

Section 3. Medicaid Provider Information

Enrollment Application

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

The Department will conduct provider enrollment screening in accordance with applicable State or Federal law or regulation.

All applications, including applications for a new practice location, shall be screened and assigned a categorical risk level of "limited," "moderate," or "high." The Division will assess each provider type and specialty and assign a risk category. If a provider fits within more than one risk level, the highest level of screening will be applicable (42CFR 455.450, N.C. Session Law 2011-399, N.C.G.S. 108C-(3).

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

Group Provider Enrollment Packets

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

Individual Provider Enrollment Packets

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

In Addition to the Enrollment Application

Prior to being initially enrolled in the Medicaid or Health Choice program, in accordance with Sections 6401(a), 10603 and section 1866(j) of the ACA, providers are required to undergo screenings and attend trainings as designated by the Department in rules, including, but not limited to, the following:

- The Basic Medicaid/Health Choice Billing Guide, common billing errors, and how to avoid them.
- Audit procedures, including explanation of the process by which the Department extrapolates audit results.
- How to identify Medicaid/ Health Choice recipient fraud.
- How to report suspected fraud or abuse.
- Medicaid recipient due process and appeal rights.

Provider Enrollment and Re-enrollment Fee

In accordance with Section 1866(j)(2)(C)(i)(I) of the ACA DMA will collect a \$505 application fee from providers and suppliers that are newly enrolling, revalidating or establishing a new practice location, or in response to a CMS revalidation request with the submission of an initial enrollment application in order to cover the cost of screening and to carry out screening and other program integrity efforts.

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

Initial enrollment is defined as an in-state or border-area provider who has never enrolled to participate in the N.C. Medicaid/Health Choice. The provider's tax identification number is used to determine if the provider is currently enrolled or was previously enrolled.

Applicants should not submit payment with their application. Upon receipt of your enrollment application, an invoice will be mailed to you if either fee is owed. An invoice will only be issued if the tax identification number in the enrollment application does not identify the applicant as a currently enrolled Medicaid provider.

Providers are reminded that payment

- is due immediately upon receipt of an invoice for the enrollment fee;
- should be remitted to the address on the invoice and not directly to CSC; and
- is accepted by check or money order made payable to DMA.

Please make every effort to remit payment promptly. Applications will not be processed if payment is not received. If payment is not received within 30 days of the date on the invoice, your application will be voided and you will be required to reapply as retroactive enrollment will not be granted.

Qualifications for Enrollment

The general requirements for provider enrollment are as follows.

Licensure, Accreditation, Endorsement and Certification

Providers must be licensed, accredited, endorsed, and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but ALL providers must complete an application and a NCDHHS Medicaid Provider Administrative Participation Agreement. All providers are responsible for maintaining the required licensure, endorsement, and accreditation specific to their provider type to remain qualified as N.C. Medicaid/Health Choice providers and are required to notify DMA immediately if a change in status occurs. For detailed information regarding specific requirements for each provider type, refer to the NCTracks website at:

<http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp> or contact the EVC Call Center at 1-866-844-1113.

Note: Behavioral Health Managed Care Organizations which operates under the Mental Health, Developmental Disabilities, and Substance Abuse Services Plan waiver are responsible for enrolling behavioral health providers in their respective provider networks.

Service Location

Services must be provided at a site within the State of North Carolina or, for some services, within 40 miles of the North Carolina border. Out-of-state providers are eligible for enrollment only under the following conditions:

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

Out-of-state providers are required to adhere to all North Carolina, rules, regulations, laws and statutes governing healthcare delivery under the North Carolina Medicaid program.

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

Provider Agreements

All providers must comply with the terms and conditions specified in the NCDHHS Medicaid Provider Administrative Participation Agreement.

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

Attestation Letter

Upon enrollment and re-enrollment in the N.C Medicaid/Health Choice Program, providers are required to complete and sign the Letter of Attestation as a condition of participation in the Medicaid and N.C. Health Choice program. In accordance with Session Law 2011-399, § 108C-9, the revised provider attestation to will contain a statement that the provider:

- has met the minimum business requirements necessary to comply with all federal and State requirements governing the Medicaid and Children's Health Insurance program,
- does not owe any outstanding taxes or fines to the U.S. or North Carolina Departments of Revenue or Labor or the Employment Security Commission,
- does not owe any final overpayment, assessment, or fine to the North Carolina Medicaid or North Carolina Health Choice program or any other State Medicaid or Children's Health Insurance program, and
- has implemented a corporate compliance program as required under federal law.”

To avoid any delay in reimbursement, providers should review their corporate compliance programs and submit the signed Medicaid Letter of Attestation.

Re-verification and Re-credentialing Requirements

The N.C. Medicaid/Health Choice Program is required to re-credential each enrolled provider every three years to verify that the provider continues to meet the conditions of participation for enrollment as a Medicaid provider. This process includes criminal background checks and queries of Federal practitioner databases, including but not limited to the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe will be routinely checked to determine the exclusion status of all enrolled providers including any person with an ownership, control interest, an agent or managing employee of the provider

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

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

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

Tax Information

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

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

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

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

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

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

Conditions of Participation

Civil Rights Act

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

Rehabilitation and Disabilities Acts

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

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

Disclosure of Information

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

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

Medical Record Documentation

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

The following principles of documentation are adopted from Medicare policy and are not an exhaustive list of documentation requirements:

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

Payment in Full

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

Provider Responsibilities

Verifying Recipient Eligibility

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

Missed Appointments

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

Prior Approval

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

Accepting a Medicaid Recipient

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

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

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

Billing the Recipient

Providers may not bill a recipient for

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

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

Third-Party Liability

State and federal regulations for third-party liability (TPL) require responsible third-party, public and private insurance carriers to pay for medical services prior to Medicaid. Providers are required to seek payment from third-party insurance carriers. A third-party insurance carrier is an individual or company who is responsible for the payment of medical services. These third parties are Medicare, private health insurance, automobile, or other liability carriers. DMA's third party recovery (TPR) unit is responsible for implementing and enforcing TPL laws. The TPR unit implements and enforces these laws through both

cost avoidance and recovery methods. Refer to **Section 7, Third-Party Insurance**, for additional information.

Contacting N.C. Medicaid/Health Choice

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

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

Provider Forms

Electronic Claims Submission (ECS) Agreement for Organizations (Groups) or Individuals – Providers must submit claims electronically (unless the claim meets one of the exceptions listed on DMA's website at <http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm>) must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims.

Electronic Funds Transfer (EFT) Authorization Agreement – At the request of North Carolina Medicaid, HP Enterprise Services provides payment to Medicaid Providers, via Electronic Funds Transfer (EFT). This is the only option for payment. The EFT service enables you to receive payments through automatic deposit to the Medicaid provider's bank. This process assists Medicaid providers with receiving payments in a timely manner.

Remittance and Status Reports in PDF Format and Correct Coding Initiative Information Request Form – RAs are only available through the NCECSWeb Tool. The NCECSWeb Tool will retain ten checkwrite versions of the PDF version of the RA. Providers will also have access to the National Correct Coding Initiative edit explanations.

Certification of Signature on File – This is an agreement for non-electronic Medicaid claims to be submitted that fall under the electronic claims submission exemptions.

Pharmacy Online Request Point-of-Sale – This agreement is required to establish online claims processing for pharmacies.

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

Name of Form	How to Obtain the Form
ADA Dental Claim Form	Call ADA at 1-800-947-4746
Certificate of Medical Necessity and Prior Approval Form (for DME and O&P)	Call HP Enterprise Services at 1-800-688-6696 or 1-919-851-8888
CMS-1500 Claim Form	Available in most Office Supply Stores
Prior Authorization for Outpatient Specialized Therapies	Available on line at http://www.medicaidprograms.org/nc/therapyservices
Prior Authorization for Prescription Drugs	Available online at http://www.ncmedicaidpbm.com/
Sterilization Consent Form	Call HP Enterprise Services at 1-800-688-6696 or 1-919-851-8888
UB-04 Claim Form	Available in most Office Supply Stores
Visual Aids Prior Approval Form (372-017 or 372-017A)	Call HP Enterprise Services at 1-800-688-6696 or 1-919-851-8888

Fee Schedule Requests

Fee schedules and reimbursement plans are available on DMA's website at <http://www.ncdhhs.gov/dma/fee/>. There is no charge for fee schedules or reimbursement plans requested from DMA and providers must bill their usual and customary charges.

The **Fee Schedule Request** may also be made by fax to DMA's Finance Management section at 919-715-2209. Telephone requests are not accepted.

Reporting Provider Changes

What Changes Must Be Reported

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

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

- Bed capacity changes
- Voluntary termination

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

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

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

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

How to Report a Change

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

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

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

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

- Group name changes
- Adding a service

- Adding a site
- Tax number changes
- Changes of ownership or ownership interest

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

Reporting a Change of Ownership

A change of ownership is constituted by

- an exchange of monies or an asset purchase, both of which result in the assignment of a new tax identification number;
- a stock purchase, which may not result in the assignment of a new tax identification number;
- a change in a shareholder's/partner's percentage of interest in ownership;
- a transfer of title and property to another party; or
- a merger of the provider corporation into another corporation or the consolidation of two or more corporations resulting in the creation of a new corporation.

To report a change of ownership, the new owner must submit a new enrollment application. The provider enrollment application is available from the NCTracks website at <http://www.nctracks.nc.gov/provider/providerEnrollment/>. The previous owner must submit a Medicaid Provider Change Form indicating the termination of participation due to a change of ownership. The Medicaid Provider Change Form is available from the NCTracks website at <http://www.nctracks.nc.gov/provider/cis.html>.

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

Voluntary Termination

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

Mail the notification and the **Medicaid Provider Change Form** to:

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

Note: Managed care providers must also notify DMA's Managed Care section of their decision to terminate. Refer to **Section 5, Community Care of North Carolina/Carolina ACCESS Provider Information**, for additional information.

Termination of Inactive Providers

If an enrolled Medicaid/Health Choice provider does not bill Medicaid/Health Choice for 12 months, DMA will send notice of termination of the Medicaid provider number. These notices are sent to the current mailing address listed in the provider's file. If a provider rendered services to N.C. Medicaid recipients or Health Choice members in the 12 months preceding the date of the notice, providers may attest and return this letter within two weeks. Returning this letter within two weeks will insure that your participation with the N.C. Medicaid/Health Choice Program remains active. If your letter is received after two weeks, the provider number will be terminated. Once terminated, providers must complete a new application and agreement to re-enroll and may have a lapse in eligibility as Medicaid/Health Choice providers.

Payment Suspension

Any correspondence that cannot be delivered due to an incorrect billing address in the provider's file will result in the suspension of all claims for the provider number. Automatic deposits cannot be processed for suspended claims.

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

Licensure Revocation or Suspension

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

Reactivation in the Medicaid program may occur when the license is reinstated by the licensing authority. Reactivation must be requested by completing and submitting a new provider enrollment packet. A copy of the reactivated license must accompany the request for reactivation. Reactivation is effective no earlier than the date on the reinstated license.

Sanctions

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

Program Integrity Reviews

Determining Areas for Review

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

- PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections.
- The Office of the State Auditor pulls a stratified sample of claims annually. PI staff review these claims to determine the payment accuracy rate for claims submitted by providers and paid by the Medicaid MMIS+ system.

- PI staff also conducts a second sampling of provider billings using methodology prescribed by CMS. This is to assist CMS in complying with HR 4878, the Improper Payments Act of 2002.
- DMA is also participating as a pilot state in a national project called Medi-Medi. In this project, Medicare and Medicaid claims are stored in a combined data warehouse. The data is then mined to identify possible fraud and abuse.
- HP Enterprise Services refers to PI any questionable services identified during claims processing.

Provider Responsibilities in a Program Integrity Review

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

- PI will request medical and/or financial records either by mail or in person. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. Providers must maintain records for six years in accordance with the recordkeeping provisions of the NCDHHS Medicaid Provider Administrative Participation Agreement.
- If you receive a recoupment letter from PI, review the information in the letter and chart. You have two options:
 - If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. Please send your check to DMA Accounts Receivable at the address on the letter. **Do not** send the check to HP Enterprise Services, as this could result in a duplication of your refund. Also, do NOT request that HP Enterprise Services adjust for the amount or items identified, as this could result in duplicate recoupment.
 - If you disagree with the overpayment decision by PI and want a reconsideration review, return the enclosed hearing request form to the DHHS Hearing Unit at the address on the letter and indicate whether you request a personal hearing or a paper review.
 - **Please pay close attention to the time frames and procedures for requesting a reconsideration review.**

Request for Reconsideration

Informal Hearings – A provider who disagrees with a DMA decision may have the right to an informal hearing. If applicable, the provider will be notified of the right to an informal hearing, conducted either in person in Raleigh or by scheduled telephone conference call. The DHHS Hearing Office will notify the provider of the date, time, and location.

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

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

Miscellaneous

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

Provider Self-Audits

Providers are encouraged to identify overpayments and correct potential billing errors by performing self-audit reviews. Participation in the self-audit program does not alleviate the possibility of further review by PI in this or future investigations, and does not affect in any manner the government's ability to pursue criminal, civil or administrative remedies or to obtain additional damages, penalties or fines for the matters that are the subject of the self-audit.

Self-audit packets are available by calling DMA PI at 919-647-8000 or 1-877-362-8471. Please note that internal claim numbers (ICN) are required on all self-audit results submitted to DMA PI to allow for refunds of Medicaid/Health Choice monies to be tracked correctly.

Overpayments

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

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

Pursuant to the authority under 10A NCAC 22F.0606, a disproportionate stratified random sampling technique may be used to establish the amount of any overpayment. Additional information may be viewed at <http://reports.oah.state.nc.us/ncac.asp>.

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

Self-Referral Federal Regulation

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

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

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

Advance Directives

Section 4751 of the OBRA 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers to provide written information to all patients 18 years of age and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or

surgical treatment, and to execute an advance directive (for example, a living will or health care power of attorney).

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

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

Reporting Fraud, Waste, and Program Abuse

DMA’s PI Section is devoted to ensuring compliance, efficiency, and accountability within the N.C. Medicaid/Health Choice Program by detecting and preventing fraud, waste and program abuse, thus ensuring that Medicaid dollars are paid appropriately. You are encouraged to report matters involving Medicaid fraud and abuse. If you want to report fraud or abuse, you can remain anonymous; however, sometimes in order to conduct an effective investigation, staff may need to contact you. Your name will not be shared with anyone investigated. (In rare cases involving legal proceedings, we may have to reveal who you are.)

To report suspected Medicaid fraud, waste or program abuse by a medical provider

- contact DMA by calling the **DHHS Customer Service Center** at 1-800-662-7030 (English or Spanish) and ask for the DMA PI Section; or
- call DMA’s PI Section directly at 1-877-DMA-TIP1 (1-877-362-8471); or
- call the State Auditor's Waste Line at 1-800-730-TIPS (1-800-730-8477); or
- call the U.S. Department of Health and Human Services Office of Inspector General's Fraud Line at 1-800-HHS-TIPS (1-800-447-8477); or
- complete and submit a Medicaid fraud and abuse confidential online complaint form on DMA’s website at <http://www.ncdhhs.gov/dma/fraud/reportfraudform.htm>.

Examples of Medicaid Fraud and Abuse by Medical Providers (list is not all-inclusive):

- Medicaid recipient failed to report other insurance when applying for Medicaid
- non-recipient uses a recipient’s Medicaid card with or without recipient’s knowledge
- provider’s credentials/qualifications are not accurate
- provider bills for services that were not rendered
- provider performs and bills for services not medically necessary

- provider alters claim forms and recipient records

Health Information Technology Incentives

Background

The American Recovery and Reinvestment Act of 2009 authorizes CMS to provide incentives for eligible professionals and hospitals who are successful in becoming “meaningful users” of certified electronic health record (EHR) technology. The Medicaid EHR incentive program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) for efforts to adopt, implement, or upgrade certified EHR technology or for meaningful use in the first year of their participation in the program and for demonstrating meaningful use during each of five subsequent years.

Certified EHR Products

The Office of the National Coordinator for Health Information Technology (ONC) has issued a Final Rule that specifies an initial set of standards, implementation specifications, and certification criteria for EHR technology. It is important to note that all EHR products must be certified under the new ONC process and procedure. Therefore, previously purchased products are not deemed to be compliant until the recertification process is complete. EPs and EHs are encouraged to keep in contact with their EHR vendors to stay informed about their progress toward product certification. Previous certification by the Certification Commission for Health Information Technology (CCHIT) does not qualify a vendor’s product as EHR ready under the new rules. CCHIT must apply to become a certifying entity under the federal rule. Refer to DMA’s website at <http://www.ncdhhs.gov/dma/provider/ehr.htm> for additional information on the Final Rule.

Listing of Certified EHR Systems

ONC has published the Certified Health IT Product List (CHPL), (<http://onc-chpl.force.com/ehrcert>) a comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program.

Each Complete EHR and EHR Module included in the CHPL has been tested and certified by an ONC-Authorized Testing and Certification Body (ATCB), and reported to ONC by an ONC-ATCB, with reports validated by ONC. Only those EHR technologies appearing on the ONC-CHPL may be granted the reporting number that will be accepted by CMS for purposes of attestation under the EHR incentive programs under the Medicare or Medicaid systems. The listing is updated as additional products are certified by ONC-ATCBs and reported to ONC for validation.

CMS EHR Incentive Programs Website

Providers can access the official website for the Medicare and Medicaid EHR incentive program (<http://www.cms.gov/EHRIncentivePrograms/>) for the most up-to-date, detailed information about the EHR incentive programs. Providers should visit the site often to learn what is considered meaningful use and for information on about who is eligible for the programs, how to register, and EHR training and events.

Provider Registration and Enrollment Process

The N.C. Medicaid Incentive Payment Solution (NC-MIPS) will administer the meaningful use incentive payments to ensure that EPs and EHs have met federal and State statutory and regulatory requirements for the EHR incentive payments.

To qualify for EHR incentive payments, Providers must first enroll in the EHR Program with CMS through the National Level Repository (NLR). Providers can find information on the CMS EHR Incentives website (http://www.cms.gov/EHRIncentiveProgram/50_Registration.asp#TopOfPage) on registration requirements regarding National Provider Identifiers, the National Plan and Provider Enumeration System (NPPES), and the Provider Enrollment, Chain, and Ownership System (PECOS). This information should be up-to-date prior to attempting to register with the NLR.

Once providers are registered with NLR, providers will receive notification of a successful registration from the State of North Carolina and can then complete the registration process with N.C. Medicaid. Providers can access NC-MIPS through the NCTracks website at http://www.nctracks.nc.gov/provider/forms/index_hit.html to complete the North Carolina-specific application attesting to the accuracy of the data entered.

Provider Information – Frequently Asked Questions

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

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

2. Where can providers get an enrollment application?

Applications for enrollment as a Medicaid provider are available from the NCTracks website (<http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>). Applications may be submitted online or by downloading the paper version of the application.

3. How do providers enroll as a managed care provider?

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

- To enroll as an ACCESS II/III provider, contact the Office of Rural Health and Community Care at 919-715-7625.
- To enroll as a provider in a Behavioral Health Managed Care Organization, contact the Provider Relations Department at the MCO directly. See the link as follows: <http://www.ncdhhs.gov/dma/lme/MHWaiver.htm>

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

4. How are group provider numbers assigned?

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

5. When can a provider begin billing for services that have been rendered to Medicaid recipients?

Prospective Medicaid providers must apply for and be enrolled in the Medicaid program, be assigned a provider number, and agree to certain conditions of participation before payment can be made for

services rendered to Medicaid recipients. For some types of providers, rates must be established by DMA's Finance Management Section prior to billing. The effective date on the participation agreement is the earliest date a provider may begin billing for services.

6. How often do Medicaid providers have to re-enroll?

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

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

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

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

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

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

Yes. The group provider must submit a new Provider Enrollment Application for a new group provider number, but the Medicaid provider numbers for the individual providers numbering the group will remain the same. If the merged group will still have separate locations, each office site must apply for a new group provider number.

Critical Access Behavioral Health Agencies and hospitals must also submit a new Provider Enrollment Application but the new entity will assume the previous entity's Medicaid provider number.

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

No. But, providers must notify the Medicaid program of the tax ID number changes. Refer to the NCTracks website at <http://www.nctracks.nc.gov/provider/cis.html> for information on how to report a change.

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

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

11. How do providers contact the Medicaid program to report changes to status?

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

12. If a provider is currently a Carolina ACCESS provider and the Medicaid provider number changes. How does the provider report this change?

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

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

13. If provider practice is participating as a provider in the Carolina ACCESS or ACCESS II/III program, whom should the provider contact when there is a change in the provider number?

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

14. If a provider participates with the Medicaid program as an administrative entity for ACCESS II/III, whom should the provider contact when there is a change in status?

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

15. If a provider is currently enrolled as a Community Alternatives Program (CAP) provider, how should the provider amend enrollment to include additional services?

CAP providers who are currently enrolled in the Medicaid Program must complete a CAP Addendum to Add Services and provide verification of appropriate licensure, certification and endorsement to the EVC Call Center at the address below. The Addendum is available on the NCTracks website at <http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>.

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

16. If the provider specialty is listed incorrectly, how should the provider correct it?

Requests to change a provider's specialty must be submitted on the **Medicaid Provider Change Form**. The form is located on the NCTracks website at: <http://www.nctracks.nc.gov/provider/cis.html>.

17. How should a provider terminate enrollment as a Medicaid provider?

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

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

18. How does a provider terminate enrollment as a Managed Care provider?

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

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

19. If a provider opens another location, can the provider use the current group number?

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