NC Medicaid Provider Operations

Virtual Office Hours

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Agenda

- EPSDT (Early and Periodic Screening, Diagnostic and Treatment)
- Behavioral Health Providers: National Accreditation Requirements - *Action Required!*
- Children and Families Specialty Plan (CFSP) Post-Launch Update
- Confirming NC Medicaid Coverage for Beneficiaries
- Credentialing Committee Post-Launch
- Carolina ACCESS Provider Enrollment
- Required Provider Disclosures
- Federal Fee Increase for Provider Applicants
- Maintain Eligibility Program
- NC Medicaid Provider Ombudsman
- Resources for Providers

Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Amanda Tromblee and Susan Bryan

Consistency and Uniformity in Administering the EPSDT Children's Benefit

Important details of EPSDT:

- **Early-** Assessing and identifying problems early
- **Periodic-** Checking children's health at periodic, age-appropriate intervals
- **Screening-** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnosis-** Performing diagnostic tests to follow up when a risk is identified

and

- **Treatment-** Control, correct or reduce health problems found

Key Definitions

- **§1905 (a):** EPSDT guarantees apply to “Medical Services” listed at §1905 (a) of the Social Security Act, sometimes known as the “Medicaid Act”.
- **Co-Pay:** a charge a provider attempts to make for an ‘encounter’ in addition to the ‘Medicaid Allowable Amount.’ These charges are forbidden for Medicaid’s children under 21 years of age.
- **Non-Covered Service:** Any service, product or treatment not listed within the State Plan of covered services. Although many necessary services for children are included in NC State Plan, some may not be covered.
- **EPSDT Review**: The term refers to the formal medical necessity review, required whenever a requested medical service isn’t covered under State Plan, when a policy limit must be overridden, or whenever a service request would otherwise be denied.

Remember the basics: EPSDT Services and §1905(a)

***Only* §1905(a) of the Social Security Act Defines Available Services under EPSDT**

There are categories of services and supplies listed in the Social Security Act, but a state may not specify an exclusionary list of specific items which it will cover within those categories.

The choice of services is driven by the *review* of *an individual case* determining medical necessity unique to that child's needs, and not by a list of available products, services or treatments.

Remember the basics: Medical Review

Before an adverse benefit determination is issued for a child Medicaid beneficiary, the EPSDT benefit requires:

- An individualized case review;
- By an appropriately licensed healthcare professional;
- Applying a uniform standard of pediatric medical necessity;
- Review against federal EPSDT regulations and requirements.

When the Service is Covered:

The service can only be covered under EPSDT if all criteria set forth below are met:

- The request is included in the categories of care and services listed in 1905(a) of the Social Security Act.
- The requested service, product, or procedure is medical in nature.
- The request is not for an experimental or investigational service, product, or procedure.
- The requested service is generally recognized as an accepted method of medical practice or treatment.
- The requested service is safe.
- The requested service is effective.

EPSDT

Early and Periodic Screening (Wellness or Health Check Visits- Preventative Services)

- These claims include an EP modifier
- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders
- Comprehensive, unclothed physical examination
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
- Laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for both the child and caregiver
- NC Medicaid follows the American Academy of Pediatrics Periodicity schedule for preventative services and visits

EPSDT determinations are made on an individual, case by case basis by the Health Plan receiving the request.

EPSDT cont.

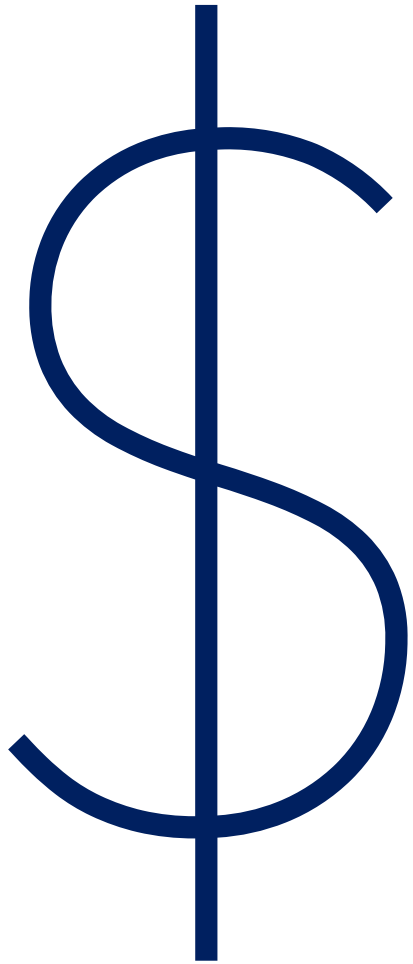
Diagnosis & Treatment

- These claims do not include an EP modifier, and do not have to be identified by the provider as EPSDT related requests
- If a problem is found during a wellness visit, providers make appropriate referrals to necessary diagnostic and treatment services. Prior Approval may be required.
- To conduct an EPSDT medical necessity review, an appropriately licensed and credentialed professional or panel must:
- Review the individual needs of the child as submitted in the request with reference to each element of the EPSDT criteria and all applicable law, policy, and standards of best practice;
- Research best practice, peer reviewed journals and find support in data for effectiveness of requested service in the individual case as presented in the request, allowing case-based exceptions to those guidelines and policies as required by EPSDT standard.

EPSDT determinations are made on an individual, case by case basis by the Health Plan receiving the request.

No Copay for Covered EPSDT Services

- *Children under the age of 21 are exempt from copays*
- *There are no additional expenses or copays for which parents or caregivers are responsible*



Pay & Chase: EPSDT Claims Reimbursement

Upon identification of an EPSDT claim per federal guidelines and requirements, all EPSDT claims are paid by the Health Plans as the primary payer. The Health Plans shall chase any recovery from the liable third-party payer unless it has been determined as not cost-effective to pursue recovery.

EPSDT claims are exempt from the standard coordination of benefits regulations in which Medicaid is the payer of last resort.

Depending on how the provider bills, the health plan may need to pay and chase claims that would have been cost-avoided.

For example, if a provider submits a bundled claim, and the bundled claim includes any cost-avoided services. Suppose the cost-avoided services cannot be identified and adjudicated separately. Then, the Health Plan must pay and chase the entire bundled claim to ensure compliance with federal requirements.

Resources

- Health Check Program Guide | NC Medicaid
- COB TPL Training and Handbook
- Coordination of Benefits & Third-Party Liability | Medicaid
- A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
- NC Medicaid: EPSDT Fact Sheet

NC Medicaid Updates

Michael Herrera
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Post-Enrollment National Accreditation Requirements

Required National Accreditation for Certain Behavioral Health Services

Requirements for Behavioral Health Services under taxonomy 251S00000X (Community/Behavioral Health Agency) providers:

- Mandatory post-enrollment national accreditation
- Accrediting bodies are determined by Behavioral Health Service
- Accreditation is required within one- or three-years post enrollment
- Respective clinical coverage policies outline specific required timeframes

One-year grace period for currently enrolled providers begins Feb. 22, 2026.

Children and Families Specialty Plan Post-Launch

Launched Dec. 1, 2025 - Policy flexibilities to promote continuity of care and ease provider administrative burden

- Medical Prior Authorizations (PAs)
- Pharmacy PAs
- Out-of-Network Provider Rates
- Out-of-Network Providers Follow In-Network PA Rules
- Primary Care Provider (PCP) Changes
- Additional Transition Support
- Expectations for Providers and CFSP

Refresher: How to Confirm Medicaid Coverage for Beneficiaries

NCTracks is used to confirm Medicaid beneficiary eligibility

Member ID cards are not required to render services

When a beneficiary presents at your office:

- Verify eligibility and enrollment using NCTracks, or call the NCTracks Call Center for more information
- Confirm if your practice participates with the assigned health plan
- If you are not the beneficiary's PCP but in-network for the health plan, you can render and be paid for Primary Care Services
- If beneficiary would like to designate you as their PCP, they should call the Prepaid Health Plan (PHP) Member Services line and ask to be reassigned

Credentialing Committee Post-Launch Update

Responsible for reviewing provider files that contain flagged items

- **First meeting:** Oct. 8, 2025
- **Cadence:** every Wednesday
- **15** members and **15** proxies
- **42** provider applications presented for review as of **Dec. 31, 2025**
- **5,915** Clean/Low-Risk Files ratified or formally approved

Credentialing Committee Bylaws

NC Medicaid Credentialing Committee webpage

NCTracks Credentialing Committee FAQ

Carolina ACCESS Provider Enrollment Refresher

A primary care case management program for the majority of Medicaid beneficiaries who are enrolled in NC Medicaid Direct.

- **Intended for organizations and individual providers with qualifying taxonomy**
  - Individual providers should answer affirmatively to “Do you wish to participate in CCNC/CA under this group?” to indicate intent to render primary care services under their affiliated Carolina Access (CA) organization
- **Approved CA providers are encouraged to:**
  - Contact Community Care of North Carolina (CCNC) to join their provider network
    - CCNC offers care management services to CA beneficiaries as well as support for providers
  - Contract with PHPs to serve as an Advanced Medical Home (AMH) provider
  - CA providers are automatically approved as AMH Tier 2 providers

Reminders About Required Provider Disclosures

- **During enrollment, providers must:**
  - Accurately answer all Exclusion Sanction questions for all listed individuals
    - Failure to disclose required information may result in automatic denial
    - Additional adverse action can occur, depending on type of application submitted
    - Enrollment applications cannot be edited once they have been submitted
- **Currently enrolled providers must:**
  - Notify department (submit Manage Change Request (MCR)) within 30 calendar days of learning of any adverse action(s)

Federal Provider Enrollment Application Fee Increase for Calendar Year 2026

- **As of Jan. 1, 2026,** the federal fee for NC Medicaid provider enrollment has increased from $730 to $750 for calendar year 2026

- This fee is **required** for:
  - Initial enrollment
  - Re-enrollment
  - Adding a new owner or a new site location
  - Reverification

Maintain Eligibility Program

Identifies enrolled providers with no claims activity within the past 12 months

- **Notification of Inactivity Letter**
  - Provides guidance for completing Maintain Eligibility Application
  - Upon application submission, provider's enrollment record will be updated with the current date

- **What if providers do not submit application in time?**
- **Certain instances will prevent a Maintain Activity letter.**

Rural Health Clinics and Federally Qualified Health Centers are excluded from this requirement

NC Medicaid Provider Ombudsman

Resource and contact for providers to resolve inquiries pertaining to NC Medicaid and associated health plans

Consists Of:

- NC Medicaid Provider Ops Team

Responsibilities

- Manages inbound provider inquiries from receipt to closure
- Report to NC Medicaid Agency Leadership

Collaboration & Support

- Teams work cross-functionally to address and resolve inquiries and cases
- Supported by the NC Medicaid Help Center

Quality Management:

- Conducts regular meetings to monitor performance and track aging cases
- Agency leadership monitors trends
- Touchpoints with Health Plans and other vendors involved
- Updates and best practices

Utilizes ServiceNow (SNOW)

- A cloud computing platform that enables documentation, tracking and navigation of provider inquiries

NC Medicaid Provider Ombudsman Contact: 866-304-7062
Medicaid.providerombudsman@dhhs.nc.gov

Provider Resource Hub

BENEFICIARY MATERIALS WEBPAGE

NC MEDICAID PROVIDER WEBPAGE

PROVIDER ENROLLMENT (Includes Credentialing Committee)

NC MEDICAID BULLETINS

NCTRACKS PROVIDER USER GUIDES & TRAININGS

NCTRACKS ANNOUNCEMENTS

NC MEDICAIDHELP CENTER

NC AHEC MEDICAID MANAGED CARE WEBPAGE

Additional Resources

- Reminders About Required Provider Disclosures
- Carolina ACCESS Enrollment Refresher
- Federal Fees & NC Enrollment Fees by Year
- Information on Maintaining Eligibility
- 2026 NC Medicaid Provider Training Courses
- Provider Playbook
- Health Plan Contacts and Resources
- Children and Families Specialty Plan
- FAQs - Medicaid Help Center
- NC Medicaid Credentialing Committee
- Provider Permission Matrix-Quick Links
- Post-Enrollment National Accreditation Requirements
- NCTracks Call Center: 800-688-6696
- NC Medicaid Contact Center: 888-245-0179

Recent Provider Communications

NC Medicaid Provider Bulletins:

- Providers with License Limitations or Non-Practice Agreements Ineligible for NC Medicaid Participation
- Refresher: How to Confirm Medicaid Coverage for Beneficiaries
- Quarterly Provider Update – Winter 2026

NC Medicaid Fact Sheets:

- What Providers Need to Know After Children and Families Specialty Plan Launch (Part 2)
- Provider Quick Reference Guide for the Children and Families Specialty Plan

NCTracks Provider Announcements:

- NCTracks Helpful Hints: Process to Update Name, DOB and/or SSN on Provider Record
- Upcoming Layout Changes for PPM
- Important Update for Taxonomies No Longer on the Provider Permission Matrix
- Important Updates for Case Manager/Care Coordinators - Taxonomy 171M00000X
- Electronic Funds Transfer Attestation Added to Reverification and MCR Provider Applications
- Update to NCTracks Provider Portal Taxonomy Classification Requirements
- Temporary Flexibilities due to January Winter Storm (Jan 28, 2026)

Thank You!

If you have any additional questions, please email

Medicaid.NCEngagement@dhhs.nc.gov

We look forward to seeing you at the next Virtual Office Hours May 7, 2026!