family planning (including Norplant)
- Health department services
- Hearing aids (under age 21)
- Hospice
- Independent and hospital lab services
- Maternity care coordination
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Psychiatric/mental health (psychiatrists; psychiatric hospitals; area mental health programs; psychiatric facilities; inpatient and outpatient services billed with a primary or secondary diagnosis of 290-319)
- Radiology (includes only services billed under a radiologist provider number)
- Services provided by schools and Head Start programs

HMO Risk Contacting

In-plan benefits are covered under the capitation rate paid to HMOs, so authorization and reimbursement for these services must be sought from the HMO. There is no copayment for any in-plan benefits. Following is a list of **in-plan benefits**.

- Adult health screening
- Ambulance
- Chiropractic services
- Clinic services (except mental health and substance abuse)
- Dialysis
- Durable medical equipment
- Emergency department
- Health check
- Family planning services and supplies
- Hearing aids
- Home health
- Home infusion therapy
- Hospice
- Inpatient hospital (except mental health and substance abuse
- Laboratory services
- Midwife services
- Occupational therapy
- Optical supplies
- Outpatient hospital
- Physical therapy
- Physician services (including PAs and FNPs – except mental health and substance abuse)
- Private duty nursing
- Prosthetics and orthotics
- Radiology
- Speech therapy
- Sterilization
- Total parenteral nutrition

Out-of-plan benefits are reimbursed by the N.C. Medicaid program on a fee-for-service basis. Recipients continue to use their Medicaid card for these services and are responsible for applicable copayments. Some of these services require prior approval by the Medicaid program (see ***Services Requiring Prior Approval***). Following is a list of **out-of-plan benefits**.

- Community Alternative Program services
- Mental health – inpatient and outpatient
- Child service coordination
- DSS nonemergency transportation
- Dental services
- ICF/MR services
- Prescription drugs
- School-related and Head Start therapies
- Mental health and substance abuse services
- At-risk case management
- Developmental evaluation center services (occupation, speech, and physical therapy)
- HIV case management
- Maternity care coordination
- Nursing care – skilled and intermediate
- Personal care services

Reporting Changes in Provider Status

Changes Requiring Notification

Providers are required to report all changes of ownership (within 30 days), name, address, tax identification number changes, group member, and licensure status to the Medicaid program. Managed Care providers (Carolina ACCESS, ACCESS II, ACCESS III, and HMO Risk Contracting) must also report changes in daytime or after-hours phone numbers.

Failure to report changes in provider status will result in incorrect information in the provider's files. Providers may then be liable for taxes on income not received by their business. CA providers must report changes to their MCR immediately to ensure that CA management fees are paid correctly.

Refer to the following tables to determine the appropriate process for reporting changes in your provider status to the Medicaid program. Refer to page 31 for a copy of the Notification of Change in Provider Status form.

Durable Medical Equipment Services **Home Infusion Therapy Services** **Personal Care Services** **Pharmacies** **Private Duty Nurses**	Report all changes to the **Division of Medical Assistance** using the **form** on page 31 along with a copy of your **new license**. Mail the form and a copy of your new license to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

Free-Standing Birthing Centers	Report all changes to the **Division of Medical Assistance** using the **form** on page 31, along with a copy of your **new accreditation** from the Commission of Free-Standing Birthing Center. Mail the form and a copy of your new license to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

Independent Free-Standing Laboratories	Report all changes to the **Division of Medical Assistance** using the **form** on page 31, along with a copy of your **new CLIA certificate**. Mail the form and a copy of your new license to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

Community Alternatives Program/AIDS **Community Alternatives Program/Children** **Community Alternative Program/Disabled Adults** **Community Alternatives Program/Mentally-Retarded-Developmentally Disabled**	Report all changes to the **Division of Medical Assistance** using the **form** on page 31. Mail the form to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506 The DMA Provider Services unit will contact you to obtain additional information as needed to complete your change request.

Ambulance Services **Certified Nurse Specialists** **Certified Registered Nurse Anesthetists** **Developmental Evaluation Centers** **DSS Case Management** **Federal Qualified Health Centers** **Head Start Programs** **Health Departments** **Hearing Aid Dealers** **HIV Case Management** **Independent Diagnostic Treatment Facilities** **Independent Practitioners** • **Audiologists** • **Occupational Therapists** • **Physical Therapists** • **Respiratory Therapists** • **Speech Therapists** **Licensed Clinical Social Workers** **Mental Health** **Nurse Midwives** **Nurse Practitioners** **Optical Services** **Out-of-State Hospitals** **Planned Parenthood Programs** **Psychologists** **Public School Health Programs** **Residential Evaluation Centers** **School Based Health Centers**	Report all changes to the **Division of Medical Assistance** using the **form** on page 31. Mail the form to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506 **Managed Care providers** must also report changes to their local **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022.

In-State **Chiropractors** **Dentists** **Optometrists** **Osteopaths** **Medical Doctors** **Podiatrists**	**All physicians** enrolled with N.C. Medicaid or participating in a Medicaid Managed Care program must report all changes to their regional **Blue Cross and Blue Shield of North Carolina** representative at one of the numbers listed below. **Charlotte 1-704-561-2740** **Greensboro 1-336-316-5374** **Greenville 1-252-758-4745** **Hickory 1-877-889-0002** **Raleigh 1-919-461-5246** **Wilmington 1-877-889-0001** **Border Areas* 1-919-765-2471** * Enrolled providers within 40 miles of the North Carolina border **Managed Care providers** must also report changes to their local **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022.

Out-of-State **Chiropractors** **Dentists** **Optometrists** **Osteopaths** **Medical Doctors** **Podiatrists**	Report all changes to the Durham office of **Blue Cross Blue and Shield of North Carolina** at **919-765-2471**. **Managed Care providers** must also report changes to their North Carolina **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022.

MQB Providers	Report all changes to **EDS** by calling **1-800-688-6696 or 919-851-8888** or submit changes in writing on company letterhead to: Provider Enrollment EDS P.O. Box 300009 Raleigh, NC 27622

Adult Care Homes **Ambulatory Surgical Centers** **Critical Access Hospitals** **Dialysis Centers** **Home Health Agencies** **Hospice** **Intermediate Care/Mental Retardation Facilities** **In-State Hospitals** **Nursing Facilities** **Portable X-Ray Suppliers** **Psychiatric Residential Treatment Facilities** **Residential Child Care Facility (Level II – IV)** **Rural Health Clinics**	Report all changes to the **Division of Facility Services** by calling **919-733-1610**. DFS will forward the appropriate documents to the Division of Medical Assistance.

Carolina ACCESS Providers	**Managed Care providers** must report changes to their local **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022. All Carolina ACCESS providers, except physicians (chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists), must also report changes to the **Division of Medical Assistance** using the **form** on page 31. Mail the form to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

HMO Providers	**Managed Care providers** must report all changes to their **HMO** and to their local **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022.

HMO Risk Contracting Managed Care Plans	**HMO Managed Care Plans** must report all changes to the **Division of Medical Assistance** using the **form** on page 31. Changes must also be reported to the **Division of Medical Assistance's Managed Care section** by calling 919-857-4022.

ACCESS II and ACCESS III Providers	**Managed Care providers** must report changes to their local **Managed Care Representative** (MCR). To obtain the name and telephone number of your MCR, call the **Division of Medical Assistance's Managed Care section** at 919-857-4022. All changes must also be reported to the **N.C. Office of Research, Demonstrations, and Rural Health Development**. N.C. Office of Research, Demonstrations, and Rural Health Development 2009 Mail Service Center Raleigh, 27699-2009 Phone: 919-733-2040 Fax: 919-733-8300 All changes must also be reported to the **Division of Medical Assistance** using the **form** on page 31. Mail the form to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

ACCESS II and ACCESS III Administrative Entities	Report all changes to the **N.C. Office of Research, Demonstrations, and Rural Health Development**. N.C. Office of Research, Demonstrations, and Rural Health Development 2009 Mail Service Center Raleigh, 27699-2009 Phone: 919-733-2040 Fax: 919-733-8300 All providers, except physicians (chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the **Division of Medical Assistance** using the **form** on page 31. Mail the form to: Provider Services DMA 2506 Mail Service Center Raleigh, NC 27699-2506

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NOTIFICATION OF CHANGE IN PROVIDER STATUS

This form is intended for use by ALL PROVIDERS except as listed on the back of this form.
ALL of the shaded areas must be completed by the provider (If you are requesting changes to a group, enter group name and number).

Indicate the type of change you are submitting by placing an "X" in the appropriate box(es).

☐ **Address Change** ☐ **Name Change** ☐ **Change of Ownership** ☐ **Tax ID Change** ☐ **Delete Group Member**

Indicate whether the change is for: ☐ **Individual Provider** ☐ **Group Provider**

Effective Date of Change _____

	NEW	**OLD (Existing Information)**
Provider Name	_____	_____
Medicaid Provider Number	_____	_____
Provider Address	_____	_____
Phone Number	_____	_____
Tax ID Number	_____	_____

Name of Individual Provider to be Deleted from Group _____

Provider Number for Individual Provider to be Deleted from Group _____

Contact Name _____ Contact Telephone Number _____

Signature of Owner or Authorized Agent _____

Print Name and Title of Owner or Authorized Agent _____

Return form to: **Provider Services, DMA, 2506 Mail Service Center, Raleigh, NC 27699-2506**

Report all changes to the Division of Medical Assistance using this form.
If you are also a Managed Care provider, call your local Managed Care Representative to report changes.**
Ambulance Services
Certified Nurse Specialists
Certified Registered Nurse Anesthetists
Developmental Evaluation Centers
DSS Case Management
Federal Qualified Health Centers
Head Start Programs
Health Departments
Hearing Aid Dealers
HIV Case Management
Independent Diagnostic Treatment Facilities
Independent Practitioners

- Audiologists
- Occupational Therapists
- Physical Therapists
- Respiratory Therapists
- Speech Therapists

Licensed Clinical Social Workers
Mental Health
Nurse Midwives
Nurse Practitioners
Optical Services
Out-of-State Hospitals
Planned Parenthood Programs
Psychologists
Public School Health Programs
Residential Evaluation Centers
School Based Health Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new CLIA certificate.
Independent Free-Standing Laboratories

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new accreditation from the Commission of Free-Standing Birthing Center.
Free-Standing Birthing Centers

Report all changes to the Division of Medical Assistance using this form. Include a copy of your new license.
Durable Medical Equipment Services
Home Infusion Therapy Services
Personal Care Services
Pharmacies
Private Duty Nurses

Report all changes to your local Managed Care Representative.**
Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.
Carolina ACCESS Providers

Report all changes to your local Managed Care Representative and to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).**
ACCESS II and ACCESS III Providers

Report all changes to the N.C. Office of Research, Demonstrations, and Rural Health Development (919-733-2040).
Providers (except chiropractors, dentists, optometrists, osteopaths, medical doctors, podiatrists) must also report changes to the Division of Medical Assistance using this form.
ACCESS II and ACCESS III Administrative Entities

Report all changes to your HMO.
HMO Providers

Report all changes to the DMA Managed Care section (919-857-4020) and to the Division of Medical Assistance using this form.
HMO Risk Contracting Managed Care Plans

Report all changes to EDS by calling 1-800-688-6696 or 919-851-8888 or submit changes in writing on company letterhead.
MQB Providers

Report all changes to the Division of Medical Assistance using this form. The DMA Provider Services unit will contact you to obtain additional information as needed to complete your change request.
Community Alternative Program Services

Report all changes to the Division of Medical Assistance using this form.
Providers must also report changes to the Division of Facility Services by calling 919-733-1610.
If you are also a Managed Care provider, call your local Managed Care Representative to report changes.**
Adult Care Homes
Ambulatory Surgical Centers
Critical Access Hospitals
Dialysis Centers
Home Health Agencies
Hospice
Intermediate Care/Mental Retardation Facilities
In-State Hospitals
Nursing Facilities
Portable X-Ray Suppliers
Psychiatric Residential Treatment Facilities
Residential Child Care Facility (Level II – IV)
Rural Health Clinics

Physicians must report all changes to their regional Blue Cross Blue Shield of North Carolina Representative.
If you are also a Managed Care provider, you must report changes to your local Managed Care Representative.**
Physicians

- Chiropractors
- Dentists
- Optometrists
- Osteopaths
- Medical Doctors
- Podiatrists

**To obtain the number of your Managed Care Representative, call DMA Managed Care at 919-857-4022.

Voluntary Termination

All providers must notify DMA in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

Managed Care providers (Carolina ACCESS, Access II, Access III, and HMOs) must also notify DMA's Managed Care section of their decision to terminate.

Licensure Revocation or Suspension

Any provider or facility whose license(s) is revoked or suspended is not eligible for participation in the N.C. Medicaid program. In the event that a provider who is licensed by the Division of Facility Services (DFS) should have their license/certification revoked or suspended, either DFS or the Health Care Financing Administration (HCFA) will notify DMA. All other providers should notify DMA immediately. Managed Care providers must also notify DMA's Managed Care section of any licensure revocation or suspension.

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

Health Care Financing Administration Sanctions

Providers who receive sanction(s) from HCFA may become ineligible for Medicaid participation and may be responsible for refunding any Medicaid payments made to them while under a HCFA sanction(s). HCFA will notify DMA of providers who are sanctioned. Individual practitioners who are sanctioned should notify DMA immediately.

Frequently Used Forms

Where to Obtain Forms

The forms included in this Special Bulletin, as well as other frequently used forms, are also available on DMA's website at www.dhhs.state.nc.us/dma.

Electronic Funds Transfer (See page 36 for a copy of the form)

EDS currently offers Electronic Funds Transfer (EFT) as an alternative to paper check issuance. EFT enables the receipt of Medicaid payments through automatic deposit at a bank while the provider continues to receive the Remittance and Status Report (RA) at the current mailing address. This process guarantees payment in a timely manner and prevents checks from being lost or stolen.

Credit Balance Reporting (See page 37 for a copy of the form)

All providers participating in the N.C. Medicaid program are required to submit a quarterly Medicaid Credit Balance Report to DMA's Third Party Recovery unit. Providers are to report any OUTSTANDING credits owed to Medicaid that have not been reported previously on a Medicaid Credit Balance Report. (Hospital and Nursing Facility providers continue to be required to submit a report every calendar quarter even if a zero ($0.00) credit balance exists.) The report is to be submitted no later than 30 days following the end of the calendar quarter (March 31, June 30, September 30, and December 31).

The Medicaid Credit Balance Report is used to monitor and recover "credit balances" owed to the Medicaid program. A credit balance results from an improper or excess payment made to a provider. For example, refunds must be made to Medicaid if a provider is paid twice for the same service (e.g., by Medicaid and a medical insurance policy; by Medicare and Medicaid; by Medicaid and a liability insurance policy) if the patient liability was not reported in the billing process; or when computer or billing errors occur.

For the purpose of completing the report, a Medicaid Credit Balance is the amount determined to be refundable to the Medicaid program. When a provider receives an improper or excess payment for a claim it is reflected in their accounting records (patient accounts receivable) as a "credit." However, credit balances include money due Medicaid regardless of its classification in a provider's accounting records. If a provider maintains a credit balance account for a stipulated period (e.g., 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to the Medicaid program. The provider is responsible for identifying and repaying all monies owed the Medicaid program.

The Medicaid Credit Balance Report requires specific information on each credit balance on a claim-by-claim basis. This form provides space for 15 claims but may be reproduced as many times as necessary to accommodate all the credit balances being reported. Specific instructions for completing the report are on the reverse side of the reporting form.

Submitting the Medicaid Credit Balance Report does not result in the credit balances automatically being reimbursed to the Medicaid program. If submitting a check is the preferred form of satisfying the credit balances, the check should be made payable to EDS and sent to EDS with the required documentation for a refund payment. If an adjustment is to be made to satisfy the credit balance, an adjustment form must be completed and submitted to EDS with all the supporting documentation for processing.

Submit **ONLY** the completed Medicaid Credit Balance Report to the Division of Medical Assistance. **DO NOT** send refund checks or adjustment forms to the Division of Medical Assistance. **DO NOT** send the Credit Balance Reports to EDS.

Failure to submit a Medicaid Credit Balance Report will result in the withholding of Medicaid payments until the report is received.

Submit **Medicaid Credit Balance Report** to:	Submit **refund checks** to:	Submit **adjustment forms** to:
Third Party Recovery Section Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508	EDS Refunds P.O. Box 300011 Raleigh, NC 27622-3011	EDS Adjustment Unit P.O. Box 300009 Raleigh, NC 27622-3009

Certification for Signature on File (See page 39 for a copy of the form)

A Provider Certification for Signature on Signature on File form must be submitted to allow providers to file paper claims without an individual signature on each claim. The form must have the provider's original signature. Stamped signatures are not accepted. For group physician and practitioner practices or clinics, each attending provider should sign a certification. For groups such as home health, hospitals and facilities (including adult care, etc.) that do not require an attending provider number on the claim, the certification should be signed by an individual who has authority to sign contracts on behalf of the provider.

EDS annotates the system to indicate the certification for signature is on file. All claims are checked for the signature on file indicator. If a form has not been received by EDS and the claim has no signature, it denies for EOB 1350, "Provider signature not on file. Sign claim and resubmit or complete the Certification for Signature on File and return to EDS."

Mail completed certification at least two weeks in advance of submitting claims without signature to:

EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622

Electronic Funds Transfer (EFT)

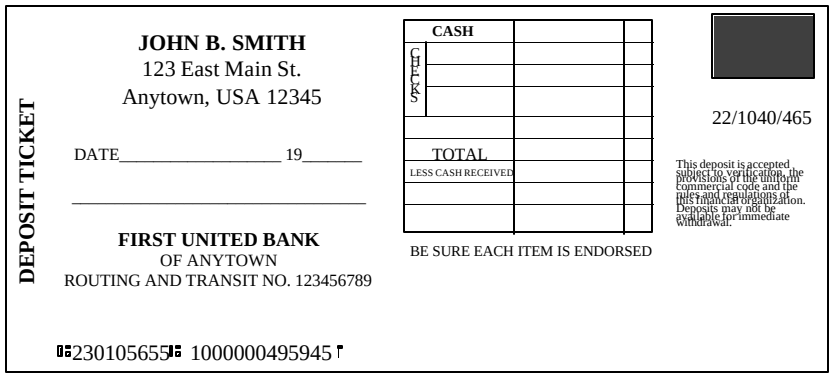
Attention: North Carolina Medicaid Providers
EDS currently offers Electronic Funds Transfer (EFT) as an alternative to manual check issuance. This service will enable you to receive your Medicaid payments through automatic deposit at your bank, while you continue to receive your Remittance and Status Report (RA) at your current mailing address. This process will guarantee payment in a timely manner and prevent your check from being lost through the mail.

To ensure timely and accurate enrollment in the EFT program, please fill out the form on this page and return it by mail to:

EDS, 4905 Waters Edge, Raleigh, NC, 27606
or
Fax: 919-851-4014, Attention: Financial Unit

We will run a trial test between our bank and yours. This test will be done on the first checkwrite you are paid after we receive this form. Thereafter, your payments will go directly to your bank account. Your RA will continue to come through the mail. On the last page of your RA in the top left corner it will state "EFT number" rather than "Check number" when the process has begun. Contact **EDS Financial Unit** at 919-851-8888 or 800-688-6696 with any questions regarding EFT.

Thank you for your cooperation in making this a smooth transition to Electronic Funds Transfer, and for helping us to make the Medicaid payment process more efficient for your provider community.



Authorization Agreement for Automatic Deposits (Credits)

Company Name: Electronic Data Systems (EDS)

I (we) hereby authorize EDS to initiate credit entries to my (our) checking or savings account indicated below and the depository name below, hereinafter call DEPOSITORY, to credit the same such account.

DEPOSITORY NAME_____

BRANCH_____

CITY_____STATE_____ZIP CODE_____

BANK TRANSIT/ABA NO._____

ACCOUNT NO._____

This authority is to remain in full force and effect until EDS has received written notification from me (or either or us) of its termination in such time and in such a manner as to afford EDS a reasonable opportunity to act on it.

PROVIDER NAME(S)_____

BILLING PROVIDER NUMBER_____

DATE_____SIGNED_____

Please list a name and telephone number of someone to contact with questions EDS may have on initiating this automatic deposit.

CONTACT_____TELEPHONE NUMBER_____

USE A SEPARATE FORM FOR EACH PROVIDER NUMBER.

⇦ **A DEPOSIT SLIP MUST BE ATTACHED FOR EACH BANK ACCOUNT**.

MEDICAID CREDIT BALANCE REPORT

PROVIDER NAME: _____ CONTACT PERSON: _____

PROVIDER NUMBER: _____ TELEPHONE NUMBER: (_____) _____

QUARTER ENDING: (Circle one) 3/31 6/30 9/30 12/31 YEAR:_____

	(1) RECIPIENT'S NAME	(2) MEDICAID NUMBER	(3) FROM DATE OF SERVICE	(4) TO DATE OF SERVICE	(5) DATE MEDICAID PAID	(6) MEDICAID ICN	(7) AMOUNT OF CREDIT BALANCE	(8) REASON FOR CREDIT BALANCE
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

Circle one: Refund Adjustment

Return form to: Third Party Recovery
DMA
2508 Mail Service Center
Raleigh, NC 27699-2508

Revised 8/00

(See back of form for instructions)

Instructions for Completing Medicaid Credit Balance Report

Complete the "Medicaid Credit Balance Report" as follows:

- Full name of facility as it appears on the Medicaid Records
- The facility's **Medicaid** provider number. If the facility has more than one provider number, use a separate sheet for each number. **DO NOT MIX**
- Circle the date of quarter end
- Enter year
- The name and telephone number of the person completing the report. This is needed in the event DMA has any questions regarding some item in the report

Complete the data fields for each Medicaid credit balance by providing the following information:

Column 1 - The last name and first name of the Medicaid recipient (e.g., Doe, Jane)

Column 2 - The individual Medicaid identification (MID) number

Column 3 - The month, day, and year of beginning service (e.g., 12/05/99)

Column 4 - The month, day, and year of ending service (e.g., 12/10/99)

Column 5 - The R/A date of Medicaid payment (not your posting date)

Column 6 - The Medicaid ICN (claim) number

Column 7 - The amount of the credit balance (not the amount your facility billed or the amount Medicaid paid)

Column 8 - The reason for the credit balance by entering: "81" if it is a result of a Medicare payment; "83" if it is the result of a health insurance payment; "84" if it is the result of a casualty insurance/attorney payment or "00" if it is for another reason. Please explain "00" credit balances on the back of the form.

After this report is completed, total column 7 and mail to **Third Party Recovery, DMA, 2508 Mail Service Center, Raleigh, NC 27699-2508**.

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

PROVIDER CERTIFICATION
FOR
SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

SIGNATURE:

_____
Print or Type Business Name of Provider

_____
Signature of Provider Date

Group provider number to which this certification applies:_____

Attending provider number to which this certification applies: _____

Return completed form to: EDS
Provider Enrollment
P.O. Box 300009
Raleigh, NC 27622

DEA Number Requirement

DMA requires DEA numbers on all recipient claims instead of UPIN numbers. Providers must have their DEA registration number on file. Failure to do so may result in denied claims. If a prescriber does not have a DEA number and needs to issue prescriptions to recipients served by the Medicaid program, the prescriber should contact the DUR section at 919-733-3590.

An identification number (ID) will be issued in lieu of the DEA number. The ID number, following the same format as the DEA number, will always begin with a Z (for example, ZF1234567). Prescribers will need to enter this number on their Medicaid prescriptions. This number is referred to as a MEDICAID IDENTIFICATION NUMBER only and should not be referred to as a DEA number.

If EDS Provider Enrollment does not have your updated information, please copy, complete, and return the following form for each prescriber in your practice. Please send the information to the following address:

EDS Provider Enrollment Unit
P.O. Box 300009
Raleigh, North Carolina 27622

FAX, 919-851-4014

DEA NUMBER

Provider Name _____

Medicaid Provider Number _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

DEA Number _____

Or

Medicaid Identification Number _____

Clinical Laboratory Improvements Amendment Certification Number Requirements

Effective June 1, 1998, the Clinical Laboratory Improvements Amendment (CLIA) requires that any provider performing laboratory tests have a CLIA certificate in order to receive reimbursement from federal programs. Providers must have their CLIA certificate number on file with the N.C. Medicaid program. Failure to do so will result in denied claims. Return a completed form and a copy of your CLIA certificate to:

EDS Provider Enrollment Unit
PO Box 300009
Raleigh, North Carolina 27622

CLIA Certification Information

Provider Name: _____Provider Number:_____

Street Address _____

City _____ State ____ Zip _____Phone Number_____

Contact Person_____

CLIA Number_____

Provider Visit Request

The Division of Medical Assistance and EDS encourage providers to attend program-specific seminars as advertised in the General Medicaid Bulletin and to utilize printed training materials to supplement the information supplied at the time of enrollment.

EDS Provider Services also offers providers support through the Automated Voice Response System for eligibility and claims inquiry; telephone attendants available to assist in answering detailed questions when resolving claims issues; and travel representatives for one-on-one training.

Individual provider visits are offered to all Medicaid providers, regardless of type and specialty, and may be requested any time during the year. To request an individual visit, complete and return the form below. An EDS Provider Representative will contact you to schedule a visit and discuss the type of issues you would like addressed.

Return completed form to:

EDS Provider Services
PO Box 300009
Raleigh, North Carolina 27622

Provider Visit Request Form

(No Fee)

Provider Name_____ Provider Number _____

Address _____ Contact Person_____

City, Zip Code_____ County _____

Telephone Number_(_____)_____ Date_____

List any specific issues you would like addressed in the space provided below.

_____

_____

_____

Medicare Crossover Reference Request Form

Medicare claims cross over automatically to Medicaid **IF** the provider's Medicare number is cross-referenced to their N.C. Medicaid provider number in Medicaid's cross-reference file.

If providers have Medicare claims that are not automatically crossing over to Medicaid, they should complete the form below and **return the form to EDS Provider Enrollment. DO NOT SEND THIS FORM TO MEDICARE**. EDS will verify the provider's Medicare and Medicaid information. If the numbers are not cross-referenced, EDS will add the provider information to the crossover file. If EDS has any questions, they will contact the provider.

If providers have multiple Medicare carriers and Medicare provider numbers, each number must be reference to a Medicaid provider number. Please use a separate form for each cross-reference.

Note: Multiple Medicare numbers can be cross-referenced to a single Medicaid number, but multiple Medicaid numbers cannot be cross-referenced from a single Medicare number.

MEDICARE CROSSOVER REFERENCE REQUEST

Provider Name:_____

Contact Person:(required)_____ Telephone Number: (required)_____

Indicate your *Medicare Carrier*, the *Action to be taken*, and your *Medicare* and *Medicaid* provider numbers**. If this section is not completed, the form will not be processed.**

These are the only carriers for which EDS can currently cross-reference provider numbers.

- ☐ NC BC/BS
- ☐ TN BC/BS
- ☐ FL BC/BS *****
- ☐ TX BC/BS
- ☐ MS BC/BS
- ☐ Palmetto
- ☐ Riverbend Government Benefits Administration
- ☐ Mutual of Omaha *****
- ☐ United Healthcare *****
- ☐ CIGNA
- ☐ United Government Services of WI
- ☐ Admina Star*****
- ☐ GA BC/BS
- ☐ Other_____

Action to be taken:

☐ *Addition - This is used to add a new provider number (Medicare or Medicaid) to the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

☐ *Change - This is used to change an existing provider number (Medicare or Medicaid) on the crossover file.*

Medicare Provider number: _____ Medicaid Provider number: _____

Mail to: Provider Enrollment
EDS
PO Box 300009
Raleigh, NC 27622

* These are additional Medicare carriers whom EDS is in the process of working with to have claims cross over with North Carolina Medicaid.

Fee Schedule Request Form

There is no charge for fee schedules or reimbursement plans requested from DMA. However, all requests for publications must be made on the Fee Schedule Request form and mailed to:

Division of Medical Assistance
Financial Operations - Fee Schedules
2509 Mail Service Center
Raleigh, N. C. 27699-2509

Or fax your request to DMA's Financial Operations section at 919-715-0896.

NOTE: NO PHONE REQUESTS

- ☐ After Care Surgery Period
- ☐ Ambulatory Surgery Center
- ☐ Anesthesia Base Units
- ☐ Community Alternatives Program
- ☐ Dental
- ☐ DME
- ☐ Health Department
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospital Reimbursement Plan
- ☐ ICF/MR Reimbursement Plan
- ☐ Laboratory
- ☐ Nurse Midwife
- ☐ Nursing Facility Reimbursement Plan
- ☐ Optical and Visual Aids
- ☐ Orthotics and Prosthetics
- ☐ Physician Fees (includes X-Ray)
- ☐ Portable X-Ray

Requestor: _____ Provider Type: _____

Address:_____

_____

_____

Technical Contact:_____Phone: _____

Frequently Asked Questions

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

A. Providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Providers must complete an application, provide verification of licensure – if applicable – and complete a N.C. Medicaid participation agreement. Refer to ***Provider Enrollment Requirements*** for additional information.

Q. What role does EDS play in the enrollment process?

A. Once a provider has enrolled with the N.C. Medicaid program, EDS supplies the provider with an information package including provider service manuals and Medicaid bulletins. EDS inputs and maintains data in the provider's file. As the fiscal agent for the N.C. Division of Medical Assistance, the EDS system of edits and audits are applied to the provider's claims for service.

Q. How long does it take to complete the enrollment process?

A. The enrollment process takes approximately four to six weeks. But, the process can take longer if supporting documentation from other entities is required. Providers receive written notification once the enrollment process has been completed.

Q. How do I enroll as a N.C. Medicaid Managed Care provider?

A. To enroll as a Carolina ACCESS (CA) primary care provider, contact your local Managed Care Representative (MCR). Providers will receive a CA Application for Participation. The MCR will assist with the application process and will answer your questions. To obtain the name and telephone number for your MCR, call the N.C. Division of Medical Assistance's Managed Care section at 919-857-4022.

To enroll as an ACCESS II or ACCESS III provider, contact the N.C. Office of Research and Rural Health by calling 919-733-2040.

To enroll as an HMO provider in Mecklenburg County or any of the other participating counties where the HMO Risk Contracting program is an option, contact the HMOs directly. Refer to page 8 for the name and telephone number of HMOs particpating in Medicaid's HMO Risk Contracting program.

Refer to ***Managed Care Provider Enrollment*** for more information.

Q. When can I begin billing for services I have furnished to Medicaid recipients?

A. Prospective Medicaid providers must apply for and be enrolled in the N.C. Medicaid program, assigned a provider number, and agree to certain conditions of participation before payment can be made for services furnished to Medicaid recipients. The effective date on the participation agreement or EDS enrollment letter (to physicians) is the date a provider can begin billing for services.

Q. How do I license my service or facility?

A. Where applicable, facilities must be licensed by the N.C. Division of Facility Services. For more information, call 919-733-7461.

Q. Where can I get an enrollment application?

A. Where applicable, applications for enrollment as a **Medicaid provider** are available from the N.C. Division of Medical Assistance (DMA) by writing:

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

Or call 919-857-4017

Applications for participation as a **Carolina ACCESS provider** are available from a Managed Care Representative (MCR). To obtain the name and telephone number of your MCR, call the DMA Managed Care section at 919-857-4022.

Refer to ***Provider Enrollment Requirements*** for additional information.

Q. How are group provider numbers assigned?

A. Group provider numbers are assigned to each physical site that delivers services to Medicaid recipients. If a group practice has 10 sites, each site has to have a separate provider number. Individual providers do not have to have separate numbers if they practice at more than one site; their individual numbers can be "floated" from one group to another. Groups must notify the N.C. Division of Medical Assistance when an individual practitioner is added to or deleted from their group practice.

Q. What is the enrollment process for physician assistants?

A. The N.C. Medicaid program does not enroll physician assistants. If they are employed by a physician or physician's group, their services are billed under the supervising physician's provider number.

Q. How often do I have to re-enroll as a N.C. Medicaid provider?

A. Enrollment periods vary according to provider types. Some enrollment periods are end-dated and require the provider to initiate the re-enrollment process at a specified time by contacting the Division of Medical Assistance's Provider Services at 919-857-4017.

All providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as a N.C. Medicaid provider. All providers are responsible for ensuring that information on file with the Medicaid program for their practice or facility remains up-to-date. Refer to ***Reporting Changes in Provider Status*** to determine the appropriate process for reporting changes in provider status to the N.C. Medicaid program.

Q. Is it necessary for a physician who already has a N.C. Medicaid provider number to re-enroll with the N.C. Medicaid program if they transfer into a new practice?

A. No. However, all providers are responsible for ensuring that information on file with the N.C. Medicaid program for their service or facility is always up-to-date. Refer to ***Reporting Changes in Provider Status*** to determine the appropriate process for reporting changes in your provider status to the N.C. Medicaid program.

A physician will usually keep the same provider number. If billing under a group provider number, the group may begin billing for the new physician as long as the physician's individual provider number is active.

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

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

All providers are responsible for ensuring that information on file with the N.C. Medicaid program for their service or facility is always up-to-date. Refer to ***Reporting Changes in Provider Status*** to determine the appropriate process for reporting changes in your provider status to the N.C. Medicaid program.

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

A. No. But, all providers are responsible for ensuring that information on file with the N.C. Medicaid program for their service or facility is always up-to-date. Refer to ***Reporting Changes in Provider Status*** to determine the appropriate process for reporting changes in your provider status to the N.C. Medicaid program.

Q. How do I contact the N.C. Medicaid program to report changes to my provider status?

A. The process for reporting changes to provider status are determined by provider type. Refer to ***Reporting Changes in Provider Status*** to determine the appropriate process for reporting changes in your provider status to the N.C. Medicaid program.

Q. I am currently a Carolina ACCESS provider and my Medicaid provider number has changed. Who do I report this change to?

A. Contact your local Managed Care Representative (MCR) immediately. To obtain the telephone number of your MCR, call the N.C. Division of Medical Assistance's Managed Care section at 919-857-4022.

If the Medicaid provider number that is changing is also your Carolina ACCESS (CA) provider number, your MCR must be alerted as soon as possible to ensure that the CA management fee is paid properly and to prevent claim denials. Until you receive notification that your CA number has been changed, claims filed using your new Medicaid provider number must also include your old Medicaid provider number (current CA number) in block 19 of the HCFA-1500 claim form. It is imperative that you use your active CA number when you refer patients.

Q. If our practice is participating as a provider in the Carolina ACCESS program, who do I contact when there is a change in our practice's provider information?

A. Carolina ACCESS providers must report all changes to their local Managed Care Representative. To obtain the telephone number of your MCR, call the N.C. Division of Medical Assistance's Managed Care section at 919-857-4022.

All providers, except physicians (chiropractors, dentists, optometrists, osteopaths, medical doctors, and podiatrists) must also report changes to the Division of Medical Assistance.

Physicians must report changes to their regional Blue Cross Blue Shield of North Carolina representative.

Refer to ***Reporting Changes in Provider Status*** for more information.

Q. If our practice is participating as a provider in the ACCESS II or ACCESS III program, who do I contact when there is a change in our practice's provider information?

A. ACCESS II and ACCESS III providers must report all changes to their local Managed Care Representative and to the N.C. Office of Research, Demonstrations, and Rural Health Development. Refer to ***Reporting Changes in Provider Status*** for more information.

Q. If our practice is participating as a provider in an HMO contracting with the N.C. Medicaid program, who do I contact when there is a change in our practice's provider information?

A. HMO providers must report all changes to their HMO(s). Refer to ***Reporting Changes in Provider Status*** for more information.

Q. My organization participates with N.C. Medicaid as an administrative entity for ACCESS II and ACCESS III. Who do I contact when there is a change in our provider status?

A. Report changes to the N.C. Division of Medical Assistance's Provider Services unit and to the N.C. Office of Research, Demonstrations, and Rural Health Development. Refer to ***Reporting Changes in Provider Status*** for more information.

Q. My organization contracts with N.C. Medicaid as an HMO Risk Contracting Managed Care Plan. Who do I contact when there is a change in our provider status?

A. Report changes to the both the Provider Services unit and the Managed Care section (919-857-4022) of the N.C. Division of Medical Assistance. Refer to ***Reporting Changes in Provider Status*** for more information.

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

A. CAP providers who are currently enrolled in the N.C. Medicaid program must send a completed enrollment application and verification of appropriate licensure and certification to the N.C. Division of Medical Assistance's Provider Services unit at the address listed below. However, it is not necessary to complete a new agreement. Applications may be obtained from the N.C. Division of Medical Assistance's Provider Services unit at the address listed below, or by calling 919-857-4017.

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

Q. Can the effective date of a provider number be changed?

A. Requests to change the effective date of a **group provider** number must be submitted in writing to the N.C. Division of Medical Assistance's Provider Services unit at the address listed below. Requests must be written on letterhead and include the group provider number and the effective date that you are requesting.

Requests to change the effective date of an **individual provider** number must be submitted in writing to the N.C. Division of Medical Assistance's Provider Services unit at the address listed below. Requests must be written on letterhead and include the individual provider number, the effective date that you are requesting, and a copy of the provider's license covering the effective date.

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

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

A. Requests to change a provider's specialty must be submitted in writing to the N.C. Division of Medical Assistance's Provider Services unit at the address listed below. Requests must be written on letterhead and include the provider number and correct specialty.

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

Q. How do I terminate my enrollment as a N.C. Medicaid provider?

A. Providers must notify the N.C. Division of Medical Assistance in writing at the address listed below of their decision to terminate their participation in the N.C. Medicaid program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Provider Services
N.C. Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506

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

A. Providers must notify the N.C. Division of Medical Assistance's Managed Care section in writing at the address listed below of their decision to terminate their participation in the Managed Care program. Notification must be on the provider's letterhead and signed by the provider, office manager, or administrator.

Managed Care Section
N.C. Division of Medical Assistance
2516 Mail Service Center
Raleigh, NC 27699-2516

Managed Care providers must also notify their Managed Care Representative (MCR) of their decision to terminate. To obtain the name and telephone number of your MCR, call the Division of Medical Assistance's Managed Care section at 919-857-4022.

Q. What is the automatic deposit process?

A. EDS generates a list of deposits on an electronic wire, which represents payments to providers who have chosen automatic deposit. This electronic wire is sent to the Federal Reserve Bank, which makes the transactions to the providers' bank. Simultaneously, the EDS account is debited for the funds.

Q. What are the advantages to automatic deposit?

A. The major advantage is that automatic deposit eliminates needless worry about check delays and checks lost in the mail. It generally takes 2 to 3 weeks to reissue a lost check.

Q. How do I enroll for EFT?

A. Providers must complete an EFT Agreement form. A copy of the form follows this article or can be obtained by calling EDS at 1-800-688-6696 (select option "1'). The form is also available online at www.dhhs.state.nc.us/dma. A separate form must be completed for each provider number your organization plans to enroll. A deposit slip or voided check **must** also be attached for each bank account to verify the account number and bank transit number.

Q. Where do I send my completed forms?

A. Mail completed form along with a deposit slip or voided check for each bank account to:
EDS
4905 Waters Edge Dr.
Raleigh, NC 27606
ATT: Finance-EFT

Or fax to: EDS, ATT: Finance-EFT, 919-859-9703

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Addresses and Phone Numbers

DMA Addresses and Phone Numbers

Administration and Regulatory Affairs Division of Medical Assistance 2504 Mail Service Center Raleigh, NC 27699-2504 919-857-4016	**Claims Analysis and Medicare Buy-in** Division of Medical Assistance 2519 Mail Service Center Raleigh, NC 27699-2519 919-857-4018
Community Care Program Division of Medical Assistance 2502 Mail Service Center Raleigh, NC 27699-2502 919-857-4021	**Director or Deputy Director** Division of Medical Assistance 2517 Mail Service Center Raleigh, NC 27699-2517 919-857-4011
Eligibility Unit Division of Medical Assistance 2512 Mail Service Center Raleigh, NC 27699-2512 919-857-4019	**Financial Operations** Division of Medical Assistance 2509 Mail Service Center Raleigh, NC 27699-2509 919-857-4015
Hearing Office Division of Medical Assistance 2505 Mail Service Center Raleigh, NC 27699-2505 919-857-4016	**Mail Management** Division of Medical Assistance 2513 Mail Service Center Raleigh, NC 27699-2513 919-857-4015
Managed Care/Carolina ACCESS Division of Medical Assistance 2516 Mail Service Center Raleigh, NC 27699-2516 919-857-4022	**Medical Policy/Utilization Control** Division of Medical Assistance 2511 Mail Service Center Raleigh, NC 27699-2511 919-857-4020
Program Integrity Division of Medical Assistance 2515 Mail Service Center Raleigh, NC 27699-2515 919-733-6681	**Provider Services** Division of Medical Assistance 2506 Mail Service Center Raleigh, NC 27699-2506 919-957-4017
Quality Control Division of Medical Assistance 2518 Mail Service Center Raleigh, NC 27699-2518 919-733-3590	**Third Party Recovery or Health Insurance Premium Payment Program (HIPP)** Division of Medical Assistance 2508 Mail Service Center Raleigh, NC 27699-2508 919-733-6294

If you do not know which DMA section or unit's address to use, send your correspondence to the following general address:

(Name of DMA employee)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

EDS Addresses

Correspondence sent Certified, UPS, or Federal Express should be sent to:

EDS
4905 Waters Edge Drive
Raleigh, NC 27606

Correspondence sent to EDS should be addressed to the appropriate P.O. Box listed below, Raleigh, NC 27622.

P.O. Box	30968	HCFA-1500 claims
P.O. Box	31188	Prior Approval requests
P.O. Box	300001	Pharmacy claims
P.O. Box	300009	Correspondence, Adjustments, and Medicare crossovers (indicate department on envelope)
P.O. Box	300010	UB-92 claims
P.O. Box	300011	Other claim types and returned checks
P.O. Box	300012	Sterilization/Hysterectomy consent form/statements **(Do not send claims to this address)**

Blue Cross Blue Shield of North Carolina

County				BCBSNC Regional Office	Phone Number
Anson Cabarrus Gaston	Lincoln Mecklenburg Montgomery	Richmond Rowan	Stanly Union	Charlotte	704-561-2740
Alamance Caswell Davidson	Davie Forsyth Guilford	Randolph Rockingham Stokes	Surry Yadkin	Greensboro	336-316-5374
Beaufort Bertie Camden Chowan Craven Currituck Dare	Edgecombe Gates Greene Halifax Hertford Hyde Jones	Lenoir Martin Nash Northampton Pamlico Pasquotank	Perquimans Pitt Tyrrell Washington Wayne Wilson	Greenville	252-758-4745
Alexander Alleghany Ashe Avery Buncombe Burke Caldwell	Catawba Cherokee Clay Cleveland Graham Haywood Henderson	Iredell Jackson Macon Madison McDowell Mitchell Polk	Rutherford Swain Transylvania Watauga Wilkes Yancey	Hickory	1-877-889-0002
Chatham Durham Franklin	Granville Harnett Johnston	Lee Orange Person	Vance Wake Warren	Raleigh	919-461-5246
Bladen Brunswick Carteret Columbus	Cumberland Duplin Hoke Moore	New Hanover Onslow Pender	Robeson Sampson Scotland	Wilmington	1-877-889-0001
Border Areas Out-of-State (Virginia, Tennessee, Georgia, South Carolina)				Durham	919-765-2471

Telephone Contact Numbers

Topic/Reason For Call	Call	Telephone Number
Accident Related Issues	DMA Third Party Recovery	1-919-733-6294
Advance Directives	DMA Medical Policy Section	1-919-857-4020
Automatic Deposits	EDS Finance Unit	1-800-688-6696 or 1-919-851-8888
Baby Love	DMA Baby Love Coordinator	1-919-857-4020
Billing Issues	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Carolina ACCESS (other than denials)	DMA Managed Care Section	1-919-857-4022
ACCESS II information	ACCESS II	1-919-715-7625
Carolina ACCESS denials	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Checkwrite information	AVR System	1-800-723-4337
Claims status	AVR System	1-800-723-4337
Community Alternatives Program (retroactive requests)	DMA Community Care	1-919-857-4021
Coverage Issues	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Denials (other than eligibility denials)	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Drug Utilization Review	DMA Program Integrity	1-919-733-3590
Electronic Data Interchange (EDI)	EDS	1-800-688-6696 or 1-919-851-8888
Eligibility information, current day	AVR System	1-800-723-4337
Eligibility information, over age 12 months	DMA Claims Unit	1-919-857-4018
Electronic Claims Submission	EDS Electronic Commerce Services (ECS) Unit	1-800-688-6696 or 1-919-851-8888
Eligibility Denials	DMA Claims Analysis	1-919-857-4018
Fee Schedules	DMA Financial Operations	1-919-857-4015
Forms (information and orders)	EDS Provider Services	1-800-688-6696
Fraud and Program Abuse	DMA Program Integrity	1-919-733-6681
Health Care Connection (Mecklenburg County Managed Care)	DMA Managed Care Section	1-919-857-4022
Health Care Connection, local	Health Benefits Advisors	1-704-373-2273
Health Check	DMA Managed Care Section	1-919-857-4250
Health Insurance Payment Program (HIPP)	DMA Third Party Recovery	1-919-733-6294
HMO Risk Contracting , including Health Care Connection	DMA Managed Care Section	1-919-857-4250
HMO enrollment verification	AVR System	1-800-723-4337
Medical Policy Questions (providers)	EDS Provider Services	1-800-688-6696 or 1-919-851-8888
Medical Policy Questions (providers/recipients)	DMA Medical Policy	1-919-857-4020
Medical Policy Questions (Home Care programs)	DMA Community Care Unit	1-919-857-4021
Medicare Crossovers	EDS Provider Enrollment	1-800-688-6696 or 1-919-851-8888
Preadmission Screening and Annual Resident Review (PASARR)	First Health of Tennessee (FH)	1-800-639-6514
Preadmission Review for In-patient Psychiatric Admissions/Continued Stay	First Health of Tennessee (FH)	1-800-770-3084
Prior Approval	EDS Prior Approval Unit	1-800-688-6696 or 1-919-851-8888
Private Insurance (Denials)	DMA Third Party Recovery	1-919-733-6294
Procedure Code Pricing	AVR System	1-800-723-4337
Provider Enrollment – Managed Care Provider Enrollment – MQB Provider Enrollment – All Other Providers	DMA Managed Care EDS Provider Enrollment DMA Provider Services	1-919-857-4022 1-800-688-6696 or 919-851-8888 1-919-857-4017
Rate Setting and Reimbursement	DMA Financial Operations	1-919-857-4015
Recipient Questions (Number for recipients to call)	DHHS Care Line	1-800-662-7030
Third Party Insurance Code Book	DMA Third Party Recovery Section	1-919-733-6294 Fax: 1-919-715-4725

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North Carolina Administrative Code

TITLE X – HEALTH AND HUMAN SERVICES
CHAPTER 26 – MEDICAL ASSISTANCE
SUBCHAPTER 26K - TITLE XIX APPEALS PROCEDURES

10 NCAC 26K .0006 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for all services provided.

(b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:

(1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing; or

(2) stating either orally or in writing that the patient has Medicaid coverage; or

(3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

(1) for allowable deductibles, co-insurance, or co-payments as specified in 10 NCAC 26C.0003; or

(2) before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services as specified under 10 NCAC 26B, 10 NCAC 26C, and 10 NCAC 26D; or

(3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is no longer eligible for Medicaid as defined in 10 NCAC 50B.

(d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

(1) the provider failed to follow program regulations; or

(2) the agency denied the claim on the basis of a lack of medical necessity; or

(3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third party payment as payment in full for all Medicaid covered services provided, except that a provider may not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount as specified in 10 NCAC 26C.0003. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may actively pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in 10 NCAC 26C .0003.

History Note: *Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 C.F.R. 447.15;*
Eff. January 1, 1988;
Amended Eff. February 1, 1996; October 1, 1994.

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Paul R. Perruzzi, Director
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