

<p style="text-align: center;">Provider Project CSR Number CSR # NCH00612 Impacts to IPRS</p>

SUMMARY OF THE IMPLEMENTATION OF THE PROVIDER PROJECT

IPRS Implications

Staff from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) initiated a customer service request with Electronic Data Systems (EDS) to make the necessary modifications to implement the collection of additional provider information. This project will provide the Division and LME's with information needed to monitor the development of the provider network, provider performance, and federal reporting requirements related to the providers of service.

EDS has designed new online browser screens that will collect the necessary information to meet the new provider project reporting requirements. These new screen shots are included in pages 5 through 11.

- Page 5 - Attending Provider Summary Add
- Page 6 - Attending Provider Summary Add cont.
- Page 7 - Attending Provider Summary Add cont.
- Page 8 - Attending Provider Summary Edit
- Page 9 - Attending Provider Summary Edit cont.
- Page 10 - Attending Provider Summary Edit cont.
- Page 11 - Attending Provider Summary Edit cont.

Attending provider fields currently collected:

- License Number (as provided by Division of Facility Services)(DFS)
- Name
- Title
- Address(currently can be mailing or physical) now both are required
- Fax Number
- Phone Number
- Tax ID or SSN (now a mandatory field)
- Email address
- Contact name
- Type/Specialty
- Type/Specialty effective dates

The new attending provider fields that have been added are as follows:

- County
- Profit or Non-Profit/Government Agency
- Director's Name
- ISATS ID (to be completed by Division Staff) **for SA Only**

- List of services provided(Admin Services Only or SA Detox, SA Treatment or Other non-treatment Services.) **for SA Only**
- Orientation- (Alcohol Abuse or Drug Abuse) **for SA Only**
- Facility Type (Hospital or Non-Hospital Residential) **for SA Only**
- Facility Size (# of beds) **for SA Only**
- Federal Operating Agency (US Army, US Air Force, US Navy, IHS, VA, BOP) **for SA Only**

Prior to submitting claims with a date of service on or after July 1, 2004, Area Programs/LME's must update their provider information utilizing the new provider screens. The new provider screens will be available for use on July 1, 2004. If date of service is on or after July 1, 2004 and the billing provider and attending provider are the same, the claim will deny with **EOB 8329 – CLAIM DENIED ATTENDING PROVIDER CANNOT BE THE SAME AS THE LMA.**

The Division has enrolled 3 attending providers for each LME that can be used for billing any services provided internally. Claims may be submitted using the internal attending providers with dates of service on or after May 1, 2004. The attending providers will be IxxDD001, IxxSA001, and IxxMH001 where xx represents the prefix used to enroll all of the other providers. Each of these attending providers was established using the type/specialty 074/113, so they should function the same as the billing provider number.

Here are a few items to note:

- ✓ Billing provider can no longer equal attending provider or your claim will deny.
- ✓ If the attending provider is a 'for profit' provider, the provider number must end with the letter 'P'.
- ✓ All new fields are mandatory. There are some fields that are noted as required for substance abuse providers only.
- ✓ The Division of Facility Services (DFS) link is: <http://facility-services.state.nc.us>. This website can be utilized to determine if your facility is licensed by Division of Facility Services (DFS).

INSTRUCTIONS ON COMPLETING THE ATTENDING PROVIDER SUMMARY ADD:

Base Provider Number: Provider number for the LME.
Financial Payer- NCDMH

Attending Provider Information:

Attending Provider NBR: Number assigned by the LME for the provider who provided the service.

Agency Type: Is the agency a for profit or non-profit/government agency? Must be designated as one of these two categories. If profit, the last character of the provider number must be the letter P.

Organization Name: The name of the organization/provider.

OR

Last Name: Last name of Individual provider.

First Name: First name of Individual provider.

Middle Initial: Middle initial of Individual provider.

Name type Code: Select name type code for organization or individual provider.

Mailing Address: Mailing address of organization or Individual provider.

Mailing City: Mailing city of organization or Individual provider.

Mailing State: Mailing state of organization or Individual provider.

Mailing Zip: Mailing zip of organization or Individual provider.

Telephone: Telephone of organization or Individual provider.

Fax Number: Fax number of organization or Individual provider.

Physical Address: Physical location address of organization or Individual provider.

(Cannot be a PO Box)

Physical City: Physical city of organization or Individual provider.

Physical State: Physical state of organization or Individual provider.

Physical Zip: Physical zip of organization or Individual provider.

Contact Name: Name of contact person.

Director's Name: Name of LME Director.

Email: Email address of contact person.

Social Security Nbr: SSN of Individual provider.

OR

Federal Tax ID Nbr: Federal tax ID of organization.

ISATS ID: To be completed by Division Staff.

Is the provider licensed by DFS? Yes or No

License Nbr: DFS License number of provider.

Type: Choose Type

Specialty: Choose Specialty

Type/Specialty Effective Date: Date Type/Specialty is effective.

Type Specialty End Date: Date Type/Specialty ends.

Please complete only if Substance Abuse Treatment Services are provided. (If types 074, 802 or 804 are selected)

List of services provided: Check Administrative Services ONLY or Substance Abuse Detoxification, Substance Abuse Treatment, or Other Non-Treatment Services. *(All three can be selected but at least 1 must be selected).*

Orientation (Select all that apply): Check boxes with alcohol abuse or drug abuse. *(At least one must be selected).*

For Substance Abuse Treatment Facilities. Select type and give estimate on # of beds.

Facility Type (if applicable): Hospital or Non-Hospital Residential. *(Only one may be selected).*

Facility Size Number of Beds: Must enter number of beds.

Federal Operating Agency: Check boxes with U.S. Army, U.S. Air Force, U.S. Navy, IHS, VA, BOP. *(This field is optional).*

ATTENDING PROVIDER SUMMARY EDIT

Use this screen to make any necessary changes/edits to the attending provider information.

Attending Provider Summary Add

Please complete the following form to add the Attending Provider information.
Click the "Submit Add" button to finalize the transaction.

Base Provider Nbr: XXXXXXXXXXXXXXXX

Financial Payer: XXXX

Attending Provider Information

Attending Provider Nbr:

Agency Type:

Profit
 Non-Profit/Government Agency

(Please enter either an Organization or an Individual Name and select the appropriate Name Type Code)

OR

Organization Name:

Name Type Code:

Last Name:

First Name:

Middle Initial:

Title:

Mailing Address of Organization:

Mailing Address 2:

Mailing City: Mailing State: Mailing Zip:

Telephone:

Fax Number:

Physical Address Physical Address 1 :

of

Organization Physical Address 2:

or

Individual Physical City: Physical State: Physical Zip:

Physical County:

Contact Name: Director Name:

Email:

Social Security Nbr.: Federal Tax ID Nbr.: I-SATS ID: License Nbr.: (To Be Completed by Division Staff)

Is the provider licensed by the Division of Facility Services (DFS)? Yes No

Type: Specialty:

Type/Specialty Type/Specialty

Effective Date: End Date:

(Please complete only if Substance Abuse Treatment Services are provided)

- List of Services Provided: **(Select all that apply)**
- Administrative Services ONLY
 - Substance Abuse Detoxification
 - Substance Abuse Treatment
 - Other Non-Treatment Services

Orientation (Select all that apply): Alcohol Abuse Drug Abuse

(For Substance Abuse Treatment Services Facilities. Select type(s) and give a size estimate.)

Facility Type (if applicable): Hospital Inpatient Hospital Number of Beds

Non-Hospital Residential Non-Hospital Number of Beds

Federal Operation Agency (if applicable):

Pop Group Payers - Check all Pop Group Payers that apply.

- | | | | | | | | | |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> All | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX |
| <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX |
| <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX | <input type="checkbox"/> XXXXX |

Pop Group Payers Effective Date:

Pop Group Payers End Date:

Attending Provider Summary Edit

Please complete the following form to edit the Attending Provider information.
Click the "Submit Edit" button to finalize the transaction.

Base Provider Nbr: XXXXXXXXXXXXXXXX

Financial Payer: XXXX

Attending Provider Information

Attending Provider Nbr:

Agency Type: Profit
 Non-Profit/Government Agency

(Please enter either an Organization or an Individual Name and select the appropriate Name Type Code)

OR
Organization Name: Name Type Code:

Last Name:

First Name: Middle Initial: Title:

Mailing Address of Organization:

Mailing Address 2:

Mailing City: Mailing State: Mailing Zip:

Telephone: Fax Number:

Physical Address Physical Address 1:

of

Organization Physical Address 2:

or

Individual Physical City: Physical State: Physical Zip:

Physical County:

Contact Name: Director Name:

Email:

Social Security Nbr.: Federal Tax ID Nbr.: I-SATS ID: (To Be Completed by Division Staff)

Is the provider licensed by the Division of Facility Services (DFS)? Yes No License Nbr.:

Type: Speciality:

Type/Specialty Type/Specialty

Effective Date: End Date:

(Please complete only if Substance Abuse Treatment Services are provided)

List of Services Provided: **(Select all that apply)**

Administrative Services ONLY **Or** Substance Abuse Detoxification

Substance Abuse Treatment Other Non-Treatment Services

Orientation (Select all that apply): Alcohol Abuse Drug Abuse

(For Substance Abuse Treatment Services Facilities. Select type(s) and give a size estimate)

Facility Type (if applicable): Hospital Inpatient Hospital Number of Beds
 Non-Hospital Residential Non-Hospital Number of Beds

Federal Operation Agency (if applicable):

Pop Group Payer	Begin Date	End Date	Action/Reason Code	Begin Date	End Date
1 XXXXX	<input type="text"/>	<input type="text"/>	List of Actions/Reasons <input type="text"/>	<input type="text"/>	<input type="text"/>
2 XXXXX	<input type="text"/>	<input type="text"/>	List of Actions/Reasons <input type="text"/>	<input type="text"/>	<input type="text"/>
3 XXXXX	<input type="text"/>	<input type="text"/>	List of Actions/Reasons <input type="text"/>	<input type="text"/>	<input type="text"/>

4 XXXX

List of Actions/Reasons ▾

List of Actions/Reasons ▾

List of Actions/Reasons ▾

Reset

Submit Edit

Cancel Edit