

Section 5. Community Care of North Carolina/Carolina ACCESS Provider Information

The North Carolina Division of Medical Assistance operates a statewide Primary Care Case Management (PCCM) program for the state's Medicaid recipients called Carolina ACCESS. The Carolina ACCESS (CA) program was initiated in 1991 and successfully increased access to medical homes. By enrolling recipients into a medical home, the need for recipients to seek primary care services and basic sick care in hospital emergency departments is reduced.

In 1998, Community Care of North Carolina was created using the existing infrastructure and established fourteen community networks that created local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients. These fourteen regional networks cover all one hundred North Carolina counties. Each network has an administrative entity that contracts with the Division of Medical Assistance. North Carolina continues to operate the original Carolina ACCESS PCCM program; however, most primary care providers are now members of a regional network and a majority of Medicaid recipients are enrolled with a provider.

Population management, care management, and coordination of treatment and prevention are provided to recipients enrolled with a network provider. Networks and providers receive increases in the per-member/per month (PM/PM) management fee for subsets of populations that are high risk, high acuity, high cost, and frequently has complex co-morbid conditions so that enhanced care management services can be provided. In addition to the services stated below, enhanced services include but are not limited to comprehensive and integrated package of high risk screening/assessment, triage, referral, hospital transitions, pharmacy reviews, medication reconciliation, inpatient, and emergency department diversion with care management across the continuum of care.

The networks provide population health management by:

- furnishing preventive services and information
- systematic data analysis to target recipients and providers for outreach, education, and intervention
- monitoring system access to care, services, and treatment including linkage to a medical home
- monitoring and building provider capacity
- monitoring quality and effectiveness of interventions to the population
- supporting the medical home through education and outreach to recipients and providers
- facilitating quality improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/national standards of care

Networks provide disease management by:

- educating network providers on evidence based standards of care to ensure that high-risk, high acuity recipients receive appropriate care
- educating recipients about disease states and self management

Disease management by the network includes Diabetes, Asthma and COPD, among others.

Population management, disease management, and medical coordination of treatment and prevention are provided to recipients enrolled with a network provider.

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

The following is a list of the networks in CCNC:

- ACCESSCare
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake/Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Community Care of the Sandhills
- Community Care of Southern Piedmont

Networks are paid PMPM management fees based on the number and type of enrollees.

CCNC Initiatives implemented in 2010 include:

- **Transitional care support and intensive care management:** This initiative embedded care managers in 15 tertiary care hospitals and primary care practices that treat a large number of recipients who are aged, blind, and disabled..
- **Mental health:** This initiative added psychiatrists to networks to facilitate best practices for treatment of depression, ADHD and substance use, and integrated care in network provider practices and local management entities.
- **Palliative care:** This initiative addressed needs of Medicaid recipients in end-of-life care.
- **Clinical pharmacy management:** This initiative increased pharmacy capacity at network level to perform medication reconciliation during transitional care.

CCNC Initiatives implemented in 2011 include:

- **Pregnancy Medical Home (PMH):** The Division of Medical Assistance (DMA), in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including Medicaid providers, local health departments, and the Division of Public Health, created a program to provide pregnant Medicaid recipients with a Pregnancy Medical Home (PMH). The goal is to improve birth outcomes in North Carolina by providing evidence-based, high-quality maternity care to Medicaid patients. This was done by modeling the PMH program after the enhanced primary care case management (PCCM) program developed by CCNC. PMH practices agree to work toward quality improvement goals. Patients at risk of poor birth outcome are identified through standardized risk screening and are referred for pregnancy care management to address those risk factors. Local health departments, working in partnership with CCNC networks, provide pregnancy care management services. The PMH program became effective on March 1, 2011.
- **Care Coordination for Children (CC4C):** DMA working in partnership with Community Care of North Carolina (CCNC) and other community stakeholders including providers, local health departments, and the Division of Public Health (DPH), transitioned the Children's Service Coordination program into a more focused care management program that targets those children with specific medical and social-emotional needs for intensive care management. The program's goals are to connect high cost and at-risk children and their families with services and resources, support children in reaching their developmental potential, and insure that children are raised in a healthy, safe, and nurturing environment. Care Coordination for Children (CC4C) is modeled after the enhanced primary care case management (PCCM) program developed by CCNC.

Recipient Enrollment

The county department of social services (DSS) is responsible for enrolling recipients with a medical home. Enrollment requirements are based on the recipient's Medicaid program aid category and classification of eligibility.

The table below identifies the recipients who are mandatory for enrollment by program aid category.

MANDATORY
AAF/Work First-Cash Assistance with Medicaid
MIC (N) and MIC (1)-Medicaid for Infants and Children
MAF-Medicaid for Families
MAABD –Medicaid for the Aged, Blind or Disabled (Without Medicare)
SAD –Special Assistance for the Disabled (Without Medicare)
SAA-Special Assistance for the Aged (Without Medicare)
MIC-J and MIC-K children enrolled in NC Health Choice *

* CCNC providers will be paid a per member, per month fee as allowed under the North Carolina Medicaid Program, in addition to Fee-for-Service reimbursement of Medicaid covered services at 100% of the allowable Medicaid rate.

Recipients in any of the mandatory categories that receive Medicare become optional for enrollment.

Recipients whose enrollment is mandatory are informed about the CCNC/CA program and enrolled during the Medicaid application process. Recipients are strongly encouraged to select a medical home from the list of PCPs serving their county of residence. This honors their right to choose their medical provider. Recipients who do not choose a medical home are assigned by the county DSS based on location, medical history, and restrictions of the provider. Each family member may have a different medical home. Recipients in the mandatory groups are not able to opt out of the program. However, they may request an exemption based on their medical needs.

Enrollees in either the Medicaid or NC Health Choice Program may request to change their medical home without cause at any time by contacting the county DSS. This can be done verbally or in writing. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines. A request to change providers will not be denied; however, the requested provider must be available to see the patient within the restrictions the provider identified on the application to enroll as a PCP in CCNC/CA.

Recipients Who Are Optional or Ineligible

Pursuant to 42 C.F.R. 438, 42 U.S.C. 1397cc(f)(3), and 42 U.S.C. 1396u-2(1)(c), certain groups of Medicaid and NC Health Choice recipients can be enrolled in the PCCM program on an optional basis.

The table below identifies recipients who are optional for enrollment by program aid category.

OPTIONAL
MPW-Medicaid for Pregnant Women
HSF-State Foster Home Fund
IAS-Medicaid with IV-E Adoption Subsidy and Foster Care
End Stage Renal Disease Patients
SSI recipients under age 19
Self-identified children with special health care needs
Native Americans
Benefit Diversion Cases
MIC-A and MIC-S children enrolled in NC Health Choice

North Carolina has chosen to enroll recipients of Medicaid and Medicare (known as duals, or dually eligible recipients), when the recipient is in a category that grants full Medicaid coverage, on an opt out basis. This means that dual recipients are notified that they have been enrolled and the name of the medical home to which they have been enrolled. They are also notified that they should contact the local DSS to choose a different provider or to declare their intention to opt out of the program. *(Providers may not charge copayments for services covered by both Medicare and Medicaid. A dual recipient maybe charged a copayment if required for services that are not covered by Medicare but are covered by Medicaid. Refer to Section 2, Recipient Eligibility, for complete copayment information.)*

All optional recipients are notified via letter or verbally by the caseworker at the local county DSS that they can request to enroll, disenroll or change medical homes at any time. This information is also contained in the educational material provided to all recipients at enrollment. Recipients can communicate their choice either in writing or verbally to the local department of social services.

Although federal regulations state that foster children must remain optional for enrollment in a managed care program, the “Fostering Connections to Success and Increasing Adoption Act of 2008” requires each state to provide a plan to ensure ongoing oversight and coordination of health care for foster children. North Carolina is meeting this need by enrolling foster children in a medical home through the CCNC/CA program. Guardians of children in foster care can choose to withdraw a foster child from enrollment or change PCPs at any time by notifying the department of social services verbally or in writing.

The table below identifies the recipients who are ineligible for enrollment by program aid category.

INELIGIBLE
MQB and RRF/ MRF
Recipients in “Deductible” status
CAP Cases with a monthly deductible
Aliens eligible for Emergency Medicaid only
Nursing Facility residents
MAF-D-Family Planning Waiver
MIC-L-NCHC Re-Enrollment Buy In
MAF-W-Breast and Cervical Cancer Medicaid

Enrollment considerations:

1. In areas that do not have access to CCNC/CA primary care providers for all potential enrollees, efforts are made to preserve existing provider-patient relationships.
2. Recipients whose third-party insurance is an HMO or who have Tri-Care may be exempted from Carolina ACCESS if their PCP does not participate with CCNC/CA.
3. At the discretion of the county DSS and the provider, recipients may choose a provider whose Carolina ACCESS agreement does not include their county of residence in the provider's service area. Recipients who need transportation assistance are generally limited to their county of residence or to a contiguous county.
4. Each family member may have a different medical home.
5. Requests for medical home changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Member identification:

CCNC/CA enrollees are identified by information on their Medicaid/Health Choice identification card. The name, address, and the daytime and after-hours telephone numbers of the medical home/primary care provider are listed on the Medicaid/Health Choice identification card. To insure they have the most current primary care provider enrollment information, providers must verify this information when they verify Medicaid/Health Choice eligibility using one of the methods outlined in **Appendix F**.

Enrollment at the participating practice:

In order to maximize enrollment, providers may enroll their patients at the practice by following these procedures:

- Inform patients of their right to choose any CCNC/CA primary care provider who is accepting new patients and their right to change PCPs at any time pursuant to processing deadlines.
- For optional recipients, providers must also inform the recipient of their right to declare their intention not to enroll at any time in the future.
- Complete the enrollment form and send to the Carolina ACCESS contact at the department of social services in the county in which the recipient resides. The form can be found on the DMA website at <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>.
- Provide the Medicaid recipient with a Carolina ACCESS Member handbook. Handbooks can be obtained by contacting the DMA at 919-855-4780.

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

Recipient Education

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

Providers should inform each enrollee about the following:

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

Free Exercise of Rights:

When enrolled in CCNC/CA, recipients are free to exercise his or her rights of choice, privacy and confidentiality. The exercise of those rights does not adversely affect the way in which they are treated. Recipients enrolled or potentially enrolled in CCNC/CA have the right to:

- **Receive information in a manner and format that may be easily understood**
- **Have assistance in understanding the program**
- **Interpretive services in the prevalent language of the recipient without cost to them**
- **Be treated in a respectful manner**
- **Be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations**

DMA's customer service center (919-855-4780) is available to help all Medicaid/Health Choice recipients understand their health care benefits. Customer service representatives also help enrolled recipients to understand the procedures for obtaining health care in a managed care program.

Provider Participation

Requirements for Participation in Primary Care Management Program

DMA and Computer Sciences Corporation's enrollment, verification, and credentialing center (CSC/EVC) work together to recruit and enroll PCPs into the CCNC/CA program. CSC is responsible for processing the applications and enrolling providers into the program. DMA is responsible for establishing PCP participation requirements, assisting providers in carrying out CCNC/CA policies and procedures, and recruiting providers into the program. Questions about the CCNC/CA program or requirements for participation can be answered by the regional consultants and DMA staff. (Regional Consultant contact information is available at www.ncdhhs.gov/dma/ca/mcc.pdf)

Providers must complete and submit a signed application and agreement confirming their compliance with all participation requirements. The **Carolina ACCESS Provider Enrollment Packet** is available on the NCTracks website at <http://www.nctracks.nc.gov/provider/providerEnrollment/index.jsp>.

The application and the agreement must each contain the original signature of the authorized representative (or a participating provider). Applications may be pended for a maximum of 90 days from the date of receipt of the application. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time unless a sanction has been imposed upon the provider's participation by DMA.

Every DSS is notified weekly of new CCNC/CA providers and changes in current CCNC/CA provider information. This notification enables the local dss office to maintain current and accurate provider directories for use by workers and for use by the recipient at enrollment in the program.

Providers are required to report any changes regarding their practice's status to CSC. Failure to report a change in practice status may result in termination from the Medicaid program, or primary care management program sanction imposed by DMA, including recoupment of PM/PM management fees. To report changes to the Medicaid program, CCNC/CA providers must submit a signed **Medicaid Provider Change Form** (refer to the NCTracks website at <http://www.nctracks.nc.gov/provider/cis.html>).

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

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

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

5. Enroll each CCNC/CA location with a separate, site-specific provider number. (This helps with claims filing, referrals, management of reports, and accurate financial reporting to the IRS.) Practices operating as a group must enroll with a site-specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the N.C. Medicaid program, and must therefore be site specific. **The CCNC/CA PCP's practice name, address, and daytime and after-hours telephone numbers are printed on the enrollee's Medicaid/Health Choice identification card. If this information changes, it must be reported on a timely basis.**
6. State on the initial application the maximum number of enrollees that will be accepted for the site and any specific enrollment restrictions such as age or gender. Enrollment of Medicaid recipients is capped at 2,000 per participating provider (MD, DO, PA, NP, or CNM).
7. Provide all reasonable medical home services including all age appropriate preventive care, as well as gender specific screening tests, preventive ancillary services, routine well care, acute care, chronic care, sick care and coordination of specialty care. Providers who choose to restrict enrollment to recipients of Medicaid for Pregnant Women (MPW) benefits only are exempted from the preventive and ancillary services requirements.
8. Develop patient–physician relationships and manage the health care needs of recipients.
9. Establish protocols for referring enrollees for specialty care or urgent care (including situations when referral was not obtained prior to the service being rendered).
10. Follow standards of appointment availability as detailed below.
11. CCNC/CA providers must comply with section 1932 (b)(7) of the Social Security Act, which states, “the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider’s license or certification under applicable State law solely on the basis of provider’s license or certification.” All referral requests from recipients and medical providers must be evaluated based on the medical needs of the patient.
12. If providers cannot provide a specific service or test, they may request an exception to refer for a specific service/test and inform DMA regarding a) the specifics of the service, b) the referral process, and c) the rendering provider including name and contact number of rendering provider for verification purposes.
13. Changes in enrollment restrictions must be reported to DMA before the change is implemented by the PCP. Approved CCNC/CA providers who have a change in their office procedures that impacts their compliance with any participation requirement must report the change timely and request an exception as outlined above.

14. CCNC/CA PCPs that serve recipients under age 21 are required to provide all age appropriate components of the Health Check preventive care screening as defined by EPSDT requirements for Medicaid recipients.
15. Accept Medicare assignment or exclude Medicare beneficiaries from the practice enrollment.
16. Refer potentially eligible recipients (women and children) to the WIC program.
17. List on the application all contiguous counties from which the practice will accept CCNC/CA enrollees. Since the provider must be accessible for primary care, these counties must include only the county in which the practice is located and the bordering counties. (DSS may enroll a recipient with a provider beyond the contiguous counties at their discretion and with the provider's agreement.)
18. Disclose on the application information regarding sanctions or termination by Medicaid or the Carolina ACCESS program. For complete information, refer to **Sanctions** in this section.
19. Establish and maintain hospital admitting privileges or provider documentation regarding admission coverage arrangements for the management of inpatient hospital admissions for all CCNC/CA enrollees.
20. Have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week and a minimum of four days per week. When the posted office hours change from what was reported in the Carolina ACCESS application, the schedule change must be reported to CSC and DMA.
21. DMA must be notified and information on how to obtain patient medical records must be included in the after hours message on all practice phone lines and be posted on the practice premises when the office is closed permanently or for an indefinite period.
22. Follow medical record documentation guidelines.
23. Review and use recipient utilization, emergency room, enrollment, and referral reports; and access those reports through the DMA Information and Report System.
24. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week without charge or limitation. Provide accurate, up to date instructions to patients and to CSC and DMA regarding how to access after hours advice and care. Refer to **24-Hour Coverage** in this section.
25. Transfer CCNC/CA patient medical records to the receiving provider upon the change of primary care provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request.

Note: The N.C. Medical Board website publishes a position statement that includes information about reasonable charges for record transfers. CCNC/CA providers may not withhold the record until the charge is paid.

26. Providers may request an exception to other participation requirements in writing. The request must include the reason the provider is unable to comply and must be submitted at the time the participation agreement is submitted. Approval of the application constitutes acceptance of the request for exception. The benefits of the provider's participation must outweigh the provider's inability to comply with the requirement.
27. All requirements of State and federal law pertaining to providers of medical care; including all such requirements referenced in the NC DHHS Provider Administrative Participation Agreement, non-discriminatory criteria as outlined in that Agreement, HIPAA privacy regulations, and availability of free oral interpretation services must be met by all providers.

Requirements for Participation in Pregnancy Care Management

The Maternity Care Coordination (MCC) program has transitioned to the Pregnancy Care Management program. The Pregnancy Care Management program provides care management for the pregnant Medicaid population.

In most cases, care management is provided by the Local Health Department, by contract with CCNC. Each PMH has a care manager assigned to the practice. Providers must submit all risk screenings to their care manager within seven business days. Care managers are expected to conduct a thorough assessment of all priority patients within 30 days. Non-PMH prenatal care providers and other community agencies may refer a patient for assessment with a pregnancy care manager, who evaluates the patient's level of need and develops a care plan accordingly.

Pregnant Medicaid patients identified as being at risk for poor birth outcome receive individualized case management services. The level of service provided is in proportion to the individual's identified needs. Care managers closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome. Care managers are an integral part of the patient's care team.

Provider Responsibilities

Providers interested in enrolling as a PMH must complete a CCNC/PMH contract and return it to their local CCNC network.

To qualify for participation as a PMH, the provider must agree to the following:

- Ensure that no elective deliveries (induction and cesarean section) are performed before 39 weeks of gestation
- Offer and provide 17p (17alpha hydroxyprogesterone) to eligible patients
- Maintain a primary cesarean section rate at or below 20%
- Complete a standardized risk screening on each pregnant Medicaid recipient in the practice at the first prenatal appointment
- Integrate the plan of care with the local pregnancy care management program
- Participate in chart reviews to evaluate progress on the PMH performance measures
- Agree to become an affiliate member of Community Care of North Carolina (CCNC)

Prenatal care providers who do not perform obstetric delivery are eligible to serve as a PMH. In order to ensure continuity of care and smooth transitions among care providers, these PMHs are expected to develop a Memorandum of Understanding (MOU) with the practice that delivers their patients. This should be completed within one year of becoming a PMH and should describe arrangements to coordinate patient care, such as availability of medical records at the time of delivery, coordination of transitions to and from intrapartum care, information for patients on how these transitions will take place, and description of how postpartum care will be managed. At the time a practice becomes a PMH, the expectation is that the practice will describe to the CCNC network what its current arrangements are for providing intrapartum care to its patients.

Provider Incentives:

In exchange for meeting the program expectations described above, the PMH receives the following incentives:

- Exemption from medical necessity prior approval on ultrasounds
- PMH providers still must register ultrasounds with MedSolutions
- Other high tech imaging continues to require prior approval
- \$50 incentive for completing the risk screening tool at initial OB visit
- By billing for this incentive payment, providers establish themselves as the patient's PMH
- \$150 incentive for the postpartum visit per Medicaid recipient

- Visit must include, at a minimum, depression screen using a validated instrument, reproductive life planning, and a referral for ongoing care
- Increased rate for a vaginal delivery, antepartum, and postpartum care when billed using CPT codes reflecting obstetric care (59400, 59425, 59426, 59409, 59430 and 59410)
- E&M codes should only be billed if the patient has a high risk condition (see OB policy 1E-5 for high risk criteria and more information).
- Exemption from prior approval on ultrasounds (providers will still need to register the ultrasounds with MedSolutions)
 - Other high-tech imaging will continue to require prior approval
- \$50 for completing a high-risk screening tool at initial visit
- \$150 incentive for the postpartum visit per Medicaid recipient
- Increased rate for a vaginal delivery

Any provider who bills the OB global package or individual pregnancy procedures is eligible to participate in this program as long as he/she agrees to the program requirements. It is **not** just for obstetric providers.

For more detailed information, please refer to DMA Pregnancy Medical Home Special Bulletin, July 2011 at <http://www.ncdhhs.gov/dma/pmh/PMHSpecialBulletin.pdf>

Care Coordination Services for Children – Information for Providers

CC4C services are provided based on patient need and according to risk stratification guidelines. The amount of care manager contacts will be determined by the patient's individual needs and plan of care, in order to effectively meet desired outcomes. Contacts may occur in various settings including the health care provider office, community, or patient's home, as well as by phone.

The overall program model seeks to improve health outcomes for enrolled children, which will be measured by: The length of time from neonatal intensive care unit discharge to first medical home visits; hospital admissions, readmissions and emergency department use; and the number of children with special health care needs and/or children in foster care who have a medical home.

Specific measures will determine to what extent the CC4C services are achieving project goals, including: the rate of comprehensive assessments completed for children/families with a priority risk factor; the percent of enrolled children who receive a Life Skills Progression assessment on entry into the system, every six months thereafter, and upon discharge from CC4C services; the number of infants ages 1 year or under referred to Early Intervention; and, as evidenced by the child making progress towards the defined goals in their treatment plan, self-sufficiency and self management of the condition.

Marketing by Community Care of NC/Carolina ACCESS Providers

Community Care of North Carolina/Carolina ACCESS participating providers and their employees are prohibited from marketing directly to potential recipient enrollees for the purpose of coercing or unfairly influencing potential recipients to enroll with that practice. The following are definitions of prohibited marketing activities:

- **Cold Call Marketing:** Unsolicited personal contact with potential recipients
- **Marketing:** Communication of any sort to a Medicaid recipient who is not enrolled with a provider but who may be influenced to enroll with a particular provider.
- **Marketing Materials:** Materials that are produced in any medium for the purpose of influencing recipients to enroll with a particular provider.

Primary Care Management Program Sanctions

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

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

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered; or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations. DMA maintains the right to waive sanctions based upon the specifics of the case or upon the recommendation of the CCNC network. Management fees will not be recouped from the CCNC network due to a provider's failure to report practice changes.

Misrepresentation, misuse or abuse of the Carolina ACCESS provider's referral number by any provider may result in recoupment of paid claims. Carolina ACCESS providers should monitor their monthly **Carolina ACCESS Referral Report** and report discrepancies to DMA.

Reasons for Sanctions

Termination from Medicaid participation and/or sanctions against CCNC/CA primary care management program participating providers may be imposed by DMA for the following reasons:

1. Failure to enroll each site with a site-specific Medicaid Provider Number.
2. Fraudulent, misrepresentative, or erroneous billing practices, including unauthorized use of another PCP's Carolina ACCESS referral number.
3. Failure to maintain after-hours coverage at no cost or penalty to the recipient.
4. Failure to report a change in after hours coverage arrangements, enrollment restrictions, office hours, ownership, contact information including phone and fax lines, practice location, individual providers servicing the location; or any change that impacts requirements or criteria stated in either the NC DHHS Provider Administrative Participation Agreement or the Agreement for Participation in North Carolina's Patient Access and Coordinated Care Program.
5. Failure to cooperate with CCNC/CA program initiatives.
6. Failure to provide all preventive and ancillary EPSDT services or to refer properly for services for all ages impacted by EPSDT services.
7. Failure to meet any terms outlined in the CCNC/CA provider agreements.

Sanction Appeals

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

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

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

Terminations

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

Provider Reports

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

DMA Information and Report System

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

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

Enrollment Report

DMA provides PCPs with a monthly **CA Provider Enrollment Report**. The **paper report** consists of three sections for both Carolina ACCESS enrollees and N.C. Health Choice enrollees, if applicable: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the Regional Consultant or the county DSS. PCPs are expected to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported, until the change or error has been resolved and reported correctly. This report may be accessed from the DMA Information and Report System and is also currently mailed to the PCP.

Emergency Room Management Report

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

Referral Report

DMA provides CCNC/CA PCPs with a monthly **Referral Report** containing information on where and when enrollees obtained services during the month. This report is only accessible from the DMA Information and Report System. Please refer any discrepancies to your Regional Consultant.

Quarterly Utilization Report

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost-effective primary care. This report is only accessible from the DMA Information and Report System.

Provider Requirements

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

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

CCNC/CA PCPs who accept enrollees under the age of 21 are required to provide all components of the Health Check preventive care screening as defined by EPSDT requirements. PCPs serving this population who do not provide Health Check screenings* are required to pursue an agreement with the local health department or other DMA approved CCNC/CA provider to provide Health Check screening components and provide a copy of this agreement at time of application to participate or at the time that the screening components available at the PCP office have changed. The agreement must be specific to services included, age of recipients to be referred and the communication process between the referring PCP and the rendering provider. (**Note:** There are certain public health departments that do not currently offer primary care services. Please contact your Regional Consultant to discuss alternatives.) PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer to DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm> for a copy of the **Health Check Agreement between**

Primary Care Provider and the Local Health Department

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

Adult Preventive Annual Health Assessments

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

24-Hour Coverage

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

Providers may not bill their CCNC/CA enrollees for after-hours consultations or for any other service that is part of their contractual agreement with DMA (Agreement for Participation in North Carolina's Patient Access and Coordinated Care Program). **Providers may not contract with a third**

party on the basis that the third party will bill the CCNC/CA enrollee. Additionally, providers may not imply by way of their after-hours coverage message or arrangement, including any arrangement the provider makes with a third party, or by any other means that there may be a charge to their enrollees for access to medical advice or care. CCNC/CA providers are prohibited from posting statements on the practice premises or recording statements on phone lines that might discourage a CCNC/CA enrollee from contacting their PCP for medical advice and care when the office is closed.

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

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

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

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

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

When the office is closed during normal business hours (e.g. vacations or holidays), sufficient information must be included in the after hours message on all practice phone lines and be posted on the practice premises that will direct patients to another medical provider for sick/urgent care. Referral to the emergency department for non-emergent medical conditions does not meet this requirement.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

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

The CCNC/CA provider has agreed to **provide or arrange for** medically necessary services according to these standards. If the appointment availability standard cannot be met, the PCP must make a referral to another provider and request documentation of the services provided for the enrollee's medical record. Follow-up care must be referred to the PCP.

Emergency Conditions

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

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

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

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

Urgent Conditions

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

Standards for Office Wait Times

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

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

The CCNC/CA provider may make referrals for sick/urgent medical care when the CCNC/CA **Standards for Wait Times** cannot be met. Referral must be made to an appropriate medical setting and documentation requested. Follow-up care should be referred to CCNC/CA PCP. Referral to the emergency department for non-emergent medical conditions does not meet this requirement.

When a situation occurs in the course of business that prevents adherence to these standards, the provider's front desk staff must notify the enrollee immediately and advise them of the estimated wait time, explain the reason for the delay and offer to reschedule the appointment or refer the patient to another medical provider for urgent conditions. Referral to the emergency department for non-emergent medical conditions does not meet this requirement.

Women, Infants, Children Special Supplemental Nutrition Program Referrals

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

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

Transfer of Medical Records

CCNC/CA PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request. The record may not be withheld until costs for copying or other costs related to the transfer of the record are paid by the recipient or requesting provider.

Medical Records Guidelines

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

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

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

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

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

Referrals and Authorizations

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

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

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

Authorization is not required for services provided in an urgent care center billing with a hospital provider number.

Recommendations for referral to a specialist for follow-up care after discharge from any urgent care center must be made to the CCNC/CA primary care provider for their assessment and authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals for routine follow-up care after discharge from a hospital must be made to the PCP. Referrals to a specialist for follow-up care after discharge from a hospital require PCP authorization and should be coordinated through the PCP's office.

Communication between after- hours staff and the PCP is very important. If the after- hours staff refers an enrollee to another health care provider or approves treatment by another provider, the PCP should grant referrals/authorizations for those services as appropriate.

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

Referrals for a Second Opinion

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

When the enrollee disagrees with the PCP's decision regarding referrals for specialty services or other care, the enrollee should be advised of their option to choose a different CCNC/CA primary care provider.

Prior Approval

Carolina ACCESS authorization does not take the place of prior approval mandated in DMA clinical policy.

Referral Documentation

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

Submitting Referral Claims

Claims submitted for reimbursement of a service authorized by a recipient's Carolina ACCESS PCP must include the PCP's referral authorization number. The referral authorization is the PCP's NPI number. Any claim filed with the PCP's Medicaid ID number will deny. The exception is if the PCP is atypical. The PCP's taxonomy number is not required. Refer to **Section 4, National Provider Identifier**, for additional information.

Refer to **Section 9, Submitting Claims**, for timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides, and referring provider information on a claim.

Exempt Services

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

- Ambulance services
- At-risk case management
- Care management provided by the Community Care of North Carolina network
- Community Alternatives Program services
- Dental care

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

- Developmental evaluations
- Emergency department services and inpatient hospital services when admitted from the emergency department. Physician services provided in the inpatient setting still require authorization from the PCP.
- Eye care services [limited to CPT codes 92002, 92004, 92012, 92014, 92015, and 92018 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]
- Family planning (including Norplant)
- Health department services
- Hearing aids (for recipients under the age of 21)
- Hospice
- Independent and hospital lab services
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist

- Services performed in a psychiatric hospitals and psychiatric facilities (see note below)
- Services provided by schools and programs directly billed by the school
- Outpatient behavioral health services provided to recipients age 21 and older.

Note: Outpatient behavioral health services provided to recipients under the age of 21 require a referral from a Carolina ACCESS PCP, or alternatively from a Medicaid-enrolled psychiatrist or the Medicaid utilization review vendor.

Override Requests

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

Authorization for medically necessary services may be obtained from HP Enterprise Services by calling before the service is rendered (1-800-688-6696, option 3, or 919-816-4321). If the service has already been provided, a written override request must be submitted to HP Enterprise Services on the Carolina ACCESS Override Request Form within 6 months of the date of service. Written requests will be evaluated within 30 days of receipt. A copy of the Carolina ACCESS Override Request Form is on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>. Forms that are incomplete or illegible when submitted will be returned.

Medical Exemption Requests

CCNC/CA was established on the premise that patient care is best served by care coordinated through a PCP. However, there may be clinical justification for recipient care to be managed by another physician. In these instances, enrollees may request a medical exemption from participation in CCNC/CA. Depending on the circumstances of the recipient's justification, the length of the exemption may vary. Exemptions are granted for the following medical conditions:

- Terminal illness—the enrollee has a life expectancy of six (6) months or less or is currently a hospice patient
- Major organ transplant
- Chemotherapy or radiation treatment—the enrollee is currently undergoing treatment

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

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

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

- End-stage renal disease

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

Patient Disenrollment

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

- Notify the CCNC/CA enrollee in writing of the disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days' notice. Advise the enrollee to contact his or her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.
- Fax a copy of the disenrollment letter to the Carolina ACCESS contact at the county DSS of the enrollee's resident county. PCPs can check with the Regional Consultant to confirm the correct Carolina ACCESS Coordinator at the county DSS. The disenrollment should be accomplished by the end of the next month.

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

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

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

Community Care of NC/Carolina ACCESS – Frequently Asked Questions

1. Is there a limit to the number of patients that can enroll for in a practice?

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

2. May PCPs change the practice enrollment limit?

PCPs may change enrollment limits or restrictions by completing and submitting a **Medicaid Provider Change Form**. Check the box in Section 1 of the form to indicate that the provider is a Carolina ACCESS provider.

3. How can providers verify that a patient is enrolled with a CCNC/CA provider?

Medicaid eligibility and CCNC/CA enrollment must be verified at each visit. This information must be verified using one of the eligibility verification methods outlined in **Appendix F**

In addition to the verification methods listed in **Appendix F**, enrollment can be verified by checking the current Carolina ACCESS Enrollment Report (CCNC/CA PCPs only).

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

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

5. What if the verified CCNC/CA provider is incorrect?

Advise the patient to contact his or her caseworker or the Medicaid supervisor at the county DSS to request a change to correct the CCNC/CA provider. In most circumstances, the change takes a minimum of 30 days. Changes are typically effective the first day of the month following the month the change is made in the system. If the recipient wants to change their CCNC/CA enrollment to your practice, refer to **Recipient Enrollment** on page 5-4 for information regarding enrolling recipients at the PCP's office. The enrollment form can be accessed from DMA's website at <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm>.

6. Will providers know that the Medicaid Identification card presented contains current information?

No. With implementation of annual Medicaid identification cards, Medicaid providers must verify eligibility and Carolina ACCESS status using another method. Medicaid Recipients receive a new identification card if they change their PCP but Medicaid providers must verify eligibility and Carolina ACCESS status each time services are provided.

7. Are CCNC/CA enrollees responsible for copayments?

CCNC/CA enrollees are subject to the same copayment requirements as fee-for-service Medicaid recipients. Providers may **not** charge copayments for services provided to enrollees under the age of 21, services to enrollees in a Community Alternatives Program, services related to pregnancy, or services covered by both Medicare and Medicaid. Refer to **Copayments in Section 2, Recipient Eligibility**, for complete information.

8. Do all Medicaid-covered services require referral/authorization from the primary care provider?

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

9. What if a CCNC/CA enrollee needs health care that the assigned PCP practice cannot provide?

PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. All referrals must be documented in the enrollee's medical record. Refer to **Carolina ACCESS Referrals and Authorizations** in this section for additional information on coordination of care.

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

A CCNC/CA enrollee may be referred to any specialist or to other health services enrolled with Medicaid. For Carolina ACCESS enrollees, your NPI number must be provided to the specialist or other health service provider as the authorization number. **Please use the NPI that you reported to DMA for the Medicaid Provider Number (MPN) used to link Carolina ACCESS recipients to your practice (refer to the MPN listed on your Carolina ACCESS Enrollment Report).** Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

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

PCPs are contractually required to provide services or authorize another provider to treat the enrollee. PCPs should develop referral or authorization protocols and ensure that all office staff is knowledgeable of the process. All referrals or authorizations must be documented in the enrollee's medical record. In the absence of a medical record, documentation should be made on the CA enrollment report and the referral log. Appointments must be available according to the standards of appointment availability (see **Standards of Appointment Availability** section).

12. What if a CCNC/CA enrollee self-refers to another practice?

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

13. Do CCNC/CA enrollees admitted through the emergency department require authorization from their primary care providers?

Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services provided to Carolina ACCESS enrollees does require authorization.** Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization for Carolina ACCESS enrollees and all referrals should be coordinated with the primary care provider.

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

Refer to **Section 9, Submitting Claims**, for timeframes and requirements for recording Carolina ACCESS referral/authorization numbers, Carolina ACCESS override numbers, and referring provider information on a claim.

15. How do practices receive guidance with questions or obtain additional information regarding Medicaid managed care programs and Community Care of North Carolina?

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

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

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