CareSource®

Provider Manual

2023 | North Carolina

Marketplace

TABLE OF CONTENTS

This content has been reviewed; however, changes and/or revisions occur frequently. The provider should check the Provider Manual and Updates & Announcements pages on **CareSource.com** for the most up-to-date information

ABOUT US

Welcome,

Welcome and thank you for participating with CareSource of North Carolina Co®.

At CareSource North Carolina Co., we call health care providers our health partners. A "health partner" is any health care provider who participates in our provider network. You may find "health partner" and health care provider used interchangeably in our manual, agreements and website.

We work together to ensure that our members – your patients – can improve their health and well-being. Because you're our partner, we strive to make it simple for you to do business with us. This manual directs you to the solutions you need, whether that's through convenient online self-service solutions, fast prior authorizations or hassle-free claims payments. It's our strong partnership that allows us to work together to facilitate a high level of care and a respectful experience for our members.

We are a nonprofit, community-based health plan that focuses on helping people of all circumstances transform their lives through quality health care and other services. We focus on prevention and partnering with local providers to offer the services our members need to remain healthy.

Primary care providers (PCPs) within the network provide a range of services to our members and coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

We also distribute the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New providers
- Existing providers

About Us

We were founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

Our mission is one we take to heart. In fact, we call our mission our “heartbeat.” It is the essence of our company, and our unwavering dedication to it is the hallmark of our success.

Vision & Mission

Our vision is transforming lives through innovative health and life services.

Our mission is making a lasting difference in our members’ lives by improving their health and well-being

Our Services

- Provider relations
- Provider services
- Member eligibility/enrollment information
- Claim processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse

- Member services, including a member call center with CareSource North Carolina Co. as well as our benefit managers:
    - Pharmacy: Express Scripts, Inc.
    - Dental: DentaQuest®
    - Vision: EyeMed®
    - Hearing: TruHearing®
    - Fitness: American Specialty Health®

In addition to the above, our care management programs include the following:

- Low, medium and complex case management – a "no wrong door" referral intake
- Telephonic case management
- High emergency department utilization focus (targeted at members with frequent utilization)
- CareSource24® (nurse advice line)
- Maternal and child health
    - Comprehensive prenatal, postpartum and family planning services
- Disease management
- Behavioral health and substance use disorder (SUD)

The CareSource Foundation

Since 2006, the CareSource Foundation has awarded more than $25 million to nonprofits that are working to eliminate poverty, provide much-needed services to low-and moderate-income families, encourage healthy communities, develop innovative approaches to address critical health issues, and enhance the lives of a diverse array of children, adults and families. We are so proud of our partnerships and ultimately, of the impact we are able to make together.

Compliance & Ethics

We serve a variety of audiences – members, providers, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our corporate compliance plan, along with state and federal regulations, outline the personal, professional, ethical and legal standards we must all follow.

Our corporate compliance plan is an affirmation of our ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize our commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state and federal laws and regulations

- Implement a system for early detection and reporting of noncompliance with laws, regulations or policies

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties and criminal sanctions.

The corporate compliance plan is a formal company policy that outlines how everyone who represents CareSource North Carolina Co. must conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants and vendors. All providers are required to review and comply with the corporate compliance plan, located at **CareSource.com** > About Us > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

For questions about provider expectations, please call Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

If you suspect potential violations, misconduct or non-compliant conduct which impacts CareSource North Carolina Co. or our members, please leverage one of the following methods to communicate the issue to us:

- Ethics and Compliance Hotline: Ethics and Compliance Hotline or http://caresource.ethicspoint.com

Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The corporate compliance plan is posted for your reference on **CareSource.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the corporate compliance plan. We appreciate your commitment to corporate compliance.

Accreditation

CareSource North Carolina Co. will pursue accreditation by the National Committee for Quality Assurance (NCQA). NCQA is a private, nonprofit organization dedicated to improving health care quality through measurement, transparency and accountability. Accreditation status indicates that a plan's service and clinical quality levels meet NCQA's rigorous requirements for consumer protection and quality improvement. Visit www.NCQA.org for more information.

CLAIMS

In general, CareSource North Carolina Co. follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **CareSource.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please ensure addresses and phone numbers on file are up to date.

Billing Methods

We accept claims in a variety of formats, including paper and electronic claims. We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claim processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Claim Submission Process

Timely Filing

For in-network providers, claims must be submitted within two years after the original claim adjudication.

Claim Appeals

A claim appeal is a review of a reconsideration claim. It is a one-time formal review of a processed claim that was partially paid or denied. If the provider was denied authorization or reimbursement due to not obtaining a required prior service, then the provider has two years after the original claim adjudication to file a claim appeal.

Information to Include in Claims

- Patient (member) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete member ID number of the patient.
- Patient's birth date – Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date(s) of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician Social Security Number – Every provider practice (e.g., legal business entity) has a different tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.
- Claim number, reason for the dispute request and reconsideration and copy of the EOP and any other documentation to support the dispute (NC DOI Approved P&P 972.01)

Checking Claim Status

You can track the progress of your submitted claims at any time through our Provider Portal.

Searching for Claims on the Provider Portal

Claim status is updated daily on our Provider Portal, and you can check claims that were submitted for the previous 36 months from the data of service (DOS). You can search by member name and date of birth, claim number, check number, or patient number.

Some of the claim features on the Provider Portal include:

- Submit claim appeal and disputes
- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date

Electronic Funds Transfer

We partner with ECHO Health, Inc. to deliver provider payments. ECHO® offers three payment options:

- Electronic fund transfer (EFT) – preferred
- Virtual card payment (QuicRemit) – Standard bank and card issuer fees apply*
- Paper checks

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Claims webpage at **CareSource.com** > Providers > Provider Portal > Claims for additional information about getting paid electronically and enrolling in EFT.

To enroll with ECHO for payment and choose EFT as your payment preference, fill out the online enrollment form. For questions, call ECHO Customer Support at 1-888-834-3511.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) thorough a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the Provider Portal.

We provide TPL/Coordination of Benefits (COB) information for EFT. This can be found in segment 2100 Claim Payment Information and loop 2110 Service Payment Information on the 835 file in this format:

- NM1*PR*AETNA US HEALTHCARE
- NM1*GB*1*YARBORO*JUSTIN •
- REF*6P*W246632770
- The NM1*PR (COB carrier), NM1* GB (other subscriber information from other payer) and REF*6P (other insurance group number)

Claim Processing Guidelines

If the claim is submitted after the timeline allotted, then the claim will receive denial for timely filing.

- If a member has other insurance and CareSource North Carolina Co. is secondary, the provider may submit for secondary payment within 365 calendar days of the original date of service.

Electronic Claim Submission

Electronic Data Interchange

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). We have invested in an EDI system to enhance our service to participating providers. Our EDI system complies with HIPAA standards for electronic claims submission.

Submitting Claims Through the Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data
- Allows tracking and monitoring of claims through a convenient online search tool

Who Can Submit Claims Via the Portal?

Traditional providers, community partners and delegates, and health homes all may submit claims through the Provider Portal.

What Types of Claims Can Be Submitted?

- Professional medical office claims
- Medical/surgical dental claims
- Institutional claims
- Behavioral health claims

Availity Clearinghouse

CareSource North Carolina Co. prefers electronic claim submission. To submit electronic claims, you may use the Provider Portal or our Availity clearinghouse. You can reach Availity at 800-282-4548 or at www.availity.com.

Please provide the clearinghouse with our payer ID number: **NCCS1**.

Submitting Claim Attachments on the Provider Portal

Providers may submit claims attachments on the Provider Portal to make processing the claim faster and easier. Supporting documentation can be uploaded on the on the Claim Information and Attachments page, under the Claims section of the left-hand menu on the portal. Attachment size is limited to 100MB.

To upload documentation, do the following:

If you have the claim number, search for the claim. After locating the claim, click **View Detail**, and then upload the documentation using the **Document Upload** tab.

If you do not have the claim number, search for the member record. After searching for the member, enter the correct date of service for the claim you have submitted. Select the appropriate reason for submitting documentation, and then upload your attachments.

Enter your contact information before submitting your attachments.

File Format

We accept electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and hospital claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 835 Health Care Claim Payments/Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 278 Health Care Services Review (Prior Authorization Requests)
- 834 Benefit Enrollment and Maintenance
- 820 Group Premium Payment for Insurance Products
- NCPDP Version D.0

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. Box or lock box can be used for the pay-to address (Loop 2010AB).

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10- CM). Available from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other vendors.

- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org.
- HCFA Common Procedure Coding System (HCPCS). Available at cms.gov.
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at 1-800-947-4746 or http://www.ada.org.
- National Drug Codes (NDC). Available at fda.gov.

Note: We require HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
    - A full, detailed description of the service provided.
    - A report, such as an operative report or a plan of treatment.
    - Any information that would assist in determining the service rendered. For example, 84999 is an unlisted lab code that would require additional explanation.
- Drug injections that do not have specific J code (J3490 thru J3999) and any assigned HCPCS J code that is not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement.

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting through the clearinghouse.

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Location of Provider Information on Professional Claims

On 837P professional claims (005010X222A1), the provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
    - Identification Code Qualifier – NM108 = XX
    - Identification Code – NM109 = Billing provider NPI

- 2310B Loop – Rendering provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Rendering provider NPI

The billing provider TIN must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

Institutional Claims

On 837I institutional claims (005010223A2), the billing provider NPI should be in the following location:

- 2010AA Loop – Billing provider name
  - Identification Code Qualifier – NM108 = XX
  - Identification Code – NM109 = Billing provider NPI

The billing provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:

- Reference Identification Qualifier – REF01 = EI (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing provider TIN or SSN

On all electronic claims, the RID number should go on:

- 2010BA Loop – Subscriber name
- NM109 = Member ID (RID) number

On paper claims, the NPI number should be placed in the following boxes based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI 24J and (is applicable) Box 33A for the group NPI
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

Claim Payment Processing

We partner with ECHO Health, Inc. to deliver provider payments. Please see the Electronic Funds Transfer section for more information.

Corrected Claims

Correcting Electronic HCFA 1500 Claims:

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF*F8* with the most recent claim number for which the corrected claim is being submitted.

Correcting Electronic UB-04 Claims:

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an additional loop in the 2300 loop, segment REF *F8* with the most recent claim number for which the corrected claim is being submitted.

Note: When billing corrected claims, providers must use the most recent claim number in the original claim ID (segment REF*F8) or the claim will be rejected.

Paper Claims

For the most efficient processing of your claims, we recommend you submit all claims electronically.

Paper Claim Submission Guidelines

Paper claim forms are only encouraged for services that require clinical documentation or other forms to process. If you submit paper claims, please submit on one of the following claim form types:

- CMS 1500
- AMA universal claim form also known as the National Standard Format (NSF)
- Standardized ADA J400 Dental Claim Form
- CMS 1450 (UB-04)

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA).

We cannot accept handwritten claims or SuperBills. Claims that have been modified must be submitted using a new claim form; correction made to a previously submitted claim using white-out or erasable ink, may not be processed.

Detailed instructions for completing each form type are available at the websites below:

- CMS 1500 Form Instructions: www.nucc.org
- UB-04 Form Instructions: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

Please note: On paper claims, the NPI number should be placed in the following box(es) based on form type:

- CMS 1500: Box 24J for the rendering provider's NPI and (if applicable) Box 33A for the group NPI
  - Three data elements are used for the standard NPI crosswalk to establish a one-to-one match:

billing

- NPI, billing taxonomy code, billing provider service location zip code +4 on file in CoreMMIS
- UB04: Box 56
- ADA: Box 54 for the treating provider's NPI and (if applicable) Box 49 for the group NPI

What to Include on Claims That Require National Drug Code

- NDC and unit of measure [e.g., pill, milliliter (cc), international unit or gram]
- Quantity administered – number of NDC units
- NDC unit price – detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for National Drug Code on Paper Claims

All of the following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Include the following on claims that require (NDC):

- NDC and unit of measure: pill, milliliter (cc), international unit or gram
- Quantity administered: the number of NDC units
- NDC unit price: detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims: submitted on the 837P format

Tips for Submitting Paper Claims

For the most efficient processing of your claims, we recommend you submit all claims electronically.

We use an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To ensure optimal claims processing timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.

- When submitting paper claims, know we require the most current form version as designated by CMS, NUCC and the ADA.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Ensure fonts are 10- to 14-point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- It is recommended that you submit your 12-digit Provider ID, located in your welcome letter, in conjunction with your required NPI number.
- Submit NPI, GNPI (if applicable) and federal TIN or physician SSN for all claim submissions.

Paper Claim Address

Please send all paper claim forms to:

CareSource North Carolina Co.
Attn: Claims Dept.
P.O. Box 967, Dayton, OH 45401

Dental Claim Submissions

Dental claims must be submitted to DentaQuest through their provider web portal: www.DentaQuest.com. For questions or more information, providers can visit the DentaQuest website.

Vision Claim Submissions

Routine vision claims must be submitted to SuperiorVision (Versant Health) through their provider web portal: www.superiorvision.com. For questions or more information, providers can visit the Superior Vision website.

Hearing Claim Submissions

Routine hearing claims must be submitted to TruHearing through their provider web portal: www.truhearing.com/. For questions or more information, providers can visit the TruHearing website.

Code Editing

We use clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

Code editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need for additional information from the provider.

Code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Explanation of Payment

Explanation of Payments (EOPs) are statements of the status of your claims that have been submitted to CareSource North Carolina Co. and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments may elect to receive an electronic remittance advice (ERA) and can access it on the Provider Portal.

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Workers Compensation

Claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Third-Party Liability/Subrogation

Where claims indicate that provided services were the result of an injury, they will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource North Carolina Co. will pay the provider for all covered services. Then, we will pursue recovery from any third parties involved.

Member Financial Liability

Some benefits under a plan may have first dollar coverage while others will require a member to first pay an annual deductible before CareSource North Carolina Co. contributes payment for the services. In addition to the deductible, copayments or coinsurance are also applicable for many covered services. It is up to the provider to collect these amounts at the time of service. If a member overpays his or her financial liability (e.g. deductible, copay, coinsurance), the provider must refund the overpayment to the member.

Explanation of Benefits

Members receive an Explanation of Benefits (EOB) that informs members of their deductible and out-of-pocket status and shows copays and coinsurance they have paid. The EOB outlines the amount the provider billed, the amount CareSource North Carolina Co. reimbursed and the remaining amount for which the member is responsible.

Marketplace Plan

Coding & Reimbursement Policies

We strive to be consistent with all federal regulations and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored, as would be any aspect of a provider contract.

In addition, the Center for Medicare and Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate.

We strive to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

We use coding industry standards, such as the AMA CPT manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

We seek to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, any claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration all the previously mentioned Medicare, CCI and national commercial standards when considering the appeal.

In order to ensure that all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the appeals team to consider why the code set(s) and modifier(s) being submitted are differing from the usual standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

We maintain reimbursement policies. To view medical, reimbursement, administrative and pharmacy policies, visit **CareSource.com** > Providers > Tools & Resources > Provider Policies.

COVERED SERVICES AND EXCLUSIONS

This section describes some of the services and exclusions to benefits that are provided to our members. All covered services are required to be medically necessary. Covered services may require prior authorization. To check whether a procedure code requires prior authorization, visit **CareSource.com** > Providers > Provider Portal > Prior Authorization and use the **Procedure Code Lookup Tool**.

Covered Services

Covered Services Information

CareSource North Carolina Co.'s Marketplace product is compliant with the Affordable Care Act in terms of benefit offerings and cost share applications, as well as providing supplemental Adult dental, vision and fitness benefits. See our Evidence of Coverage and Schedules of Benefits at **CareSource.com** > Plans > Plan Documents for more detail. Please refer to our website and the Utilization Management section for more information about referral and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check that the member has not already exhausted benefit limits before providing services by checking our Provider Portal or calling Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Covered services may require prior authorization. Please visit **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization for the most up-to-date list of services that require prior authorization. Prior authorization requirements for members enrolled with CareSource North Carolina Co. are determined and enforced by CareSource North Carolina Co.

Pediatric Dental and Vision

All pediatric members have access to dental and vision benefits through the end of the month in which they turn age 19.

Pediatric dental provides coverage for the majority of dental services from dental exams and preventive services to major/comprehensive services, and even medically necessary orthodontic services. These benefits are provided exclusively through our Dental Benefits Manager, DentaQuest.

Pediatric vision services are provided exclusively through our Vision Benefits Manager, EyeMed, and the benefit covers eye exams (no cost), eyewear including glasses or contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services. For coverage to apply to the vision services, they must see an EyeMed provider.

Routine Hearing Exams and Hearing Aids

All members have access to no cost routine hearing exams.

While not a covered benefit, members can access reduced cost hearing aids through our relationship with TruHearing. Members must contact TruHearing's member services to establish a relationship with a hearing specialist who will guide them through finding a provider, setting up an appointment, as well as supporting them through any follow up processes to ensure satisfaction. For coverage to apply to these services, they must see a TruHearing provider.

Optional Adult Dental, Vision and Fitness

Our dental, vision, and fitness benefits provide adult members the ability to access the following benefits:

Dental – Adult (age 20 and above) dental benefits include services such as preventive and diagnostic (cleanings and exams), basic restorative (fillings) and major restorative (extractions, dentures and crowns). Two preventive visits are allowed each year for cleanings and oral examination. Subject to an $1,000 per member per benefit year limit. Services are available exclusively through our dental benefits manager DentaQuest.

Vision – Adult (age 20 and above) routine vision benefits are available exclusively through our Vision Benefits Manager, EyeMed, and include eye exams (cost share may apply), eyewear including contact lenses, as well as other value add services through the relationship such as low vision exams/aids and discounts on a wide array of materials and services. Eyewear (glasses and contacts) are subject to a $250 allowance each calendar year with no copay/deductible.

Fitness – Available for members aged 18 and above, CareSource North Carolina Co. is proud to offer our adult members access to the Active&Fit program with no member cost share. The Active&Fit program provides your patient with a no cost access to their network of participating fitness centers and select YMCAs. Alternatively, members can have access to up to two home fitness kits per benefit year, online tools such as fitness center search, a quarterly online newsletter, online classes and more.

The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit is a trademark of ASH and used with permission herein.

Immunization

Immunizations are an important part of preventive care for children and should be administered during exams as needed.

Many of these services are covered by CareSource North Carolina Co.'s Marketplace plans.

Immunization Codes

Please bill CareSource North Carolina Co. with the appropriate CPT and ICD-10 vaccination codes for the immunization(s) being administered and the appropriate administration code. Please refer to the code tables located on the CMS website at https://www.cms.gov/Medicare/Coding/ ICD10/2016-ICD-10-CM-and-GEMs.html. You can also get CMS coding guidelines at https://www.cms.gov/ Medicare/Coding/ICD10/ Downloads/2016-ICD-10-CM-Guidelines.pdf.

Vaccine Schedule

Immunizations are an important part of preventive care for children and should be administered during preventive health exams as needed.

We endorse the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). The recommended schedule is updated annually, and the most current updates are located on www.aap.org.

Pharmacy

CareSource North Carolina Co. is a qualified health plan in the Health Insurance Marketplace that provides prescription drug coverage. This benefit will provide coverage for prescriptions obtained from an in-network retail pharmacy, mail-order pharmacy, or specialty pharmacy. Some drugs administered in the patient's home may also be covered under the pharmacy benefit.

Prescription Drug Coverage

Copayment/Coinsurance Requirements

Members may be required to pay a copayment or coinsurance for covered prescription drugs. Our plans offer lower cost shares for less costly drugs. For example, there may be a lower charge for a generic drug, a higher copay for a preferred brand-name drug and an even higher copay for a non-preferred drug. A drug's copay will never exceed the actual cost of the drug itself.

For specialty pharmacy, a coinsurance is applied. Coinsurance is a percentage of the drug's cost. When members pay a percentage, their cost may be higher than expected for many reasons:

- The cost of the drug may be high. For example, assume the coinsurance is 30 percent. In this case, a $250 drug will be more costly than a $25 drug.
- The member may be buying a more expensive brand-name drug when there is a generic equivalent available for lesser cost, if authorized.

Tiered Medications
Every drug covered on the Marketplace Drug Formulary is in one of the tiers below. Typically, the higher the cost-sharing tier number, the higher the cost for the drug:

Tier 0:	No copayment or coinsurance. These medications include preventive medications.
Tier 1:	Prescription drugs in this tier contain low-cost generic drugs.
Tier 2:	Prescription drugs have a higher coinsurance or copayment than those in Tier 1. This tier will contain preferred medications that may be single or multi-source brand-name drugs.
Tier 3:	Prescription drugs have a higher coinsurance or copayment than those in Tier 2. This tier will contain non-preferred medications. This will include medications considered single- or multi-source brand-name drugs.
Tier 4:	Prescription drugs have a higher coinsurance or copayment than those in Tier 3. Medications generally classified as specialty medications fall into this category.

Drug Formulary

We use evidence-based guidelines to ensure health care services and medications meet the standards of excellent medical practice and are the lowest cost alternative for the member. We use a Drug Formulary of covered drugs. The Drug Formulary contains information about drugs covered, their cost share tiers and limitations of coverage (such as prior authorizations, quantity limits and step therapy protocols). Drugs are listed by therapeutic class and also by alphabetical index so that therapeutic interchanges for most drug classes are easier to compare. To learn more about how to use our pharmaceutical management procedures, please visit our website's Pharmacy page at **CareSource.com** > Provider Overview > Education > Patient Care > Pharmacy. We update the Drug Formulary regularly and communicate any updates online on the Drug Formulary Changes pages. Drugs not listed on the Drug Formulary are not covered without prior approval.

Quantity, Supply, Duration and Benefit Limits

Quantity limits and dosing limits are based on FDA-approved recommended dosing frequencies and long-term safety considerations, diagnosis and best practices. Limits on opioids or other substances of potential abuse or safety concern are based upon maximal morphine equivalent dosing limits or applicable law. Additionally, benefit limitations may pertain to preventive coverage or as defined by applicable rights to coverage for our members.

Step Therapy

Certain medications on the Drug Formulary are covered if utilization criteria are met. Step therapy is one such utilization technique that requires a first step formulary medication be tried and failed prior to the approval of a step two formulary medication. A reasonable clinical trial of the step one drug is defined to

include appropriate use for labeled or compendia-supported indications, titration of the step one drug (where appropriate) and supporting evidence (such as provider notes or lab results) to show the step one drug has failed. Step two drugs are formulary medications which may require the member to pay higher cost share and also may be more costly to the plan. Step therapy is designed to preserve best practice and protect our member's financial medication burden.

Generic Substitution & Therapeutic Exchange

Generic substitution occurs when a pharmacy dispenses a generic drug that is equivalent to the prescribed brand-name drug. Generic drugs are usually priced lower than their brand-name equivalents and should be considered the first line of prescribing subject to applicable rules. Members and providers can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. Additionally, if a non-formulary brand drug is requested instead of the generic equivalent, a prior authorization request would be required. Our Medical Necessity for DAW policy requires submission of clinical documentation including clinical notes, proper MedWatch form submissions, etc., as explained in the policy. A determination of medical necessity will be made as explained in the Prior Authorizations section below. If approved, members may pay higher copayments. This can be significant for our members.

Prior Authorization

To submit prior authorization requests please fax all documents to 866-930-0019. Pharmacy prior authorization requests are reviewed and determinations are made within 72 hours of receipt. If your request is urgent, please mark it as "expedited" and a decision will be rendered within 24 hours of receipt. If you experience technical difficulties or have an urgent need where fax may not be sufficient, you may call in your request. Please note that requests for exceptions or prior authorizations without clinical documentation supplied as required may experience a higher rate of denial and/or appeals due to incomplete policy requirements. We encourage all requests to be faxed or electronically submitted whenever possible for the best outcomes of our members. For more information about submitting pharmacy prior authorizations, please call Provider Services at **1-833-230-2101** and follow the prompts. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Medically Necessary Reasons for Exceptions

Exceptions are requests for drugs not covered on the health plan's formulary. Typically, our Drug Formulary includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective or considered a treatment standard of care equal to or better than the drug you are requesting, we will generally not approve your request for an exception. Medically necessary reasons for approving an exception could include lack of available alternatives on our Formulary to treat the member's condition, a severe intolerance or allergy to all of our formulary drugs causing hospitalization or submission of a MedWatch notice to the FDA, or the member has failed all available formulary options.

As mentioned previously, drugs that are on the Formulary may have utilization management applied for reasons of cost, safety, allowances by state laws and more. All documentation to request an exception must establish medical necessity of the requested drug over the available drugs covered by the plan as per each policy.

CareSource North Carolina Co. has an exception process that allows the member, the member's representative or the prescribing physician to make a request for a formulary coverage exception, or an exception to utilization management. The member, member's representative or prescribing physician may initiate the request by calling Member Services. CareSource North Carolina Co. then reaches out to the provider to obtain the appropriate documentation.

We will provide a decision no later than 72 hours after the request is received, or within 24 hours if the request is expedited. If the initial exception request is denied, providers have the right to request an external review by an Independent Review Organization (IRO). The external review process is outlined in the "Grievances and Appeals" chapter of this manual.

Other Medical Supplies and Durable Medical Equipment

Limited durable medical equipment (DME) may be covered on the Drug Formulary. Please visit our website for the most recent formulary list at **CareSource.com** > Providers > Tools & Resources > Drug Formulary.

Medications Administered in the Provider's Clinical Setting

Medications that are administered in a provider setting, such as a physician's office, hospital outpatient department, clinic, dialysis center or infusion center will be billed to the health plan through the member's medical benefit. Prior authorization requirements now exist for many injectable medications.

Medication Therapy Management Program

We offer a Medication Therapy Management (MTM) program for all members. MTM services allow local pharmacists to work collaboratively with physicians and other prescribers to enhance quality of care, improve medication compliance, address medication needs and provide health care to patients in a cost-effective manner. You may be contacted by a pharmacist to discuss your patients' medications. We also encourage members to talk with their pharmacist about their medications, as we want to make sure they are getting the best results from the medications they are taking.

Pharmacy Lock-In Program

The CareSource pharmacy operations team monitors the pharmacy lock-in program to ensure appropriate services are received and to reduce unnecessary or inappropriate utilization.

Network Pharmacies

Our Pharmacy Directory gives members a complete list of our network pharmacies, or all of the pharmacies that have agreed to fill covered prescriptions for our plan members. Please visit our website for a complete list of network pharmacies at **CareSource.com** > Members > Tools & Resources > Find My Prescriptions > Find A Pharmacy.

CREDENTIALING AND RECREDENTIALING

CareSource North Carolina Co. credentials and recredentials all licensed independent practitioners, including physicians, facilities and non-physicians with whom we contract and who fall within the scope of authority and action. Through credentialing, CareSource North Carolina Co. checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

Credentialing Process

Council for Affordable Quality Healthcare (CAQH) Application

CareSource North Carolina Co. is a participating organization with the Council for Affordable Quality Healthcare (CAQH). Please make sure that we have access to your provider application prior to submitting your CAQH number:

- Log on to the CAQH website at www.CAQH.org, utilizing your account information.
- Select the “Authorization” tab and ensure CareSource North Carolina Co. is listed as an authorized health plan (if not, please check the “Authorized” box to add).

Marketplace Plan

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current)
- Clinical Laboratory Improvement Amendment (CLIA) certificate (if applicable)
- Collaborative Practice Agreement
- Collaborative Agreement for Prescriptive Authority

Required Disclosures

CareSource North Carolina Co. verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource North Carolina Co. also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees or persons with beneficial ownership of more than five percent of the entity's equity.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and their employees must execute the attestation titled, "CareSource North Carolina Co. Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with verification activities) as a part of the credentialing and recredentialing process.

CareSource North Carolina Co. conducts credentialing and recredentialing activities utilizing the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and credentialing as defined in the North Carolina Department of Insurance.

Providers Credentialed

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with CareSource North Carolina Co. This independent relationship is defined through contracting agreements between CareSource North Carolina Co. and a provider or group of providers and is defined when CareSource North Carolina Co. selects and directs its enrollees to a specific provider or group of providers.
- Providers who see members outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Providers who are hospital-based but see the organization's members as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.
- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.

Providers Who Do Not Need Credentialed by CareSource North Carolina Co.

The following providers listed in the Provider Directory do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's members only as a result of the members being directed to the hospital or other inpatient setting.
- Providers who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the Provider Directory.
- Pharmacists who work for a pharmacy benefit management (PBM) organization.
- Providers who do not provide care for members in a treatment setting (e.g., board-certified consultants).

Provider Selection Criteria

We are committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

Quality of care delivery, as defined by the Institute of Medicine, states: *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*

We have developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. We base selection on quality of care and service aspects, in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members.

Selection Criteria:

- Active and unrestricted license in the state issued by the appropriate licensing board.
- CSR certificate (if applicable)
- Successful completion of all required education.
- Successful completion of all training programs pertinent to one's practice.
- For MDs and DOs, successful completion of residency training pertinent to the requested practice type.
- For dentists and other providers where special training is required or expected for services being requested, successful completion of training.

Marketplace Plan

- Board certification is not required for primary care specialties. PCPs who are approved by the Credentialing Committee will appear in Provider Directories.
- Providers approved by the Credentialing Committee in non-primary care specialties will be listed in the Provider Directory as specialists if certified by a specialty board, which is recognized by the Credentialing Committee.
- Advanced practice nurse (APN) may be credentialed as a primary care provider.
- Education, training, work history and experience are current and appropriate to the scope of practice requested.
- Malpractice insurance at specified limits established for all practitioners by the credentialing policy.
- Good standing with Medicaid and Medicare.
- Quality of care and practice history as judged by:
    - Medical malpractice history.
    - Hospital medical staff performance.
    - Licensure or specialty board actions or other disciplinary actions, medical or civil.
    - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction.
    - Other quality of care measurements/activities.
    - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing.
    - Lack of issues on HHS-OIG, SAM/ EPLS, or state site for sanctions or terminations (fraud and abuse).
- Signed, accurate credentialing application and contractual documents.
- Compliance with standards of care and evidence of active initiatives to engage members in preventive care.
- Agreement to comply with drug formulary requirements or acceptance of drug formulary as administered through the pharmacy benefit manager.
- Agreement to access and availability standards established by the health plan.
- Compliance with service requirements outlined in the provider agreement and Provider Manual.

Note: Any pending and/or suspected fraud, waste and abuse investigation(s) or case(s) against the provider may affect the provider's credentialing application.

Organizational Credentialing/Recredentialing

The following organizational providers are credentialed and recredentialed:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing ambulatory surgery centers
- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting

Additional organizational providers are also credentialed:

- Hospice providers
- Urgent care facilities, free-standing and not part of a hospital campus
- Dialysis centers
- Free-standing facilities that provide outpatient, non-emergent advanced radiology services (including MRI/MRA, CT and PET scans)

In addition to the urgent care and ambulatory surgical facilities being credentialed, the Medical Director or senior provider responsible for medical services will be credentialed using the standard credentialing and recredentialing processes.

The following elements are assessed for organizational providers:

- Provider is in good standing with state and federal regulatory bodies.
- Provider has been reviewed and approved by an accrediting body.
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body.
- Liability insurance coverage is maintained.
- CLIA certificates are current.
- Completion of a signed and dated application.

Providers will be informed of the credentialing committee decision within 60 business days of the committee meeting. Providers will be considered recredentialed unless otherwise notified. Please note that is a provider is not elected to be part of the CareSource network, for reasons that do not require review of the application, CareSource will provide written notice to the applying provider of the determination within 30 days after receipt of the application (11 NCAC 20.0405 Verification of Credentials).

Provider Credentialing Rights

- Providers have the right to review information submitted from outside sources (e.g. malpractice insurance carriers and state licensing boards) to support their credentialing application upon request to the CareSource North Carolina Co. Credentialing department. We keep all submitted information locked and confidential.
- Providers have the right to correct incomplete, inaccurate or conflicting information that was submitted to support their application prior to presenting to the Credentialing Committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, we will request that the provider submit written clarification to the Credentialing Department electronically, by e-mail, fax, or by certified mail, return receipt requested and the provider will be given 5 business days to respond. We will notify the provider within 15 days of receipt of the application that the application is incomplete and the reason (11 NCAC 20.0405(c)). Non-response within that timeframe will result in discontinuance on the 6th day.
- Providers have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing department. An automated email is sent to providers once their application is submitted via the Provider Portal. This email directs providers to call Provider Services at 1-833-230-2101 to obtain application status updates. Provider Service Representatives can inform providers if their application is completed and they are showing as participating in the network, or if their application is still in process while referencing the state-specific timeframes. Practitioners also have the ability to check the status of their application by visiting the website or logging into the Provider Portal to enter application and NPI numbers.

Provider Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. We will initiate immediate action in the event that the participation criteria are no longer met. Providers are required to inform us of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource North Carolina Co. considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

Board Certification Requirements

Physicians applying to become participating providers must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board, with the exception of general dentists who will have board certification requirements waived in lieu of adequate education and training.

Primary care providers (PCPs) may be exempted from the board certification requirement if they have successfully completed a primary care residency program and their education and training is consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating provider.

Physicians whose boards require periodic re-certification will be expected but not required to be re-certified, although failed attempts at re-certification may be reason for termination. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the VP, Senior Medical Director or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist, physicians must:

- Complete an approved fellowship training program in the respective subspecialty, and
- Be board certified by a board recognized and approved by the Credentialing Committee. If no subspecialty board exists or the board is not a board recognized and approved by the Credentialing Committee, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

Delegation of Credentialing/Recredentialing

CareSource North Carolina Co. will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, utilizes an NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

Delegates must be in good standing with Medicaid and CMS. Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource North Carolina Co. may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource North Carolina Co. may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource North Carolina Co.'s network. If this happens, the applying or participating provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Reconsideration and appeal opportunities are available as identified in the Provider Hearing Plan.

Process

To submit a request, the following steps apply:

Step 1	Step 2
Submit a request in writing to: CareSource North Carolina Co. Attn: Credentialing Committee Chairman P.O. Box 8738 Dayton, OH 45401-8738 All requests must be submitted within 14 days of receipt of the date the provider was notified of the decision. Once the request and support documentation is received the Chairman will promptly schedule a hearing where the provider will present information deemed relevant for reconsideration.	The Provider Hearing Plan Panel will render their decision within 7 (seven) business days of the conclusion of the hearing which shall be deemed full and final and not subject to appeal. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal. If you would like to review the Provider Hearing Plan, please visit the website.

Disputes

Provider disputes for issues related to quality, professional competency or conduct should be sent to:

CareSource North Carolina Co.
Attn: Quality Improvement
P.O. Box 8738
Dayton, OH 45401-8738

Summary Suspensions

We reserve the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider who, in the opinion of the Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our members. Any participating provider that is subject to a suspension or termination may dispute the action and request a hearing through the Fair Hearing Plan unless an exception applies. Exceptions are set forth in the Fair Hearing Plan.

GRIEVANCES AND APPEALS

Member Procedures

Members may contact Member Services at **1-833-230-2099** with any questions they have about benefits, including any questions about coverage and benefit levels; annual deductibles, coinsurance copayment, and annual out-of-pocket maximum amounts; specific claims or services they have received; our network; and our authorization requirements.

We have implemented the grievance process and the internal and external grievance procedures to provide fair, reasonable, and timely solutions to grievances that members may have concerning the Plan, benefit determinations, coverage and eligibility issues, or the quality of care rendered by network providers.

The Grievance Process

We have put in place a grievance process for the quick resolution of grievances members submit to us that are unrelated to benefits or benefit denials. For purposes of this grievance process, we define a grievance as an expression of unhappiness or dissatisfaction, orally or in writing, concerning any matter relating to any aspect of the Plan's operation. If members have a grievance concerning the Plan, they may contact us by sending a letter at the following address:

CareSource North Carolina Co.
Attn: Member Grievances
P.O. Box 1947
Dayton, OH 45401-1947

They may also submit a complaint by calling us at **1-833-230-2099**. They may arrange to meet with us in-person to discuss the complaint.

Within thirty (30) calendar days of our receipt of a grievance, we will investigate, resolve, and respond to the grievance and send a letter explaining the Plan's resolution of the grievance. For grievances related to quality of care, we will respond within ten (10) calendar days.

Adverse Benefit Determination Internal and External Review Processes

Please note that the Adverse Benefit Determination Grievance Process below addresses issues related to benefits, benefits denials, or other Adverse Benefit Determinations.

Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means our denial, reduction, or termination of a health care service, in whole or in part, based on any of the following:

- A determination that the member is not eligible for benefits under the plan;
- A determination that a health care service is not a covered service;
- A determination that the health care service does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational services;
- The imposition of an exclusion or other limitation on benefits that would otherwise be covered;
- A determination not to issue the member coverage, if applicable to the plan; or
- A determination to rescind coverage under the plan regardless of whether there is an adverse effect on any particular benefit at that time.

External Review means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted by an Independent Review Organization (IRO).

Final Internal Adverse Benefit Determination means an adverse benefit determination that has been upheld by the plan at the completion of the internal grievances process described in this section.

Grievance (or internal grievance) means a written complaint submitted by a covered person about any of the following:

- CareSource's decisions, policies, or actions related to availability, delivery, or quality of health care services.
- Per North Carolina law, a written complaint submitted by a covered person about a decision rendered solely on the basis that the health plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
- Claims payment or handling; or reimbursement for services.

- The contractual relationship between a covered person and CareSource.

Independent review entity (IRE) means an entity that conducts independent external reviews of adverse benefit determinations pursuant to this section.

Adverse Benefit Determination Appeals

If we make an Adverse Benefit Determination, we will provide the member or authorized representative with a Notice of an Adverse Benefit Determination, as described above. An Adverse Benefit Determination is a decision by us to deny benefits because services are not covered, are excluded, or limited under the Plan, or because the member is not eligible to receive the benefit. The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Request of Reconsideration

If a member wishes to file an appeal on a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, the member or authorized representative must submit an appeal in writing within one hundred eighty (180) calendar days of receiving the Adverse Benefit Determination. An expedited appeal of claims involving urgent care does not need to be in writing. This communication should include:

- The covered person's name and identification number as shown on the ID card;
- The provider's name;
- The date of the medical service;
- The reason the member or authorized representative disagree with the denial; and
- Any documentation or other written information to support the request.
- A consent form signed and dated by the member authorizing the provider or other representative to appeal on their behalf

The member or authorized representative may send a written request for an appeal to:

CareSource
Attn: Member Appeals
P.O. Box 8738
Dayton, OH 45401-8738

The member or authorized representative may also file an Adverse Benefit Determination appeal by calling us at **1-833-230-2099**.

For Urgent Care requests for benefits that have been denied, members or their provider can call the Plan at **1-833-230-2099** to request an appeal.

The Plan offers one (1) level of appeal. The Plan must notify the members of the appeal determination within

thirty (30) calendar days after receiving the completed appeal for a pre-service denial and thirty (30) days after receiving the completed post-service appeal. The Plan offers a 72-hour deadline for resolving an expedited appeal.

Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. CareSource North Carolina Co. will review all appeals in accordance with applicable federal and state laws.

Within three (3) business days after we receive an appeal of an Adverse Benefit Determination, we will send to the appealing party a letter acknowledging the date the Plan received the appeal and a list of documents the appealing party must submit. If the appeal was oral, the Plan will enclose an appeal form clearly stating that the form must be returned to CareSource North Carolina Co. for prompt resolution. The Plan has thirty (30) calendar days from receipt of a written appeal of Adverse Benefit Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a medical doctor not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review.

Notice of our Final Internal Adverse Benefit Decision on the appeal will include the dental, medical and contractual reasons for the resolution; clinical basis for the decision and the specialization of provider consulted.

Internal Expedited Appeal of Adverse Benefit Determination

Expedited appeal of an adverse benefit determination may be started orally, in writing, or by other reasonable means available to the member or provider. If we determine your appeal meets expedited criteria then the review will be completed within 72 hours of the receipt of request.

Members may request an expedited review for:

- Any pre-service request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
    - Could seriously jeopardize your life or health or your ability to regain maximum function, or,
    - In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided above, a pre-service request involving urgent care services is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any pre-service request that a physician with knowledge of your medical condition determines is a claim involving urgent care.

External Reviews

Members are entitled to an external review by an IRO in the following instances:

- The internal appeal process was completed or jointly waived by the member and/or CareSource North Carolina Co.
- CareSource North Carolina Co. failed to make a determination within 30 days of receiving the written appeal and/or within 72 hours of receiving the request for an expedited appeal
- The member was covered on the date of service or, if a prospective denial, the member was eligible to receive benefits on the date the proposed service was requested.

There are three (3) types of IRE reviews: standard, expedited, and external investigation/experimental. Standard reviews and external investigation/experimental reviews are normally completed within forty-five (45) calendar days. An expedited review for urgent medical situations must be complete within 3 days from receipt of all required information, unless the member and CareSource North Carolina Co. agree to a 24-hour extension, and can be requested if the member is hospitalized, or if, in the opinion of the treating providers, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the member or, with respect to a pregnant woman, the health of the member or her unborn child in serious jeopardy;
- Subjecting the member to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ.
- If the noncertification or appeal concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement;
- An expedited external review is sought simultaneously with an expedited appeal; or
- We failed to meet any requirements of the appeal process.

External review requests must be made through Smart NC:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201

Phone: 855-408-1212

Binding Nature of External Review Decision

An external review decision is binding on us and the member except to the extent there are other remedies available under state or federal law. Subject to the foregoing, upon receipt of notice by an IRO to reverse an Adverse Benefit Determination, we will immediately provide coverage for the Heath Care Service in question. Members may not file a subsequent request for an External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to us. A decision issued by the IRO will be admissible in any civil action related to our coverage decision. The IRO's decision is presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

Provider Questions

Providers may contact us by mail, fax, or phone. Please call Provider Services at **1-833-230-2101**. Providers may also contact the North Carolina Department of Insurance at:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
855-408-1212 (toll free)

Provider Procedures

Provider Grievances

Providers may file grievances related to members, other providers or operational issues of the plan. CareSource North Carolina Co. will thoroughly investigate each provider complaint using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying the CareSource North Carolina Co. written policies and procedures. Providers may file grievances within 180 days of the issue related to members, other providers, or operational issues of the plan through the Provider Portal, Customer Care, fax, or mail.

Claim Appeals

If you do not agree with the decision of the processed claim, you will have 24 months from the date of service or discharge to file a claim dispute. Providers have 180 days from the date of service or the date of discharge, whichever is later, to request a medical necessity dispute/appeal. If the dispute/appeal is not submitted in the required time frame, the claim will not be considered and the dispute/appeal will be denied. If the dispute/appeal is denied, providers will be notified in writing. If the dispute/appeal is approved, payment will show on the provider's Explanation of Payment (EOP).

How to Submit Claim Disputes/Appeals

Provider Portal:

The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the dispute/appeal.

Writing:

Use the Form located on **CareSource.com** > Providers > Tools & Resources > Forms. Please include:

- Member's name and member ID number
- The provider's name and ID number.
- The code(s) and why the determination should be reconsidered.
- If you are submitting a timely filing dispute/appeal, you must send proof of original receipt of the dispute/appeal by fax or Electronic Data Information (EDI) for reconsideration.
- If the dispute/appeal is regarding a clinical edit denial, the grievance must have all the supporting documentation as to the justification of reversing the determination.

Completed forms should be returned to CareSource of North Carolina Co. via fax or mail, using the contact information on the form.

If you are submitting a timely filing appeal (a dispute past the 24-month time frame), you must send proof of original receipt of the claim by fax or Electronic Data Information (EDI) for reconsideration.

For additional information, contact Provider Services at **1-833-230-2101**.

No Surprise Act / Balance Billing

The Federal and State No Surprise Act establishes patient protections for members enrolled in Marketplace plans, including protection from out-of-network providers' surprise bills ("balance billing") for emergency care and other specified items or services. CareSource will comply with these new state and federal requirements including how we process claims for certain out-of-network providers. Claims paid in accordance with this act are notated in the claim detail above the Remark Code N830. If you wish to file a claim appeal during the open negotiation period, please do so within 30 days from the date of initial payment or notice of denial of payment. Please visit the Provider Portal for more information, or email MarketplaceIDR@CareSource.com for inquiries and Independent Dispute Resolution (IDR) initiations.

Arbitration

If the provider is dissatisfied with the decision of CareSource North Carolina Co., the provider may submit the matter in accordance with the dispute resolution provisions of the agreement with CareSource North Carolina Co. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of North Carolina at 27 N.C.A.C. Chapter 1E – Section .0405 of the NC Uniform Arbitration Act unless:

- The provider and CareSource North Carolina Co. mutually agree to some other binding resolution procedure or process in the agreement between the parties; or
- CareSource North Carolina Co. or the providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.
- The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving CareSource North Carolina Co. and the provider.
- The fees and expenses of arbitration or other binding resolution procedure shall be borne by the non-prevailing party.

MEMBER ENROLLMENT AND ELIGIBILITY

The Health Insurance Marketplace is responsible for determining whether applicants are eligible for benefits under the plan, the application and enrollment processes and any subsidy level that may apply. Applicants must be citizens of the United States and reside in the plan's service area.

Members must enroll in the Marketplace every year. They must inform the Marketplace if they become pregnant, have a baby, change address or phone number, have a change in income or marital status or become eligible for other health care coverage.

New Member Welcome Kits

Once a member has paid to effectuate their coverage, each household receives a new member kit and two or more ID cards that include each family member who has joined CareSource North Carolina Co. The new member kits are mailed separately from the ID card.

- A welcome letter
- A Member Handbook and an Evidence of Individual Coverage and Health Insurance Contract, which explain plan services and benefits and how to access them
- Prior authorization list
- Schedule of Benefits which explains deductibles, copays, coinsurance and out-of-pocket limits for essential health benefits
- A postcard with which the member can request a Provider Directory
- A flier describing supplemental benefits

Members are referred to the Provider Directory, which lists participating providers and facilities. A current list of providers can be found at any time on our website, **CareSource.com** > Members > Tools & Resources > Find a Doctor.

Eligibility

As with other commercial health plans, our Marketplace plan members are responsible for copays, coinsurance and deductibles. Providers are responsible for collecting the appropriate payments.

Payment Responsibility

As with other commercial health plans, CareSource North Carolina Co.'s Marketplace plan members are responsible for copays, coinsurance and deductibles. Providers are responsible for collecting the appropriate payments.

Disenrollment

Members may disenroll from CareSource North Carolina Co. for a number of reasons. Disenrollment may be initiated by the member, CareSource North Carolina Co. or the Health Insurance Marketplace.

Grace Period

Members have a federally mandated 90-day grace period if they are receiving APTC, or a 31-day grace period if they are not receiving APTC in which to make their payment. This is not applicable for their initial payment. For APTC-receiving members, 30 days after their due date CareSource North Carolina Co. will: flag the

member in the eligibility file on the Provider Portal, suspend pharmacy benefits and pend claims rendered. For non-APTC members, the day after their due date, CareSource North Carolina Co. will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend claims rendered. If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again and pended claims will be processed.

Member Termination

After the grace period has expired, the member is terminated for non-payment of premium.

- CareSource North Carolina Co. will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- CareSource North Carolina Co. will then deny claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.

MEMBER SUPPORT SERVICES

CareSource North Carolina Co. provides a wide variety of support and educational services to our members to facilitate their use and understanding of our plan's services, to promote preventive health care and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

Member Services

Members can access Member Services by calling our toll-free number at **1-833-230-2099** (TTY: 711), 7 a.m. to 7 p.m. ET, and telling our interactive voice response system (IVR) what their question is regarding.

Holiday Hours

Representatives are available by telephone Monday through Friday, except on certain holidays. Holiday hours can be found at **CareSource.com** > Contact Us.

Care Management

Care Management/Outreach

We provide the services of care management from medical and behavioral health nurses, social workers and community health workers to provide one-on-one, personal interaction with patients. We have pharmacists on staff to assist with medication reconciliation and to function as a part of the interdisciplinary care team.

Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and re-admission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions, and assessing social and safety needs, as well as educating pregnant women on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

You can refer a member to Care Management by calling Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Providers can also make referrals to care management on behalf of the member by submitting the request in the Provider Portal.

Care Management Services

Our Care Management program is designed to support the care and treatment you provide and recommend to your patient.

One-on-one personal interaction with community health workers and licensed, professional case managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food.

We encourage you to take an active role in your patient's care management program through the Patient Profile feature on the Provider Portal. This profile provides member-specific information on pharmacy, inpatient and Emergency Department (ED) utilization, scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient.

In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

We offer individualized education and support for many conditions and needs, including:

- Asthma
- Diabetes
- Heart disease
- Depression
- High blood pressure and cholesterol
- Low back pain
- Pregnancy
- Weight loss

We encourage you to take an active role in your patients' care management programs and participate in the development of individualized care plans to help meet their needs. Together, we can make a difference.

MyResources

The MyResources search engine is a social service and community resource search tool. The MyResources Tool connects members with local low-cost and no cost community-based programs and social services.

The tool is easy to use and allows our staff and members to search for a wide category of resources like food, housing, transportation and job training programs by simply entering a zip code from anywhere in the United States.

The search information is provided in real time, including hours of operation, distance from the zip code entered, and other locations nearby. More than 100 languages are supported and resources can be updated and new resources suggested directly from the site. Other features include the ability to send a resource to a friend via email or text.

Members can log into their My CareSource account to learn more or call Member Services at **1-833-230-2099** (TTY: 711). Hours of operation are Monday through Friday, 7 a.m. to 7 p.m., Eastern Time (ET).

Perinatal Care Management

Our perinatal and neonatal care management program utilizes a multi-disciplinary team with extensive obstetrics and neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and care coordination and involves direct telephone contact with members and providers.

All pregnant members receive educational packets throughout their pregnancy and in the immediate postpartum period. Pregnant members in care management will receive one-to-one perinatal education throughout her pregnancy.

Disease Management

Our free Disease Management Program helps our members find a path to better health through information, resources and support.

We help our members through:

- The MyHealth online program for members 18+ to participate in a journey to improve their health
- Newsletters with helpful tips and information to manage their disease, promote self-management skills, and provide additional resources.
- Coordination with outreach teams such as wellness advocates and health coaches
- One-to-one care management (if they qualify)

Members with specific disease conditions are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment. All ages (children, teens, and adults) are eligible. These members are automatically mailed quarterly condition-specific newsletters. The materials are available in English and Spanish. Any member may self-refer or be referred into the disease management program to receive condition-specific information or outreach. If a member does not wish to receive newsletters or outreach, they can call 1-844-438-9498.

Disease Management Program Benefits

Members identified in the Disease Management Program receive help finding the appropriate level of care for their condition, and they are encouraged to actively participate in the patient-provider relationship. The program improves the percentage of members who receive their recommended screenings.

If you have a patient with a chronic condition who you believe would benefit from this program and are not currently enrolled, please call 1-844-438-9498.

Health Education

Our members receive health information from us through a variety of communication vehicles including easy-to-read newsletters, brochures, phone calls and personal interaction. We also send preventive care reminder messages to members via mail and automated outreach messaging.

Telehealth

Telehealth technology makes health care more accessible, cost-effective, and can increase patient engagement. CareSource North Carolina Co. wants to support your telehealth program by covering select telehealth services you provide to our members.

If you do not have a telehealth program or if you need help servicing your patients during busy times, we have partnered with Teladoc® to provide the convenience of telemedicine to all of our members over the age of two. Teladoc physicians can consult, diagnose and also prescribe medications when appropriate (DEA controlled substances excluded) and provide treatment for non-emergency conditions like allergies, asthma, sore throat, cold and flu, ear infection, pink eye, UTI, skin inflammation, joint aches and pains and sinus infections. CareSource North Carolina Co. will continue to encourage our members to engage with their PCP first, but much like using retail clinics or urgent care as a way to meet medical needs, we are providing another access point through Teladoc.

Members can connect to Teladoc by:

- Downloading the Teladoc app to a smart phone.
- Visiting www.Teladoc.com/CareSource
- Calling 1-800-Teladoc (1-800-835-2362)

CareSource24, Nurse Advice Line

Members can call our nurse advice line 24-hours a day, seven days a week. With CareSource24, members have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support.

CareSource24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider (PCP) by explaining the importance of their role in coordinating the member's care. For improved care coordination with PCPs, summaries of the call are posted on the Provider Portal, including a record of why the member called and what advice the nurse gave.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Members may access CareSource24 any time night or day. The phone number is on the member's ID card.

Sign & Language Interpretation Assistance

We offer over-the phone language interpreters for members who need assistance to communicate with CareSource North Carolina Co. These services are available at no cost to the member.

Providers, at their own expense, are required to offer sign and language interpreters for members who are hearing impaired, do not speak English, or have limited English-speaking ability. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your patients and offer assistance to them appropriately. We can provide, at no charge, some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed.

Emergency Department Diversion

We are committed to making sure our members access the most appropriate health care services at the appropriate time for their needs. We instruct members to call their PCP or the CareSource24 Nurse Advice Line if they are unsure if they need to go to an ED. We also educate members on the appropriate use of urgent care facilities and which urgent care sites they can access.

Members are informed to call 911 or go to the nearest emergency department (ED) if they feel they have an emergency. We cover all emergency services for our members.

Member ED utilization is tracked closely. If there is frequent ED utilization, members are referred to our Care Management Department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education, as well as assistance with removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

PROVIDER RESOURCES

We strive to make it easy for you to work with us. This section compiles resources you need for contacting CareSource, finding key information and monitoring updates.

Hours of Operation

Provider Services		
Provider Services Phone	Monday to Friday	8 a.m. to 6 p.m. Eastern Time

Member Services		
Member Services Phone	Monday to Friday	7 a.m. to 7 p.m. Eastern Time

Holiday Hours

Representatives are available by telephone Monday through Friday, except on observed holidays. Please visit **CareSource.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Phone

Our interactive voice response (IVR) system will direct your call to the appropriate professional for assistance. We also provide telephone based self-service applications that allow you to verify member eligibility.

Provider Services	1-833-230-2101
Prior Authorizations	1-833-230-2101
Claims	1-833-230-2101
Credentialing	1-833-230-2101
Member Services	1-833-230-2099
TTY	711
CareSource 24 – Nurse Advice Line	1-833-687-7355
Fraud, Waste & Abuse Hotline	1-833-230-2101
TTY for the Hearing Impaired	1-800-735-2962 or 711
EyeMed	1-888-581-3648
TruHearing	1-866-202-2674
Active&Fit	1-877-771-2746
DentaQuest	1-855-398-8413 ext. 38517

Fax

Care Management Referral	TBD
Credentialing	866-573-0018
Contract Implementation	TBD
Fraud, Waste & Abuse	TBD
Medical Prior Authorization*	TBD
Pharmacy Prior Authorization	866-930-0019
Specialty Pharmacy Prior Authorization Fax	888-399-0271
Provider Appeals	TBD
Provider Maintenance	TBD

Mail

CareSource
P.O. Box 8738
Dayton, OH 45401-8738

Provider Appeals Mailing Address	Member Appeals and Grievances Mailing Address
CareSource Attn: Provider Appeals P.O. Box 2008 Dayton, OH 45401- 2008	CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401-1947

Claims Mailing Address	Fraud, Waste and Abuse Mailing Address
CareSource Attn: Claims P.O. Box 967 Dayton, OH 45401-967	CareSource Attn. Program Integrity P.O. Box 1940 Dayton, OH 45401-1940

Information reported to us can be reported anonymously and is kept confidential to the extent permitted by law.

Website

Accessing our website, **CareSource.com**, is quick and easy. On the Provider section of the site you will find:

- Commonly used forms
- Newsletters, updates and announcements
- The provider manual and other plan resources
- Claim information
- Frequently asked questions
- Clinical and preventive guidelines
- Behavioral health information
- And much more

Provider Portal

URL: https://providerportal.caresource.com

Our secure online Provider Portal allows you instant access at any time to valuable information. You can access the Provider Portal at **CareSource.com** > Login > Provider Portal. Simply enter your username and password (if already a registered user) or submit your information to become a registered user. Assisting you is one of our top priorities in order to deliver better health outcomes for our members.

Benefits

- Free access to important resources
- Availability 24 hours a day, seven days a week
- Secure, convenient access to time-saving services and critical information
- Accessibility on any web browser without any additional software

Tools

We encourage you to take advantage of the following time-saving tools:

- **Payment history** – Search for payments by check number or claim number
- **Claim Features**
    - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes.
    - Claim Status – Search for status of claims.
    - Claims Attachments – Submit documentation needed for claims processing.
    - Rejected Claims – Find claims that may have been rejected so that you can resubmit them.
- **Claim Dispute and Appeals** – Submit and search for claim appeals and disputes.
- **Prior authorization (PA)** – Request prior authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.

Registration

If you are not registered with the Provider Portal, please follow these easy steps:

- **CareSource.com** > Login > Provider and select North Carolina. Click on the "Register for an account" button and complete the registration process. Note: you will need to have your tax ID number and Provider ID.
- Click Continue. Note the username and password you create so that you can access the portal's many helpful tools.
- If you do not remember your username/password, please call Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Forms

Providers may access key forms on our website by navigating to **CareSource.com** > Providers > Tools & Resources > Forms.

Policies

Policies offer guidance on determination of medical necessity and appropriateness of care for approved benefits. Medical, reimbursement, administrative and pharmacy policies may be found at **CareSource.com** > Providers > Tools & Resources > Provider Policies.

Provider Training

We encourage our providers to access our on-demand video trainings on topics related to your practice. These trainings provide key information for you to do business with us. Providers may access trainings and events by visiting **CareSource.com** > Providers > Education > Training & Events.

Newsletters

Our provider newsletter contains operational updates, clinical articles and new initiatives underway. Our newsletter is both mailed and posted online at **CareSource.com** > Education > Newsletters & Communications.

Network Notifications

We regularly communicate policy and procedure updates to providers via network notifications. Network notifications are found on our website at **CareSource.com** > Providers > Tools & Resources > Updates & Announcements.

Clinical Practice Registry and Member Profile

Quick and easy to access on our secure Provider Portal, the Clinical Practice Registry helps PCPs improve patient health outcomes efficiently. The primary use of the Registry is to help PCPs manage their patient population.

PCPs can quickly sort their membership into actionable groups. The Clinical Practice Registry is a proactive approach to patient care and helps place emphasis on preventive care.

Key Benefits of the Registry

- The registry is color-coded, which provides easy identification of members in need of tests and/or screenings.
- The information can be downloaded as a PDF or in an Excel spreadsheet format (the Excel spreadsheet contains patient contact information).
- It provides direct access to the Member Profile feature for individual members of interest.

Information Included on the Registry

- Well-baby visits (zero to 15 months)
- Well-care (two to 21 months)
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening

- Lead screening
- Diabetes (e.g. cholesterol, eye exam, hematology, kidney)
- Emergency room visits

The Clinical Practice Registry is located on our secure Provider Portal.

Member Profile

With its comprehensive view of patient medical and pharmacy data, our Member Profile can help you improve health outcomes for your patients. The Member Profile can also help you determine an accurate diagnosis more efficiently, reduce unnecessary diagnostic tests and minimize emergency room visits.

Key Benefits of the Member Profile

- Provides medical history
- Identifies potential prescription non-adherence or abuse
- Identifies duplication of services
- Introduces disease or care management options

Please Note: The Member Profile tool can be found on the Eligibility and Prior Authorization screens of the Provider Portal.

Benefit Managers

Dental	Vision
Dental benefits are administered by DentaQuest. Member Services: 1-833-615-0434	Vision benefits are administered by EyeMed. Member Services: 1-833-337-3129

Fitness	Hearing
Fitness benefits are administered by American Specialty Health and offered as Active&Fit. Member Services: 1-877-771-2746	Hearing benefits are administered by TruHearing Member Services: 1-866-202-2636

PROVIDER RESPONSIBILITIES

Access Standards

We have a comprehensive quality program to help ensure our members receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers.

We expect participating providers to have procedures in place to see patients within these time frames and to offer hours of operation to their CareSource North Carolina Co. patients that are no less (in number or scope) than the hours of operation offered to other patients. Please keep in mind the following access standards for differing levels of care.

Primary Care Providers

Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 14 calendar days

Non-Primary Care Providers (Specialists)

Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 30 calendar days

Behavioral Health Providers

Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based off the condition

Telephone Arrangements/24-Hour Access

PCPs and specialty physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services. They must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours.
- Answer the member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a member.
- Identify and reschedule broken and no-show appointments.
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After hours telephone care for non-emergent, symptomatic issues within 30 minutes.

  - Same day for non-symptomatic concerns.
  - Crisis situations within 15 minutes.

- Schedule continuous availability and accessibility of professional, allied and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method and then transferred to the member's medical record.
- During after-hours calls, a provider must have arrangements for the following:
  - Office phone is answered after hours by an answering machine service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes;
  - Office phone is answered after hours by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the provider has designated to return the call within a maximum of 30 minutes; and
  - Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes.

Americans with Disabilities Act

Providers are required to comply with ADA standards, including but not limited to:

- Providing waiting room and exam room furniture that meet the needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or providing enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

The Americans with Disabilities Act (ADA) prohibits discrimination against persons with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications. Both public and private hospitals and health care facilities must provide their services to people with disabilities in a nondiscriminatory manner. To do so, providers may have to modify their policies and procedures, provide auxiliary aids and services for effective communication, remove barriers from existing facilities, and follow ADA accessibility standards for new construction and alteration projects. Furthermore, providers' diagnostic equipment must accommodate individuals with disabilities.

The provider network will reasonably accommodate persons and ensure that their services are as accessible to a member with disabilities as they are to a member without disabilities. CareSource North Carolina Co. and its provider network will comply with the ADA (28 C.F.R. 35.130) and the Rehabilitation Act of 1973 (29 U.S.C. 794) and will maintain capacity to deliver services in a manner that accommodates the needs of its members.

For more information about the ADA, go to www.ada.gov/.

Health Equity and Cultural Competency

We are dedicated to the communities in which we serve and making a positive impact in the lives of our members by eliminating health disparities, supporting our organization's health equity initiatives, and partnering with community stakeholders to carry out this much needed work.

We recognize language and cultural differences have a significant impact on member health care experience and outcomes. We participate in efforts to promote the delivery of services in a culturally competent manner to all members. Participating providers must also meet any applicable state and federal laws or regulations pertaining to provision of services and care.

National Culturally & Linguistically Appropriate Standards (CLAS Standards)

CareSource North Carolina Co. adheres to the National Culturally & Linguistically Appropriate Standards (CLAS), which serve as a blueprint for health care providers and organizations to implement culturally and linguistically appropriate services. CLAS consists of 15 standards that encompass the following topic areas:

Principal Standard: Provision of effective, equitable, understandable, and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs

- Governance, Leadership, and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement & Accountability

Network providers must ensure that:

- Members understand that they have access to free medical interpreter services in their native language, including Sign Language. No cost TDD/TTY services are available to facilitate communication with hearing impaired members.
- Health care is provided with consideration of the members' cultural background, encompassing race/ethnicity, language and health beliefs. Cultural considerations may impact/influence member health decisions related to preventable disease or illness.
- The provider office staff makes reasonable attempts to collect race-and language-specific member data. Staff is available to answer questions and explain race/ethnicity categories to a member, to assure accurate identification of race/ethnicity for all family members.
- Treatment plans are developed based on evidence-based clinical practice guidelines with consideration of the member's race, country of origin, native language, social norms, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Participating providers must also meet the requirements of all applicable state and federal laws and regulations as they pertain to provision of services and care.

Our providers and partners are prohibited from refusing to treat, serve or otherwise discriminate against an individual because of race, color, religion, national origin, sex, age, gender orientation (i.e. intersex, transgendered and transsexual) or disability. In consideration of cultural differences, including religious beliefs and ethical principles, we will not discriminate against providers who practice within the permissions of

existing protections in provider conscience laws, as outlined by the U.S. Department of Health and Human Services (HHS).

We encourage our participating providers to visit the Office of Minority Health, Cultural Competency Resources website found at www.ThinkCulturalHealth.hhs.gov for toolkits and educational resources. Included on the site is a free nine-credit Continuing Medical Education (CME) course, A Physician's Practical Guide to Culturally Competent Care. This self-directed e-learning program equips providers to better understand and treat diverse populations.

Fraud, Waste and Abuse

Overview

Health care fraud, waste and abuse hurts everyone, including members, providers, taxpayers and CareSource North Carolina Co. As a result, we have a comprehensive Fraud, Waste and Abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations.

Definition of Terms

Fraud

Fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law" (42 CFR, Part 455.2).

Waste

Waste involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by player with control over, or access to, government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse, and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight (Inspector General).

Abuse

Abuse is defined as "provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program" (42 CFR Part 455.2).

Improper Payment

Improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act, IPERA). Any improper payment may constitute fraud, waste and/or abuse. We have the right to recoup improper payments.

Examples of Member Fraud, Waste and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions – i.e. changing prescription form to get more than the amount of medication prescribed by their physician
- Sharing a member ID card
- Non-disclosure of other health insurance coverage
- Changing prescription forms to get more than the amount of medication prescribed by a physician
- Obtaining unnecessary equipment and supplies
- Member receiving services or picking up prescriptions under another person's name or ID (identity theft)
- Providing inaccurate symptoms and other information in order get treatment, drugs, etc.
- Any other action by a member that CareSource North Carolina Co. considers to be fraud, waste and/or abuse

Note: This is not an all-inclusive list.

Examples of Provider Fraud, Waste and/or Abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Billing for services not provided
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not checking member IDs, resulting in claims submitted for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using member/enrollee lists for the purpose of submitting fraudulent claims
- Billing drugs billed for inpatients as if they were outpatients
- Accepting payments stemming from kickbacks or Stark violations
- Retaining overpayments made in error by CareSource North Carolina Co.
- Preventing members from accessing eligible or covered services resulting in underutilization of services offered
- Failing to comply with federal and/or state laws

Note: This is not an all-inclusive list.

Examples of Pharmacy Fraud, Waste and/or Abuse:

- Dispensing prescription drugs not dispensed as written
- Submitting claims for a more expensive brand name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, tainted or illegal drugs
- Billing prescriptions not filled or picked up

Examples of Vendor Fraud, Waste and/or Abuse:

- Falsifying business data or reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered
- Billing for a more expensive service, but providing a less expensive service

Corrective Actions

The Program Integrity department routinely monitors for potential fraud, waste and abuse. We review claims data and medical records to look for billing discrepancies. When found, an investigation is initiated and, if warranted, a corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Written corrective action plan
- Provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Reporting to one or more applicable state and federal agencies
- Contract termination
- Employee disciplinary actions
- Legal action

Refer to your Provider Agreement for specific information on each type of provider termination/suspension. Also, refer to the Fair Hearing Plan, for the information on the appeal process. The Fair Hearing Plan is

available at **CareSource.com** > Provider Overview > Education > Fraud, Waste & Abuse. The "Fair Hearing Plan" provides information on an appeal process for specific corrective actions.

Network providers are to report and return to CareSource North Carolina Co. any overpayment within sixty (60) calendar days of identification, and to notify CareSource North Carolina Co. in writing of the reason for the overpayment.

The False Claims Act

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government – known as "qui tam" suits – against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

As amended in 2009, the False Claims Act addresses those who:

- Knowingly* present, or cause to be presented, a false or fraudulent claim for payment or approval
- Knowingly* make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim
- Conspire to commit a violation of any other section of the False Claims Act
- Have possession, custody or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property
- Are authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and intending to defraud the government, makes or deliver the receipt without completely knowing that the information on the receipt is true
- Knowingly* buy, or receive as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property
- Knowingly* make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the government.

*"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.

An example would be if a provider, such as a hospital or a physician knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The time period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity.

Protection for Whistleblowers

Federal and state law and our corporate policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department using one of the reporting methods outlined at the end of this section.

Individuals bringing the suit may receive a percentage of the proceeds of the action or settlement. Additional information on the False Claims Act and our fraud, waste and abuse policies can be found at **CareSource.com** > Providers > Education > Fraud, Waste & Abuse.

Anti-Kickback Statute

Under the Federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program (42 U.S.C. §1320a-7b).

Stark Law

Under the Federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal health care programs (42 U.S.C. §1395nn).

Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347).

Affordable Care Act

Section 6402(a) of the Affordable Care Act established section 1128J(d) of the Social Security Act. Section 1128J(d)(1) of the Act requires a person who has received an overpayment to report and return the overpayment with a written explanation of the reason for the overpayment. An overpayment must be reported 60 days after the date on which the overpayment is identified.

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource North Carolina Co. is required to comply with certain provisions of the DRA.

One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste and abuse when handling CareSource North Carolina Co. business.

Prohibited Affiliations

CareSource North Carolina Co. is prohibited by its federal and state contracts from knowingly having relationships with persons who are debarred, suspended or otherwise excluded from participating in federal procurement and non-procurement activities (42 C.F.R. § 438.610).

Relationships must be terminated with any trustee, officer, employee, provider or vendor who is identified to be debarred, suspended, or otherwise excluded from participation in federal or state health care programs. If you become aware that your corporate entity, those with more than five percent ownership in your corporate entity, your office management staff or you are a prohibited affiliation, you must notify us by emailing providermaintenance@caresource.com.

Confidentiality

Physicians shall prepare, maintain and retain as confidential the health records of all members receiving health care services, and members' other personally identifiable health information received from CareSource North Carolina Co., in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Disclosure of Ownership, Debarment and Criminal Convictions

Before CareSource North Carolina Co. enters into or renews an agreement with your practice or corporate entity, you must disclose any debarment or suspension status and any criminal convictions related to federal health care programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.

You must also notify us of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by emailing providermaintenance@caresource.com.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations (CFR) 42 CFR 455.100-106 for more information and definitions of relevant terms.

How to Report Fraud, Waste or Abuse

It is our policy to detect and prevent any activity that may constitute fraud, waste or abuse, including violations of the federal False Claims Act or any state Medicaid fraud laws.

If you have knowledge or information that any such activity may be or has taken place, please contact our Program Integrity department. Reporting fraud, waste or abuse can be anonymous or not anonymous.

Options for reporting anonymously:	
Call: 1-844-607-2831 and ask to report fraud.	Write: CareSource of North Carolina Attn: Program Integrity P.O. Box 1940 Dayton, OH 45401-1940

Options for reporting that are not anonymous:	
Fax: 800-418-0248	Email*: fraud@caresource.com

**Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.*

Or you may choose to use the **Fraud, Waste and Abuse Reporting Form** located on **CareSource.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law. Thank you for helping us keep fraud, waste and abuse out of health care.

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste and abuse. This brochure can be found on the Office of Inspector General's website at https://oig.hhs.gov/compliance/physician-education/index.asp.

Key Contract Provisions

To make it easier for you, we have outlined key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Provider Responsibilities

- Providing CareSource North Carolina Co. with advance written notice of any intent to terminate an agreement with us. In terminations without cause, written notice must be done 120 calendar days prior to the date of the intended termination and submitted on your organization's letterhead.
    - 60 calendar days' notice is required if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting members for a 60-calendar day period following notification.
- For Primary Care Providers (PCPs) only: Providing 24-hour availability to your patients by telephone. Whether through an answering machine or a taped message used after-hours, patients should be given the means to contact their PCP or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.
- Submission of claims or corrected claims should be submitted within two years after the original claim adjudication.
- Appeals must be filed within the required timeframe from the date of service or discharge.
- Providers should keep all demographic and practice information up to date. Information updates can be submitted on the Provider Portal at **CareSource.com** > Login > Provider Portal.

CareSource North Carolina Co. Responsibilities

- Paying claims timely.
- Providing you with an appeals procedure for timely resolution of any requests to reverse a determination regarding claims payment. Our appeal process is outlined in the appeals section of this manual.
- Offering a 24-hour nurse advice line service for members to reach a medical professional at any time with questions or concerns.
- Coordinating benefits for members with primary insurance which involves subtracting the primary payment from the lessor of the primary carrier allowable or the CareSource North Carolina Co. allowable. If the member's primary insurer pays a provider equal to or more than CareSource North Carolina Co.'s fee schedule for a covered service, CareSource North Carolina Co. will not pay the additional amount.
- Making available member details on coverage and benefits.

These are just a few of the specific terms of our agreement. In addition, we expect participating providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

Examples

- Participating providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- Participating PCPs are expected to have a system in place for following up with patients who miss scheduled appointments.
- Participating providers are expected to treat members with respect. Members should not be treated any differently than patients with any other health care insurance. Please reference member rights in the "Member Support Services and Benefits" section of this manual.

We expect participating providers to verify member eligibility and ask for all of their health care insurance information before rendering services, except in an emergency. You can verify member eligibility and obtain information for other health care insurance coverage that we have on file by logging onto the Provider Portal from the menu options.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing.

Member Rights and Responsibilities

As a CareSource North Carolina Co. provider, you are required to respect the rights of our members. Our members are informed of their rights and responsibilities via their Member Handbook. The list of our members' rights and responsibilities are listed below. All members are encouraged to take an active and participatory role in their own health and the health of their family.

Member rights, as stated in the Member Handbook, are as follows:

- To receive information about CareSource North Carolina Co., its services, its practitioners and providers, and member rights and responsibilities.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- To be treated with respect and with regard for their dignity and privacy.
- To discuss any appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- To participate in decisions regarding his or her health care, including the right to refuse treatment.
- To be able to file an appeal, a grievance (complaint) or request for external review about CareSource North Carolina Co. or the care it provides, and that the exercise of those rights will not adversely affect the way the member is treated.
- To make advance directives (a living will).
- To make recommendations regarding our member rights and responsibility policy.

Members are also informed of the following responsibilities:

- Supply information needed, to the extent possible, that the organization and its doctors need in order to provide care.
- Be enrolled and pay any required premiums.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and pharmacies.
- Follow the advice and instructions for care he/she have agreed upon with his/her doctors and other health care providers.
- Always carry his/her ID card and present it when receiving services.
- Provide the information that we and his/her providers need in order to provide care.

Notification of Practice Changes

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up to date, and reduces unnecessary calls to your practice.

How to Submit Changes:

The Provider Portal is the preferred method to submit changes. Simply log in to the Provider Portal by visiting **CareSource.com** > Login > Provider Portal, entering your login credentials, and selecting Provider Maintenance from the left hand navigation. You may also use the methods below. If submitting updates by email, mail, or fax, providers must utilize the HIE form to submit the updates.

Email ProviderMaintenance@caresource.com

Fax 937-396-3076

Mail CareSource North Carolina Co.
Attn: Provider Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

Timeline of Provider Changes Type of Change	**Notice Required** Please notify CareSource North Carolina Co. of the change prior to the timeframes listed below.
New providers or deleting providers	Immediate
Providers leaving the practice	Immediately upon provider notice
Phone number change	10 calendar days
Address change	60 calendar days
Change in capacity to accept members	60 calendar days
Provider's intent to terminate	90 calendar days

Personally Identifiable Information

In the day-to-day business of patient treatment, payment and health care operations, CareSource North Carolina Co. and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when no longer needed.
- Ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource North Carolina Co., like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

HIPAA Notice of Privacy Practices

Members are notified of our privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our privacy practices are available at **CareSource.com** > About Us > Legal > HIPAA Privacy Practices, selecting the applicable state and plan. They include a description of how and when member information is used and disclosed within and outside of the organization. The notice also informs members how they may obtain a statement of disclosures or request their medical claim information.

CareSource North Carolina Co. takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members. Please remember that as a provider/covered entity, you are obligated to follow the same HIPAA regulations as CareSource North Carolina Co. and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

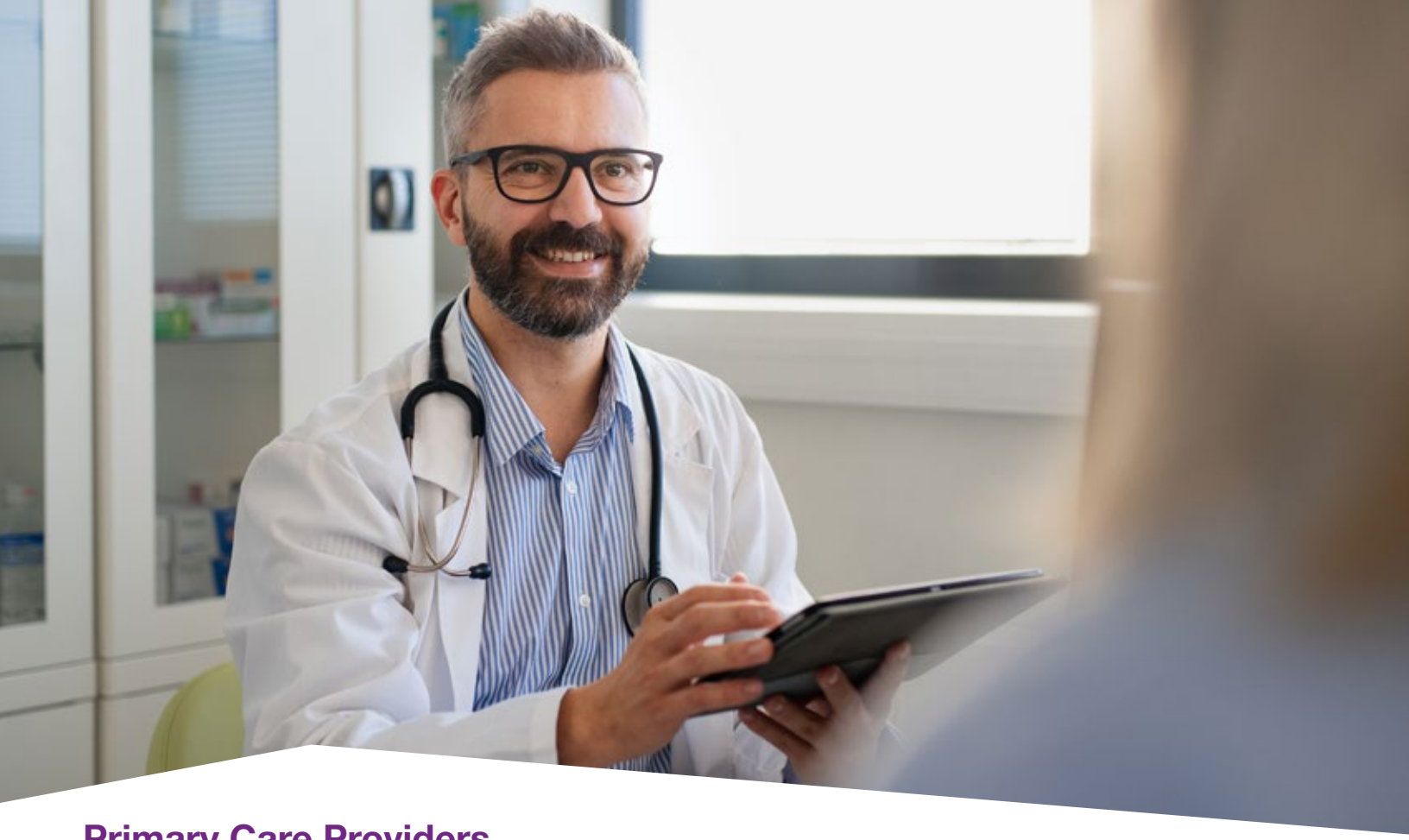
Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to CareSource North Carolina Co. for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information in a timely manner.

Member Consent

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the Provider Portal at **CareSource.com** > Login > Provider Portal and search for the patient using the "Member Eligibility" option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all of the patient's health information on the Provider Portal.

Please encourage your patients who have not consented to complete a Member Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSource.com** > Members > Tools & Resources > Forms. The Member Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.



Primary Care Providers

All members may, though are not required, choose a PCP upon enrollment in the plan. PCPs should help facilitate a medical home for members. This means that PCPs will help coordinate health care for the member and provide additional health options to the member for self-care or care from community partners. Members select a PCP from our online Provider Directory available at **CareSource.com** > Members > Tools & Resources > Find a Doctor. Members have the option to change to another participating PCP as often as needed. Members initiate the change by updating on the Member Portal, or by calling Member Services.

Primary Care Provider Roles and Responsibilities

PCP care coordination responsibilities include the following:

- Assisting with coordination of the member's overall care, as appropriate for the member. Serving as the ongoing source of primary and preventive care.
- Recommending referrals to specialists, as necessary.
- Triaging members.
- Participating in the development of case management care treatment plans and notifying us of members who may benefit from case management.
- Treating members with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the member's health needs and taking appropriate action.

- Providing phone coverage for handling patient calls 24 hours a day, seven days a week. Following all referral and prior authorization policies and procedures as outlined in this manual. Complying with the quality standards of our health plans outlined in this manual.
- Providing 30 days of emergency coverage to any patient dismissed from the practice.
- Maintaining clinical records, including information about pharmaceuticals, referrals, inpatient history, etc.
- Obtaining patient records from facilities visited by patients for emergency or urgent care if notified of the visit.
- Ensuring demographic and practice information is up to date for directory and member use. In addition, PCPs play an integral part in coordinating health care for our members by providing:
    - Availability of a personal health care practitioner to assist with coordination of a member's overall care, as appropriate for the member
    - Continuity of the member's total health care
    - Early detection and preventive health care services
    - Elimination of inappropriate and duplicate services

Please see the "Member Support Services and Benefits" chapter on how to refer members for case management.

Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered as needed. We endorse the same recommended childhood immunization schedule that is recommended by the Center for Disease Control and approved by the Advisory Committee on Immunization Practices (ACIP), the AAP and the American Academy of Family Physicians (AAFP). This schedule is updated annually, and the most current updates can be found at www.aap.org.

QUALITY IMPROVEMENT PROGRAM

We are committed to providing evidence-based care in a safe, member-centered, timely, efficient and equitable manner. The scope of the Quality Improvement (QI) Program is comprehensive and inclusive of both clinical and non-clinical services, as well as health, safety, and/or welfare concerns. We use a population health lens to monitor and evaluate the quality of the care and service delivered to our members emphasizing:

- Equitable delivery of service
- Accessibility and availability to medical, behavioral health and other care
- Quality of care and member safety
- Internal evaluation of program areas, including Utilization Management, Care Management and Pharmacy

Program Scope

We support an active, ongoing and comprehensive quality improvement program across the enterprise. To maintain a robust QI program, our scope includes:

- Assessing member population characteristics and needs
- Advocating for members across settings, including review and resolution of quality-of-care issues
- Meeting member access and availability needs for physical and behavioral health care
- Determining interventions for HEDIS overall rate improvement to improve preventive care scores and facilitate support of members' acute and chronic health conditions and other complex health, safety, or welfare needs.
- Assessing and incorporating feedback or voice of
- Utilizing the annual member QHP Enrollee Survey to capture member perspectives on health care quality and establishing interventions based on results to enrich member and provider experiences
- Demonstrating enhanced care coordination and continuity across settings
- Ensuring CareSource North Carolina Co. is effectively serving members with complex health needs
- Evaluating practitioner adherence to clinical practice guidelines
- Partnering collaboratively with network providers, practitioner, regulatory agencies, and community agencies
- Mandating regulatory and accrediting agency compliance, including:
    - All federal requirements as outlined in 45CFR Part 156, Managed Care
    - Perform HEDIS compliance audit and performance measurement
    - Ensure compliance with NCQA accreditation standards

Quality Strategy

CareSource North Carolina Co. seeks to advance a culture of quality and safety that begins with our senior leadership and is cultivated throughout the organization. We utilize the Institute of Healthcare Improvement (IHI) framework developed to optimize health system performance, as well as the Institute for Healthcare Improvement Quadruple Aim for Populations.

The Institute for Healthcare Improvement Quadruple Aim Framework

CareSource North Carolina Co. aligns with the IHI framework to:

- Improve the member experience of care (including clinical quality and satisfaction)
- Improve the health of populations
- Reduce the per capita cost of health care
- Improve provider satisfaction (professional wellness)

In addition, we use Six Sigma tools, when indicated, to focus on improving member experience, member safety and enduring our processes consistently deliver the desired results.

Quality Measures

We continually assess and analyze the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes. We use HEDIS measures to monitor the quality of care delivered to our members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA). The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most significant areas of care. Potential quality measures for the Health Insurance Marketplace are:

- Wellness and prevention
    - Preventive screenings (breast cancer, cervical cancer, chlamydia)
    - Well-child
- Chronic disease management
    - Comprehensive diabetes care
    - Controlling high blood pressure
- Behavioral Health
    - Follow up after hospitalization for mental illness
    - Antidepressant medication management

We use the annual member survey, QHP Enrollee Survey, to capture member perspectives on health care quality. The QHP Enrollee Survey is a consumer experience survey that assesses enrollee experiences with the QHPs offered through Marketplace. The survey includes a set of core questions that address key areas of care and service provided to members.

- Potential QHP measures include:
- Customer service
- Getting care quickly
- Getting needed care
- How well doctors communicate
- Ratings of all health care, health plan, personal doctor, or specialists

Patient Safety Program

We recognize that patient safety is the cornerstone of high-quality health care, contributing to the overall health and welfare of our members. Our Patient Safety Program evaluates patient safety trends with the goal of reducing avoidable harm. Our patient safety program is developed in the context of our population health management approach and includes regulatory/accreditation, policies and procedures, training and implementation, continuous monitoring and program evaluation and improvement. Safety events are monitored through retrospective review of quality-of-care concerns and real-time reporting of claims data. Data analysis of our provider and health system network ensures situational risks can be identified in a timely manner, reviewed and mitigated by a proactive corrective action, or performance improvement steps.

Preventive Guidelines and Clinical Practice Guidelines

We approve and adopt evidence-based nationally accepted standards and guidelines and promotes them to practitioners and members to help inform and guide clinical care provided to members. Member health resources are available on the website and cover a broad range of wellness, preventive health and chronic disease management topics. Guidelines are reviewed at least every two years or more as often as appropriate and updated as necessary. They may be found at **CareSource.com** > Providers > Education > Patient Care > Health Care Links. The use of these guidelines allows us to measure its impact on member health outcomes. Review and approval of the guidelines are completed by the Provider Advisory Committee (PAC) and Enterprise PAC. The Quality Enterprise Committee (QEC) is notified of guideline approval. Topics for guidelines are identified through analysis of Marketplace plan members. Guidelines may include, but are not limited to:

- Behavioral health (e.g., depression)
- Adult health (e.g., hypertension and diabetes)
- Population health (e.g., obesity and tobacco cessation)

Guidelines may be promoted to practitioners and providers through newsletters, our website, direct mailings, provider manual, and through focused meetings with Provider Engagement Specialists. Information regarding clinical practice guidelines and other health information may be made available to members via member newsletters, the member website, or upon request.

If you would like more information on Quality Improvement, please call Provider Services.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Confidentiality

Physicians shall prepare, maintain and retain as confidential the health records of all members receiving health care services and members' other personally identifiable health information received from CareSource North Carolina Co., in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Quality of Care Reviews

We ensure the provision of safe and quality care to members by investigating and mitigating potential quality of care concerns, that include:

- Inappropriate or inconsistent treatment
- Delay in care
- Care that compromises member health, safety or welfare

In order to properly assess quality of care concerns Clinical Quality and Health Safety initiates contact with providers to request medical records using established processes and timelines. As per our policies and provider contracts, we are authorized to ask for protected health information for health care operations, which includes quality issue reviews. Medical record requests are forwarded to providers via mail, e-mail or fax and may be returned to CareSource North Carolina Co. via these same mechanisms as detailed in the medical record request document.

All providers are expected to return medical record requests related to quality-of-care concerns within 14 days from initial receipt of the request, unless otherwise defined by program guidelines or state or federal law requirements. In the event that a state, federal or regulatory agency, or if the health and safety of a member requires that medical records must be submitted under a shorter timeframe, providers are expected to comply with the shorter turnaround time. Providers and facilities that utilize third party health information management vendors are responsible for providing medical records to CareSource North Carolina Co. or facilitating delivery of medical records to CareSource North Carolina Co. by the identified contractor. We are legally bound to interact with providers only and CareSource North Carolina Co. is not subject to any fees charged by health information management companies for medical record retrieval or submission.

Your health partner representative may contact you if medical records are not received within the 14-day timeframe to ensure you received the request. In addition, our market Chief Medical Officer may also be in contact to facilitate and ensure receipt of the required medical records to complete the quality-of-care reviews. Providers or facilities who repeatedly fail to return requested medical records are reported to the Credentialing Committee and may face other directed intervention or penalties up to and including contract termination.

Provider Performance and Profiling

We monitor over- and under-utilization of medical services. Provider profiling is done periodically to measure utilization of common inpatient and outpatient services such as preventive services. Healthcare Effectiveness Data and Information Set (HEDIS®) clinical performance measures and pharmacy utilization*. Summary reports for these measures are available to individual providers upon request, and routine periodic reporting is under development.

If a provider is found to be performing below minimum care standards for participation with our plan, this information is shared with the provider so practitioners can make positive changes in practice patterns. We work with the provider to develop an action plan for improvement. Further action may include onsite assessment, auditing medical care at specific intervals, disseminating comparative data or standards of care, meeting with physicians, probation, reporting deficiencies to appropriate authorities, or termination of participation with CareSource North Carolina Co. We also work with participating providers, if necessary, to develop corrective action plans for those who do not meet the standards.

UTILIZATION MANAGEMENT

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to members. The Utilization Management Department performs all utilization management activities including prior authorization, concurrent review, discharge planning and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources.

We also monitor the coordination of medical care to ensure its continuity. Referrals to the care management team are made, if needed. We make UM criteria available in writing by mail, fax and online. On an annual basis, we complete an assessment of satisfaction with the UM process and identifies any areas for improvement opportunities.

UM criteria is available via the following request methods:

Fax 877-716-9480

Mail CareSource
P.O. Box 1307
Dayton, OH 45401-1307

CareSource of North Carolina Co.® Managed Care

In processing claims, CareSource of North Carolina Co. reviews requests for prior authorization, predetermination and medical review for purposes of determining whether requested health care services are covered services. This managed care process is described below. Members with questions regarding the information contained in this section may call Member Services at **1-833-230-2099**.

Definitions

- ***Prior Authorization*** – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date pursuant to the terms of this plan.

- ***Predetermination*** – An optional, voluntary prospective or concurrent request for a benefit coverage determination for a service or treatment. We will review the EOC to determine if there is an exclusion for the health care service. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the health care service meets the definition of medical necessity under this plan or is experimental/investigative as that term is defined in this plan.

- ***Medical Review*** – Medical reviews occur for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Most network providers know which services require prior authorization and will obtain any required prior authorization or request a predetermination if they feel it is necessary. The ordering network provider will contact us to request prior authorization or a predetermination review. We will work directly with network provider regarding such prior authorization request. However, they may designate an authorized representative to act on their behalf for a specific request.

We will utilize our clinical coverage guidelines in determining whether health care services are covered services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

Members are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, please contact Member Services.

Categories of Prior Authorization, Predetermination and Medical Requests:

- **Urgent Review Request** – A request for review of any adverse decision of any prior authorization determination for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: 1) Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, 2) Could seriously jeopardize the life, health or safety of the member or others due to the member's psychological state, 3) In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care of treatment that is subject of the review, or 4) In the opinion of a physician with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is subject of the review. In addition, a request involving urgent care services includes any request that a physician with knowledge of the members' condition determines is a request involving urgent care.

- **Prospective Review Request** – A request for prior authorization or predetermination that is conducted prior to the service, treatment or admission.

- **Concurrent Review Request** – A request for prior authorization or predetermination that is conducted during the course of treatment or admission. If a concurrent review request is not approved, a covered person who is receiving an ongoing course of treatment may request an expedited External Review while simultaneously pursuing an internal grievance, the procedures for which are described below.

- **Retrospective Review Request** – A request for prior authorization that is conducted after the service, treatment or admission has occurred. Medical reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Timing of Decisions and Notifications

We will issue our benefit decisions and related notifications within the time frames set forth below. Please call Member Services at 1-833-230-2099 with any questions.

Review Request Category	Time Frame for Notice of Decision
Urgent Care Claims*	As soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours from the receipt of all necessary information to support the request.
Prospective Care Claims**	Within three (3) business days of our receipt of all necessary information to support the request.
Concurrent Care Claims*	Within twenty-four (24) hours of our receipt of all necessary information to support the request.
Retrospective Care Claims***	Within thirty (30) calendar days of our receipt of your request.

This period may also be extended one time by the plan, for up to fifteen (15) days, if the plan determines that such an extension is necessary due to matters beyond the plan's control and notify you, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the we expect to render a decision.

We will provide notification of our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting provider via telephone or via email, fax or portal, if agreed to by the provider.

- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the covered person or his or her authorized representative.

If we do not approve the benefits, we will provide members with a notice of an adverse benefit determination. The notice of an adverse benefit determination will include the specific reason or reasons for the adverse

benefit determination; the reference to the specific plan provisions on which the adverse benefit determination is based; a description of any additional material or information necessary for the member or provider to perfect the claim for benefits; and a description of our review procedures and the time limits applicable to such procedures.

Members have 180 calendar days after receiving the notice of an adverse benefit determination to file an appeal with us.

Criteria

CareSource North Carolina Co. utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist providers in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource North Carolina Co. defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. We have medical policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a Medical Director for further review and determination. Physician reviewers are available to discuss individual cases with attending physicians upon request.

Providers can access medical policies online at **CareSource.com** > Provider > Provider Policies.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. We do not reward providers or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, we provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling or faxing the Utilization Management department. If you would like to discuss an adverse decision with our physician reviewer, please call the peer-to-peer line at 1-833-230-2168. within five business days of the determination.

Referrals

Generally, we do not require referrals or prior authorization before members can see in-network specialty physicians. However, some providers require referrals before they will schedule new patients. Also, prior authorizations are needed before CareSource North Carolina Co. will pay for services from out-of-network providers, except in cases of emergency and other scenarios as defined in the Evidence of Coverage.

Referral Procedures

Any treating provider can refer members to specialists. Simply put a note about the referral in the patient's chart. Please remember, in most cases, non-participating specialists must request prior authorization for any services rendered to patients. Members may schedule self-referred services with participating providers as long as applicable benefit limits have not been exhausted.

If you have difficulty finding a specialist for your member, please use our online Find a Doctor/ Provider tool

at **CareSource.com** > Members > Tools & Resources > Find a Doctor or call Provider Services at **1-833-230-2101**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Referring Doctor – Document the referral in the patient's medical chart. You are not required to use a referral form or send a copy of it to our health plan. However, you must notify the specialist of your referral.

Specialist – Document in the patient's chart that the patient was referred to you for services. Referral numbers are not required on claims submitted for referred services. Generally, specialist-to-specialist referrals are not allowed. However, in some cases, specialists may provide services or make referrals in the same manner as a PCP. Documentation in the medical record should contain the number of visits or length of time of each referral. Medical records may be subject to random audits to ensure compliance with this referral procedure. We expect specialists to collaborate on the member's care and inform the member of treatment plan updates.

Standing Referrals – A PCP may request a standing referral to a specialist for a member with a condition or disease that requires specialized medical care over a prolonged period of time. The specialist may provide services in the same manner as the PCP for chronic or prolonged care.

Referrals to Nonparticipating Providers – A member may be referred to an out-of-plan provider if the member needs medical care that can only be received from a doctor or other provider who is not participating with our health plan. Treating providers must get prior authorization from CareSource North Carolina Co. before sending a member to an out-of-plan provider.

Referrals for Second Opinions – A second opinion is not required for surgery or other medical services. In accordance with 42 CFR 438.206(b)(3), CareSource North Carolina Co. complies with all member requests for a second opinion from a qualified professional. If our network does not include a provider who is qualified to give a second opinion, we can arrange for the member to obtain a second opinion from a provider outside the network, at no cost to the member.

The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating provider. If not, prior authorization must be obtained to send the patient to a nonparticipating provider.
- The provider must not be affiliated with the member's PCP or the specialist practice group from which the first opinion was obtained.
- The provider must be in an appropriate specialty area.

Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

Non-Participating Providers

CareSource North Carolina Co. uses a select network of hospitals, physicians and ancillary providers. Typically, we do not pay for non-network, non-emergent services; however, these may be provided in limited situations with prior authorization (PA) from our Utilization Management (UM) team. Any participating facility/provider requesting prior authorization for an elective admission must obtain prior authorization for the use of any out-of-network RAPHL (Radiologist, Anesthesiologist, Pathology, Hospitalist and Laboratory). Please visit the Provider Portal at **CareSource.com** for the most current information on PA and referral requirements.

Prior Authorizations

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations. Services are provided within the benefit limits of the member's enrollment. Prior authorization requirements by service type may be found at **CareSource.com** > Provider Overview > Provider Portal > Prior Authorization using the Procedure Code Lookup Tool.

Requesting Prior Authorizations

The Provider Portal is the preferred method to request prior authorization for health care services. You can get immediate approval or pend status, and also can check pending claim status.

	**Email:**	Email us at CiteAutoAssistance@caresource.com for portal login assistance.
	**Online**	Visit **CareSource.com** > Login > Provider. Alternate methods include phone, fax or mail.
	**Phone**	Please call 1-833-230-2101 then tell our IVR that you need to submit an authorization request. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).
	**Fax**	Inpatient Prior Authorization/Skilled Nursing Facilities: 937-396-3702 Outpatient Prior Authorizations: 937-396-3802
	**Mail**	Send prior authorization requests to: CareSource P.O. Box 1307 Dayton, OH 45401-1307

Information Required for Prior Authorization Submissions

When requesting an authorization, please provide the following information:

- Member/patient name and member ID number
- Provider name, TIN and NPI

- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-network provider, if applicable
- Clinical information to support the medical necessity for the service

Prior Authorization Criteria

Please Note: Below is a list of common prior authorization criteria; however, it is not a comprehensive listing and other criteria may be associated to other items requiring prior authorization.

If the request is for **inpatient admission** (whether it is elective, urgent or emergency), please include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If **inpatient surgery** is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment and any appropriate clinical and anticipated discharge needs.

If the request is for **outpatient surgery**, please include the date of surgery, surgeon and facility, diagnosis and procedure planned and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limitations (this is not an all-inclusive list). When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received.

When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of the service. CareSource North Carolina Co. is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization should be authorized before the service is delivered. We are not able to pay claims for services in which prior authorization is required, but not obtained by the provider.

Notice of Prior Authorization Determinations

We will notify you of prior authorization determinations by a letter mailed to the provider's address on file.

Post Stabilization Services

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the member's stabilized condition. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a participating provider.

To request prior authorization for observation services as a non-participating provider or to request authorization for an inpatient admission, please visit the Provider Portal at **CareSource.com** > Login > Provider Portal.

You can also request a prior authorization by calling our Provider Services at **1-833-230-2101** and selecting the option to request a prior authorization. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET). During regular business hours, your call will be answered by our UM Department. If calling after regular business hours, the call will be answered by CareSource24, our Nurse Advice Line.

Access to Staff

Providers may call Provider Services at **1-833-230-2101** to contact our UM staff with any questions. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

Staff Availability

- Staff members are available via the toll-free telephone line or direct dial telephone number from 8 a.m. to 6 p.m. ET Monday through Friday for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours. Providers may leave voice mail messages on these telephone lines after business hours, 24 hours a day, 7 days a week. A dedicated fax line and Provider Portal for medical necessity determination requests is also available 24 hours a day, 7 days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by first name/last initial, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about UM processes.

For the best interest of our members and to promote their positive health care outcomes, we encourage continuity of care and coordination of care between medical care providers as well as between physical care providers and behavioral health providers.

Authorization Determination Timeframes

For all prior authorization decisions (standard or urgent), CareSource North Carolina Co. provides notice to the provider and member as expeditiously as the member's health condition requires. Please specify if you believe the request is urgent.

Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Review Category	Timeframe for CareSource North Carolina Co. to respond when all information is present	Timeframe for CareSource North Carolina Co. to request additional information	Provider response time to submit additional information	CareSource North Carolina Co. response time after receiving additional information
Inpatient – Initial	24 hours if request is received before current authorization end date/3 calendar days if received after end date	24 hours	24 hours	Within 72 hours of initial request
Inpatient – Continued Stay Review (CSR)	24 hours	24 hours	N/A	24 hours if request is received before current authorization end date/3 calendar days if received after end date
Outpatient/ Elective – Non-Urgent	Three business days from receiving all necessary information to make a decision	N/A	N/A	Three business days from receiving all necessary information to make a decision
Outpatient/ Elective – Urgent	24 hours after obtaining all necessary information to make a decision	24 hours	48 hours	24 hours after obtaining all necessary information to make a decision
Retrospective	30 calendar days	N/A	N/A	30 calendar days

Retrospective Review

All services that require prior authorization from CareSource North Carolina Co. should be authorized before the service is delivered. CareSource North Carolina Co. is not able to pay claims for services in which prior authorization is required but not obtained by the provider.

A retrospective review is a request for an initial review for authorization of care, service or benefit for which an authorization is required but was not obtained prior to the delivery of the care, service or benefit. Prior

authorization is required to ensure that services provided to our members are medically necessary and provided appropriately.

Providers must submit a retro authorization within 30 calendar days of the service date, or discharge date for inpatient services where prior authorization was required but not obtained. CareSource North Carolina Co. will provide a determination on the provider's request within 30 calendar days of the receipt of the request. Claims not meeting the requirement as described above will be administratively denied.

If the request is received within these time frames and a denial is issued, you may submit a request for an appeal within 30 days from the date of denial.

A request for retrospective review can be made by contacting the Utilization Management department at **1-833-230-2101** and following the appropriate menu prompts or by faxing the request to 1-844-676-0370. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET). You must include clinical information supporting the request for services.

CareSource®

May 2023
NC-EXC-P-1642450a