

# Chapter Two

## Hospital Provider Information

### Chapter Overview

**Introduction** This chapter gives information on the qualifications and requirements of hospital providers, how to enroll in the Medicaid program, and how to report changes in provider information.

**In This Chapter** This chapter covers the following topics:

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### Qualifications for Enrollment

**Licensure** The facility must be licensed by the North Carolina Division of Facility Services (DFS) as a hospital (general or psychiatric) or by the hospital’s state agency charged with licensure if the hospital is located outside North Carolina borders.

**Certification** The hospital must be certified for participation in Medicare and Medicaid to be enrolled as a Medicaid provider.

<b>Swing Bed Policy</b>	Hospitals enrolled by the Medicaid program as swing bed providers of long-term care services must meet all state and federal requirements governing hospitals, as well as the requirements governing long-term care facilities, 42 CFR 482.66.
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### Qualifications for Enrollment, Continued

<p><b>Swing Bed Policy,</b> (continued)</p>	<p><b>Eligibility:</b> A hospital must meet the following eligibility requirements:</p> <ul style="list-style-type: none"> <li>• The facility has fewer than 100 hospital beds, excluding beds for newborns and bed in intensive care type inpatient units</li> <li>• The hospital is located in a rural area. This includes all areas not delineated as “urbanized” areas by the Census Bureau based on the most recent census</li> <li>• The hospital has been granted a certificate of need for the provision of long-term care services from the state</li> <li>• The hospital does not have in effect a 24-hour nursing waiver</li> <li>• The hospital has not had a swing-bed approval terminated within the two (2) years previous to application</li> <li>• A hospital with more than 49 beds, but fewer than 100, approved after March 31, 1988 must -             <ul style="list-style-type: none"> <li>• Unless a Medicare-participating skilled nursing facility (SNF) is not available, or the SNFs are not willing to enter into an agreement when one is offered, have an availability agreement with each SNF in its geographic region that requires the SNF to notify the hospital of the availability of posthospital SNF care beds and the dates when those beds will be available; and</li> <li>• Transfer the extended care patient within five (5) days (excluding weekends and holidays) after learning that a SNF bed is available or in the case of prospective notification by the SNF, within five (5) days of the date the bed becomes available, unless the patient’s physician certifies that the transfer is not medically appropriate</li> </ul> </li> <li>• The hospital must provide written assurance to HCFA that the hospital will not operate over 49 or over 99 beds except in connection with a catastrophic event. The hospital bed count is determined as follows:             <ul style="list-style-type: none"> <li>• A hospital bed count is calculated by excluding from the count beds that because of their special nature, such as newborn and intensive care beds, would not be available for swing-bed use. Also excluded are beds separately certified as “distinct part” SNFs and NFs, and beds in a psychiatric or rehabilitation unit that is excluded from the prospective payment system</li> <li>• A hospital licensed for more than 49 or 99 beds is considered to have the number of beds that it consistently utilizes and staffs. Hospitals at a minimum document their count by staffing schedules and census information for the previous 12 months before application to be a swing-bed hospital</li> </ul> </li> </ul> <p><b>Skilled Nursing Facility Services:</b> The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter.</p> <ul style="list-style-type: none"> <li>• Resident rights 483.10 (b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (1), and (m)</li> <li>• Admission, transfer and discharge rights 483.12 (a)(1), (a)(2), (a)(3), (a)(4), (a)(5), (a)(6), and (a)(7)</li> <li>• Resident behavior and facility practices 483.13</li> <li>• Patient activities 483.15 (f)</li> <li>• Social Services 483.15 (g)</li> <li>• discharge planning 483.20 (e)</li> <li>• Specialized rehabilitative services 483.45</li> <li>• Dental services 483.55</li> </ul>
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**Qualifications for Enrollment, Continued**



**Conditions of Participation, Continued**

**Utilization Review**

All Medicaid enrolled hospitals, including psychiatric and rehabilitation hospitals, must have in effect a written utilization review (UR) plan as well as a discharge planning process for recipients that has been approved by the state Medicaid agency (DMA) before implementation. UR plans should be submitted when there are changes in hospital operation (e.g. hospital name changes, changes in ownership, increases/decreases in specialty beds).

Hospitals must complete the necessary treatment and discharge the patient from acute care in the minimum number of days consistent with good medical practice. Charges for unnecessary days of care may not be collected from the Medicaid program, patients, or family of the patients except when the patient or his family elects not to accept an alternate placement determined to be appropriate by the attending physician and consistent with UR requirements. Review information, including review dates, should be entered into the UR record and the recipient's medical record.

42 CFR §456 subpart C (See Appendix E) details the requirements for control of utilization of inpatient hospital services, including requirements concerning certification of need of care, plan of care, and utilization review plans.

**Documentation**

The hospital must keep any records necessary to disclose the extent of Medicaid services furnished to recipients and any information regarding claim payments for a period of not less than five years from the date of services rendered, unless a longer retention period is required by applicable federal or state law, regulations, or agreements. These records must be furnished upon request to the appropriate state or federal authorities.

**Disclosure of Information**

The hospital must comply with the requirements of the Social Security Act and federal regulations concerning:

- disclosure by providers (other than an individual practitioner or group of practitioners) of ownership and control information
- disclosure of information of a hospital's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the Title XX program

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**Conditions of Participation, Continued**

**Payment in Full**

The hospital must agree to accept as payment in full the amounts paid by the North Carolina Medicaid Program plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. The hospital may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) or 42 CFR 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge. (42 CFR §447.15)

Each provider makes a determination whether or not to accept an individual Medicaid recipient for treatment. Agreement to treat that individual may not require a copayment for services, but the provider must accept payment by the NC Medicaid agency (Division of Medical Assistance, DMA) as payment in full. Services excluded from copayment include but are not limited to: persons under age 21, services related to pregnancy, family planning, hospital inpatient and emergency room services. A provider enrolled as a NC Medicaid provider **cannot**, under federal law, demand these additional payments. See Recipient Billing block under "Provider Responsibilities."

DMA may place appropriate limits on a service based on medical necessity or utilization control criteria (42 CFR 440.230(d)). If providers do not accept a particular patient for treatment, the hospital has the responsibility of assuring delivery of these medically necessary services.

**Reassignment of Claims/ Payments**

Medicaid payments are made only to:

- The enrolled provider who renders the services billed, or
- A business agent that furnishes statements and receives payments in the name of the provider. The agent's compensation must be related to the cost of processing the billing; it cannot be based on a percentage or other non-cost basis of the amount billed or collected, nor can it be dependent on collection of the payment

Payments may be reassigned by:

- The provider to a government agency, or
- Court order to another entity

Medicaid payments are prohibited to or through an individual or organization that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the organization for a fee or percentage of the accounts receivable.

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**Conditions of Participation, Continued**

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

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**Rehabilitation and Disabilities** The hospital must comply with the following requirements in addition to the laws specifically pertaining to Medicaid:

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

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**Program Integrity Reviews**

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<b>Program Integrity (PI)</b>	<p>Program Integrity (PI) operates under federal and state laws and regulations that are both stringent and comprehensive. The state rules are found in the NC Administrative Code Title 10, Section 26G, and the federal rules are found in 42 CFR 455.</p> <p>Information regarding requirements resulting from these laws and rules are provided through provider manuals and monthly Medicaid Bulletins.</p>
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<b>PI Mission</b>	<p>It is the mission of the DMA Program Integrity Section to insure that:</p> <ul style="list-style-type: none"> <li>• Medicaid dollars are paid correctly by identifying overpayments to providers and recipients occurring due to error, abuse, or fraud</li> <li>• Overpayments are recovered and the proper agencies are informed of any potentially fraudulent actions</li> <li>• Recipients’ rights are protected and recipients receive quality care</li> <li>• Problems found are communicated to appropriate staff, providers or recipients <u>and</u> corrected through education and/or changes to the policy, procedure, or process, and monitored for corrective action</li> </ul>
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**Program Integrity Reviews, Continued**

<p><b>Mission Achievement</b></p>	<p>The mission is achieved by PI:</p> <ul style="list-style-type: none"> <li>• conducting post payment reviews of             <ul style="list-style-type: none"> <li>▷ provider billing practices and cost reports</li> <li>▷ payment of claims by the fiscal agent</li> <li>▷ recipient eligibility determinations</li> </ul> </li> <li>• identifying overpayments for recoupment</li> <li>• identifying medical, administrative, and reimbursement policies or procedures that need to be changed</li> <li>• educating providers on errors made</li> <li>• assessing the quality of care for Medicaid recipients</li> <li>• assuring that Medicaid pays for only medically necessary services</li> <li>• identifying and referring suspected Medicaid fraud cases to the Attorney General’s Office Medical Investigations Unit (AGO MIU), other state agencies, professional boards (e.g., boards of pharmacy, dentistry, etc.), or to federal agencies for investigations (e.g., DEA)</li> <li>• overseeing recipient fraud and abuse activities by the county departments of social services to assure that recipient overpayments are recouped</li> </ul>
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<p><b>Determining Areas For Review</b></p>	<p>PI reviews are initiated for a variety of reasons. The following are some common examples (list not all-inclusive):</p> <ul style="list-style-type: none"> <li>• PI investigates specific complaints and referrals. These may come from recipients, family members, providers, state or county agencies, or other DMA sections</li> <li>• The quarterly Surveillance and Utilization review Subsystem (SURS) reports identify providers and recipients whose billing patterns or use of services exceed the norm for their peer groups</li> <li>• Special ad-hoc computer reports are run that target specific issues, procedure codes, or duplications of services, etc.</li> <li>• Identified billing errors and problems can be linked among similar provider groups and may generate additional investigations to determine their prevalence</li> <li>• Random sampling of all claim types are reviewed for possible fraud and abuse</li> <li>• EDS refers questionable services identified during claims processing to PI</li> </ul>
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<p><b>Provider Responsibilities With a PI Review</b></p>	<p>If notified that PI has initiated a review, a provider can ensure the review will be both positive and educational by adhering to the following:</p> <ul style="list-style-type: none"> <li>• PI will request medical and/or financial records either by mail or in person. EDS, as the fiscal agent for DMA, may also request records. The records must substantiate all services and billings to Medicaid. Failure to submit the requested records will result in recoupment of all payments for the services. You must maintain records for five years in accordance with the recordkeeping provisions of your provider participation agreement.</li> <li>• If you receive a recoupment letter from PI, review the information and details in the letter and chart. You have two (2) options:</li> </ul>
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**Program Integrity Reviews, Continued**

<p><b>Provider Responsibilities With a PI Review, (continued)</b></p>	<p>1. If you agree that an overpayment has occurred, use the form sent with the letter to indicate your preferred method for reimbursing DMA. The options include sending a check or having the repayment withheld from future Medicaid payments. (Send the check to DMA Accounts Receivable at the address on the letter. <u>Do not</u> send the check to EDS as this could result in duplication of your recoupment.)</p> <p>2. If you disagree with the overpayment decision by PI and want a reconsideration review, then return the enclosed hearing request form to the DMA Hearing Unit (at the address on the letter) and indicate whether you are requesting a personal hearing or a paper review. <b>Please pay close attention to the time frames and procedures for requesting a reconsideration review.</b></p> <p style="padding-left: 40px;"><b>Personal hearings</b> – These are in Raleigh and the Hearing Unit assigns the date, time, and place. You will be notified in writing of the Hearing Officer’s final decision within 10 working days after the personal hearing.</p> <p><b>Paper reviews</b> - You may instead send additional relevant documentation to the Hearing Unit for reconsideration. Your written material will then be evaluated and a final decision rendered.</p>
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<p><b>Miscellaneous</b></p>	<ul style="list-style-type: none"> <li>• If you or your staff need assistance and/or education, call EDS at 919-851-8888 or 1-800-688-6696 and request a provider education contact.</li> <li>• If you call EDS or DMA to get clarification of policy, record the date, name of the staff person, the policy issue discussed, and a summary of the guidance given.</li> <li>• You have the responsibility to maintain the provider manuals and Medicaid Bulletins and assure that all staff who plan care, supervise services, and file claims for Medicaid reimbursement have access to the Medicaid guidelines.</li> </ul>
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<p><b>Self Referral Federal Regulation</b></p>	<p>For Medicaid payments, OBRA 1993 prohibits self referral by a physician to designated health services in which the physician has certain ownership or compensation arrangements. If post payment review determines that inappropriate payments were made due to the providers’ failure to follow Medicaid policies, recoupments will be made. Exceptions are listed in OBRA 1993 and in section 1877 of the Social Security Act.</p> <p>Designated health services include the following:</p> <ul style="list-style-type: none"> <li>• clinical laboratory services</li> <li>• physical and occupational therapy services</li> <li>• contact lenses</li> <li>• hearing aids</li> <li>• radiation therapy services</li> <li>• parenteral and enteral nutrition equipment and supplies</li> <li>• prosthetic and orthotic devices</li> <li>• home dialysis</li> <li>• ambulance services</li> <li>• eyeglasses</li> <li>• home infusion therapy services</li> <li>• Radiology services (including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services)</li> <li>• durable medical equipment</li> <li>• comprehensive outpatient rehabilitation facility services</li> <li>• outpatient drugs</li> <li>• home health services</li> <li>• inpatient and outpatient hospital services</li> </ul>
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## Provider Responsibilities

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**Verifying Eligibility** The hospital is responsible for verifying Medicaid eligibility each time a recipient presents for services. Information on ways to verify Medicaid eligibility is provided under the “Medicaid Eligibility” section in *Chapter Three, Medicaid Overview*.

**Noncovered Services** When a noncovered service is requested by a recipient, the hospital must inform the recipient orally and in writing that the requested service is not covered under the Medicaid program and will, therefore, be the financial responsibility of the recipient. This must be done prior to performing the service.

<b>Quality of Patient Care</b>	<p>A hospital accepting a Medicaid patient for treatment accepts the responsibility for making sure that patient receives all medically necessary services. The conditions of participation governing hospitals providing care to Medicaid patients require the governing body of the hospital to assure accountability of the medical and hospital staff for the quality of care provided to patients. An effective hospital-wide quality assurance program must be in place to evaluate the provision of patient care. All organized services related to patient care, including services furnished by a contractor, must be evaluated. Where deficiencies are identified, remedial action must be taken. (42 CFR §482 Subpart B,C, &amp; D)</p> <p>DMA may place appropriate limits on a service based on medical necessity or utilization control criteria (42 CFR §440.230(d)). If providers do not accept a particular patient for treatment, the hospital has the responsibility of assuring delivery of these medically necessary services. For example, where epidurals are a covered benefit and the service is determined to be medically necessary, a pregnant Medicaid beneficiary is entitled to receive the service from a provider who has accepted her as a patient. The pregnant Medicaid beneficiary is not liable for deductibles, cost sharing or similar charges.</p>
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**Recipient Billing** A Medicaid recipient may only be billed for:

- a noncovered service, when the recipient was informed, prior to the service, that Medicaid would not pay for the service. A provider may refuse to accept a patient as a Medicaid patient and bill the patient as private pay only if the provider informs the patient that Medicaid will not be billed by the provider for any services but will charge the patient for all services provided
- a noncovered service, when the recipient is enrolled in a private health plan and failed to comply with that plan’s requirements
- copayments not collected at the time of the service
- services rendered for which proof of Medicaid eligibility cannot be obtained
- services rendered to a patient ineligible for Medicaid
- services for which either commercial insurance or Medicare reimbursed the recipient and not the hospital
- physician visits in excess of the 24-per-fiscal year limit
- services for an MQB recipient that are not covered by Medicare
- psychiatric services for a Medicare-eligible recipient that have been designated noncovered by Medicare as a result of the Medicare psychiatric reduction
- prescriptions in excess of the 6-per-month limit

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**Provider Responsibilities, Continued**

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**Recipient  
Requests Copy  
of Hospital Bill**

A recipient who is authorized for Medicaid should not receive a bill unless he requests it. Participation in the Medicaid program is limited to hospitals that accept Medicaid payment as payment in full, excluding the exceptions listed under Recipient Billing block.

North Carolina Administrative Code (NCAC) T10: 03C.3100 states: “The facility shall either present an itemized list of charges to all discharged recipients or the facility shall include on recipient’s bills which are not itemized notification of the right to request an itemized bill within thirty (30) days of receipt of the nonitemized bill.”

In order to comply with the above regulation, it is suggested that the facility provide each Medicaid recipient or responsible party a statement informing him/her of the right to request an itemized bill. The hospital must state in its written policies how it will inform the Medicaid recipients.

Frequently, a recipient is applying for Medicaid and is on a Medicaid deductible. The recipient needs an itemized bill to take to the county DSS for determination of the beginning date of eligibility.

If the hospital receives a request for an itemized bill from a recipient who is authorized for Medicaid or an authorized representative (attorney or insurance company), it is possible that the recipient may have insurance or a responsible third party payer that is not known to the Medicaid program. Hospital billing staff must write across the top of the itemized bill “Medicaid Recipient, Benefits Assigned.” See *Chapter Eight, Reimbursement and Billing* for refund instructions.

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**Medicaid  
Overpayments**

The Program Integrity Section of the Division of Medical Assistance (DMA) conducts regular postpayment reviews in an ongoing effort to assure that:

1. Medicaid payments are made only for services that are covered under Medicaid policy.
2. Coding on Medicaid claims correctly reflects services provided.
3. Third party carriers are billed before Medicaid was billed and that providers report any such payments from third parties on claims filed for Medicaid payment.
4. Recipient deductible balance and patient liability have been properly applied to charges.

When overpayments are identified, the hospital is given written information about the errors and is required to refund the overpayment amount. Additional information on how DMA determines the amount of overpayment is in NCAC, Chapter 26G.0707.

In order to keep recoupment amounts to a minimum, hospital providers should read the provider manual and the Medicaid Bulletins. Direct any questions to EDS Provider Relations Representatives at the phone number listed in Appendix B.

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**Provider Responsibilities, Continued**


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<p><b>Teleconsults</b></p>	<p>Teleconsulting services include initial, follow-up or confirming consults in hospitals and outpatient facilities. The patient must be present and the telecommunications must permit real time interactive audio and video communication with the consulting practitioner. The referring practitioner is involved as appropriate to the medical needs of the recipient. Payment is shared between the consulting and referring practitioner. The payment amount must not exceed the current fee schedule of the consulting physician.</p> <p>The referring practitioner and consulting physician must be enrolled as NC Medicaid providers. Teleconsultations are only covered within NC borders. All services are subject to the same edits and audits as any other consult.</p> <p>See <i>Chapter Eight, Reimbursement and Billing</i>, for billing information.</p>
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## Advance Directives

**Background**

Section 4751 of the Omnibus Reconciliation Act (OBRA) 1990, otherwise known as the Patient Self-Determination Act, requires certain Medicaid providers, including hospitals, to provide written information to all patients 18 years and older about their rights under state law to make decisions concerning their medical care, to accept or refuse medical or surgical treatment, and to execute an advance directive, e.g., living will or health care power of attorney.

**Advance Directives Brochure**

DMA, in conjunction with an advisory panel, has developed the required summary of state law concerning patients’ rights that must be distributed by providers. This brochure, revised in May 1999, is entitled “Medical Care Decisions and Advance Decisions and Advance Directives: What You Should Know.” See the Attachment A at the end of this chapter for a copy.

The brochure is two pages, should be photocopied on the front and back of one sheet of paper and folded in half to form a four-page brochure. Prior to distributing the brochure the provider must indicate in the box on the last page of the brochure a contact for the patient to obtain more information. Providers are expected to photocopy and distribute the brochure **as is**. If providers choose to alter the document graphically, they **may not** change or delete text, or the order of the paragraphs. In addition, a provider-published brochure must include the NC DHHS logo and production statement on page four of the folded brochure.

## Enrollment For Medicaid Participation—In-State Hospitals

### Steps for Enrollment

Hospitals located within North Carolina:

Step	Action	Time Frame
1	Hospital contacts Division of Facility Services (DFS) Certification Unit and requests a Medicare/Medicaid application .	Provider Dependent
2	Complete the application according to directions and return it to DFS Certification Unit	Provider Dependent
3	DFS processes application and verifies licensure	
4	DFS forwards information to HCFA	
5	HCFA reviews application and assigns a 6-digit provider Medicare number	HCFA Dependent
6	HCFA sends facility approval letter to DFS	
7	DFS notifies DMA Provider Enrollment Unit	
8	DMA Provider Enrollment Specialist sends Medicaid Participation Agreement and Civil Rights Amendment to the hospital	10 Working Days
9	Hospital completes Participation Agreement and Civil Rights Amendment and returns to DMA	Provider Dependent
10	After receipt of HCFA Approval Letter and Medicare number, DMA processes Participation Agreement and assigns a North Carolina Medicaid number (using the Medicare number as a base number)	10 Working Days
11	A copy is forwarded to: <ul style="list-style-type: none"> <li>• DMA Financial Operations Unit for rate analysis</li> <li>• DMA Medical Policy Unit</li> <li>• DMA Audit Section</li> <li>• The county department of social services where the hospital is located</li> </ul>	

## Enrollment For Medicaid Participation—Out-of-State General Acute Care Hospitals

### Limitations

Enrollment for out-of-state general acute care hospitals is limited to cases where:

1. the hospital has rendered emergency medical treatment for a North Carolina Medicaid recipient  
**OR**
2. North Carolina has given prior approval for treatment or care of a North Carolina Medicaid recipient because the necessary treatment or care was determined not to be available in North Carolina  
**OR**
3. DMA determines that it is general practice for North Carolina residents living near the border to use an out-of-state hospital located near the border

### Steps for Enrollment

Hospital located out of state:

Step	Action	Time Frame
1	Out-of-state facility can send the UB92 claim to DMA Provider Enrollment Section to initiate the enrollment process, or contact the enrollment section for instructions.	Provider Dependent (Facility must contact DMA and complete enrollment within 365 days from date of service in order to enroll and be paid.)
2	DMA sends the facility a Participation Agreement.	10 Working Days
3	Facility returns to DMA the Participation Agreement, the UB-92 (HCFA-1450) claim form, and verification of enrollment in the state's Medicaid program	Provider Dependent
4	DMA processes the Participation Agreement and sends provider number to the hospital.	10 Working Days
5	DMA forwards UB-92 claim form to DMA Financial Operations for rate analysis.	10 Working Days
6	DMA Financial Operations forwards UB92s to EDS for processing.	5 to 10 Working Days

## Reporting Changes In Provider Information

### Provider Changes Requiring Notification

Certain changes made by a hospital require written notification to DFS and DMA. These changes must be reported in writing on the hospital letterhead and signed by an authorized employee of the facility. Include in the letter all provider numbers assigned to the facility, as well as the effective date of the change.

See Appendix B for appropriate DMA and DFS phone numbers and addresses.

The following changes require written notification:

Type of Change	Documentation Required
<ul style="list-style-type: none"> <li>• Name Changes</li> <li>• Change of Ownership</li> <li>• Change in the Number of Beds</li> </ul>	Indicate the new information in a letter to DFS and to DMA. DFS processes information and notifies DMA of changes. After DFS notifies DMA, DMA will send a Participation Agreement to the facility for changes requiring a new Participation Agreement.
Change in the Physical Location of the Facility	Requires re-enrollment by DFS, HCFA and DMA.
Tax Identification Number and/or Name Changes	Inform DFS and DMA in writing of the change and attach a completed and signed W-9 form.*

\* Note: W-9 forms are available from IRS.

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

**Whom should I talk to about an advance directive?**

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

**Where should I keep my advance directive?**

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

**What if I have an advance directive from another state?**

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

**Where can I get more information?**

Your health care provider can tell you how to get more information about advance directives by contacting:

*This document has been developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.*



# Medical Care Decisions and Advance Directives What You Should Know

## **What are My Rights?**

**Who decides about my medical care or treatment?**

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

**What is an "advance directive"?**

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

**Do I have to have an advance directive and what happens if I don't?**

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

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### ***Living Will***

#### **What is a living will?**

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine (“respirator” or “ventilator”), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube (“artificial nutrition or hydration”).

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### ***Health Care Power of Attorney***

#### **What is a health care power of attorney?**

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your “health care agent.” In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

#### **How should I choose a health care agent?**

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

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### ***Advance Instruction for Mental Health Treatment***

#### **What is an advance instruction for mental health treatment?**

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

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### ***Other Questions***

#### **How do I make an advance directive?**

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

#### **Are there forms I can use to make an advance directive?**

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

#### **When does an advance directive go into effect?**

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you. An advance instruction for mental health treatment expires after two years.

#### **What happens if I change my mind?**

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your

