

**PROCUREMENT CONTRACT FOR PROVISION OF SERVICES  
BETWEEN  
<<LOCAL MANAGEMENT ENTITY/PREPAID INPATIENT HEALTH PLAN  
NAME>>  
(LME/PIHP ACRONYM)  
AND  
NAME OF LICENSED INDEPENDENT PRACTITIONER (Solo or Group)  
\_\_\_Solo Practice \_\_\_Group Practice (check which applies)  
A PROVIDER OF MH/DD/SA SERVICES**

**ARTICLE I:  
GENERAL TERMS AND CONDITIONS**

**1. DEFINITIONS:**

**Any term that is defined in NCGS122C-3 shall have the same definition in this contract unless otherwise specified.**

- a. "Catchment area" Geographic Service Area meaning a defined grouping of counties.
- b. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.
- c. "Contract" means this Procurement Contract for the Provision of Services between the Local Management Entity/ Prepaid Inpatient Health Plan" (LME/PIHP) and Licensed Independent Practitioner (LIP), including any and all Appendices and Attachments.
- d. "Controlling Authority" is defined in Article I, paragraph 4 of this contract.
- e. "Department" means the North Carolina Department of Health and Human Services (DHHS) and includes the Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).
- f. "Emergency services": With respect to an emergency service, covered inpatient and outpatient services that:
  - 1) are furnished by a provider that is qualified to furnish such services; and
  - 2) are needed to evaluate or stabilize an emergency medical condition.
- g. "Enrollee" refers to an individual whose Medicaid or state funding eligibility arises from residency in a county covered by the LME/PIHP or is currently enrolled in LME/PIHP.
- h. A LIP is a professional practitioner in a solo or group practice licensed to provide behavioral health services under the auspices of a licensing board established by the General Statutes of North Carolina including psychiatrists licensed by the NC Medical Board.
- i. An LME/PIHP is the political subdivision organized pursuant to N.C.G.S. §122C-3(20)(3) responsible for authorizing, managing and reimbursing providers for all Medicaid and State-funded mental health, substance abuse, and developmental disability services pursuant to contracts with the Department for those Enrollees within the LME/PIHP defined catchment area.
- j. "Medical Record" means a single complete record, maintained by the Provider of services, which documents all of the treatment plans developed for, and behavioral health services received by, an Enrollee.
- k. "Notice" means a written communication between the parties delivered by trackable mail, electronic means (i.e. E-mail), facsimile or by hand.

- l. "Prepaid Inpatient Health Plan" (PIHP): An entity that: (1) provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and (3) does not have a comprehensive risk contract.
- m. "Provider Operations Manual" refers to the manual approved by the Department and posted on the LME/PIHP website.
- n. "State funded consumer" means an individual who receives Mental Health, Developmental Disabilities and Substance Abuse (MH/DD/SA) services that are paid with State funds (which may include state and/or federal block grant funds).
- o. "Unmanaged Visits" refers to visits not requiring prior authorization.

## **2. BASIC RELATIONSHIP:**

LIP enters into this contract with LME/PIHP for the purpose of providing medically necessary MH/DD/SA services to the LME/PIHP's Enrollee(s) and agrees to comply with Controlling Authority, the conditions set forth in this Contract and all Appendices or Attachments to this Contract. LIP is an independent contractor of LME/PIHP. This Contract is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between the parties, their employees, partners, or agents but rather LIP is an independent contractor of the LME/PIHP. Further, neither party shall be considered an employee or agent of the other for any purpose including but not limited to, compensation for services, employee welfare and pension benefits, workers' compensation insurance, or any other fringe benefits of employment.

## **3. ENTIRE AGREEMENT/ REVISIONS:**

This Contract, consisting of the Procurement Contract for the Provision of Services, and any and all Appendices and Attachments, constitutes the entire Contract between the LME/PIHP and the LIP for the provision of services to Enrollee(s). Except for changes to Controlling Authority published by the Centers for Medicare and Medicaid Services (CMS), the LME/PIHP, the Department, its divisions and/or its fiscal agent as referenced in Article I, Paragraph 4, any alterations, amendments, or modifications in the provision of the Contract shall be in writing, signed by all parties, and attached hereto.

## **4. CONTROLLING AUTHORITY:**

This Contract is required by 42 C.F.R. §438.206 and §438.214 and shall be governed by the following, including any subsequent revisions or amendments thereto, (hereinafter referred to as the "Controlling Authority"):

- a. Title XIX of the Social Security Act and its implementing regulations, N.C.G.S. Chapter 108A, the North Carolina State Plan for Medical Assistance, the North Carolina Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) health plan waiver authorized by CMS pursuant to section 1915(b) of the Act, and the N.C. Home and Community Based Services Innovations waiver authorized by CMS pursuant to section 1915(c) of the Act; and
- b. The federal anti-kickback statute, 42 U.S.C. §1320a-7b (b) and its implementing regulations; the federal False Claims Act, 31 U.S.C. §3729 – 3733 and its implementing regulations; and the North Carolina Medical Providers False Claims Act, N.C. Gen. Stat. §108A-70-10 *et seq.*; and
- c. All federal and state Enrollee's rights and confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards, 45 C.F.R. Part 164, alcohol and drug abuse patient records laws codified at 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2, the Health Information Technology for Economics and Clinical

- Health Act (HITECH Act) adopted as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and those State laws and regulations denominated in Appendix G; and
- d. Regulations concerning access to care, utilization review, clinical studies, utilization management, care management, quality management, disclosure and credentialing activities as set forth in 42 C.F.R. parts 438, 441, 455, and 456; and
  - e. State licensure and certification laws, rules and regulations applicable to LIP; and
  - f. Applicable provisions of Chapter 122C of the North Carolina General Statutes; and
  - g. Medical or clinical coverage policies promulgated by the Department in accordance with N.C.G.S. §108A-54.2; and
  - h. The North Carolina Medicaid and Health Choice Provider Requirements, N.C. Gen. Stat. Ch. 108C.
  - i. The Americans With Disabilities Act, Titles VI and VII of the Civil Rights Act of 1964, Section 503 and 504 of the Vocational Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and subsequent amendments and regulations developed pursuant thereto, to the effect that no person shall, on the grounds of sex, age, race, religious affiliation, handicap, or national origin, be subjected to discrimination in the provision of any services or in employment practices; and
  - j. The Drug Free Workplace Act of 1988; and
  - k. The requirements and reporting obligations related to the Substance Abuse and Treatment Block Grant (SAPTBG), Community Mental Health Services Block Grant (CMHSBG), Social Services Block Grant (SSBG) and accompanying State Maintenance of Effort (MOE) requirements; Projects to Assist in the Transition from Homelessness (PATH) formula grant; Strategic Prevention Framework – State Incentive Grant (SPF-SIG), Safe and Drug Free Schools and Communities Act (SDFSCA), and all other applicable federal grant program funding compliance requirements, if applicable.
  - l. Any other applicable federal or state laws, rules or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid-reimbursable or State-funded MH/DD/SA services.
  - m. The LME/PIHP’s Provider Operations Manual.

LIP agrees to operate and provide services in accordance with Controlling Authority. LIP shall be responsible for keeping abreast of changes to Controlling Authority and to provide education and training to its staff and employees as appropriate. Commensurate with level of operation, LIP shall develop and implement a compliance program in accordance with 42 U.S.C. §1396a (kk) (5).

**5. TERM:**

The term of this Contract shall begin on <<DATE>> day of <<MONTH>>, <<YEAR>>, and shall remain in effect for << NO MORE THAN THREE YEARS>> years from the date of execution, unless terminated by either party prior to the expiration of the specified term in accordance with section 13 of this Contract. The LME/PIHP reserves the right to impose shorter time limits on the term of this Contract should LIP fail to comply with the terms of this Contract. LIP understands that State and Federal statutory and regulatory requirements may be changed or updated during the term of this Contract. The LME/PIHP will provide notice to the LIP thirty (30) days prior to any changes to LME/PIHP manuals or forms. This contract may be terminated at any time upon mutual consent of both parties or after thirty (30) days upon notice of termination by one of the contracting parties.

**6. CHOICE OF LAW/FORUM:**

The validity of this contract and any of its terms and provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The place of this contract and all transactions and agreements relating to it and their sites and forum, shall be the County of North Carolina in which the LME/PIHP’s principal place of business is located, where all matters, whether

sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

**7. HEADINGS:**

The Paragraph headings used herein are for reference and convenience only, and shall not enter into the interpretation hereof. Any appendices, exhibits, schedules referred to herein or attached or to be attached hereto are incorporated herein to the same extent as if set forth in full herein.

**8. COUNTERPARTS:**

The Contract shall be executed in two counterparts, each of which will be deemed an original.

**9. NONWAIVER:**

No covenant, condition, or undertaking contained in the Contract may be waived except by the written agreement of the Parties. Forbearance or indulgence in any other form by either party in regard to any covenant, condition or undertaking to be kept or performed by the other party shall not constitute a waiver thereof, and until complete satisfaction or performance of all such covenants, conditions, and undertakings have been satisfied, the other party shall be entitled to invoke any remedy available under the Contract, despite any such forbearance or indulgence.

**10. DISPUTE RESOLUTION AND APPEALS:**

The LIP may file a complaint and/or appeal as outlined in the LME/PIHP Provider Operations Manual, and promulgated by LME/PIHP pursuant to N.C. Gen. Stat. §122C-151.3 and as provided by N.C.G.S. Chapter 108C.

**11. SEVERABILITY:**

If any one or more provisions of this Agreement are declared invalid or unenforceable, the same shall not affect the validity or enforceability of any other provision of this Agreement and such invalid or unenforceable provision(s) shall be limited or curtailed only to the extent necessary to make such provision valid and enforceable.

**12. NOTICE:**

Any notice to be given under this Contract will be in writing, addressed to the Contract Administrators designated by each party and noted at the address listed below, or such other address as the party may designate by notice to the other party, and will be considered effective upon receipt when delivery is either by trackable mail, postage prepaid, or by electronic means, or by fax, or by hand delivery.

LIP	LME/PIHP
ADDRESS	ADDRESS
PHONE: SAMPLE	PHONE: SAMPLE
FAX: SAMPLE	FAX: SAMPLE
EMAIL: SAMPLE	EMAIL: SAMPLE

**13. TERMINATION:**

The Contract may be terminated under the following circumstances:

- a. Either party may terminate the Contract if Federal, State or local funds allocated to the LME/PIHP are revoked or terminated in a manner beyond the control of the LME/PIHP for any part of the Contract period. If Federal, State, or local funds allocated to the LME/PIHP are reduced in a manner beyond the control of the LME/PIHP, the LME/PIHP will notify LIP and provide payment

to LIP for services provided which were authorized by the LME/PIHP prior to the notification and for which LIP has been qualified and/or credentialed.

- b. Please note that termination of this Contract is not disenrollment from the North Carolina Medical Assistance Plan. Either party may terminate the Contract with cause upon thirty (30) days' written notice to the other party; cause shall be documented in writing detailing the grounds for the termination after providing notice of any grounds for termination and, where feasible, an opportunity to cure any defects. A Plan of Correction may be entered upon the Parties' agreement if not in contradiction with Rule, Statute or other Regulation, and if the parties both agree that the deficiency is likely to be remedied by such a Plan. As required by its contract with DMA, the LME/PIHP shall provide information on its appeal process in its Provider Operations Manual. Cause for termination of the Contract may include, but is not limited to:
  - 1) Failure of either party to implement or provide functions or services as specified in the Contract. Failure to provide timely complete and accurate documentation of services as required by this Contract may lead to withholding of funds or termination of the Contract; and/or
  - 2) The conduct of either party or either party's employees or agents or the standard of services provided threatens to place the health or safety of any Enrollee in jeopardy. Conduct of either party's employee(s) or agent(s) that threatens to place the health or safety of any Enrollee in jeopardy shall not constitute grounds for termination of the entire Contract provided the party takes appropriate action toward said employee(s) or agent(s). Either party maintains its right to terminate this Contract should the other party fail to take appropriate action toward employees or agents whose conduct threatens to place the health or safety of any Enrollee in jeopardy; and/or
  - 3) LIP fails to cooperate with any investigation authorized by Controlling Authority and deemed necessary by the LME/PIHP in regard to LME/PIHP Enrollees; and/or
  - 4) LME/PIHP fails to make payments as established in Article IV, Billing and Reimbursement; and/or
  - 5) LME/PIHP fails to make authorization as established in Article III, 7; and/or
  - 6) LIP fails to reimburse the LME/PIHP for final overpayments identified by the LME/PIHP or fails to comply with payment plans established by the LME/PIHP as outlined in Article IV, Billing and Reimbursement; and/or
  - 7) Any other material breach of this Contract.
- c. LME/PIHP may terminate this Contract immediately without prior written notice in the following circumstances:
  - 1) Loss of LIP's required facility or professional licensure; or
  - 2) The final substantiation and determination by DMA of Medicaid fraud and/or abuse. 42 C.F.R. Part 455 – Program Integrity: Medicaid; 10A NCAAC 22F – Program Integrity, NCGS §108A – 63 Medical assistance provider fraud; 51 FR 34788 and/or any other applicable law, regulation or rule.
- d. This Contract may be terminated at any time upon mutual consent of both parties with mutually agreed upon notice to Enrollees.
- e. The Contract may be terminated without cause after thirty (30) days' notice of termination to either party by one of the contracting parties.
- f. In the event that Federal and State laws should be amended or judicially interpreted so as to render the fulfillment of the Contract on the part of either party unfeasible or impossible, both the LIP and the LME/PIHP shall be discharged from further obligation under the terms of this Contract, except for settlement of the respective debts and claims up to the date of termination.

#### **14. EFFECT OF TERMINATION:**

- a. The obligations of both parties under this Contract shall continue following termination, only as to the terms and conditions outlined in Article II, Paragraphs 4, 5, and 9, Article III, Paragraphs 1, 2, 7 and Article IV.
- b. Upon notice of termination, a post-payment review of billing, documentation and other fiscal records may be performed and any adjustments for amounts due or owed to either party shall be added or deducted from the final Contract payments.
- c. In the event of termination the LIP shall submit all claims or registrations of putative Enrollees within ninety (90) days of the date of termination.
- d. The parties shall settle their respective debts and claims within the timeframes established within Article II, Paragraph 5, Article III, Paragraphs 7, and Article IV.
- e. In the event of any audit or investigation described in Paragraph 14.b. above, both parties shall settle their debts and claims within thirty (30) days of the completion of such audit or investigation and receipt of all final billing and required documentation. All payments provided herein shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination. If advance payments have been made for services not provided as of the date of termination, the LIP shall promptly refund all excess funds paid within the above-referenced thirty (30) days.
- f. Continuity of Care: LIP shall comply with Controlling Authority and provide notice to the LME/PIHP with respect to the closing of an office. A transition plan shall be developed for each enrollee prior to being discharged.

**15. NON-EXCLUSIVE ARRANGEMENT:**

The LME/PIHP has the right to enter into a Contract with any other provider of MH/DD/SA services. The LIP shall have the right to enter into other Contracts with any other LME/PIHP or third party payers to provide MH/DD/SA services. Both parties shall ensure that any subcontractors performing any of the obligations of this Contract shall meet all requirements of the Contract. When a subcontractor meets the URAC definition of a delegated or partially delegated entity, prior approval by the LME/PIHP may be required.

**16. NO THIRD PARTY CONTRACT RIGHTS CONFERRED:**

Nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by any third party, against LME/PIHP, LIP or the Department.

Furthermore, nothing in this Contract shall be construed as creating or justifying any liability, claim or cause of action, however alleged or arising, by LME/PIHP or LIP against the Department.

**ARTICLE II:**  
**RIGHTS AND OBLIGATIONS OF THE LIP CONTRACTOR**

**1. DISCLOSURE:**

- a. The LIP shall make those disclosures to the LME/PIHP as are required to be made to DMA pursuant to 42 C.F.R. §455.104 and 106 and are required by the LME/PIHP accrediting body. LME/PIHP will share accrediting body requirements with LIP upon request.
- b. To the extent any of the above required disclosure information is captured in current or existing Medicare or NC Medicaid enrollment application documentation, the LME/PIHP shall accept electronic or paper copies of such documentation as meeting this requirement. Entities no longer enrolled in Medicaid or Medicare will be required to independently meet all disclosure requirements of this Paragraph, federal and state laws, rules and regulations, and the LME/PIHP accrediting body.

**2. LICENSES, ACCREDITATIONS, CREDENTIALING AND QUALIFICATIONS:**

- a. The LIP shall maintain all licenses, certifications, accreditations and registrations required for its facilities and staff providing services under the Contract as are required by Controlling Authority. "Facilities" means any person at one location whose primary purpose is to provide services for those with mental health, intellectual developmental disability and/or substance abuse needs. N.C.G.S 122C §3 (14). Within ten (10) days after the LIP receives notice of any sanction by any applicable licensing board, certification or registration agency, or accrediting body or other authority which affect the ability of LIP to bill the LME/PIHP for services, the LIP shall forward a copy of the notice to the LME/PIHP.
- b. The LIP shall not bill the LME/PIHP:
  - 1) For any services provided by LIP during any period of revocation or suspension of required licensure or accreditation of the LIP office;
  - 2) For any services provided by a member of the LIP staff during any period of revocation or suspension of the staff member's required certification, licensure, or credentialing.
- c. The LIP certifies that at the time of execution of this Contract that neither LIP nor any of its staff or employees is excluded from participation in Federal Health Care Programs under section 1128 of the Social Security Act and/or 42 C.F.R. Part 1001. Within five (5) business days of notification of exclusion of LIP or any of its staff or employees by the U.S. Office of Inspector General, CMS or any other State Medicaid program, LIP shall notify the LME/PIHP of the exclusion and its plan for compliance.
- d. The LME/PIHP will conduct a re-credentialing of the LIP qualifications to remain in the LME/PIHP's network at a minimum of once every three (3) years in compliance with LME/PIHP accreditation standards and the DMA/LME/PIHP Contract.

**3. EVENT REPORTING AND ABUSE/ NEGLECT/ EXPLOITATION:**

- a. The LIP shall use best efforts to ensure that Enrollee(s) are not abused, neglected or exploited while in its care.
- b. The LIP shall report all events or instances involving abuse, neglect or exploitation of Enrollees as required by incident reporting guidelines by all applicable agencies and the by Controlling Authority.
- c. The LIP shall not use restrictive interventions except as specifically permitted by the individual Enrollees' treatment/habilitation plan or on an emergency basis, as specified in 10A, NCAC, Subchapter 27 E.
- d. The LME/PIHP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines

by the LIP. The LIP shall cooperate with all such investigative requests. Failure to cooperate is a material breach of this contract. The LME/PIHP will provide the LIP a written summary of its findings within 30 days. During such an investigation, if any issues are cited as out of compliance with this Contract or federal or state laws, rules or regulations, the LIP may be required to document and implement a plan of correction.

**4. BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION:**

- a. Unmanaged visits do not require prior authorization. All service delivery, both managed and unmanaged, require documentation and record retention in accordance with this section.
- b. The LIP shall participate in and use best efforts to comply with the LME/PIHP's Utilization Management process, which may include requirements for pre-authorization, concurrent review and care management, credentialing review, and a retrospective utilization review of services provided for Enrollees whose services are reimbursed by the LME/PIHP. The LIP shall provide the LME/PIHP with all necessary clinical information for the LME/PIHP's utilization management process. LIP shall provide specifically denominated clinical or encounter information required by the LME/PIHP to meet State and Federal monitoring requirements within fifteen (15) calendar days of the request, except that LME/PIHP may grant additional time to respond for good cause shown and depending upon the size and scope of the request. Additionally, LIP will provide any documentation directly to the LME/PIHP for review when requested. LIP may satisfy any request for information by either paper or electronic/digital copy.
- c. The LIP shall be responsible for completion of all necessary and customary documentation required for the services provided under the Contract in accordance with all Controlling Authority.
- d. Documentation must support the billing diagnosis, the number of units provided and billed, and the standards of the billing code. The LIP will be responsible for the adoption, assessment, collection, and disposition of fees in accordance with G.S. 122C-146; and
- e. LIP shall maintain all documentation and records supporting Enrollees' medical necessity for the services and shall provide it to the LME/PIHP within fifteen (15) days of requests for program integrity activities, including but not limited to audits, investigations or post-payment reviews, except that LME/PIHP may grant additional time to respond for good cause shown and depending upon the size and scope of the request.
- f. The LIP agrees and understands that the LME/PIHP may inspect financial records concerning claims paid on behalf of Enrollees, records of staff who delivered or supervised the delivery of paid services to Enrollees demonstrating compliance with Controlling Authority, Enrollee's clinical records, and any other clinical or financial items related to the claims paid on behalf of Enrollees deemed necessary to assure compliance with the Contract. LIP is also subject to audits, investigations and post-payment reviews conducted by the United States Department of Health and Human Services, including the Department's Office of Inspector General, CMS and the Department, or their agents. Program integrity activities do not have to be arranged in advance with LIP. The equipment purchased with non unit-cost reimbursement funds, such as start up or special purpose funding, title to assets purchased under the contract in whole or in part rests with the contractor so long as that party continues to provide the services which were supported by the contract; if such services are discontinued, disposition of the assets shall occur as approved by the DHHS.
- g. The LIP shall maintain a medical record and adhere to the federal record retention schedule for each Enrollee served, either in original paper copy or an electronic/digital copy.
- h. LIP agrees to maintain necessary records and accounts related to the Contract, including personnel and financial records in accordance with Generally Accepted Accounting Procedures and Practices to assure a proper accounting of all funds, including budget revisions.
- i. In accordance with Controlling Authority, specifically 42 C.F.R. §420.300 through §420.304, for any contracts for services the cost or value of which is \$10,000 or more over a 12-month period,



including contract for both goods and services in which the service component is worth \$10,000 or more over a 12-month period, the Comptroller General of the United States, Health and Human Services (HHS), and their duly authorized representative shall have access to LIP books, documents, and records until the expiration of four years after the services are furnished under the contract.

- j. The LME/PIHP shall also require LIPs to submit a plan for maintenance and storage of all records for approval by the LME/PIHP or transfer copies of medical records of Enrollees served pursuant to this Contract to the LME/PIHP in the event that the LIP closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state, or any other reason. The LME/PIHP has the sole discretion to approve or disapprove such plan. The LME/PIHP shall not be held liable for any LIP records not stored, maintained or transferred pursuant to this provision so long as it has attempted, in good faith, to obtain a written plan for maintenance and storage or a copy of such records from the LIP. In the event the Contract is terminated between the LME/PIHP and the LIP, and the LIP is still operational in North Carolina, the LIP shall either: 1) provide copies of Medical records of Enrollees to MCO, or 2) submit a plan for maintenance and storage of all records for approval by the LME/PIHP. The LME/PIHP has the sole discretion to approve or disapprove such plan.
- k. The LIP shall make available to the LME/PIHP its accounting records for the purpose of audit by State authorities and that the party will, when required by general statute, have an annual audit by an independent certified public accountant. A copy will be forwarded to the office of the State Auditor and the LME/PIHP.

**5. FRAUD, ABUSE, OVER UTILIZATION AND FINAL OVERPAYMENTS, ASSESSMENTS OR FINES:**

- a. LIP understands that whenever LME/PIHP receives a credible allegation of fraud, abuse, overutilization or questionable billing practice(s), the LME/PIHP is required to investigate the matter and where the allegation(s) proves credible, the LME/PIHP is required to provide DMA with the provider name, type of provider, source of the complaint, and approximate dollars involved. LIP agrees to cooperate in any such investigation and failure to do so, may result in possible sanction up to and including termination of this contract. LIP understands that the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office or DMA, at their discretion, may conduct preliminary or full investigations to evaluate the suspected fraud, abuse, over utilization or questionable billing practice(s) and the need for further action, if any. Fraudulent billing may include, but is not limited to, unbundling services, billing for services by non-credentialed or non-licensed staff, or billing for a service that LIP never rendered or for which documentation is absent or inadequate.
- b. If the LME/PIHP determines LIP has failed to comply with Controlling Authority and has been reimbursed for a claim or a portion of a claim that the LME/PIHP determines should be disallowed, or that LIP has been paid for a claim that was fraudulently billed to the LME/PIHP, the LME/PIHP will provide thirty (30) days' notice to the LIP of the intent to recoup funds. Such notice of adverse action shall identify the Enrollee(s) name and date(s) of service in question, the specific determination made by the LME/PIHP as to each claim, and the requested amount of repayment due to the LME/PIHP. LIP shall have thirty (30) days from date of such notification to either appeal the determination of the LME/PIHP or to remit the invoiced amount.
- c. If the LME/PIHP or LIP determines that the LIP has received payment from the LME/PIHP as a result of an error or omission, the LME/PIHP will provide thirty (30) days' notice to the LIP of its intent to recoup funds related to errors or omissions. The LME/PIHP will provide an invoice to the LIP including the Enrollee(s) name and date(s) of service in question. LIP shall have thirty (30) days from date of such notification to either appeal the determination of the LME/PIHP or to remit the invoiced amount.

- d. Requests for Reconsideration by the LIP and appeals of audit determinations are as defined by Controlling Authority and as outlined in the Provider Operations Manual, and promulgated by LME/PIHP pursuant to N.C. Gen. Stat. §122C-151.3 and Chapters 108C and 150B of the North Carolina General Statutes.
- e. LIP understands and agrees that self-audits are encouraged by the LME/PIHP.

**6. FEDERALLY REQUIRED CERTIFICATIONS:**

The LIP shall execute and comply with the attached federally required certifications, as follows:

- a. Environmental Tobacco Smoke – Certification for Contracts, Grants, Loans and Cooperative Agreements,
- b. Lobbying – Certification for Contracts, Grants, Loans and Cooperative Agreements,
- c. Drug-Free Workplace Requirements, and
- d. Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions.

**7. ENROLLEE GRIEVANCES:**

- a. The LIP shall address all clinical concerns of the Enrollee as related to the clinical services provided to the Enrollee pursuant to this contract. LIP shall refer any unresolved concerns or requests to the LME/PIHP. In accordance with 10A NCAC 27G .0201(a)(18), the LIP shall have in place a written policy for a Complaint and Grievance Process and a procedure for review and disposition of client grievances. The process must be accessible to all Enrollees and operates in a fair and impartial fashion.
- b. The LME/PIHP may receive complaints directly, which involve the LIP. If a complaint is received by the LME/PIHP, State rules/regulations regarding the investigation and/or mediation of complaints will be followed. Based on the nature of the complaint, the LME/PIHP may choose to investigate the complaint, as authorized by Controlling Authority, in order to determine its validity. LIP will be required to cooperate fully with all investigative requests as required by Controlling Authority. Failure to cooperate is a material breach of this contract.
- c. The LME/PIHP will maintain documentation on all follow up and findings of any complaint investigation. The LIP will be provided a written summary of the LME/PIHP's findings upon completion of the investigation.
- d. The LIP will maintain a system to receive and respond timely to complaints received regarding the LIP. The LIP will maintain documentation on the complaint to include, at a minimum, date received, points of complaint, resolution/follow up provided, and date complaint resolved.

**8. TERMINATION OF LIP SERVICES:**

For purposes of this contract, discharge is considered termination of service by the LIP. The LIP shall notify the LME/PIHP of termination of service within seven (7) days of the termination. The LIP will work with the LME/PIHP on coordination of care for any continuing services when necessary. LIP shall provide information pertinent to the development of an Individual Service Plan (ISP) for persons with Intellectual or other Developmental Disabilities, and a Person-Centered Plan (PCP) for persons with a Mental Health or Substance Abuse Disorder, or shall directly participate in the planning process.

**9. PROPRIETARY INFORMATION AND INTELLECTUAL PROPERTY:**

Neither the LIP nor the LME/PIHP shall publish or disseminate any advertising or proprietary business material either printed or electronically transmitted (including photographs, films, and public announcements) or any business papers and documents which identify the other party or its facilities without the prior written consent of the other party. Any documents, reports, or other products, with the exception of any and all proprietary business papers and documents, developed in connection with the performance of the Contract, shall be in the public domain and shall not be copyrighted or marketed for profit by the LIP/ the LME/PIHP, any individual, or other entity; provided, however, that medical

records, business records, and any other records related to the provision of care to and billing of patients shall not be in the public domain. The LME/PIHP acknowledges in advance that any documents or data concerning administrative costs and all other expenses submitted by LIP pursuant to this Contract are restricted as confidential trade secrets pursuant to a request per N.C. Gen. Stat. §132-1.2. LIP consents to the use of its demographics, including practice specialties, phone numbers and addresses, in the LME/PIHP provider directory listings.

**10. CONFIDENTIALITY:**

For some purposes of the Contract (other than treatment purposes) the LIP may be considered a “Business Associate” of the LME/PIHP as defined under HIPAA and as such will comply with all applicable HIPAA regulations for Business Associates as further expanded by the HITECH Act) which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as “ARRA” (Public Law 111-5). Pursuant to Controlling Authority, specifically 45 C.F.R. § 164.506, LIP and LME/PIHP may share an Enrollee’s protected health information (PHI) for the purposes of treatment, payment, or health care operations without the Enrollee’s consent. The nature of the relationship with the Licensed Independent Practitioner dictates whether a Business Associate Agreement is legally required. Each LME/PIHP is responsible for determining whether or not a Business Associate Agreement is necessary with its Licensed Independent Practitioner.

**11. HOURS OF OPERATION:**

If the LIP has a state funded contract with the LME/PIHP the LIP shall offer for State funded consumers, at a minimum, hours of operation that are no less than the hours of operation offered to Medicaid recipients.

**12. ADVOCACY FOR ENROLLEES:**

During the effective period of this contract, the LIP shall not be restricted from communicating freely with, providing information to, or advocating for, Enrollees regarding the Enrollees’ mental health, developmental disabilities, or substance abuse care needs, medical needs, and treatment options regardless of benefit coverage limitations.

**13. RESTRICTIONS ON THE EXPENDITURE OF SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SAPTBG) FUNDS, COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (CMHSBG) FUNDS AND PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) FUNDS:**

- a. CMHSBG funds shall not be used to provide inpatient services;
- b. SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except that SAPTBG funds may be used with the exception as described in 45 CFR 96.135 (c), along with documentation of the receipt of prior written approval of the DMHDDSAS Director of Financial Operations and the Chief of Addictions and Management Operations;
- c. SAPTBG and Mental Health Block Grant (MHBG) funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or behavioral health services. The provision of cash or cash cards is strictly prohibited, as is the provision of gift cards, which are considered to be cash equivalents.
- d. SAPTBG and MHBG Funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment;
- e. SAPTBG and MHBG Funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any state, local or other funding match requirement);

- f. SAPTBG and MHBG Funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity;
- g. SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs;
- h. SATBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, holding facilities, etc.);
- i. SAPTBG and MHBG Funds are prohibited to be used towards the annual salary of any contractor or subcontractor, including the Local Management Entity-Managed Care Organization (LME-MCO), provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule;
- j. Agencies or organizations receiving federal funds are required to receive prior written approval from the Chief of the Addictions and Management Operations Section regarding the use of evidence-based program incentives, including the specification of the type(s) and equivalent dollar value(s) of any such nominal incentives offered, and the manner of utilization of any such approved incentives for clients, recipients, students, or other persons. "Nominal incentives" are restricted to those of no more than twenty-five dollars (\$25.00) in value per recipient, per event. Programs are strictly prohibited from utilizing any incentive items that could potentially be converted to cash, or that could be used for the purchase of any age-restricted product, such as tobacco, alcohol, drugs, weapons, or lottery tickets or any sexually oriented materials.
- k. Federal funds shall not be utilized for law enforcement activities;
- l. No part of any federal funding shall be used for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any state legislative body itself;
- m. No part of any federal funding shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any state legislature.
- n. PATH formula grant funds shall not be expended:
  - 1) to support emergency shelters or construction of housing facilities;
  - 2) for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
  - 3) to make cash payments to intended recipients of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

#### **14. RESPONSE TO SURVIVORS OF DISASTERS AND OTHER HAZARDS:**

If designated by LME/PIHP, CONTRACTOR providing MH/DD/SA services paid for with State and/or federal block grant funds, under the direction of the LME/PIHP and in coordination with the local Emergency Management agency(ies) shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by the LME/PIHP. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/teletypewriter (TTY) machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g. The Federal Emergency Management Agency (FEMA) Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities and/or substance abuse services CONTRACTORS behavioral health disaster responders shall refer such persons in need to the LME/PIHP or its designee for further assistance.

#### **15. CLINICAL OUTCOME MEASURES:**

LIP providing MH/DD/SA services paid for with Medicaid, State, and/or federal block grant funds shall complete DHHS required outcomes assessments on clients in accordance with DHHS guidelines and any subsequent changes thereto, including, but not limited to:

- a. submission of NC Treatment Outcomes and Program Performance System (NC-TOPPS) data for individuals receiving mental health or substance abuse services, as specified in the NC-TOPPS Guidelines, Appendix F, and any subsequent changes thereto;
- b. collection of outcome data for special populations such as consumers transitioning from residential facilities as a result of the 2012 U.S. Department of Justice Settlement Agreement with the State of North Carolina in accordance with the guidelines and the age and disability appropriate outcome instruments defined by the LME/PIHP; and
- c. participation in surveys of provider staff and consumers conducted by DHHS and LME/PIHP in accordance with DHHS guidelines and any subsequent changes thereto.

**16. INSURANCE:**

LME/PIHP shall require all Network Providers to obtain and continuously maintain the following, if applicable in amounts that equal or exceed the limits established by LME/PIHP, which may include exception criteria to ensure adequate access to the services covered under this Contract:

- a. General Liability Insurance;
- b. Automobile Liability Insurance;
- c. Worker's Compensation Insurance;
- d. Employer's Liability Insurance; and
- e. Professional Liability Insurance;

Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain Automobile Liability Insurance. LME/PIHP shall review its insurance limits annually and revise them as needed. LME/PIHP shall require all Network Providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the carrier gives 30-days prior written notice to LME/PIHP. LME/PIHP shall require Network Providers to submit certificates of coverage to LME/PIHP. Upon DMA's request, LME/PIHP shall submit copies of these certificates to DMA.

**ARTICLE III:**  
**RIGHTS AND OBLIGATIONS OF THE LME/PIHP**

**1. REIMBURSEMENT:**

- a. The LME/PIHP shall reimburse LIP for services to Enrollees according to the terms and conditions outlined in Article IV of this contract and as authorized by the LME/PIHP, except in those instances where treatment authorization is not required (unmanaged visits).
- b. Any changes to reimbursement shall be in writing to LIP thirty (30) days prior to such change based on the availability of the various types of funds.

**2. CONFIDENTIALITY:**

- a. If the LIP discloses confidential information, as that term is defined in G.S. § 132-1.2, to the LME/PIHP in connection with the LIP's performance of this contract, the LME/PIHP can protect the information from public disclosure to the extent permitted by G.S. § 132-1.2, if the LIP takes one or more of the following steps before disclosing the confidential information to the LME/PIHP. If the LIP determines that all of the information on any given document constitutes trade secret information, as that term is defined in G.S. § 66-152(3), the LIP may designate the entire page as confidential by marking the top and bottom of the page with the word "CONFIDENTIAL" in upper-case bold-face type. If the LIP determines that any given page of a document contains a mixture of trade secrets and non-confidential information, the LIP may highlight the trade secrets and indicate in the margins that the highlighted text constitutes a confidential trade secret. By so marking any page, the LIP warrants that it has formed a good faith opinion, upon advice of counsel or other knowledgeable advisors, that the items marked confidential meet the requirements of G.S. §§ 66-152(3) and 132-1.2(1). Note that 1 NCAC 5B .1501 and 9 NCAC 6B .1001 specify that price information may not be designated as confidential.
- b. The LME/PIHP may serve as the custodian of the LIP's trade secrets but not as an arbiter of claims against the LIP's assertion of confidentiality. If an action is brought pursuant to G.S. § 132-9 to compel the LME/PIHP to disclose information marked confidential, the LIP agrees that it will intervene in the action through counsel and participate in defending the LME/PIHP, and NC DHHS and its officials and employees against the action. The LIP agrees that it shall hold the State and its employees, officials, and agents and the LME/PIHP and its officials and employees harmless from any and all damages, costs, and attorneys' fees awarded against the LME/PIHP or the State in the action. The LME/PIHP agrees to give the LIP prompt written notice of any action seeking to compel the disclosure of LIP's trade secrets. The LME/PIHP and the State shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The LME/PIHP and the State shall have no liability to LIP with respect to the disclosure of LIP's trade secrets pursuant to an order issued by a court of competent jurisdiction pursuant to G.S. § 132-9 or any other applicable law.

**3. REFERRALS TO CONTRACTOR:**

The LME/PIHP may refer enrollees to LIP for services based on medical necessity and the Enrollee's individual choice. The LME/PIHP reserves the right to refer Enrollees to other providers, and no referrals or authorizations are guaranteed to take place under this Contract.

**4. UTILIZATION MONITORING:**

The LME/PIHP shall monitor and review service utilization data related to the LIP and the LME/PIHP's Provider Network to ensure that services are being provided in a manner consistent with Controlling Authority and the LME/PIHP's agreements with the Department.

**5. QUALITY ASSURANCE AND QUALITY IMPROVEMENT:**

The LME/PIHP shall establish a written program for Quality Assessment and Performance Improvement in accordance with 42 C.F.R. §438.240 that shall include Enrollees, family members and providers through a Global Quality Assurance Committee, and the LME/PIHP shall:

- a. Provide LIP with a copy of the current program and any subsequent changes within thirty (30) days of changes to the Global Quality Assurance Plan.
- b. Measure the performance of LIP's and Enrollee specific outcomes from service provisions based on the global CQI performance indicators. Examples include, but are not limited to, conducting peer review activities such as identification of practices that do not meet standards, recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by providers.
- c. Measure LIP's performance through medical record audits and clinical outcomes agreed upon by both parties.
- d. Monitor the quality and appropriateness of care furnished to Enrollees and assure compliance with the rules established by the Mental Health Commission, the Secretary of DHHS and G.S. 122C-142.
- e. Provide performance feedback to providers including clinical standards and the LME/PIHP expectations.
- f. Follow up with LIP concerning grievances reported to LME/PIHP by Enrollees.
- g. Provide data about individual Enrollees for research and study to the LIP based on the parameters set by the LME/PIHP.

**6. CARE MANAGEMENT/ COORDINATION OF CARE:**

- a. Where services are provided by other entities, the LME/PIHP shall ensure the coordination of care with each Enrollees' primary care provider and any behavioral health provider enrolled to provide care for each Enrollee. LME/PIHP shall coordinate the discharge of Enrollees with LIP to ensure that appropriate services have been arranged following discharge and to link Enrollee with other providers or community assistance. The LIP will make best efforts to collaborate with LME/PIHP Care Management/Care Coordination, primary care physicians and other services providers.
- b. If an Enrollee requires medically necessary MH/DD/SA services, the LME/PIHP shall arrange for Medicaid-reimbursable services for the Enrollee.

**7. AUTHORIZATION OF SERVICES:**

- a. Except for unmanaged visits that do not require prior authorization, the LME/PIHP shall determine medical necessity for those services requiring prior authorization as set forth in Controlling Authority, including DMA Clinical Coverage Policies.
- b. For those services requiring prior authorization, the LME/PHIP shall issue a decision to approve or deny a service within fourteen (14) calendar days after receipt of the request, provided that the deadline may be extended for up to fourteen (14) additional calendar days if:
  - 1) The Enrollee requests the extension; or
  - 2) The LIP requests the extension; or,
  - 3) The LME/PIHP justifies to the Department upon request:
    - A. A need for additional information; and
    - B. How the extension is in the Enrollee's interest.
- c. In those cases for services requiring prior authorization in which LIP indicates, or LME/PIHP determines, that adherence to the standard timeframe could seriously jeopardize a Enrollee' life or health or ability to attain, maintain, or regain maximum function, including but not limited to psychiatric inpatient hospitalization services, LME/PIHP shall issue a decision to approve or deny a service within three calendar days after it receives the request for services, provided that the deadline may be extended for up to fourteen additional calendar days if:
  - 1) The Enrollee requests the extension; or

- 2) The LME/PIHP justifies to the Department upon request:
  - A. A need for additional information; and
  - B. How the extension is in the Enrollee's interest.
- d. For those services requiring prior authorization, the LME/PIHP shall permit retroactive authorization of such services in instances where the Enrollee has been retroactively enrolled in the Medicaid program or in the LME/PIHP program, or where the Enrollee has primary insurance which has not yet paid or denied its claim. Retroactive authorizations include requests for deceased Enrollees. The request for authorization must be submitted within ninety (90) days of primary denial or notice of enrollment.
- e. Upon the denial of a requested authorization, the LME/PIHP shall inform Enrollee's attending physician or ordering provider of the availability of a peer to peer conversation, to be conducted within one business day.
- f. For appeal information, please refer to the LME/PIHP Provider Operations Manual.
- g. In conducting prior authorization, LME/PIHP shall not require LIP to resubmit any data or documents previously provided to LME/PIHP for the Enrollee's presently authorized services.



**ARTICLE IV:**  
**BILLING AND REIMBURSEMENT**

1. It is the LIP's responsibility to verify the Enrollee's Medicaid coverage prior to submitting claims to the LME/PIHP. If an individual presents for services who is not eligible for Medicaid and the LIP reasonably believes that the individual meets Medicaid financial eligibility requirements, LIP shall refer the Individual to Division of Social Services to apply for Medicaid.
2. The LME/PIHP Medicaid reimbursement rate can be revised unilaterally by the Department at any time. The LME/PIHP may unilaterally revise reimbursement rates under this contract with 30 days' notice.
3. LIP shall comply with all terms of this Contract even though a third party agent may be involved in billing the claims to the LME/PIHP. It is a material breach of the Contract to assign the right to payment under this Contract to a third party in violation of Controlling Authority, specifically 42 C.F.R. §447.10.
4. LIP acknowledges that the LME/PIHP and this Contract covers only those Medicaid-reimbursable MH/DD/SA services listed in Attachment A, and does not cover other services outlined in the North Carolina State Plan for Medical Assistance. The LIP may bill any such other services for Medicaid recipients directly to the North Carolina Medicaid program.
5. LIP further understands that there are circumstances that may cause an Enrollee to be disenrolled from or by the LME/PIHP. If the disenrollment arises from Enrollee's loss of Medicaid eligibility, the LME/PIHP shall be responsible for claims for the Enrollee up to and including the Enrollee's last day of eligibility. If the disenrollment arises from a change in the Enrollee's Medicaid county of residence, LME/PIHP shall be responsible for claims for Enrollee up to the effective date of date of the change in Medicaid county of residence. In any instance of Enrollee's disenrollment, preexisting authorizations will remain valid for any services actually rendered prior to the date of disenrollment. It is the LIP's responsibility to verify Medicaid eligibility at every appointment for service.
6. LIP shall bill LME/ PIHP for all MH/DD/SA services as listed in Attachment A provided to Enrollees who reside in the LME/PIHP catchment area.
7. Unless otherwise indicated, LME/PIHP will pay LIP the lesser of the LIP's current usual and customary charges or the LME- PIHP established rate for services.
8. **SUBMISSION OF CLAIMS:**
  - a. Claims must be submitted to the LME/PIHP electronically either through HIPAA Compliant 5010 EDI Transaction Sets: 837P – Professional claims, 837I – Institutional claims, or through direct data entry in the LME/PIHP's secure web based claims system. The LIP will receive from the LME/PIHP a HIPAA Compliant 5010 EDI Transaction Sets: 835 – Remittance advice and/or a Remittance Advice can be generated directly from the secure web based claims system.
  - b. LIP's claims shall be compliant with the National Correct Coding Initiative effective at the date of service.
  - c. Both parties shall be compliant with the requirements of the National Uniform Billing Committee.
  - d. Claims for services must be submitted within ninety (90) days of the date of service except in the instances denominated in subparagraph 8.e. below. All claims submitted past ninety (90) days of the date of service or discharge (whichever is later) will be denied and cannot be resubmitted except in the instances denominated in subparagraph 8.e. and f. below. LME/PIHP is not responsible for

processing or payment of claims that are submitted more than ninety (90) days after the date of service or discharge (whichever is later) except in the instances denominated in subparagraph 8.e. and f. below. The date of receipt is the date the LME/PIHP receives the claim, as indicated on the electronic data records.

- e. If LIP delays claims due to the subrogation of benefits or the determination of eligibility for benefits for the Enrollee, LIP shall submit claims to the LME/PIHP within ninety (90) days of receipt of notice by the LIP of the Enrollee's eligibility for Medicaid.
- f. If LIP delays submission of the claims due to the coordination of benefits, subrogation of benefits or the determination of eligibility for benefits for the Enrollee, LIP shall submit such claims within ninety (90) days from the notice of determination of coverage or payment by the third party up to 180 days from date of service.
- g. If a claim is denied for reasons other than those stated above in subparagraph 8.e. and f., and the LIP wishes to resubmit the denied claim with additional information, LIP must resubmit the claim within ninety (90) days after LIP's receipt of the denial. If the LIP needs more than ninety (90) days to resubmit a denied claim, LIP must request and receive an extension from the LME/PIHP before the expiration of the ninety (90) deadline, such extension not to be unreasonably withheld.
- h. All claims shall be adjudicated as outlined in the Provider Operations Manual and Chapter 108C of the North Carolina General Statutes.
- i. Billing Diagnosis submitted on claims must be consistent with the service provided.
- j. If a specific service (as denominated by specific identifying codes such as CPT or HCPCS) is rendered multiple times in a single day to the same Enrollee, the specific service may be billed as the aggregate of the units delivered rather than as separate line items.

## **9. PAYMENT OF CLAIMS:**

- a. LME/PIHP shall reimburse LIP for approved Clean Claims for covered services requiring prior authorization within thirty days (30) of the date of receipt of the claim. Clean claims for emergency services which do not require prior authorization shall be reimbursed within thirty days of the date of receipt.
- b. Within eighteen (18) days after the LME/PIHP receives a claim from LIP, the LME/PIHP shall either: (1) approve payment of the claim, (2) deny payment of the claim, or (3) request additional information that is required for making an approval or denial.
  - 1) If the LME/PIHP denies payment of a claim the LME/PIHP shall provide LIP the ability to electronically access the specific denial reason.
  - 2) "Claims Status" of a claim shall be available within five to seven (5-7) days of the LME/PIHP receiving the claim.
  - 3) If the LME/PIHP determines that additional information in either original or certified copy form is required for making the approval or denial of the claim, LME/PIHP shall notify the LIP within eighteen (18) days after the LME/PIHP received the claim. The LIP shall have fifteen (15) days to provide the additional information requested, or the claim shall be denied. Upon LME/PIHP receipt of the additional information from the LIP, the LME/PIHP shall have an additional eighteen (18) days to process the claim as set forth in Paragraph 2, above.
  - 4) The LME/PIHP is not limited to approving a claim in full or requesting additional information for the entire claim. Rather, as appropriate, the LME/PIHP may approve a claim in part, deny a claim in part, and/or request additional information for only a part of the claim, as long as the LME/PIHP either approves, denies, or requests additional information for each part of the claim within the required eighteen (18) day period.
  - 5) If LME/PIHP fails to pay LIP within these parameters, LME/PIHP shall pay to LIP interest in the amount of eight percent of the claim amount beginning on the date following the day on which the payment should have been made.

- c. The LME/PIHP will not reimburse LIP for services provided by staff not meeting licensure, certification, credentialing or accreditation requirements.
- d. LIP understands and agrees that reimbursement rates paid under this Contract are established by the LME/PIHP.

**10. THIRD PARTY REIMBURSEMENT:**

- a. LIP will comply with N.C.G.S. §122C-146, which requires the LME/PIHP to make every reasonable effort to collect payments from third party payors. Each time an Enrollee receives services, LIP shall determine if the Enrollee has third party coverage that covers the service provided.
- b. LIP is required to bill all applicable third party payors prior to billing the LME/PIHP.
  - 1) Medicaid benefits payable through the LME/PIHP are secondary to benefits payable by a primary payer, including Medicare, even if the primary payer states that its benefits are secondary to Medicaid benefits or otherwise limits its payments to Medicaid Enrollees.
  - 2) The LME/PIHP makes secondary payments to supplement the primary payment if the primary payment is less than the lesser of the usual and customary charges for the service or the rate established by the LME/PIHP.
  - 3) The LME/PIHP does not make a secondary payment if the LIP is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.
  - 4) If LIP or Enrollee receives a reduced primary payment because of failure to file a proper claim with the primary payor, the LME/PIHP secondary payment may not exceed the amount that would have been payable if the primary payer had paid on the basis of a proper claim.
  - 5) LIP must inform the LME/PIHP that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.
- c. LIP shall bill the LME/PIHP for third party co-pays and/or deductibles only as permitted by Controlling Authority.

**11. UNDERPAYMENT/PAYMENTS POST APPEALS:**

- a. If the LME/PIHP determines that LIP has not been paid a claim or a portion of a claim that the LME/PIHP determines should be allowed for any reason, the LME/PIHP shall provide thirty (30) days' notice to the LIP of the intent to pay the claims or portions of claims. Such notice of action shall identify the Enrollee(s) name and date(s) of service in question, the specific determination made by the LME/PIHP as to each claim, and the amount of payment due to the LIP. LIP shall have thirty (30) days from date of such notification to appeal the determination of the LME/PIHP. The LME/PIHP shall make such payment within thirty (30) days of the date of the notice of intent to pay claims or portions of claims.
- b. Within thirty (30) days of the conclusion of any grievance, appeal or litigation that determines that LME/PIHP improperly failed to pay a claim or a portion of a claim to LIP, the LME/PIHP shall remit the amount determined to be owed to LIP.

**REQUIRED APPENDICES/ATTACHMENTS:**

\_\_\_\_\_ **Appendix A Certification Regarding Environmental Tobacco Smoke**

\_\_\_\_\_ **Appendix B Certification Regarding Lobbying**

\_\_\_\_\_ **Appendix C Certification Regarding Drug-Free Workplace Requirements**

\_\_\_\_\_ **Appendix D Certification Regarding Debarment, Suspension, Ineligibility and  
Voluntary Exclusion-Lower Tier Covered Transactions**

\_\_\_\_\_ **Appendix E Outcomes and Reporting Requirements**

\_\_\_\_\_ **Appendix F Mixed Services Payment Protocol**

\_\_\_\_\_ **Appendix G Provider Specialty Practice Information**

\_\_\_\_\_ **Attachment A Contracted Services and Qualified/Approved Sites**

\_\_\_\_\_ **Attachment B Provider Disclosure Form**

REMAINDER OF PAGE BLANK

*Signature Page Between:*

**LME/PIHP Name**

**And**

**SAMPLE**

---

**IN WITNESS WHEREOF, each party has caused this agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind LIP to the terms of this Contract and any Addendums or Attachments thereto.**

**LME/PIHP**

\_\_\_\_\_  
Legally Authorized Representative

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

Title: \_\_\_\_\_

LME/PIHP: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

\_\_\_\_\_  
LME/PIHP Legally Authorized Representative      Date  
Chief Financial Officer

\_\_\_\_\_  
Licensed Independent Practitioner  
Legally Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and Title Above

SAMPLE SAMPLE

SAMPLE

SAMPLE

SAMPLE, NC SAMPLE

Federal ID or SS #: SAMPLE

NPI #: SAMPLE

Agreement Contact: SAMPLE SAMPLE

Telephone Number: SAMPLE