CSC

Critical Access Behavioral Health Agencies (CABHA) Workshop

North Carolina Department of Health and Human Services

OFFICE OF MMIS SERVICES

August 2010

Application

- **Providers who have achieved certification as a CABHA must complete and submit the Organization In-State Provider Enrollment Application to obtain a Medicaid Provider Number.**

- **Providers should visit NCTracks Web Site http://www.nctracks.nc.gov for:**
  - **Provider enrollment applications**
  - **Forms**
  - **Updated CABHA enrollment information**
  - ***Do not use the online enrollment application for CABHA enrollment at this time*.**

Provider Resources: NCTracks Web Site

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Welcome!

NCTracks is provided as a service for North Carolina's health care providers and consumers as part of the new, multi-program NC Medicaid Management Information System. The site offers information and forms to help providers enroll in the Medicaid program. In the future, the site will expand to support additional features for Medicaid and other programs including NC Health Choice for Children, public health and mental health services.

Quick Links

- NC Division of Medical Assistance
- Official State of North Carolina Government Website
- NC Department of Health and Human Services

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Download Application

Based on your provider type, download the application. These applications are in Adobe PDF format. The free Adobe Acrobat Reader is required to view and Print these PDF files.

Individual

In State/Border (Application) (366 KB PDF)	In State/Border (Help) (59 KB PDF)
With CCNC/CA (Application) (469 KB PDF)	With CCNC/CA (Help) (66 KB PDF)
CCNC/CA (Application) (487 KB PDF)	CCNC/CA (Help) (37 KB PDF)
Out-of-State (Application) (314 KB PDF)	Out-of-State (Help) (49 KB PDF)

Organization

In State/Border (Application) (483 KB PDF)	In State/Border (Help) (63 KB PDF)
With CCNC/CA (Application) (486 KB PDF)	With CCNC/CA (Help) (67 KB PDF)
CCNC/CA (Application) (388 KB PDF)	CCNC/CA (Help) (38 KB PDF)
Out-of-State (Application) (316 KB PDF)	Out-of-State (Help) (52 KB PDF)
Atypical (Application) (343 KB PDF)	Atypical (Help) (48 KB PDF)

Tips for Enrollment

- Every question or blank with an asterisk beside it must be completed.
- The Organization name is your Legal Name as shown on your tax return. If you have a Doing Business As (DBA) name, please fill out that section on page one.
- It is recommended that your Organization obtain a new NPI for your CABHA billing number.
  - Providers with current NPIs may choose to subpart, or request multiple NPIs for specific entities within the organization.
- The effective date requested for enrollment can be no earlier than 07/01/2010.

North Carolina Department of Health and Human Services
In State Organization Provider Enrollment Application

For assistance completing this application, please call the CSC EVC Center at 866-844-1113.

Organization Information

Organization Name – as shown on income tax return *

NPI *

Employer Identification Number (EIN) *
-

Month of Fiscal Year End *

Do you operate under a trade or company name, (i.e., Acme Health Care Inc doing business as (DBA) Community Family Practice)? *
Yes No

Doing Business As (DBA) Information

DBA Name

NC Secretary of State ID #

Years Doing Business Under This Name

Former Doing Business As (DBA) Information

Have you used a different DBA Name?
Yes No

Former NC Secretary of State ID#

Former Doing Business As (DBA) Name

Effective Date and Provider Number

Effective Date Requested (MM/DD/CCYY)
/ /

Note: The effective date is the earliest date a provider may begin billing for services. The effective date of enrollment shall not be more than 365 days prior to the date that a complete Provider Enrollment Packet is received by the CSC EVC Center and shall not precede applicable licensure/accreditation/certification/endorsement documents that are required for enrollment.

Have you previously been enrolled as a provider with the Division of Medical Assistance? *
Yes No

If yes, what is your NC DHHS Provider Number?

Change of Ownership/Merger/Acquisition

Is this application in conjunction with a change of ownership, stock purchase, change in a shareholder/partner's percentage of interest in ownership, transfer of title, or a merger? *
Yes No

Date of ownership change:
/ /

NC DHHS Number Assigned to Previous Owner(s)

Tips for Enrollment (cont.)

- Answer "No" when asked if the organization has previously been enrolled with DMA since this is your first time enrolling for a CABHA Medicaid Provider Number.

- On page 2 under Community Programs, select Critical Access Behavioral Health Agency (CABHA) by checking the box. Please leave page 3 blank.

- Page 4 is the CABHA services page where you will select the CABHA services that make up your Continuum of Care.

- Comprehensive Clinical Assessment, Medication Management, and Outpatient Therapy must all be checked. Also, in addition to these three core services, select a minimum of two enhanced service and/or residential services.

Provider Type (Please select only one)

Ancillary

- ☐ Ambulance
- ☐ Hearing Aid Dealer [1]
- ☐ Optical Supplier

Case Management

- ☐ At Risk Case Management [1]
- ☐ HIV Case Management [1]
- ☐ Maternity Care Coordination (MCC)/Child Service Coordination (CSC) Services [1]
- ☐ Targeted Case Management for Developmental Disabilities [1]

Community Program – See Page 3

- ☐ Community Alternatives Program (CAP) [1]
- ☐ Community Intervention Services (CIS) [1]
- ☒ Critical Access Behavioral Health Agency (CABHA) [1] – See Pages 4-10

Group Home – See Page 11

- ☐ Adult Care Home [1]
- ☐ ICF, MR – Privately Owned [1]
- ☐ ICF, MR – State Owned [1]
- ☐ Residential Treatment Facility
- ☐ Therapeutic Family Services [1]

HMO

- ☐ ACCESS II – Community Care [1]
- ☐ Mental Health HMO (Piedmont) [1]
- ☐ ACCESS II – Enhanced Care [1]
- ☐ PACE (Program of the All-Inclusive Care for the Elderly) [1]

Home Health Programs

- ☐ Home Health Agency [1]
- ☐ Home Infusion Therapy (HIT) [1]
- ☐ Hospice [1]
- ☐ Personal Care Service (PCS) [1]
- ☐ Private Duty Nurse [1]

Independent Practitioner (non-physicians)

- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Independent Practitioner
- ☐ Nurse Midwife
- ☐ Nurse Practitioner
- ☐ Outpatient Behavioral Health [1]

Inpatient Facilities – See Page 11

- ☐ Critical Access Hospital [1]
- ☐ Hospital
- ☐ Nursing Facility
- ☐ Psychiatric Hospital – Privately Owned [1]
- ☐ Psychiatric Hospital – State Owned [1]
- ☐ Psychiatric Residential Treatment Facility (PRTF) - Privately Owned
- ☐ Psychiatric Residential Treatment Facility (PRTF) - State Owned [1]

Lab, Radiology, Pharmacy, DME

- ☐ Cochlear Implant External Parts/Repairs
- ☐ Durable Medical Equipment (DME)
- ☐ Independent Diagnostic Testing Facility (IDTF) [1]
- ☐ Independent Laboratory
- ☐ Pharmacy
- ☐ Portable X-Ray and Ultrasound [1]

Outpatient Clinic/Facility

- ☐ Ambulatory Surgery Center
- ☐ Birthing Center
- ☐ Dialysis Center
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Planned Parenthood [1]
- ☐ Rural Health Clinic (RHC)

Doctor of Medicine or Dentistry

- ☐ Chiropractor
- ☐ Optometrist
- ☐ Dentist
- ☐ Orthodontist
- ☐ Oral Surgeon
- ☐ Physician Group
- ☐ Periodontist
- ☐ Pedodontist
- ☐ Podiatry

State Agencies

- ☐ Health Department [1]
- ☐ Local Education Agency (LEA) [1]
- ☐ Local Management Entity (LME) [1]

[1] Only in state providers can enroll.

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CABHA Services (Choose all that apply)

In order to become a CABHA provider, you must provide the following three services:

- [x] Comprehensive Clinical Assessment
- [x] Medication Management
- [x] Outpatient Therapy

In addition to the three above, you must also select a minimum of two services below:

- [ ] Assertive Community Treatment Team
- [ ] Child and Adolescent Day Treatment
- [x] Child Residential Level II-Family/Program Type, III, or IV
- [ ] Community Support Team
- [x] Intensive In-Home
- [ ] Multi-Systemic Therapy
- [ ] Opioid Treatment
- [ ] Partial Hospitalization
- [ ] Psychosocial Rehabilitation
- [ ] Substance Abuse Comprehensive Outpatient Treatment Program
- [ ] Substance Abuse Intensive Outpatient Program
- [ ] Substance Abuse Medically Monitored Community Residential Treatment
- [ ] Substance Abuse Non-Medical Community Residential Treatment
- [ ] Therapeutic Family Services

In addition to the above, you may also provide the following two services below:

- [x] Targeted Case Management for Mental Health and Substance Abuse
- [ ] Peer Support

Group Homes and Inpatient Facilities – CABHA Only

Bed Accommodations

Type of Bed Accommodations	# of beds
Residential Treatment Level II	
Residential Treatment Level III	3
Residential Treatment Level IV	

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Tips for Enrollment (cont.)

- CABHAs that will be providing Targeted Case Management for Mental Health and Substance Abuse must check this box on the enrollment application to receive an additional Medicaid Provider Number for MH/SA-TCM.
- CSC will issue each certified and enrolled CABHA a statewide MH/SA-TCM Medicaid Provider Number until site-specific enrollment can be achieved.
  - More information on site-specific enrollment will be provided in future communications.
- CSC will contact those CABHA providers that have already enrolled to assist with obtaining a MH/SA-TCM Medicaid Provider Number if so desired.
- If one of your services is a Residential Treatment Facility, please complete the bottom section of page 4.

Attending Information

- When completing the Attending Provider Information section of the application, pages 5-10, you must list all the attending Medicaid Provider Numbers for Individual Providers, Enhanced Services, and Residential Services.

- All Individual Providers and Enhanced Services that your CABHA Organization will be billing for, must be linked to your CABHA NPI or claim payment could be affected. Please make copies if additional pages are needed.

- For enrollment purposes, Residential Services must be linked to your CABHA Medicaid number as part of your service continuum. These services will be billed with the current Residential Service's NPI number and not the CABHA NPI number.

Individuals: Name, MPN, and NPI associated with that Individual Provider and each Individual Provider must be actively enrolled in Medicaid to be affiliated (i.e., Outpatient Therapists and Physicians).

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA.
Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #
MATT CLARK, MD	5901101	1234567890

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☑ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Targeted Case Management for Mental Health and Substance Abuse
- ☐ Therapeutic Family Services

(ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)

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Identify the CABHA Service that the attending Provider will be responsible for by checking the box next to that service.

Enhanced Services: Organization Name, attending MPN (identified by the alpha suffix appended to the core number), and NPI associated with that MPN (i.e., Intensive In-Home, Assertive Community Treatment Team, Opioid Treatment, etc.).

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA. Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #
ABC CLINIC	830100H	2345678901

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☐ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☑ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
- ☐ Peer Support
- ☐ Psychosocial Rehabilitation
- ☐ Substance Abuse Comprehensive Outpatient Treatment Program
- ☐ Substance Abuse Intensive Outpatient Program
- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Targeted Case Management for Mental Health and Substance Abuse
- ☐ Therapeutic Family Services

(ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)

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Identify the CABHA Service that the attending Provider will be responsible for by checking the box next to that service.

Residential Services: Organization Name, MPN, and RCC billing NPI number.

Attending Provider Information To Be Identified With This CABHA

Please complete the following form for each attending provider associated with your CABHA. Entries must match those on your ECS Agreement.

Attending Provider Name	Medicaid Provider #	NPI #
ABC CLINIC	6603000	3456789021

Identify the CABHA service(s) this attending will be responsible for:

(Please only select services the CABHA is authorized to provide.)

- ☐ Assertive Community Treatment Team
- ☐ Child and Adolescent Day Treatment
- ☑ Child Residential Level II-Family/Program Type, III, or IV
- ☐ Community Support Team
- ☐ Comprehensive Clinical Assessment
- ☐ Intensive In-Home
- ☐ Medication Management
- ☐ Multi-Systemic Therapy
- ☐ Opioid Treatment
- ☐ Outpatient Therapy
- ☐ Partial Hospitalization
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- ☐ Substance Abuse Medically Monitored Community Residential Treatment
- ☐ Substance Abuse Non-Medical Community Residential Treatment
- ☐ Targeted Case Management for Mental Health and Substance Abuse
- ☐ Therapeutic Family Services

(ATTACH ADDITIONAL SHEETS AS NEEDED TO INCLUDE ALL ATTENDING PROVIDERS ASSOCIATED WITH THE CABHA.)

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Identify the CABHA Service that the attending Provider will be responsible for by checking the box next to that service.

Attending Information (cont)

- **The Electronic Claim Submission Agreement, pages 5 and 6, must also be filled out with the Attending Provider's name, MPN, and Attending Provider's Signature. For the Enhanced and Residential Services Attending numbers, the signature should be an Authorized Agent of the Organization.**

- **For every Attending Provider number listed on the application, that same Attending Provider number must be listed on the ECS Agreement. Please make copies of page 6 if additional pages are needed.**

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name: ABC CLINIC
(must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

100 LAKE LANE
*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

Raleigh | NC | 27616-3421
*City | *State | *Zip Code + Four (Last 4 digits required)

Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

*Provider Name	*Provider Individual Number	*Signature of Provider
ABC CLINIC	830100H	Mary Brown
ABC CLINIC	6603000	Mary Brown
Matt Clark, MD	5901101	Matt Clark, MD

Attending Information (cont.)

- **The proper procedure for an existing CABHA to add additional enhanced services to the CABHA is to submit a CABHA Addendum and an Electronic Claim Submission (ECS) Agreement.**
- **The proper procedure for an existing CABHA to add individual core attending providers is to submit a Provider Change Form and an Electronic Claim Submission (ECS) Agreement.**
- **The proper procedure for an existing CABHA to delete individual core attending providers or enhanced services is to submit a Provider Change Form.**
- **The CABHA Addendum and the updated Provider Change Form to delete attending providers or delete services for the CABHA will be available on August 29, 2010 on www.nctracks.nc.gov .**

Physical Site Address

- **Providers may have several physical site locations in which services are provided.**

- **The physical site address indicated on page 12 of the application should match the address on your Organization's Certification Letter of Approval for CABHA.**

- **Please indicate if you Organization wishes to receive Correspondence at a different address by filling out the Correspondence/Accounting address section.**

Physical Address Information (Physical Site Location)

This is the physical location where service will be rendered, or in the case of mobile services, where management/supervision occurs. (No P.O. Boxes)

Address Line 1 *

Address Line 2

City *	State *	Zip Code+4 *

County *

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Contact Person (Authorized Individual)

Individual authorized to receive information or make business decisions on behalf of the applying provider.

Full Name (Last, First, Middle) *		Business Relationship to Enrolling Provider (Title) *	
Office Phone Number * ( ) -	Ext	Other Phone Number ( ) -	Ext
Fax Number ( ) -		Email Address *	

Correspondence / Accounting Address Information

This is the address where all paper and accounting correspondence is to be mailed.

☐ Check if correspondence address is the same as the physical address listed on this application

Attention *

Address Line 1 *

Address Line 2

City *	State *	Zip Code *

Provider Communication

- CSC has a dedicated credentialing staff that will process the CABHA enrollment applications with a high priority.
- Providers will be notified if any information is required to complete the application.
- For additional assistance or further information please feel free to contact the CSC EVC Call Center.
  - Customer Service Agents are available Monday through Friday, 8:00 a.m. through 5:00 p.m. Eastern Time
  - 1.866.844.1113
  - Select menu option 2 for CABHA.

Provider Resources: DMA Web Site

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NC Department of Health and Human Services

NC Division of **Medical Assistance**

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Quick Links

- Basic Medicaid Billing Guide
- Medicaid Clinical Coverage Policies and Provider Manuals
- False Claim Act Education
- Medicaid Bulletin
- NC Health Choice Clinical

DHHS > DMA > Providers

Medicaid and Health Choice Providers

Service specific information for North Carolina Medicaid providers. Please select the program or service from the menu below and click GO.

- Medicaid Information for Consumers
- Health Choice Information for Consumers

SELECT PROGRAM OR SERVICE Go

What's New

- August 2010 Medicaid Bulletin
- July 2010 Pharmacy Newsletter (PDF, 120 KB)
- N.C. Health Choice Clinical Coverage Policies
- Remittance and Status Reports in PDF Format Request Form (PDF, 29 KB)

Hot Topics

- DMA Budget Initiatives
- Electronic Health Records Incentives: Information from CMS on provisions in the American Recovery and Reinvestment Act of 2009 to promote the use of electronic health records
- Medicaid Integrity Program Provider Audit
- NC PASRR Online System
- Outpatient Pharmacy Program
- Payment Error Rate Measurement (PERM)
- Prior Authorization Criteria for Medications Covered by Medicaid
- Provider Credentialing and Verification

Provider Resources: DMA Web Site

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Quick Links

- Annual Visit Limits
- Basic Medicaid Billing Guide
- Clinical Coverage Policies and Manuals
- Medicaid Bulletins
- Proposed Medicaid Clinical Coverage Policies
- Reporting a Change in Provider Status

Related Sites

- Information about DMA Budget Initiatives

DMA Clinical Policy and Programs

Phone 919-855-4260

Fax 919-733-2796

The N.C. Medicaid Program structures benefits available to Medicaid clients in a manner that promotes access to medically necessary and cost-effective care.

To see provider information specific to your provider program or service type, visit your **program or service** page from the alphabetical listing.

Adult Care Homes (ACH)

Ambulance Services

Ambulatory Surgical Center

Anesthesia Services

Baby Love

Behavioral Health Services

- Community Alternatives Program for Mentally Retarded/Developmentally Disabled Individuals (CAP/MR-DD)
- Critical Access Behavioral Health Agency (CABHA)
- Early Intervention Services (through Children's Developmental Service Agencies)

Provider Resources: NCTracks Web Site

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Welcome!

NCTracks is provided as a service for North Carolina's health care providers and consumers as part of the new, multi-program NC Medicaid Management Information System. The site offers information and forms to help providers enroll in the Medicaid program. In the future, the site will expand to support additional features for Medicaid and other programs including NC Health Choice for Children, public health and mental health services.

Quick Links

- NC Division of Medical Assistance
- Official State of North Carolina Government Website
- NC Department of Health and Human Services

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Provider Resources: NCTracks Web Site

Notice to Applicants

Critical Access Behavioral Health Agency (CABHA) Enrollment

The Department of Health and Human Services (DHHS) has approved a new category of provider agency for mental health and substance abuse services, a Critical Access Behavioral Health Agency (CABHA). Effective May 10, 2010, providers who have achieved certification as a CABHA must complete and submit the downloadable paper version of the In-State Organization Provider Enrollment Application to obtain a Medicaid Provider Number. The online version of the Provider Enrollment Application to enroll as a CABHA will be available beginning May 24, 2010. Additional information about CABHAs can be found at the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services website.

The Medicaid State Plan Amendment for Targeted Case Management for Individuals with Developmental Disabilities was recently approved by CMS. All targeted case management provider agencies are required to be directly enrolled to provide Medicaid reimbursable Targeted Case Management for Individuals with Developmental Disabilities. Effective May 10, 2010, providers of Targeted Case Management for Individuals with Developmental Disabilities must complete and submit the downloadable paper version of the In-State/Border Organization Provider Enrollment Application to obtain a Medicaid Provider Number. The online version of the Provider Enrollment Application to direct enroll as a provider of Targeted Case Management for Individuals with Developmental Disabilities will be available beginning May 24, 2010. Additional details about existing and new providers of Targeted Case Management for Individuals with Developmental Disabilities can be found in the North Carolina Department of Health and Human Services Memorandum - Implementation Update #71.

Thank you for participating

in the NC Medicaid Program!

CABHA Frequently Asked Questions

1. **How do I enroll to be a CABHA?**

   Once you have received your Certification letter from the Division of Mental Health, go to NCTracks (http://www.nctracks.nc.gov) to download the Organizational application. Currently, an online application for CABHA cannot be submitted. We will inform you when the online application is available.

2. **What application do I download and what do I select to enroll as a CABHA?**

   You will select the In-State Organization application. On page 2, select Critical Access Behavioral Health Agency (CABHA). On page 4, check the three services that make up your CABHA agency, Comprehensive Clinical Assessment, Medication Management, and Outpatient Therapy. Also, check a minimum of two Enhanced or Residential Services from the list that your CABHA will be providing.

3. **How do I indicate the services / providers that make up my CABHA organization on the application?**

   Starting on page 5 of the application, you should list all the Individual, Enhanced, and Residential services that will be linked with your CABHA organization. You will list the Name of the Provider, Medicaid number, and NPI. Also, please identify the service(s) that the attending provider will be responsible for. You may make copies of this page to accommodate all the attending Providers that will be linked with your Organization.

4. **I have a lot of attending providers. Do they all have to be listed, and do they all have to sign the ECS Agreement?**

   Yes, all the Individual providers will have to sign the ECS Agreement to be included as an attending provider with your CABHA organization. The Enhanced and Residential Services must also be listed on the ECS agreement and the authorized agent will sign in the signature section for these services.

   All the attending Individual providers and services must be listed for your claims to adjudicate properly. If they are not listed, this may cause a claim to deny or cause your claims to not pay properly.

5. **What Medicaid number do I use on page 1 when it asks if I have been previously enrolled? I have several Medicaid numbers.**

   This question is designed for reinstating a terminated Medicaid number and can be left blank since this is your first time enrolling as a CABHA agency.

6. **What physical address do I put on the application? I have several sites and will be billing CABHA services from several locations.**

   The physical address should be your corporate location or main site location. The address on the application should match the address listed on your Certification Letter of approval for CABHA from the Division of Mental Health.

7. **How do I add or remove an individual attending provider for my core services? How do I add or remove Enhanced / Residential services?**

   You can add or remove an individual attending provider for your core services by completing the provider change form. You can also complete a provider change form to delete an enhanced or residential service. The form will be available on our Web site www.nctracks.nc.gov on Aug. 29th .

You can add an enhanced or residential service to your CABHA agency by completing and submitting the CABHA addendum. The addendum will be available on our Web site www.nctracks.nc.gov on Aug. 29th. For any additions that need to be made prior to the release of the CABHA addendum, please call CSC EVC Center at 1-866-844-1113 for further instructions.

8. **I want to know where I am in the process of being approved to become a CABHA. I have not received my Certification Letter yet. Whom do I contact?**

   Please call the Division of Mental Health at 919.733.7011 or the Division of Medical Assistance at 919.855.4100. Their office hours are between 8:00 a.m. and 5:00 p.m. Eastern Time. Staff will be able to assist you with where you are in the process. Once you are certified and have any questions about how to enroll as a CABHA, please feel free to call CSC EVC Center at 1-866-844-1113 and a Call Center Agent can assist you through the application process.

9. **Where do I go to obtain the latest information about CABHA?**

   The web site is http://www.ncdhhs.gov/dma/services/cabha.htm.

10. **Will providers who provide Intensive In-home, Community Support Team, and/or Child and Adolescent Day Treatment have their Medicaid numbers terminated on July 1 if they are not yet CABHA providers?**

    No, these services have been extended through 12/31/2010 to allow providers to complete the process of obtaining their CABHA Certification. DMA Clinical Policy would be your resource for any policy questions. Their contact number is 919.855.4290.

11. **What does subpart NPIs mean?**

    Subpart NPIs means to obtain a different NPI for each service that you have enrolled in Medicaid. If your CABHA NPI is the same NPI as your existing NPI numbers, the claims will adjudicate and pay to the CABHA first according to the NPI mapping solution. If you want to continue to bill for your Group Physicians, Group OPMH, or Core CIS provider numbers, we recommend that you obtain a different NPI for your CABHA number.

Important Tips in Completing Your CABHA Application

1. **Don't** send an application to CSC until you receive you a CABHA certification letter from DMH.
2. **Don't** put two different names on the CABHA application; only use the name that is on the letter from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
3. **Do** ensure the organization name on the application matches the letter with the NPI for CABHA.
4. **Don't** send different addresses on the ECS Agreement, Signature on File, and Medicaid Participation agreement.
5. **Do** send one address for the corporate office address that matches the CABHA letter.
6. **Do** fill out Attending Provider information to be identified with this CABHA. Please select only services the CABHA is authorized to provide.

Example

If the service is medication management, provide the individual name, not the CIS suffix number.

If the service is CIS services, provide the Child and Adolescent Day treatment number (830000R), not the individual number.

7. **Don't** send any provider numbers on the Attending Provider information sheets or the ECS Agreement that are end-dated. We cannot link **end-dated** providers.
8. **Do** send Attending Provider information to be identified with CABHA Page 5-10 of 22 of the in-state organization application for any provider who will provide CABHA services. Make additional copies as necessary.
9. **Do** provide an ECS Agreement for each provider number on Page 5-10 of the CABHA application. Each attending must sign the ECS agreement.

Example

Provider Name	Provider Individual Number	Signature of Provider
Joe Smith Smith's Family Care	5000000 8300000R	

Critical Access Behavioral Health Agencies Feedback Form

Enrollment Presentation

Date: **Location:**

We value your opinion! Your opinion counts. We review every evaluation, so please let us know what you think about today's training by completing this form.

	Not Satisfactory		Average		Excellent
What is your overall rating of the training?	1	2	3	4	5
Appropriateness and Effectiveness of training	1	2	3	4	5
Did this training session meet your expectations ?	1	2	3	4	5
Clarity and Pace of Delivery	1	2	3	4	5
Training Materials / Handouts	1	2	3	4	5

If you have additional questions, please provide contact information below.

Medicaid Provider Number:

Provider Name:

Contact Person:

Phone Number:

Please share any additional questions related to enrollment:

Please share your comments or suggestions about today's training:

Thank you for participating in the N.C. Medicaid program. Your time and feedback are appreciated!

North Carolina Medicaid Authorizations: Changes Related to CABHAs

Sean Dougherty, LPC
Provider Relations Manager
August 17, 2010

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Requesting Authorizations

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Requesting Authorizations: Forms

- **Inpatient Treatment Request (ITR)**
  - Enhanced Services
  - Residential (Program type and Family type)
- **Outpatient Request Form (ORF2)**
  - Basic Benefit Services (CPT and H codes)
- **Available at:** http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

****Reminder** - All of the levels of care above can be submitted online via ProviderConnect.

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Requesting Authorizations: Enhanced Services and Residential

- **What has changed with regard to how providers complete the ITR when requesting these services?**
  - **NOTHING**
- **Per IU73 and IU76:** Providers should continue to request authorizations in the same way they do today for all Enhanced Services, Level II Family Type (TFC) and Level II-IV Program Type (RCC**)**
- **Exception:** CST requests submitted July 1, 2010 forward must include the MPN with the V suffix (per IU76)

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Requesting Authorizations: Enhanced Services and Residential

- **New requests do not need to be submitted for recipients with active authorizations**
- **Submit a concurrent request prior to the expiration date of current authorization, per standard operating procedure**
- **Providers should not attempt to request authorizations under a CABHA MPN (per IU76)**
- **Authorizations are entered to the site-specific Medicaid Provider number (MPN) listed as the Facility ID on the ITR**

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Requesting Authorizations: Enhanced Services and Residential

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INPATIENT TREATMENT REPORT (ITR) - Page On

Requested Start Date for this Authorization ____/____/____

Level of Care: ❑ Inpatient ❑ 23 hr ❑ CSU ❑ Partial ❑ PRTF/RTC ❑ IOP/SOP
❑ Residential (I-IV excl. Foster Care) ❑ Foster Care ❑ Community Support Indv.
❑ Community Support Group ❑ Community Support Team
❑ Other _____

Type of Review: ❑ Prospective ❑ Concurrent ❑ Discharge ❑ Retrospective
❑ Additional Units for current authorization period
Type of Care: ❑ Mental Health ❑ Substance Abuse ❑ Detox
Precipitating Event: _____

Patient's Current Location: ❑ ER ❑ Jail/Detention ❑ Facility
❑ Provider's Office ❑ Home/Community

Demographics:
Patient's Name _____ Date of Birth: ____/____
Patient/Policyholder ID#: _____ Tel #: _____
Patient's City/State: _____
Subscriber's Employer/Benefit Plan: _____
Facility: _____ Fac: ID#_____
Fac. Address/City/St: _____
Attending Provider: _____ Tel #:_____
UR Name: _____
UR Phone #: _____ UR Fax #: _____

Current Impairments: Scale 0=none, 1=mild, 2=moc
0 1 2 3 na Mood Disturbance (Depression or mania)
0 1 2 3 na Anxiety
0 1 2 3 na Psychosis
0 1 2 3 na Thinking/Cognition/Memory
0 1 2 3 na Impulsive/Reckless/Aggressive
0 1 2 3 na Activities of Daily Living
0 1 2 3 na Weight Change Assoc. w/Behav Dx ⇨ ❑
0 1 2 3 na Medical/Physical Condition(s) p
0 1 2 3 na Substance Abuse/Dependent C
0 1 2 3 na Job/School Performance H
0 1 2 3 na Social/Marital/Family Problems
0 1 2 3 na Legal

Mental Health/Psychiatric Treatment History: *(Ple*
❑ Outpatient. *If "Outpatient" is checked, please indic*
Outcome: ❑ Unknown ❑ Improved ❑ No C
Treatment compliance (non-med): ❑ Unknov
❑ IOP/Partial. *If "IOP/Partial" is checked, please in*
Outcome: ❑ Unknown ❑ Improved ❑ No C
Treatment compliance (non-med): ❑ Unknov
❑ Inpatient/Residential/Group Home: *If "Inpatient/R*
Outcome: ❑ Unknown ❑ Improved ❑ No C
Treatment compliance (non-med): ❑ Unknov

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Requesting Authorizations: Outpatient

- **What has changed with regard to how providers complete the ORF2 when requesting outpatient services?**
  - No changes regarding completion of the ORF2 as a result of CABHA
  - Still provide Attending Provider number; Billing Provider number not required through December 31, 2010 (per IU76)
- **Can more than one Attending Provider number be included on the ORF2?**
  - Yes. If clinically appropriate, up to 3 Medicaid Provider Numbers (MPNs) may be included on the Attending Provider line to allow for "reserve" therapists (per IU77)
  - Can be combination of directed enrolled MPN, LME MPN (for provisionally licensed individuals), or a physician MPN (for "incident to")

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Requesting Authorizations: Outpatient (continued)

- **Does ValueOptions enter outpatient authorizations to the Attending Provider number?**
  - Yes. Effective July 1, 2010 outpatient authorizations are entered to the Attending Provider number included on the ORF2 (per IU73, IU76, IU77)

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Requesting Authorizations: Outpatient (continued)

VALUEOPTIONS **OUTPATIENT REVIEW FORM (ORF 2)**

START HERE⇨ **Requested Start Date for this authorization:** _____

Select Type of Service Requested: ❑ Mental Health ❑ Substance Abuse

Provider and Member Demographics:

Member's Name: _____

Date of Birth: _____ Member's ID # _____

Member's Address (City and State only): _____

Insured's Employer/Benefit Plan: _____

Is member currently receiving disability benefits? ❑ Yes ❑ No ❑ Unknown

Attending Provider Name/Medicaid #: _____

Billing Provider Name/Medicaid #: _____

Referring MD/LME/Medicaid #: _____

Service Address: _____

Attending Provider Telephone#: _____

Provider SSN or Tax ID #: _____

Current Risks: *(please select one rating for each type of risk. Key: 0= none; 1= mild, ideation only; 2= moderate, ideation with EITHER plan or history of attempts; 3= severe, ideation AND plan, with intent or means; na= not assessed)*

Member's risk to self:	0	1	2	3	na
Member's risk to others:	0	1	2	3	na

Current Impairments: *(please select/circle one value for each type of impairment)*

Key: 0=none, 1=mild or mildly incapacitating, 2=moderate or moderately incapacitating, 3= severe or severely incapacitating, na = not assessed for this impairment

Diagnosis:
Axis I: 1. _____
Axis II: 1. _____
Axis III: 1. _____
Axis IV: _____
Axis V: Current GAF = _____ Hig

ASAM Dimensions:
1: Intoxicated/WD Potential ❑Lo❑Med❑Hi 4: Readiness
2: Biomedical Conditions ❑Lo❑Med❑Hi 5: Relapse F
3: Emot/Beh/Cog Condtns ❑Lo❑Med❑Hi 6: Recovery

Treatment History: *(please select all that apply)*

Psychiatric Treatment in the Past 12 Months, excluding cu
❑None ❑Unknown ❑Outpatient ❑Partial/IOP ❑
Outcome: ❑Unknown ❑Improved ❑No change ❑
Treatment Compliance (Non-Med): ❑ unknown ❑

Substance Abuse Treatment in Past 12 Months, excluding
❑None ❑Unknown ❑Outpatient ❑Partial/IOP ❑
Outcome: ❑Unknown ❑Improved ❑No change ❑
Treatment Compliance (Non-Med): ❑ unknown ❑

Treatment Plan: Reason for continued treatment: *(plea*
❑Remains symptomatic ❑Prepare for dischar
❑Maintenance ❑Facilitate return to

Please indicate type(s) of service provided BY YOU, and the fr
❑Medication Management 90862 ❑Wkly ❑M
❑Indiv. Psychotherapy (20-30 min) 90804 ❑Wkly ❑M

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Requesting Authorizations: MH/SA Targeted Case Management

- **Upon receipt of the MH/SA TCM MPN, providers may begin to request MH/SA TCM**

- **For CABHA recipients receiving the case management component of CS where one wishes to retroactively change to MH/SA TCM, if clinically appropriate:**
  - CABHAs may submit to ValueOptions a completed MH/SA TCM Attestation Letter of Recipient Eligibility for each recipient (per IU77)
  - ITR and PCP are not required

- **For future-looking initial and concurrent requests for MH/SA TCM:**
  - Submit complete prior authorization request consisting of ITR, PCP, and signed service order

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Requesting Authorizations:

- Q & A

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Critical Access Behavioral Health Agencies Feedback Form

Authorization Presentation

Date: **Location:**

We value your opinion! Your opinion counts. We review every evaluation, so please let us know what you think about today's seminar by completing this form.

	Not Satisfactory		Average		Excellent
What is your overall rating of the training?	1	2	3	4	5
Appropriateness and Effectiveness of training	1	2	3	4	5
Did this training session meet your expectations ?	1	2	3	4	5
Clarity and Pace of Delivery	1	2	3	4	5
Training Materials / Handouts	1	2	3	4	5

If you have additional questions, please provide contact information below.

Medicaid Provider Number:

Provider Name:

Contact Person:

Phone Number:

Please share any additional questions related to authorizations:

Please share your comments or suggestions about today's seminar:

Thank you for participating in the N.C. Medicaid program. Your time and feedback are appreciated!

North Carolina Medicaid Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

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

To ensure timely and accurate enrollment in the EFT program, please fill out the form on the following page, attach a voided check (not a deposit slip, starter check, or counter check) and return them by mail, fax, or email. You must include your NC Medicaid Billing Provider Number on the form.

Email to:

NCXIXEFT@hp.com

Fax to:

919-816-3186
Attn: Finance Dept. – EFT

Mail to:

HP Enterprise Services
Finance Department
2610 Wycliff Rd., Suite 401
Raleigh, NC 27607

In addition, we strongly recommend that you check the routing and account number with your bank to confirm that it is accurate and will not result in an EFT return.

Once the form is processed, payments will be electronically deposited directly to the Medicaid Provider's bank account one business day after the checkwrite day.

Thank you for your cooperation.

HP Enterprise Services Provider Services
North Carolina Medicaid
Phone: 1-800-688-6696

North Carolina Medicaid
Electronic Funds Transfer (EFT)
Authorization Agreement for Automatic Deposits

Request type (must be checked) ☐ Initial Request (Start) ☐ Change Request (Close & Start) ☐ Cancel Request (Closing)

I hereby certify that the checking OR savings accounts indicated on this form are under my direct control and access; therefore, I authorize HP Enterprise Services, as fiscal agent for the State of North Carolina, to initiate, change or cancel credit entries to those checking or savings account(s) as indicated on this form. *This authority is to remain in full force and effect until HP Enterprise Services has received written notification, from either myself or a verifiable Officer of the Agency, of the account's termination in such time and in such a manner as to afford HP Enterprise Services a reasonable opportunity to act upon it.*

MEDICAID BILLING PROVIDER NUMBER (REQUIRED)_____
***EACH PROVIDER NUMBER REQUIRES A SEPARATE REQUEST**

PROVIDER/FACILITY:_____

NPI NUMBER (OPTIONAL)_____

PRINTED NAME _____ DATE: _____

SIGNATURE: _____

IF YOU ARE A PROVIDER CHANGING FROM AN EXISTING DIRECT DEPOSIT ACCOUNT OR CLOSING AN ACCOUNT FOR ANY REASON, COMPLETE THIS SECTION:

ACCOUNT ON FILE PRIOR TO CHANGE

BANK NAME: _____

BRANCH ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE:_____

BANK TRANSIT/ABA NO:_____

ACCOUNT NO:_____

CHECKING OR SAVINGS _____

In order for HP Enterprise Services to either change or close an account established to receive funds from North Carolina Division of Medical Assistance or North Carolina Division of Mental Health, all information above MUST be provided.

IF YOU ARE A PROVIDER STARTING DIRECT DEPOSIT OR CHANGING YOUR DIRECT DEPOSIT ACCOUNT, COMPLETE THIS SECTION:

BANK NAME:_____

BRANCH ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

BANK TRANSIT/ABA NO:_____

ACCOUNT NO:_____

CHECKING OR SAVINGS _____

Under penalties of perjury, we hereby certify the checking or savings account(s) indicated above is/are under our direct control and access. Therefore, we authorize HP Enterprise Services to initiate, change or cancel credit entries to those checking or savings account(s) and the bank name(s) as indicated above.

Please list the contact name, telephone number and exact street address responsible for completion of this form. **PO Boxes will be not be accepted.**

PROVIDER CONTACT NAME:_____

CONTACT TELEPHONE NUMBER:_____

PROVIDER STREET ADDRESS:_____

CITY_____ STATE_____ ZIP _____

A VOIDED CHECK OR OFFICIAL BANK LETTER VERIFYING ACCOUNT NAME, ACCOUNT NUMBER, ROUTING NUMBER AND ACCOUNT TYPE MUST BE ATTACHED FOR EACH BANK ACCOUNT IN ORDER TO PROCESS DIRECT DEPOSIT REQUESTS.

DO NOT SUBMIT DEPOSIT SLIPS, COUNTER CHECKS LACKING PRE-PRINTED INFORMATION, PERSONAL LETTERS OR PROVIDER LETTERS (UNLESS REQUESTED).

Remittance and Status Reports in PDF Format Request Form Instructions

Please complete the "Remittance and Status Reports in PDF Format Request" form. Attach one Remittance Advice cover page (no Protected Health Information; PHI) for each Provider number you wish to enroll and return them either by email, fax, or postal mail. **Failure to complete the form entirely, correctly and to include RA cover page(s) may result in a delay in processing.**

IMPORTANT!!!!

THE COVER PAGE (This page does not include any PHI) OF EACH REMITTANCE ADVICE MUST BE ATTACHED SHOWING THE PROVIDER NUMBER, PROVIDER NAME AND ADDRESS FOR EACH PROVIDER NUMBER ASSOCIATED WITH THIS REQUEST.

THIS FORM IS TO BE COMPLETED BY PROVIDERS ONLY!! IF THE PROVIDER WISHES THE PDF RA TO BE AVAILABLE TO THEIR BILLING AGENT OR VENDOR, THE PROVIDER MUST COMPLETE THE FORM GIVING AUTHORIZATION FOR THAT BILLING AGENT OR VENDOR TO RECEIVE THE PDF RA.

IF YOU ARE UNABLE TO SEND THE COVER PAGE FROM THE PAPER RA(S), PLEASE CONTACT ELECTRONIC COMMERCE SERVICES AT 1-800-688-6696 Option 1.

Please choose **ONE** of the three following methods for sending request form and attachments:

Email:
Please scan the request form and RA pages then email to:

ECSPDF@hp.com

Fax:
Fax your request form and RA pages to:

919-859-9703 or 919-233-6834
Attn: ECS Unit – PDF RA Request

Mail:
Mail your request form and RA pages to (Please place all information on outside of envelope):

HP Enterprise Services
ECS Unit
2610 Wycliff Rd., Suite 401
Raleigh, NC 27607

The PDF versions of the Remittance and Status Report will be available through the NCECS Web tool within two checkwrites after HP Enterprise Services / NC Medicaid receives your request. Thank you for your cooperation.

QUESTIONS? – Call 1-800-688-6696 Option 1 (ECS Unit - NC Medicaid)

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Remittance and Status Reports in PDF Format Request Form

This form is used by PROVIDERS for the purpose of establishing or discontinuing the PDF format of the Remittance and Status Advice (RA). It is a requirement that the form be completed and signed off by an official representative of the provider.

(please type or print clearly)

Date: _____ Number of pages including this form: _____

Choose from the following: (Only Choose *One* Option)

- **I currently have an NCECS Webtool Login ID and wish to have direct access to the PDF RA with that ID. That Login ID number is: _____**
- **I wish to authorize my Vendor/Billing Agency have access to my PDF RA on my behalf. Vendor/Billing Agency's Name: _____ The Vendor/Billing Agency's Login ID is: _____**
- **I wish to have direct access to the PDF RA and need to have a new Login ID assigned to me: _____**
- **I wish to discontinue all access to my PDF RA. That login ID number is: _____**

IMPORTANT!! – Be sure to attach your RA cover page(s)

Please Complete:

Provider Name:_____

Contact Name: _____

Address:_____

Telephone Number: (_____) _____-_____

Fax Number: (_____) _____-_____

Email Address: _____

I hereby certify that the provider numbers indicated by the RA pages included with this form are under my direct control and access; therefore, I authorize HP Enterprise Services, as fiscal agent for the State of North Carolina, to initiate, change or cancel my enrollment to receive PDF version of the Remittance and Status Reports. *This authority is to remain in full force and effect until HP Enterprise Services has received written notification, from either myself or a verifiable Officer of the Agency, of the account's termination in such time and in such a manner as to afford HP Enterprise Services a reasonable opportunity to act upon it.*

Printed Name: _____

Authorized Signature: _____

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North Carolina Department of Health and Human Services
Division of Medical Assistance
Instructions for Completing the Electronic Claims Submission (ECS) Agreement

Providers who plan to submit claims electronically must agree to abide by the conditions for electronic submission outlined in the Electronic Claims Submission Agreement. The signature of the provider constitutes acceptance of the conditions for electronic submission of claims.

The ECS Agreement is not transferable from one group practice to another, from one owner of a group practice to another or for individual providers affiliated with a group practice moving to another group practice or a solo practice.

Who Needs to Submit an ECS Agreement?

1. Currently enrolled organizations (group practices or agencies/facilities) who did not elect to submit claims electronically at the time of their initial enrollment must complete and submit an ECS Agreement prior to beginning electronic claims submission. The ECS Agreement must include the original signature of each individual provider affiliated with your group.
2. Currently enrolled organizations (group practices) who completed and submitted an ECS Agreement and who have subsequently added new individual providers to their group practice must complete and submit an additional ECS Agreement with the original signature of the new individual providers.
3. **If you are already filing electronically, it is not necessary to complete this Agreement if you are only changing your clearinghouse or billing agent.**

How to Complete the Form:

1. Type or print in black ink.
2. The ECS Agreement cannot be altered; text cannot be highlighted, struck through, or obstructed through the use of correction fluids.
3. The ECS Agreement must be submitted to CSC by mail; ECS Agreements sent by fax are not acceptable.
4. Provider Name
   a. Enter the name of your organization.
   b. The provider name entered on the ECS Agreement must match the name on file with the N.C. Medicaid Program (as indicated on your Remittance and Status Report).
   c. If the name of your organization has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.html.
   d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.
5. Medicaid Provider Number - Enter the Medicaid Provider Number for the organization. Payments will be made to this Medicaid Provider Number.
6. National Provider Identifier (NPI) - Enter the NPI for the organization.
7. Site/Physical Address

a. Enter the physical address for the organization. (The physical address is the street address for the location where services will be rendered.)
b. The physical address entered on the ECS Agreement must match the address on file with the N.C. Medicaid Program.
c. If the physical address for your organization has changed, you must submit a correction according to the process outlined on CSC's website at http://www.nctracks.nc.gov/provider/cis.jsp.
d. CSC cannot process an ECS Agreement that does not reflect current information on file for the provider.

8. Group Practice Member Information
   a. This portion of the ECS Agreement must be completed by an enrolled organization (group practice) when they elect to submit claims electronically. Enter the name and Medicaid Provider Number for each individual provider affiliated with your group for whom you will be submitting claims using your group provider number. This is required even if there is only one provider in the group.
   b. This portion of the ECS Agreement must be completed by an enrolled organization (group practice) when a new individual is added to the group practice. Enter the name and Medicaid Provider Number for only the new individual provider for whom you will be submitting claims using your group provider number.
   c. The individual provider(s) must sign where indicated. All signatures must be original; signature stamps and copies are not acceptable.
   d. This portion of the ECS Agreement is not applicable to agency/facility providers.
8. Signature Authorization and Related Information

   An authorized agent such as the medical director, owner, vice president, business officer, etc., who has the authority to enter into contracts on behalf of the group must sign group ECS Agreement.
   a. All signatures must be original.
   b. Signature stamps are not acceptable.
   c. Photocopies are not acceptable.
9. Claims should not be submitted electronically until notification of approval of the ECS Agreement is received from CSC. You must contact the ECS unit at EDS by calling 1-800-688-6696 or 919-851-8888 (option "1" on the voice response menu.) to obtain an authorization/logon number and verify that testing has been successfully completed.

Return the completed ECS Agreement to CSC:

USPS Mail:
CSC EVC Center
P. O. Box 300020
Raleigh, NC 27622-8020

For certified /overnight mail only:
CSC EVC Center
2610 Wycliff Road, Suite 102
Raleigh, NC 27607-3073

North Carolina Department of Health and Human Services
Division of Medical Assistance
ELECTRONIC CLAIMS SUBMISSION (ECS) AGREEMENT

The Provider of Medical Care ("Provider") under the Medicaid Program in consideration of the right to submit claims by paperless means rather than by, or in addition to, the submission of paper claims agrees that it will abide by the following terms and conditions:

1. The Provider shall abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance (DMA) and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA.

2. Provider's signature electing electronic filing shall be binding as certification of Provider's intent to file electronically and its compliance with all applicable statutes, rules, regulations and policies governing electronic claims submission. The Provider agrees to be responsible for research and correction of all billing discrepancies. Any false statement, claim or concealment of or failure to disclose a material fact may be prosecuted under applicable federal and/or state law (P.L. 95-142 and N.C.G.S. 108A-63), and such violations are punishable by fine, imprisonment and/or civil penalties as provided by law.

3. Claims submitted on electronic media for processing shall fully comply with applicable technical specifications of the State of NC, its fiscal agent and/or the federal government for the submission of paperless claims. DMA or its agents may reject an entire claims submission at any time due to provider's failure to comply with the specifications or the terms of this Agreement.

4. The Provider shall furnish, upon request by DMA or its agents, documentation to ensure that all technical requirements are being met, including but not limited to requirements for program listings, tape dumps, flow charts, file descriptions, accounting procedures, and record retention.

5. The Provider shall notify the CSC EVC Center in writing of the name, address, and phone number of any entity acting on its behalf for electronic submission of the Provider's claims. The Provider shall execute an agreement with any such entity, which includes all of the provisions of this agreement, and Provider shall provide a copy of said agreement to CSC prior to the submission of any paperless claims by the entity. Prior written notice of any changes regarding the Provider's use of entities acting on its behalf for electronic submission of the Provider's claims shall be provided to CSC. For purposes of compliance with this agreement and the laws, rules, regulations and policies applicable to Medicaid providers, the acts and/or omissions of Provider's staff or any entity acting on its behalf for electronic submission of the Provider's claims shall be deemed those of the Provider, including any acts and/or omissions in violation of Federal and State criminal and civil false claims statutes.

6. The Provider shall have on file at the time of a claim's submission and for five years thereafter, all original source documents and medical records relating to that claim, (including but not limited to the provider's signature and all electronic media and electronic submissions), and shall ensure the claim can be associated with and identified by said source documents.

Provider will keep for each recipient and furnish upon request to authorized representatives of the Department of Health and Human Services, DMA, the State Auditor or the State Attorney General's Office, a file of such records and information as may be necessary to fully substantiate the nature and extent of all services claimed to have been provided to Medicaid recipients. The failure of Provider to keep and/or furnish such information shall constitute grounds for the disallowance of all applicable charges or payments.

7. The Provider and any entity acting on behalf of the provider shall not disclose any information concerning a Medicaid recipient to any other person or organization, except DMA and/or its contractors and as provided in paragraph 6 above, without the express written permission of the recipient, his parent or legal guardian, or where required for the care and treatment of a recipient who is unable to provide written consent, or to bill other insurance carriers or Medicare, or as required by State or Federal law.
8. To the extent permitted by applicable law, the Provider will hold harmless DMA and its agents from all claims, actions, damages, liabilities, costs and expenses, which arise out of or in consequence of the submission of Medicaid billings through paperless means. The provider will reimburse DMA processing fees for erroneous paperless billings when erroneous claims constitute fifty percent or more of paperless claims processed during any month. The amount of reimbursement will be the product of the per-claims processing fee paid to the fiscal agent by the State in effect at the time of submission and the number of erroneous claims in each submission. Erroneously submitted claims include duplicates and other claims resubmitted due to provider error.
9. Sufficient security procedures must be in place to ensure that all transmissions of documents are authorized and protect recipient specific data from improper access.
10. Provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid.
11. Either the Provider or DMA has the right to terminate this agreement by submitting a (30) day written notice to the other party; that violation by Provider or Provider's billing agent(s) of the terms of this agreement shall make the billing privilege established herein subject to immediate revocation by DMA; that termination does not affect provider's obligation to retain and allow access to and audit of data concerning claims. This agreement is canceled if the provider ceases to participate in the Medicaid Program or if state and federal funds cease to be available.
12. No substitutions for or alterations to this agreement are permitted. In the event of change in the Provider billing number, this agreement is terminated. Election of electronic billing may be made with execution of a new provider participation agreement or completion of a separate electronic agreement.
13. Any member of a group practice that leaves the group and establishes a solo practice must make a new election for electronic billing under his solo practice provider number.
14. The cashing of checks or the acceptance of funds via electronic transfer is certification that the Provider presented the bill for the services shown on the Remittance Advice and that the services were rendered by or under the direction of the Provider.

15. Provider is responsible for assuring that electronic billing software purchased from any vendor or used by a billing agent complies with billing requirements of the Medicaid Program and shall be responsible for modifications necessary to meet electronic billing standards.
16. Electronic claims may not be reassigned to an individual or organization that advances money to the Provider for accounts receivable that the provider has assigned, sold or transferred to the individual or organization for an added fee or deduction of a portion of the accounts receivable.

Required Fields are marked with an asterisk (*).

*Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

*Medicaid Provider Number | National Provider Identifier (NPI)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

Street Address Line 2

*City | *State | *Zip Code + Four (Last 4 digits required)

Group Practice Member Information:

This portion of the ECS Agreement must be completed if you are billing as a group (for example, dental groups, physician groups, nurse practitioner groups, etc.)

List each individual provider for whom you will submit claims using your group provider number even if there is only one provider in your group practice.

All provider signatures must be original. Signature stamps and copies are not acceptable.

*Provider Name	*Provider Individual Number	*Signature of Provider

*Provider Name	*Provider Individual Number	*Signature of Provider

(Attach additional sheets if necessary)

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

*Signature of Authorized Agent *Date

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date by

North Carolina Department of Health and Human Services

Division of Medical Assistance

PROVIDER CERTIFICATION FOR SIGNATURE ON FILE

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

A separate certification is required for each individual in the group in addition to the group certification.

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.

_____

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)

_____

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

_____

Street Address Line 2

_____

*City *State *Zip Code + Four (Last 4 digits required)

_____

*Signature of Applicant or Authorized Individual *Date

_____

*Printed Name and Title

DMA/FISCAL AGENT APPROVAL

Acceptance Date: _____ by _____

Helpful Information

DMA Web site	http://www.ncdhhs.gov/dma
CABHA	http://www.ncdhhs.gov/services/cabha.htm
Enhanced Services Implementation Updates	http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/index.htm
Budget Initiatives	http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm
ECS Exceptions	http://www.ncdhhs.gov/dma/provider/ECSExceptions.htm
Basic Medicaid Billing Guide	http://www.ncdhhs.gov/dma/basicmed/
DMA Contacts	http://www.ncdhhs.gov/dma/provider/provcontacts.htm
Medicaid Bulletins	http://www.ncdhhs.gov/dma/bulletin/
Provider Forms	http://www.ncdhhs.gov/dma/provider/forms.htm
Clinical Coverage Policies	http://www.ncdhhs.gov/dma/MP/
NC Tracks	http://www.nctracks.nc.gov
Annual List Limitation	http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm
HIPAA Companion Guides	http://www.ncdhhs.gov/dma/hipaa/compguides.htm
Provider Fee Schedules	http://www.ncdhhs.gov/dma/fee/
EPSDT Information	http://www.ncdhhs.gov/dma/provider/epsdthealthcheck.htm
EFT Agreement	http://www.ncdhhs.gov/dma/provider/forms.htm
CCNC/CA Override Request	http://www.ncdhhs.gov/dma/provider/forms.htm
NCECS Special Bulletin-September 2009	http://www.ncdhhs.gov/dma/bulletin/pdfbulletin/0909SpecBull3.pdf
HP Enterprise Services	1-800-688-6696
Automated Voice Response System	1-800-723-4337
CSC, EVC Call Center	1-866-844-1113 http://www.nctracks.nc.gov/provider/providerEnrollment/
Value Options	888-510-1150 – Medicaid 800-753-3224 – Healthchoice http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm
The Durham Center	Phone - 919-560-7100 Fax - 919-560-7377 http://www.durhamcenter.org
Eastpointe	Phone – 800-513-4002 Fax – 910-298-7189 http://www.eastpointe.net

Extracted from IU #73:

Critical Access Behavioral Health Agencies Enrollment, Authorization, and Claims

Several organizations have now been certified as meeting Critical Access Behavioral Health Agency (CABHA) status. As a reminder, CABHA status will be certified once for the entire state through a review by a certification team comprised of staff from: local management entities (LMEs), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and Division of Medical Assistance (DMA). The provider is still required to enter into standardized Memoranda of Agreements (MOAs) with LMEs in the catchment areas where they deliver services and a standardized contract with those same LMEs for State-funded services. Continued certification as a CABHA will be based upon the agency's meeting or exceeding the required performance standards established by the Department of Health and Human Services (DHHS).

Additional information about CABHA can be found at http://www.ncdhhs.gov/mhddsas/cabha/.

CPT and HCPCS Billing Information
Each CABHA is required to offer, at a minimum, the following "Core" services:

1. Clinical Assessment
CABHA attending providers may bill the following CPT and HCPCS codes for clinical assessments:
- **90801, 90802, H0001, and H0031**

For provider types and service limitations, please refer to DMA Clinical Coverage Policy 8C http://www.ncdhhs.gov/dma/mp/. Physicians may also bill any of the CPT codes in this policy.
- **T1023 – Diagnostic Assessment**

For provider types and service limitations, please refer to DMA Clinical Coverage Policy 8A http://www.ncdhhs.gov/dma/mp/.
- **99201, 99202, 99203, 99204, and 99205**

Physicians and advanced practice nurses may also bill these evaluation and management (E/M) CPT codes. E/M codes are not specific to mental health and are not subject to prior approval. E/M codes are subject to published benefit limits, including the 24-visit-per-year limit for adults. These assessment codes are limited to one per attending provider, per recipient, in a three year period.

2. Medication Management
Physicians and advanced practice nurses may bill the following E/M CPT codes: **90862, 99211, 99212, 99213, 99214, and 99215.** E/M codes are not specific to mental health and are not subject to prior approval. E/M codes are subject to published benefit limits, including the 24-visit-per-year limit for adults. For recipients under the age of 21, there is no limit to E/M codes allowed per year.

3. Outpatient Therapy
For provider types, billable codes, and service limitations, please refer to DMA Clinical Coverage Policy 8C on DMA's website at http://www.ncdhhs.gov/dma/mp/. Physicians may also bill any of the CPT codes in this policy.

4. At least two additional MH/SA services (from the list below)

See DMA Clinical Coverage Policy 8A for Enhanced Behavioral Health Services and DMA Clinical Coverage Policy 8D-2 for Residential Child Care Services on DMA's website at http://www.ncdhhs.gov/dma/mp/.

- H2022 Intensive In-Home (IIH)
- H2015 HT Community Support Team (CST)
- H0015 Substance Abuse Intensive Outpatient Program (SAIOP)
- H2035 Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- H2012 HA Child and Adolescent Day Treatment
- H2017 Psychosocial Rehabilitation (PSR)
- H0040 Assertive Community Treatment Team (ACTT)
- H2033 Multi-Systemic Therapy (MST)
- H0035 Partial Hospitalization (PH)
- H0013 Substance Abuse Medically Monitored Community Residential Treatment
- H0012 HB Substance Abuse Non-Medical Community Residential Treatment
- H0020 Outpatient Opioid Treatment
- S5145 (Therapeutic Foster Care) Child Residential Level II – Family Type
- H2020 Child Residential Level II – Program Type
- H0019 Child Residential Level III and IV
- Therapeutic Family Services (upon approval by CMS)

5. Only CABHAs will be able to provide Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM). CABHAs are not required to provide this service.

CABHA Enrollment

Per Implementation Update #70 (http://www.ncdhhs.gov/mhddsas/servicedefinitions/servdefupdates/), providers who have achieved certification as a CABHA will need to complete a Medicaid Provider Enrollment Application (http://www.nctracks.nc.gov/provider/providerEnrollment/) to obtain a Medicaid provider billing number (MPN). CABHA applicants must complete and submit the downloadable paper version of the In-State/Border Organization Provider Enrollment Application or the online version of the Provider Enrollment Application to enroll as a CABHA. When completing the Affiliated Provider Information section of the application, the CABHA **must** list the name, MPN, and NPI associated with that number for each independently enrolled behavioral health practitioner and the name, attending MPN (identified by the alpha suffix appended to the core number), and the NPI associated with that number for each community intervention service that will be billed through the CABHA.

CABHA and National Provider Identification (NPI)

At enrollment, CABHAs will need to identify an NPI associated with the CABHA billing MPN. Providers with current NPIs may choose to subpart, or request multiple NPIs for specific entities within the organization. **All CABHAs are encouraged to obtain a separate NPI for the CABHA for ease of claims reimbursement.**

This CABHA NPI must be used by the CABHA in order to bill for services rendered by the direct-enrolled individuals (for example, medical doctor (MD), licensed clinical social worker (LCSW)) and for enhanced services (for example, Community Support Team) provided by the CABHA. This CABHA NPI will be used as the "billing number." **Please see special instructions below for Therapeutic Foster Care (Level II – Family Type), and Residential Levels II – Program Type, III, and IV Residential Child Care (RCC) services.**

For dates of service July 1, 2010, forward, **if a provider has multiple MPNs but does not elect to subpart their CABHA, the claim will adjudicate through the NPI mapping solution and adjudicate to the CABHA MPN only.** For example, if a single NPI is linked to a CABHA, a physician group, and a psychology group or a CABHA and a Community Intervention Services Agency (CISA), the NPI mapping solution will assign the CABHA MPN as the billing provider for services that are rendered by a CABHA. **Please see special instructions below for Therapeutic Foster Care (Level II – Family Type) and Residential Levels II – Program Type, III, and IV Residential Child Care (RCC) services.**

Please refer to the NPI section on the DMA website at http://www.ncdhhs.gov/dma/NPI/ for additional information regarding NPI.

Claims Submission

Claims for all CABHA services (with the exception of Levels II–Program Type, III, and IV) will be billed using the professional claim (CMS-1500/837P) format. The CABHA NPI should be listed as the 'billing provider." The "attending provider number" should be the NPI associated with the provider/service for which prior authorization was obtained. **Claims for Therapeutic Foster Care (Level II–Family Type) must continue to be submitted through the LME for processing.** In other words, providers should continue to submit Therapeutic Foster Care claims in the same way as they do today.

Claims for Residential Levels II–Program Type, III, and IV (provided by CABHAs) should continue to be billed using the institutional claim (UB-04/837I) format. In these instances, providers must continue to submit claims with the current billing NPI associated with the Level II–Program Type, III, or IV. In other words, providers should continue to submit claims for Levels II–Program Type, III, and IV services in the same way as they do today. If providers submit RCC claims under the CABHA's NPI, the claim will be denied.

CABHA's performing State funded services will continue to have services approved and billed to the Integrated Payment and Reporting System (IPRS) through the LMEs.

Medicaid enrollment questions may be directed to Computer Sciences Corporation (CSC): 1-866-844-1113. Medicaid claims questions may be directed to HP Enterprise Services, 1-800-688-6696 and policy questions may be directed to DMA Behavioral Health Section at 919-855-4290.

Additional information about CABHA can be found at http://www.ncdhhs.gov/mhddsas/cabha/.

Extracted from IU #77:

Update on Mental Health/Substance Abuse Targeted Case Management

Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) was implemented effective with date of service July 1, 2010 with a weekly case rate of $81.25. The procedure code for MH/SA TCM is H0032 and the billing limit is one unit per week (Sunday through Saturday). Prior approval is required for this service. To bill this weekly case rate, the case manager must provide at least 15 minutes of case management activity per week (assessment, person centered plan (PCP) development, linkage/referral, monitoring). However, the case manager must provide all services necessary to meet the case management needs of the recipient. For audit and rate setting purposes, each contact must be documented, and documentation must include the amount of time spent during the contact. Please see the Division of Medical Assistance (DMA) Clinical Coverage Policy 8L (http://www.ncdhhs.gov/dma/mp/) for the full description of the service.

Claims Submission

System implementation for payment of the weekly rate for MH/SA TCM is expected to be completed by September 1, 2010. Providers should not submit claims for MH/SA TCM prior to September 1, 2010. In the interim weeks, providers may continue to provide and bill the case management component of CS, if authorized for a recipient under the CISA MPN.

MH/SA TCM claims will always be billed using the professional (CMS-1500/837P) claim type. For claims submission the National Provider Identifier (NPI) associated with the CABHA MPN will always be the "billing" number and the NPI associated with the MH/SA TCM MPN will always be the "attending" number. Providers must bill MH/SA TCM claims with dates of service that correspond with MH/SA TCM authorization dates. The billing limit is one unit per week (Sunday through Saturday).

When a claim is submitted for MH/SA TCM, HP Enterprise Services will automatically recoup any payments for CS during any week (Sunday through Saturday) that the MH/SA TCM procedure code is billed. Claims will be recouped from the original CISA billing MPN that provided the service. The weekly unit may not be billed for any week in which there was no contact with the recipient. Services reimbursed will be subject to audit and recoupment if policy requirements were not met for that week.

Tips

- **IU#73** At enrollment, CABHAs will need to identify an NPI associated with the CABHA billing MPN. Providers with current NPIs may choose to subpart or request multiple NPIs for specific entities within the organization. The CABHA NPI must be used by the CABHA in order to bill for services rendered by the direct-enrolled individuals (for example, medical doctor (MD), licensed clinical social worker (LCSW)) and for enhanced services (for example, Community Support Team) provided by the CABHA. This CABHA NPI will be used as the "billing number."

- **IU#73** Claims for all CABHA services (non-residential) will be billed using the professional claim (CMS-1500/837P) format. The CABHA NPI should be listed as the "billing provider". The "attending provider number" should be the NPI associated with the provider/service for which prior authorization was obtained

- **IU#73 Therapeutic Foster Care Claims**- Therapeutic Foster Care (Level II-Family Type) must continue to be submitted through the LME for processing. In other words, providers should continue to submit Therapeutic Foster Care claims in the same way as they do today

- **IU#73** Providers must continue to submit claims with the current billing NPI associated with the Level II-Program Type, III, or IV. In other words, providers should continue to submit claims for Levels II - Program Type, III, and IV services in the same way as they do today. CABHAs are able to provide RCC services but they need to be billed with the current RCC billing NPI number and not the CABHA NPI number. If providers submit RCC claims under the CABHA's NPI, the claim will be denied

- **IU#77 Mental Health/Substance Abuse Targeted Case Management:** The procedure code for MH/SA TCM is H0032 and the billing limit is one unit per week (Sunday through Saturday). Providers should not submit claims for MH/SA TCM prior to September 1, 2010. In the interim weeks, providers may continue to provide and bill the case management component of CS if authorized for a recipient under the CISA MPN. MH/SA TCM claims will always be billed using the CMS-1500/837P claim type. For claims submission, the NPI associated with the CABHA MPN will always be the "billing" number and the NPI associated with the MH/SA TCM MPN will always be the "attending" number. When a claim is submitted for MH/SA TCM, HP Enterprise Services will automatically recoup any payments for CS during any week (Sunday though Saturday) that the MH/SA TCM procedure is billed. Claims will be recouped from the original CISA billing MPN that provided the service.

- **When submitting claims for outpatient or enhanced services, the CABHA NPI number is the billing number that will be listed on line 33a of your claim form. The attending (individual or enhanced service) NPI number associated with the attending (individual or enhanced service) MPN that requested and received authorization for services should be listed as the attending provider number on line 24j of the claim form. When submitting claims under CABHA, you should continue to follow the current guidelines for Carolina Access. The Carolina Access NPI will be listed on line 17b of your claim form.**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI XXXXXXXXXX

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 01 10 07 01 10			H2015	HT		14 50	1		ZZ NPI	XXXXXXXXXX XXXXXXXXXX
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED XXXXXXXX DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. XXXXXXXXXX b. ZZ XXXXXXXXXX

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

How to Obtain an NPI

Healthcare providers can apply for their NPIs at https://nppes.cms.hhs.gov/NPPES/Welcome.do (click on the link to *National Provider Identifier* and follow the instructions for applying). All HIPAA-covered physicians, suppliers, and other health care providers must apply for and be issued an NPI number. In addition, all health plans began accepting the NPI instead of plan-specific provider identifiers on all HIPAA standard transactions on May 23, 2008. When applying for an NPI, providers are urged to include all MPNs on the NPI application form and indicate North Carolina as the state name.

Note: Applying for an NPI does not replace any enrollment or credentialing processes for N.C. Medicaid.

Once NPIs are obtained, they must be reported to N.C. Medicaid. A copy of the National Plan and Provider Enumeration System (NPPES) certification letter or NPPES certification e-mail for each NPI number must also be provided.

Top Reasons That Could Cause An Interruption In Payment

Please contact HP Provider Services at 1-800-688-6696, option 3, for assistance with the EOBs listed below.

EOB	EOB Description	Common Resolution
5400	EXACT DUP: SAME ATTD PROV/PCODE/TOS/DOS/MOD/DTL $$/DIFF ICN	A claim with the same dates and services has paid, previously in history. If previous payment is incorrect, submit a replacement claim to address overpayment or underpayment. If payment is correct, no action necessary.
79	THIS SERVICE IS NOT PAYABLE TO YOUR PROVIDER TYPE OR SPECIALTY IN ACCORDANCE WITH MEDICAID GUIDELINES	Provider is most likely billing for a code with the incorrect NPI associated with assigned MPN. Resubmit the claim with the correct NPI.
5111	PROVIDER NUMBER ON CLAIM DOES NOT MATCH PROVIDER NUMBER ON PRIOR AUTHORIZATION RECORD	Provider needs to verify the provider number associated with the authorization number and resubmit the claim with the correct NPI associated with the authorization.
23	SERVICE REQUIRES PRIOR APPROVAL	Claim was received with authorization number omitted from the claim. Provider needs to include authorization on the claim or obtain authorization for the service.
5308	PRIOR AUTHORIZED UNITS EXCEEDED	Units are exceeded. Provider needs to obtain additional authorization.
82	SERVICE IS NOT CONSISTENT WITH/OR NOT COVERED FOR THIS DIAGNOSIS/OR DESCRIPTION DOES NOT MATCH DIAGNOSIS	Provider needs to verify the diagnosis code: Missing-incomplete-invalid diagnosis or condition.

Please contact HP Provider Services at 1-800-688-6696, option 3, and then option 1, for assistance with the EOBs listed below.

EOB	EOB Description	Common Resolution
270	BILLING PROVIDER IS NOT THE RECIPIENT'S CAROLINA ACCESS PCP. AUTHORIZATION IS MISSING OR UNRESOLVED. CONTACT PCP FOR AUTHORIZATION OR HP PROV SVCS IF AUTHORIZATION IS CORRECT	Submitted claim requires a referring NPI. The referring NPI is either not found on the claim or is unresolved (cannot map to single MPN). Correct and resubmit the claim.
286	INCORRECT AUTHORIZATION NUMBER ON CLAIM FORM. VERIFY NUMBER AND REFILE CLAIM	Referring NPI on processed claim does not match the CCNC/CA PCP listed on the recipient's eligibility file for submitted date of service. Contact referring PCP, obtain the correct referral information and resubmit claim.

Although the suggested resolution is for common denial cases, each claim may propose a unique processing scenario. For further information or claim research, contact HP Provider Services for claim-specific analysis.

HP Enterprise Services
1-800-688-6696 or 919-851-8888

Medicaid fraud/abuse costs

You

Thinking Medicaid fraud and abuse "don't hurt anyone" is just wrong! Every dollar wasted or stolen is a dollar that could have been spent on health care for someone who needs it and who follows the rules. And those dollars add up —tens of millions in North Carolina each year.

Whether you're a Medicaid provider, recipient or simply a taxpayer, fraud and abuse cost YOU! If you know or suspect someone has gained Medicaid benefits improperly, report it to the state Division of Medical Assistance.

Call 1-877-DMA-TIP1. (1-877-362-8471)

Or report online at **www.ncdhhs.gov/dma/fraud/reportfraudform.htm**

How you can save Medicaid dollars:

Keep all paperwork together.

Be alert for:

- *Services promised but never given*
- *Unnecessary tests or procedures*
- *Repeat billing for same procedure*
- *Statements that don't match your actual health or medical condition*

Do not allow anyone to use your Medicaid card.

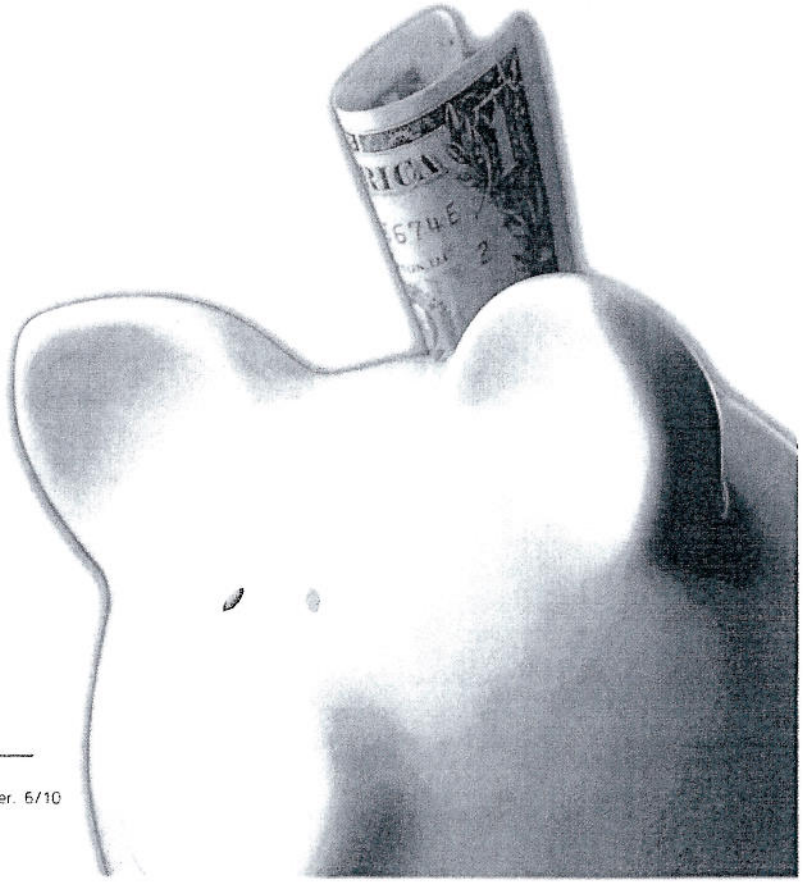
Never sign a blank form.

Do not share medical records or your Medicaid number with anyone except your doctor, hospital, pharmacist or other health care provider.

Report Medicaid recipients who:

- *Lie about eligibility*
- *Lie about medical conditions*
- *Forge prescriptions*
- *Sell prescription drugs*
- *Loan Medicaid cards to others*

Don't feel guilty about reporting someone who steals health care from those who need and deserve it!



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Critical Access Behavioral Health Agencies Feedback Form

We value your opinion! Your opinion counts. We review every evaluation, so please let us know what you think about today's seminar by completing this form.

	Not Satisfactory		Average		Excellent
What is your overall rating of the seminar?	1	2	3	4	5
Appropriateness and Effectiveness of training	1	2	3	4	5
Did this training session meet your expectations ?	1	2	3	4	5
Clarity and Pace of Delivery	1	2	3	4	5
Training Materials / Handouts	1	2	3	4	5

Would you like onsite training scheduled? Yes No

If you answered yes, please provide contact information below.

Medicaid Provider Number:

Provider Name:

Contact Person:

Phone Number:

Do you have any additional questions?

Please share your comments or suggestions about today's seminar:

Thank you for participating in the N.C. Medicaid program. Your time and feedback are appreciated!