



NC Medicaid Provider Enrollment CSC EVC Center

P. O. Box 300020
Raleigh, NC 27622-8020

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

Dear CIS Provider,

Thank you for your interest in providing additional services as a Community Intervention Services (CIS) provider with the N.C. Medicaid Program. In order for us to complete the process, please mail the following documents to CSC:

- A completed and signed CIS Addendum to Add Services. The authorized individual indicated on page 1 of the addendum must sign and date the addendum.
- A completed and signed NC Department Of Health And Human Services (DHHS) Provider Administrative Participation Agreement
- A completed and signed Letter of Attestation
- A copy of current licensure, certification, LME Endorsement and other required documents. See Community Intervention Services (CIS) Provider Qualifications and Requirements.

Retain a copy of your completed CIS Addendum to Add Services packet and all documentation submitted for your records.

You will be notified by mail once the enrollment process has been completed. Please do not submit claims for any services until you have been notified.

Billing information and clinical coverage policies are available on DMA's website at <http://www.ncdhhs.gov/dma/provider/index.htm>.

Thank you again for your interest. If you have any questions or need additional information, please feel free to contact NC Medicaid Provider Enrollment at the CSC EVC Center at 866-844-1113 or email the CSC EVC Center at NCMedicaid@csc.com.

If any of the following changes have been made to your site location since enrollment (or your last reported change), you must complete a new Provider Enrollment Application:

- Group Name/Tax name
- Tax Number
- Change of Ownership

If any of the following changes have been made to your site location since enrollment (or your last reported change), you must complete a Medicaid Provider Change Form before you Add Services:

- National Provider Number
- Billing contact information or site (physical location) contact information (telephone number, fax number, e-mail)
- Billing Address
- Site (physical location) Address

Please visit the NCTracks Provider Services (<http://www.nctracks.nc.gov/provider/>) to complete a new application or to obtain a Medicaid Provider Change form.



Community Intervention Services (CIS) Requirements and Qualifications

CIS Services	Requirements and Qualifications
<ul style="list-style-type: none"> • <u>Assertive Community Treatment Team</u> • <u>Mobile Crisis Management</u> • <u>Medically Supervised or ADATC Detox/Crisis Stabilization</u> • <u>Diagnostic Assessment</u> • <u>Multisystemic Therapy</u> 	<p>Notification of Endorsement by the Local Management Entity</p>
<ul style="list-style-type: none"> • <u>Early Intervention Services</u> 	<p>Letter of approval from the Children's Developmental Services Agency</p>
<ul style="list-style-type: none"> • <u>Professional Treatment Services in Facility-based Crisis Program - Adult</u> • <u>Professional Treatment Services in Facility-based Crisis Program - Child</u> • <u>Partial Hospitalization</u> • <u>Ambulatory Detox</u> • <u>Substance Abuse Comprehensive Outpatient Treatment</u> • <u>Non-hospital Medical Detox</u> • <u>Substance Abuse Non-medical Community Residential Treatment</u> • <u>Substance Abuse Medically Monitored Community Residential Treatment</u> • <u>Substance Abuse Intensive Outpatient Program</u> • <u>Psychosocial Rehab</u> • <u>Opioid Treatment</u> 	<p>Notification of Endorsement by the Local Management Entity</p> <p>Licensed by NC DHSR as a Mental Health Facility</p>



North Carolina Department of Health and Human Services
Community Intervention Services (CIS) Addendum to Add Services

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

Current Medicaid Provider Information

Current Medicaid Provider Number * National Provider Identifier (NPI) Number *

Contact Person (Authorized Individual)

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

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

Indicate the Community Intervention Service(s) your organization is adding:

- Ambulatory Detoxification
Assertive Community Treatment Team
Community Based Rehabilitative Service – Early Intervention1
Diagnostic Assessment
Medically Supervised or ADATC Detoxification/Crisis Stabilization
Mobile Crisis Management
Multi-systemic Therapy (MST)
Non Hospital Detoxification
Opioid Treatment
Partial Hospitalization
Professional Treatment Services in Facility Based Crisis Programs - Child
Professional Treatment Services in Facility Based Crisis Programs - Adult
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

1 does not require endorsement

Managing Relationships

As required by 42 CFR 1002.3, providers must disclose the following for each individual officer, director, managing employee (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individual. Failure to provide the required information may result in a denial for participation.

Relationship 1

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 2

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 3

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 4

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 5

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 6

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Managing Relationships Continued . . .

Relationship 7

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 8

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 9

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 10

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 11

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Relationship 12

Full Name (Last, First, Middle) *	
Social Security Number * - -	Date of Birth (MM/DD/CCYY) * / /
Business Relationship to Enrolling Provider (Title) *	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership Information

How would you describe the ownership? *

<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> City/Municipality	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Single-Owner LLC
			<input type="checkbox"/> Sole Proprietor

Corporations, Partnerships, Non-Profits and Sole Proprietors:
 Does anyone have direct or indirect ownership or control interest of 5% or more in the organization/entity? * Yes No

If you answered yes to the above question you must list ownership information for each owner who owns 5% or more.

Ownership 1

Full Name (Last, First, Middle) / Business Name*

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
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Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
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Ownership 2

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
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Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
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Ownership 3

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
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Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
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Ownership 4

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
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Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
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Ownership 5

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) * / /	Ownership % *
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Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*
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Ownership Information Continued . . .

Ownership 6

Full Name (Last, First, Middle) / Business Name*

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 7

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 8

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 9

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 10

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Ownership 11

Full Name (Last, First, Middle) *

Social Security Number / Employer Identification Number *	Date of Birth (MM/DD/CCYY) *	Ownership % *
	/ /	

Business Relationship to Enrolling Provider (Title)	Familial Relationship to Enrolling Provider (i.e., Mother, Father, Sister, Brother, None, etc)*

Certification, Licensure, Accreditation, and Endorsement

Please complete required certification, licensure, accreditation, and endorsements as applicable

Certification

Certifying Entity

Current Effective date	Expiration Date	State	Certificate Number
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License

Licensing Entity

Current Effective Date	Expiration Date	State	License / Certificate Number
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Accreditation

Accreditation Entity

Current Effective Date	Expiration Date	State	Accreditation Number
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Local Management Entity (LME) Endorsement

All CIS Services except Early Intervention Service require a Notification of Endorsement by the LME.

List the Local Management Entity that conducted your business verification

Consent to Release Information

I understand that the North Carolina Division of Medical Assistance (DMA) and its representatives is responsible for the evaluation of my professional training, experience, professional conduct, and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Medicaid Program. I understand and agree that as an applicant for participation in the Medicaid Program, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize DMA and its representatives to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between DMA and its representatives and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by DMA and its representatives to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of the Program and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions acting in good faith and without malice for acts performed in gathering or exchanging information in this credentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Program's credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or DMA to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

Signature of Authorization Required

Information Must Be Entered For The Agreement To Be Processed

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.

Signature of Authorized Individual *	Date *
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Print Name *	Title *
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North Carolina Department of Health and Human Services PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement

This Medicaid Provider Administrative Participation Agreement (“Agreement”) is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the “Department”, and the below identified provider, hereinafter referred to as the “Provider.”

STATE/FISCAL AGENT USE ONLY
<input type="checkbox"/> Initial Enrollment
<input type="checkbox"/> Re-Enrollment
<input type="checkbox"/> CHOW
<input type="checkbox"/> Other Change

2. Agreement Document

The Agreement Documents shall consist of this Agreement, any addendum, and the Provider’s application, incorporated herein by reference. Except for changes to DHHS medical coverage policies, or other guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent as referenced in Section 3, below, no alterations or modifications shall be made to the terms of the Agreement unless through a written amendment executed by both parties.

3. Governing Law and Venue

This Agreement is required by 42 CFR §431.107 and shall be governed by the following (hereinafter referred to as the “Controlling Authority”):

- (a) Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, and any Title XIX waivers authorized by the Centers for Medicare and Medicaid Services (CMS); and
- (b) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
- (c) The Family Educational Rights and Privacy Act (FERPA); and
- (d) N.C.G.S §108A-80; and
- (e) The following that are consistent with and expressly or implicitly authorized by the authority in subdivision (a) herein: state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered.

By execution of this Agreement, the Provider does not release, waive or modify in any way any procedural or substantive rights it may have pursuant to Controlling Authority related to its participation in the Medicaid program. In case of conflict between any provision of this Agreement and any current or future provision of Controlling Authority, the Controlling Authority shall govern and the terms of this Agreement shall be deemed to be modified so as to comply with Controlling Authority. In the event of a

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lawsuit or administrative petition involving this Agreement, venue is proper in Wake County, North Carolina.

The Provider agrees to operate and provide services in accordance with the Controlling Authority. Unless otherwise required by this Agreement or Controlling Authority, the Department may publish notice of changes in policies, guidelines, or other procedures on its website within 30 days advance notice to provide for implementation thereof.

Nothing in this Agreement creates in the provider a property right or liberty right in continued participation in the North Carolina Medicaid program.

4. License

The Provider agrees to:

- a. Be licensed, certified, registered, accredited and/or endorsed as required by Controlling Authority or Department policy, as appropriate for the service provided by the Provider, at all times those services are provided.
- b. Notify the Department within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.

5. Billing and Payment

The Provider agrees:

- a. To submit claims for services rendered to eligible North Carolina Medicaid recipients (hereinafter "recipients") in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies in claims submitted by the Provider or its authorized agent.
- b. To accept as sole and complete remuneration the amount paid in accordance with the finally determined reimbursement rate for services covered by the Department, except for payments from legally liable third parties, and authorized co-payments, coinsurance and/or deductibles authorized by the Controlling Authority or the Department. A Provider may bill for goods, services, or supplies provided to a recipient if such are not covered under Medicaid and the recipient has been notified in advance that such services are not covered and that the recipient is financially responsible. By agreeing to this provision, the Provider does not waive any potential rights to challenge or appeal its reimbursement rate or payment calculation in accordance with Controlling Authority.
- c. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the Provider or any other party that may provide services.
- d. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of the Agreement to assign the right to payment under this Agreement to a third party in violation of 42 CFR §447.10.
- e. To inquire about other coverage and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
- f. To not bill the recipient or any other person for items and services covered by Medicaid and to refund payments made by the recipient or by a third party on behalf of the recipient for Medicaid covered services for any claims for which the recipient has been approved for payment by the Department, including retroactive authorization for payment. No refund is due by the Provider to the recipient or any

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- other person until payment to the Provider is final and has been made in full by Medicaid to the Provider.
- g. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
 - h. To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents.
 - i. That payment for covered services by the Department is limited to those services that are medically necessary. Medical necessity and appeals of medical necessity determinations will be determined in accordance with the Controlling Authority.
 - j. That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the same professional standards and principles as herein agreed to by the Provider.
 - k. That payment and satisfaction of claims will be from federal and state funds.
 - l. That claims are subject to the Medical Assistance Provider False Claims Act (Part 7, Article 2, Chapter 108A of the General Statutes), the North Carolina False Claims Act, Chapter 1, Article 51 of the North Carolina General Statutes (N.C.G.S §§1-605 through 617), and the federal False Claims Act.
 - m. That the Department may withhold payments because of irregularity without regard to cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. The Department shall provide timely notice to the Provider that states the Department's reasons for withholding payments, the conditions that must be met to resolve the irregularity and the Provider's right to appeal. This withhold shall be subject to adjustment in accordance with Controlling Authority as a result of any contrary final determination in any challenge or appeal brought by the Provider. The Department may also withhold or suspend payments to a Provider as authorized by Controlling Authority. A Provider that is subject to a withhold recoupment, recovery, suspension, or penalty initiated by the Department shall not directly or indirectly bill through a different provider number for the purpose of evading the action.
 - n. Any Providers that share the same IRS Employee Identification Number are equally subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until any overpayment, penalty, or invalid payment incurred by such Provider(s) is resolved, either by payment in full or final agency decision. Any Provider that does not share the same Employee Identification Number but that is more than fifty percent (50%) owned, in whole or in part, by an individual or entity that has more than fifty percent (50%) ownership interest in a separate provider entity that owes an outstanding overpayment, penalty, or invalid payment to the Department shall also be subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until such overpayment, penalty, or invalid payment is resolved, either by payment in full or final agency decision.
 - o. That billings and reports related to services rendered shall be submitted in the format and frequency specified by the Department, any of its divisions and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time frames established by Department rule or policy may result in suspension of payments and/or other enforcement actions.
 - p. That claims shall be received by the Department within 365 calendar days of the date of service except as otherwise provided by Controlling Authority.
 - q. That electronic and non-electronic Medicaid claims may be submitted without signature and same is binding upon Provider, its employees, or its agents who provide services to recipients or who file claims under the Provider name and identification number.
 - r. That all claims shall be true, accurate, and complete and that services billed shall be personally furnished by Provider, its employees, or persons with whom the Provider has contracted to render services, under its direction.
 - s. That, except for hospital services as set forth in 42 CFR §413.65 the assigned Medicaid Provider Number

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is specific to the Provider name and site location identified on the signature page of this Agreement, and that Provider shall not bill for services provided at or from other site locations using Medicaid Provider Number assigned to the site location identified on the signature page of this Agreement.

- t. That any change of ownership of Provider shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including but not limited to cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by Provider.
- u. To not bill the Department for services that were rendered during any period in which the institutional or professional license, certification, registration, accreditation and/or endorsement required of the individual or entity providing the service has become invalid due to suspension or termination by the issuing agency.

6. Disclosure

- a. At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:
 - i. ownership;
 - ii. licensure;
 - iii. federal tax identification number;
 - iv. bankruptcy;
 - v. additions, deletions, or replacements in group membership; and
 - vi. any change in address or telephone number.
- b. The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:
 - i. Proof of a valid license, operating certificate, and/or certification if required by Controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
 - ii. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
 - iii. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.
- c. The Provider agrees to furnish on request, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
- d. The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement.

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- e. The Provider agrees to screen all its employees and contractors regularly using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees or contractors is excluded from participation in Medicare, Medicaid, or other federal health care programs. The LEIE database is maintained by the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG) and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Provider shall promptly notify the Department upon discovery that any employee or contractor is on the LEIE. Provider understands and acknowledges that employment of or contractual arrangements with persons listed in the LEIE will subject the Provider, in accordance with Controlling Authority, to recoupment of funds paid to the Provider during the period in which the employment or contract was in effect.
- f. The Provider agrees to comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR Chapter IV, part 489, subpart I and 42 CFR §417.436(d).

7. Inspection; Maintenance of Records; Filing Reports

- a. For a minimum of six years from the date of services, or longer if required specifically by Controlling Authority, the Provider shall:
 - i. Promptly furnish upon request copies of any and all documentation set forth below in subpart ii of this paragraph, whether in the possession of contractors, agents, or subcontractors, for review by the Department, its agents and/or assigns. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for medical or behavioral health care services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program. The Provider further understands that it is the Department's position that failure to promptly furnish records upon request creates a presumption that the records do not exist.
 - ii. Keep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department. For providers who are required to submit annual cost reports, fiscal records shall include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Controlling Authority or Department policy.
- b. Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Department. If the Provider is notified that an audit or investigation has been initiated, the Provider shall retain all original records and supportive materials until the audit or investigation is completed and all issues are resolved if the period of retention extends beyond the minimum required 6-year period.
- c. Federal and State officials, employees and their agents may visit Provider facilities to make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to recipients. Such visits including unannounced visits must be allowed at any time during normal hours of operation. Failure to grant immediate access upon reasonable request may result in suspension of the Provider and/or of reimbursements.

8. Termination

Subject to applicable provisions of Controlling Authority:

- a. Either the Department or the Provider may terminate this Agreement with or without cause at any time upon 30 days written notification to the other;

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- b. The Department may summarily terminate without giving 30 days written notice under the following circumstances:
- i. The Provider does not meet conditions for participation, including necessary licensure, certification, or endorsement requirements or other terms and conditions stated in this Agreement; or
 - ii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense set forth in 42 CFR §1001.101 or 42 CFR §1001.201; or
 - iii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct, or crime of moral turpitude; or
 - iv. The Provider fails to disclose information required under 42 CFR §1002.3; or
 - v. Any person with ownership or controlling interest in the Provider, or an agent as that term is defined in accordance with 42 CFR §1001.1001 or managing employee of the Provider, has been excluded by the United States Department of Health and Human Services from participation in the Medicare or Medicaid programs; or
 - vi. The Provider poses an imminent health or safety risk to a patient; or
 - vii. The Provider has been found by the Department to be in breach or violation of any law, rule, or policy for which summary termination is authorized by Controlling Authority or by a rule authorized by and consistent with the Controlling Authority and adopted pursuant to Chapter 150B of the General Statutes; or

The Provider's right to appeal or otherwise contest any termination shall be determined in accordance with Controlling Authority.

9. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

10. Release of Liability

The Provider agrees to fully release and discharge the State of North Carolina, the Department and any of their officers, agents and employees, from any and all liability, claims and causes of action that may be brought by third parties against the Provider arising out of this Agreement. This is a complete and irrevocable release and waiver of liability. The State of North Carolina, the Department, and any of their officers, agents and employees are not liable for claims and causes of action that may be brought by third parties arising out of any act or omission of the Provider or any subcontractor.

11. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be modified to conform to existing law.

12. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Department.

NC DHHS Provider Administrative Participation Agreement

13. Discrimination

The Provider agrees that the Department may make payments for medical or behavioral health care services rendered to Department recipients only to a person or entity who has a provider agreement in effect with the Department; who is performing services or supplying goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964; Section 504 of the 1973 Rehabilitation Act; the 1975 Age Discrimination Act; the 1990 Americans With Disabilities Act; and all applicable federal and state statutes and regulations relating to the protection of human subjects of research. The authority of the Department and its Division of Medical Assistance to limit payment to the Provider under this Section or otherwise shall be restricted exclusively to payments for services rendered on specific dates as to which the above-referenced requirements were not met.

14. Waiver

No waiver of any term, right or condition of this Agreement shall be valid unless it is set forth in a writing duly executed by both parties. No delay or failure by either party to exercise or enforce at any time any right or provision of this Agreement will be considered a waiver thereof or of such party's right thereafter to exercise or enforce each and every right and provision of the Agreement. No single waiver will constitute a continuing or subsequent waiver.

15. Survival

All provisions of this Agreement which by their nature give rise to continuing obligations of the parties shall survive the expiration or termination of this Agreement, including without limitation the terms of paragraphs 3, 5, 7, 9, and 10.

16. Effective Date

This Agreement is effective on the date the Provider meets all requirements of participation as set forth in 42 CFR §431.108.

NC DHHS Provider Administrative Participation Agreement

Required Fields are marked with an asterisk (*).

*Medicaid Provider Name (Last, First, Middle or Organization Name)

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

*Street Address Line 2 *Phone Number

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

*Correspondence Address Line 1 (Accounting)

*Correspondence Address Line 2

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

* Medicaid Provider Number (if applicable)

I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

*Signature of Applicant or Authorized Agent *Date

*Printed Name and Title

DHHS/DMA/FISCAL AGENT APPROVAL

*Signature *Date



North Carolina Department of Health and Human Services MEDICAID LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall –

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least \$5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 et seq., administrative remedies for false claims and statements established under 31 USCS §. 3801 et seq., and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

