

2020 Provider Manual



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INTRODUCTION

Welcome

Welcome to Carolina Complete Health. Thank you for being part of the Carolina Complete Health network of participating physicians, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Carolina Complete Health works to accomplish this goal by partnering with the providers who oversee the healthcare of Carolina Complete Health beneficiaries.

About Us

Carolina Complete Health is a Prepaid Health Plan (PHP) contracted with the Department of Health and Human Services to serve beneficiaries through the NC Medicaid Managed Care program. Carolina Complete Health has the expertise to work with beneficiaries to improve their health status and quality of life. Carolina Complete Health's management company, Centene Corporation ("Centene"), has been providing comprehensive Medicaid Managed Care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than twenty-seven (27) years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals and to the rising number of uninsured Americans. It also contracts with other healthcare and commercial organizations to provide specialty services. Carolina Complete Health is a physician-driven organization that is committed to building collaborative partnerships with providers. Carolina Complete Health will serve beneficiaries consistently with our core philosophy that quality healthcare is best delivered locally.

Mission

Carolina Complete Health strives to provide improved health status, successful outcomes, and beneficiary and provider satisfaction in a coordinated care environment. Carolina Complete Health is designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We hope that you will assist Carolina Complete Health in reaching these goals and look forward to your active participation.

About this Manual (Including Billing Guidelines)

Carolina Complete Health is committed to working with our provider community and beneficiaries to provide a high level of satisfaction in delivering quality healthcare benefits.

We are committed to providing comprehensive information through this Provider Manual as it relates to Carolina Complete Health operations, benefits, and policies and procedures. This Provider Manual is posted on the Carolina Complete Health website where it can be reviewed and printed free of charge. Providers are notified via bulletins and notices posted on the provider website and in our weekly Explanation of Payment notices, of material changes to the Manual. For hard copies of this Provider Manual please contact the Provider Services department at 1-833-552-3876 or if you need further explanation on any topics discussed in the manual.

Billing Guidelines

Billing guidelines and instructions are located in the dedicated Carolina Complete Health Billing Manual. The Billing Manual includes comprehensive information about claims and payments, including details on timely claim payments, which may be found in the “Prompt Pay” section of the Carolina Complete Health Billing Manual. The Billing Manual is located in the “For Providers” section of our website at: www.carolinacompletehealth.com. The Billing Manual includes information on:

- Encounter data submission guidelines
- Claims submission protocols and standards; including timeframe requirements
- Instructions/information for Clean Claims
- Claims Dispute Process
- Payment policies
- Client Participation Requirements
- Cost Sharing Requirements
- Third Party Liability and Other Instructions

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling Carolina Complete Health, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (“TIN”) number
- Beneficiary’s ID number

Health Plan Information		
	Carolina Complete Health 10101 David Taylor Dr. Suite 300 Charlotte, NC 28262 https://carolinacompletehealth.com/	
Department	Telephone Number	Fax Number
Provider Services	1-833-552-3876 TDD/TYY: 800-735-2962	1-844-915-0459
Beneficiary Services	1-833-552-3876 TDD/TYY: 800-735-2962	1-833-537-2330
Authorization Request Concurrent Review Care Management	1-833-552-3876 TDD/TYY: 800-735-2962	1-833-238-7689
Involve (24/7 Availability)	1-833-552-3876 TDD/TYY: 800-735-2962	
North Carolina Department of Health and Human Services	1-919-855-4800	1-919-715-4645
Medical Claims	Reimbursement Rate Dispute	Medical Necessity Appeal
Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Carolina Complete Health PO Box 8040 Farmington, MO 63640-8040	Carolina Complete PO Box 8040 Farmington, MO 63640-8040
Electronic Claims Submission		
Carolina Complete Health c/o Centene EDI Department 1-800-225-2573, ext. 25525 or by e-mail to: EDIBA@centene.com		

PRODUCT SUMMARY

The Medicaid Managed Care population is comprised of beneficiaries who fall into one of the categories of eligibility listed below:

Eligible Populations

Eligibility of Parents/Caretakers, Children, Pregnant Women, and Refugees:

- Parents/Caretakers of Children eligible
- Children eligible for Poverty Level Children
- Pregnant women and women up to sixty (60) days post-partum
- Individuals eligible under Participants of Refugee
- Individuals who are eligible under the above groups and are Autism or Developmental Disabilities (DD) waiver participants

Eligible Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance:

- All children in the care and custody of the North Carolina Department of Health and Human Services, Division of Social Services
- All children placed in a not-for-profit residential group home by a juvenile court
- All children receiving adoption subsidy assistance
- All children receiving non-medical assistance (i.e., living expenses) that are in the legal custody of the North Carolina Department of Health and Human Services, Division of Social Services shall remain the responsibility of the North Carolina Department of Health and Human Services, Division of Social Services

State Child Health Plan: North Carolina has an approved combination State Child Health Plan under Title XXI of the Social Security Act (the Act) for the Children's Health Insurance Program (CHIP).

Voluntary Populations

Medicaid Managed Care eligible members in the above specified eligibility groups may voluntarily disenroll from the Medicaid Managed Care Program or choose not to enroll in the Medicaid Managed Care Program if they:

- Are eligible for Supplemental Security Income (SSI) under Title XVI of the Act
- Are described in Section 501(a)(1)(D) of the Act
- Are described in Section 1902 (e)(3) of the Act

- Are receiving foster care or adoption assistance under part E of Title IV of the Act
- Are in foster care or otherwise in out-of-home placement
- Meet the SSI disability definition as determined by the North Carolina Department of Health and Human Services, Division of Social Services

ENROLLMENT

The Department of Health and Human Services, Division of Social Services is responsible for eligibility determinations. The state agency will conduct enrollment activities for Medicaid Managed Care eligible members.

Provider Restrictions

Providers shall not conduct or participate in health plan enrollment, disenrollment, or transfer or opt-out activities, or attempt to influence a beneficiary's enrollment. Prohibited activities include:

- Requiring or encouraging the beneficiary to apply for an assistance category
- Requiring or encouraging the beneficiary and/or guardian to use the opt out as an option in lieu of delivering health plan benefits
- Mailing or faxing enrollment forms
- Aiding the beneficiary in filling out health plan enrollment forms
- Aiding the beneficiary in completing on-line health plan enrollment
- Photocopying blank health plan enrollment forms for potential beneficiaries
- Distributing blank health plan enrollment forms
- Participating in three-way calls to the enrollment helpline
- Suggesting a beneficiary transfer to another health plan
- Other activities in which a provider attempts to enroll a beneficiary in a particular health plan or in any way assisting a beneficiary to enroll in a health plan

Provider Marketing Guidelines

Participating providers may conduct marketing activities to beneficiaries subject to DSS guidelines.

VERIFYING ELIGIBILITY

Beneficiary Eligibility Verification

To verify beneficiary eligibility, please use one of the following methods:

1. **Log on to the secure provider portal at <https://provider.carolinacompletehealth.com>.** Using our secure provider website, you can check beneficiary eligibility. You can search by date of service and either of the following: beneficiary name and date of birth.
2. **Call our automated beneficiary eligibility IVR system.** Call 1-833-552-3876 from any touch tone phone and follow the appropriate menu options to reach our automated beneficiary eligibility-verification system twenty-four (24) hours a day.
3. **Call Carolina Complete Health Provider Services.** If you cannot confirm a beneficiary's eligibility using the methods above, call our toll-free number at 1-833-552-3876. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the beneficiary name to verify eligibility.

Through the Carolina Complete Health secure provider web portal, primary care providers (PCPs) are able to access a list of eligible beneficiaries who have selected their services or were assigned to them. The patient list reflects all changes made within the last twenty-four (24) hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to <https://provider.carolinacompletehealth.com>. Since eligibility changes can occur throughout the month and the beneficiary list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify beneficiary eligibility on date of service.

All new Carolina Complete Health beneficiaries receive a Carolina Complete Health beneficiary ID card. A new card is issued only when the information on the card changes, if a beneficiary loses a card, or if a beneficiary requests an additional card. Since beneficiary ID cards are not a guarantee of eligibility, providers must verify beneficiary's eligibility on each date of service.

Providers must have a policy in place regarding the provision of non-emergency services to an adult Medicaid Managed Care beneficiary, including requesting and inspecting the adult beneficiary's health plan beneficiary ID card. If the adult beneficiary does not produce their health plan beneficiary ID card, and the provider verifies eligibility and health plan enrollment, the provider may provide service if they have notified the health plan that the beneficiary has no health plan identification card. The provider must document this verification in the beneficiary's medical record.

Beneficiary Identification Card

Providers are required to implement a policy of requesting and inspecting an adult beneficiary's health plan beneficiary ID card, prior to providing non-emergency services. If you suspect fraud, please contact Provider Services at 1-833-552-3876 immediately. Beneficiaries must keep the beneficiary ID card in order to receive benefits not covered by Carolina Complete Health, such as Pharmacy services. Beneficiaries are directed to present both identification cards when seeking non-emergency services.

	10101 David Taylor Dr. Suite 300 Charlotte, NC 28262
NAME: JANE C. DOE	RX: Envolve Pharmacy Solutions
MEMBER ID#: XXXXXXXXXXXX	RXBIN: 020545
DATE OF BIRTH: MM/DD/YYYY	RXPCN: RXA380
EFFECTIVE: MM/DD/YYYY	RXGRP: RXGMCNC01
AMH/PCP Name:	
AMH/PCP Address:	
AMH/PCP Phone Number:	
MEMBER PORTAL: CarolinaCompleteHealth.com	

IMPORTANT CONTACT INFORMATION / INFORMACIÓN IMPORTANTE DE CONTACTO

Members/Miembros: Call 1-833-552-3876 (TTY: 711)
For **Member Services** / Servicios para los miembros
24/7 Nurse Advice Line / Línea de consejo de enfermería 24/7
Behavioral Health Crisis Line / Need Spanish

PROVIDERS/PROVEEDORES: Call 1-833-552-3876 for
Provider Service Line
Prescriber Service Line
Prior Authorization

Pharmacy Help Desk: 1-800-518-9072 **Pharmacy Prior Authorization:** 1-833-585-4309
Pharmacy Paper Claims: PO Box 419069, Rancho Cordova, CA 95741
All Medical Claims: Carolina Complete Health, PO Box 8010, Farmington, MO 63640

If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call 1-919-881-2320.

Some services are carved out. A full list of benefits can be found in the Member Handbook at CarolinaCompleteHealth.com

CAROLINA COMPLETE HEALTH WEBSITE

Carolina Complete Health Website

The Carolina Complete Health website can significantly reduce the number of telephone calls providers need to make to the health plan. Utilizing the website allows immediate access to current provider and beneficiary information twenty-four (24) hours, seven (7) days a week.

Please contact your Provider Relations Representative or our Provider Services department at 1-833-552-3876 with any questions or concerns regarding the website. Carolina Complete Health website is located at <https://www.carolinacompletehealth.com>.

Physicians can find the following information on the website:

Provider Reference Manual

Provider Billing Manual

Prior Authorization List

Forms

Carolina Complete Health News

Clinical Guidelines

Provider Bulletins

Check to See if an Authorization is Required

Secure Website

The Carolina Complete Health website allows providers to obtain information at your convenience (24/7) without having to make a phone call. Carolina Complete Health contracted providers and their office staff have the opportunity to register for our secure provider website. Here, we offer tools which make obtaining and sharing information easy. It's simple and secure! Go to <http://www.carolinacompletehealth.com> to register. On the home page, select the Login link on the top right to start the registration process.

Through the secure site you can:

- View the PCP panel (patient list)

Check beneficiary eligibility

View beneficiary's health record

View beneficiary gaps in care

Provider/Patient Analytics (quality scorecard including loyalty and risk scores)

View and submit claims and adjustments

View payment history

View and submit Prior Authorizations

Submit demographic changes

Contact us securely and confidentially

Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

We are continually updating our website with the latest news and information, so please save the link to your Internet "Favorites" list and check our site often. Please contact a Provider Relations Representative for a tutorial on the secure site.

GUIDELINES FOR PROVIDERS

Primary Care Providers (PCP)

The primary care provider (PCP) is the cornerstone of the Carolina Complete Health service delivery model. A PCP is the participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required.

The PCP serves as the "medical home" for the beneficiary. The "medical home" concept assists in establishing a beneficiary/provider relationship, supports continuity of care and patient safety, leads to elimination of redundant services, more cost effective care and better health outcomes. Carolina Complete Health offers a robust network of PCPs to ensure every beneficiary has access to a medical home within the required travel distance. Carolina Complete Health requests that PCPs inform the Carolina Complete Health Beneficiary Services Department ("Beneficiary Services") when a Carolina Complete Health beneficiary misses an appointment so we may monitor it in our systems and provide outreach to the beneficiary on the importance of keeping appointments. This will assist our providers in reducing their missed appointments and reduce the inappropriate use of Emergency Department services.

Provider Types That May Serve As PCPs

Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners, Internal Medicine physicians, Nurse Practitioners and Physician Assistants. The PCP may practice in a solo or group setting or at a FQHC, RHC or outpatient clinic. Carolina Complete Health may allow some specialists to serve as a beneficiary's PCP for beneficiaries with multiple disabilities or with chronic conditions as long as the specialists agrees, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this Manual.

Assignment of Medical Home

Carolina Complete Health offers a robust network of primary care providers to ensure every beneficiary has access to a "medical home" within the required travel distance standards.

For those beneficiaries who have not selected a PCP during enrollment, Carolina Complete Health will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns beneficiaries to a PCP according to the following criteria and in the sequence presented below:

1. **Beneficiary history with a PCP.** The algorithm will first look to see if the beneficiary is a returning beneficiary and attempt to match them to their previous PCP. If the beneficiary is new to Carolina Complete Health, claim history provided by the state will be used to match a beneficiary to a PCP with whom the beneficiary had a previous relationship where possible.
2. **Family history with a PCP.** If the beneficiary has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the beneficiary's family, such as a sibling, is or has been assigned to.

3. **Geographic proximity of PCP to beneficiary residence.** The auto-assignment logic will ensure beneficiaries' travel time and mileage do not exceed Carolina Complete Health access standards.
4. **Appropriate PCP type.** The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. In the event that the pregnant beneficiary does not select a pediatrician, or other appropriate PCP, Carolina Complete Health will assign one for her newborn.

Medical Home Model

Carolina Complete Health is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by beneficiaries of their own care and reduce avoidable costs over time. Carolina Complete Health will actively partner with our providers, with community organizations, and groups representing our beneficiaries to achieve this goal through the meaningful use of health information technology (HIT).

Carolina Complete Health will evaluate all potential Medical Home providers according to the criteria established by DHHS, and will regularly assess each contracted Medical Home's compliance with these requirements. In order to be contracted as an Advanced Medical Home (AMH) with Carolina Complete Health, all AMH providers must demonstrate and maintain their compliance with the following requirements:

- Accept Members and be listed as a primary care provider in Carolina Complete Health's Member-facing materials for the purpose of providing care to Members and managing their health care needs.
- Provide Primary Care and Patient Care Coordination services to each Member, in accordance with Carolina Complete Health policies.
- Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week, not including referral to the hospital emergency department.
- Provide direct patient care a minimum of 30 office hours per week.
- Provide preventive services as outlined in the Primary Care Provider (PCP) Responsibilities section of this manual.
- Maintain a unified patient medical record for each Member following Carolina Complete Health medical record documentation guidelines.
- Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

- Transfer the beneficiary's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or Carolina Complete Health (if applicable) and as authorized by the beneficiary within thirty (30) days of the date of the request, free of charge.
- Authorize care for the beneficiary or provide care for the beneficiary based on the standards of appointment availability as defined by Carolina Complete Health's network adequacy standards.
- Refer for a second opinion as requested by the beneficiary, based on DHHS guidelines and PHP standards.
- Review and use beneficiary utilization and cost reports provided by Carolina Complete Health for the purpose of AMH level utilization management and advise Carolina Complete Health of errors, omissions, or discrepancies if they are discovered.
- Review and use the monthly enrollment report provided by Carolina Complete Health for the purpose of participating in Carolina Complete Health's, or practice-based population health or care management activities.

From an information technology perspective, we will be offering several HIT applications for our network providers. Our secure Provider Portal offers tools that will help support providers in the medical home model of care. These tools include:

- Online Care Gap Notification
- Beneficiary Panel Roster including beneficiary detail information
- TruCare Service Plan
- Health Record
- Provider Overview Report

Primary Care Provider (PCP) Responsibilities

As an extension of the Carolina Complete Health Participating Provider Agreement, all Carolina Complete Health contracted providers are obligated to comply with the requirements stipulated in this Provider Manual.

Primary Care Providers (PCP) shall serve as the beneficiary's initial and most important contact. PCPs responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all linked beneficiaries, or entering into an arrangement for management of inpatient hospital admissions of beneficiary;
- Manage the medical and healthcare needs of beneficiaries to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including beneficiaries with special needs and chronic conditions;

- Educate beneficiaries on how to maintain healthy lifestyles and prevent serious illness;
- Provide screening, well care and referrals to community health departments and other agencies in accordance with Carolina Complete Health provider requirements and public health initiatives;
- Conduct a behavioral health screen to determine whether the beneficiary needs behavioral health services;
- Maintain continuity of each beneficiary's healthcare by serving as the beneficiary's medical home;
- Offer hours of operation that are no less than the hours of operating hours offered to commercial beneficiaries or comparable to commercial health plans if the PCP does not provide health services to commercial beneficiaries;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide;
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program;
- Collaborate with Carolina Complete Health's care management program as appropriate including, but not limited to, performing beneficiary screening and assessment, development of care plans to address risks and medical needs, linking the beneficiary to other providers, medical services, residential, social, community and to other support services as needed;
- Maintain a current and complete medical record for the beneficiary in a confidential manner, including documentation of all services and referrals provided to the beneficiary, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services;
- Adhere to the EPSDT periodicity schedule for beneficiaries under age twenty-one (21);
- Follow established procedures for coordination of in-network and out-of-network services for beneficiaries, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the beneficiary is receiving from another health plan during transition of care;
- Share the results of identification and assessment for any beneficiary with special health care needs with another health plan to which a beneficiary may be transitioning or has transitioned so that those services are not duplicated;
- Actively participate in and cooperate with all Carolina Complete Health quality initiatives and programs;
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of beneficiary care.

PCPs may have a formalized relationship with other primary care providers to see their beneficiaries when needed. However, PCPs shall be ultimately responsible for the above listed activities for the beneficiaries assigned to them.

Care Management for High Risk Pregnancies (CMHRP)

Care Management for High-Risk Pregnancies (CMHRP) is a program available to all pregnant women enrolled with Carolina Complete Health. With a focus on healthy moms and babies, pregnant beneficiaries receive comprehensive, coordinated maternity care services with a focus on preventing pre-term birth. These services are provided by local maternity care providers.

Care Management for At-Risk Children (CMARC)

Care Management for At-Risk Children (CMARC) is a program offered to children enrolled in Carolina Complete Health that are between ages zero-to-five and who meet specified criteria. Under this program, local health departments work with the beneficiary's primary care provider as well as social service organizations to assure these children have access to coordinated care management services between health care providers, linkages and referrals to community programs and family supports.

Vaccines for Children (VFC) Program

Federally-provided vaccines are available at no charge to public and private providers for eligible children under age nineteen (19) years through the VFC program. Carolina Complete Health requires providers who administer immunizations to qualified eligible children to enroll in the VFC program. The North Carolina Department of Health and Human Services (DHHS) administers the VFC program. Providers should contact the DHHS at:

North Carolina Department of Health and Human Services
cdcinfo@cdc.gov
800-CDC-INFO (800-232-4636)

Carolina Complete Health participating providers who administer vaccines must enroll on the North Carolina Immunization Branch Registry (NCIR), <https://www.immunize.nc.gov/providers/ncir.htm>. Participating providers must utilize the VFC program for Carolina Complete Health beneficiaries. Carolina Complete Health will require that primary care providers administer vaccines consistent with the AAP/Bright Future periodicity schedule.

Carolina Complete Health will only pay for the vaccine administration fee for VFC eligible children and reimburse an administration fee per dose to providers who administer the free vaccine to eligible beneficiaries **except** to those providers enrolled as rural health clinics (RHCs) or Federally Qualified Health Centers (FQHCs). Please refer to the Carolina Complete Health Provider Billing Manual for instructions on how to submit claims. Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.

Carolina Complete Health encourages specialists to communicate to the PCP the need for a referral to another specialist. This allows the PCP to better coordinate their beneficiary's care and become aware of the additional service request.

Referrals

As promoted by the Medical Home concept, PCPs should coordinate the healthcare services for Carolina Complete Health beneficiaries. PCPs can refer a beneficiary to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a beneficiary's healthcare, Carolina Complete Health encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

In accordance with North Carolina Law, providers are prohibited from making referrals to healthcare entities with which the provider or a member of the provider's family has a financial relationship.

Referrals can be submitted via the Provider Portal, Fax or Phone. Any beneficiary seeking care from an out-of-network primary or specialty care provider will continue to require Prior Authorization, which is subject to Medical Necessity review.

As a participating PCP in the Carolina Complete Health Network, it is important to understand the requirements for both the Referral and Prior Authorization processes to ensure your patients do not experience any disruption in care, and claims are paid in a timely and accurate manner. Please see the Referral Process outlined below for more detail.

Carolina Complete Health's Referral Process

Carolina Complete Health utilizes both Referrals and Prior Authorizations to help manage beneficiary care delivery.

Prior Authorization, or pre-certification, may be required prior to a beneficiary receiving a service or procedure.

Some covered services and procedures require a Prior Authorization even if the service is provided by an in network provider. Providers can access the Prior Authorization Tool at <https://www.carolinacompletehealth.com> to check which services require a Prior Authorization.

All services and procedures provided by an out-of-network provider require Prior Authorization

Referral – approval required prior to a beneficiary seeing a specific in-network specialty provider for an office visit.

Referral Submission:

- Referrals can be submitted by PCPs via phone, fax or web portal;
- Referrals will cover the beneficiary's office visits to the specialist indicated on the referral for a span of six (6) months from the date of submission;
- If additional services or procedures are required following the specialist office visit, providers should utilize the Prior Authorization Tool located on Carolina Complete Health's Provider website to determine whether the needed procedure is covered or requires Prior Authorization before proceeding;

- Payment will be denied for any claims submitted by one of the above-listed specialty types if there is not an active referral in place on the date of service; and
- A referral cannot be submitted for an out-of-network specialist.

If you are a Participating PCP

You are responsible for managing the care for your patients, including the care provided by other clinicians.

The referral process helps to facilitate adequate contact between you and the specialist to whom you are referring a beneficiary. It will help provide you with opportunities to complete health screenings, manage ongoing conditions, and understand how beneficiaries are navigating available healthcare resources.

The referral process outlined herein is aligned with current goals in healthcare around the “Triple Aim”- the right care, at the right time, in the right place.

Specialist Responsibilities

Specialists are required to report to Carolina Complete Health limitations on the number of referrals accepted. The Specialist must notify Carolina Complete Health when the Specialist reaches eighty-five (85) percent capacity.

Carolina Complete Health encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the beneficiary’s care and ensure the referred specialty physician is a participating provider within the Carolina Complete Health network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following Carolina Complete Health referral guidelines.

Emergency admissions will require notification to Carolina Complete Health Medical Management Department within one (1) business day, following the date of admission to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Carolina Complete Health.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from Carolina Complete Health Medical Management Department (“Medical Management”) if needed before providing services;
- Coordinate the beneficiary’s care with the PCP;
- Provide the PCP with consult reports and other appropriate records within five business days;

- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of beneficiary care;
- Maintain the confidentiality of medical information;
- Actively participate in and cooperate with all Carolina Complete Health quality initiatives and programs.

As a participating Specialist in the Carolina Complete Health Network, it is important to understand the requirements for both the Referral and Prior Authorization processes to ensure your patients do not experience any disruption in care, and claims are paid in a timely and accurate manner. Please see the Referral Process outlined below for more detail.

Protected Health Information (PHI)

PHI may be shared only for Treatment, Payment, or Operations (TPO).

- Treatment – the provision, coordination, or management of health care and related services by a healthcare provider(s), to include third party healthcare providers and health plans for treatment alternatives and health-related benefits. Example: A PCP discloses identifying information to Carolina Complete Health when obtaining authorization for services.
- Payment - activities to determine eligibility benefits and to ensure payment for the provision of healthcare services. Example: Provider submitting a claim with PHI to Carolina Complete Health for the purpose of payment for services.
- Health Care Operations – activities that manage, monitor, and evaluate the performance of a health care provider or health plan. Example: CMS conducting an internal audit. Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Mainstreaming

Carolina Complete Health considers mainstreaming of its beneficiaries an important component of the delivery of care and expects its participating providers to treat beneficiaries without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program beneficiary or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a beneficiary a covered services or availability of a facility
- Providing a Carolina Complete Health beneficiary a covered service that is different or in a different manner, at a different time, or at a different location than to other “public” or private pay beneficiary’s (examples: different waiting rooms or appointment times or days)

- Subjecting a beneficiary to segregation or separate treatment in any manner related to covered services

Appointment Accessibility Standards

Carolina Complete Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Carolina Complete Health monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency department utilization. Providers who fail to comply with published appointment standards may be subject to corrective action.

Visit Type	Standard
Primary Care	
Preventive Care Service – adult, twenty-one (21) years of age and older	Within thirty (30) Calendar days
Preventive Care Services – child, birth through twenty (20) years of age	Within fourteen (14) Calendar days for Beneficiary less than six (6) months of age Within thirty (30) Calendar days for Beneficiary's six (6) months or age and older.
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) Calendar days
After-Hours Access – Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care	
Initial Appointment – 1st or 2nd Trimester	Within fourteen (14) Calendar days
Initial Appointment – high risk pregnancy or 3rd Trimester	Within five (5) Calendar days
Specialty Care	
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) Calendar days
After-Hours Access – Emergent and Urgent Instructions	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Behavioral Health Care	
Mobile Crisis Management Services	Within thirty (30) minutes
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days

Routine Services for SUDs	Within fourteen (14) calendar days
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Covering Providers

PCPs and specialty physicians must arrange for coverage with another Carolina Complete Health network provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement.

Telephone Arrangements

PCPs and Specialists must:

- Answer the beneficiary’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a beneficiary
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special beneficiary 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 thirty (30) minutes
 - Same day for non-symptomatic concerns
- 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 beneficiary medical record

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to beneficiary receiving urgent or emergent care.

Carolina Complete Health will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (“QIP”).

24-Hour Access

Carolina Complete Health PCPs, behavioral health providers, and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to beneficiary as needed twenty-four (24) hours a day, seven (7) days a week.

- A provider’s office phone must be answered during normal business hours, and normal business hours must be maintained for at least 30 hours per week.
- During after-hours, a provider must have arrangements for:
 - Access to a covering physician,
 - An answering service,
 - Triage service, or
 - A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish, if the provider’s practice includes a high population of Spanish speaking beneficiaries.

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

- The provider’s office telephone number is only answered during office hours;
- The provider’s office telephone is answered after-hours by a recording that tells patients to leave a message;
- The provider’s office telephone is answered after-hours by a recording that directs patients to go to an Emergency Department for any services needed; and
- Returning after-hours calls outside thirty minutes.

The selected method of twenty-four (24) hour coverage chosen by the beneficiary must connect the caller to someone who can render a clinical decision or reach the PCP, behavioral health provider, or specialist for a clinical decision. Whenever possible, PCP, behavioral health provider, specialty physician, or covering medical/behavioral professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office’s daytime telephone number.

Carolina Complete Health will monitor providers’ offices through after-hours calls conducted by Carolina Complete Health Provider Relations staff.

Provider Directory Demographic Changes

To ensure accurate information is provided to our beneficiaries, Carolina Complete Health require advanced notice of any demographic changes, such as location, office hours, hospital privileges,

and phone and fax number. Please provide this information to Carolina Complete Health at least thirty (30) days prior to the effective date of the change. Demographic changes can be submitted via Carolina Complete Health secure provider portal at <https://provider.carolinacompletehealth.com>.

Hospital Responsibilities

Carolina Complete Health utilizes a network of hospitals to provide services to Carolina Complete Health beneficiaries. Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this provider manual.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the beneficiary's emergency department visit.
- Obtain prior authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Carolina Complete Health Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the beneficiary's name, presenting symptoms/diagnosis, DOS, and beneficiaries phone number.
- Notify Carolina Complete Health Medical Management department of all admission within one (1) business day.
- Notify Carolina Complete Health Medical Management department of all newborn deliveries within one (1) business day of the delivery.

Carolina Complete Health hospitals should refer to their contract for complete information regarding the hospitals' obligations and reimbursement.

Advance Directives

Carolina Complete Health is committed to ensuring that its beneficiaries are aware of and are able to avail themselves of their rights to execute advance directives. Carolina Complete Health is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to Carolina Complete Health beneficiaries must ensure adult beneficiaries eighteen (18) years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Carolina Complete Health recommends to its PCPs and providers that:

- The first point of contact for the beneficiary in the PCP's or provider's office should ask if the beneficiary has executed an advance directive and the beneficiary response should be documented in the medical record.
- If the beneficiary has executed an advance directive, the first point of contact should ask the beneficiary to bring a copy of the advance directive to the PCP's or provider's office and document this request in the beneficiary's medical record.
- An advance directive should be included as a part of the beneficiary's medical record and include mental health directives.

If an advance directive exists, the physician should discuss potential medical emergencies with the beneficiary and/or designated family beneficiary/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Voluntarily Leaving the Network

Providers must give Carolina Complete Health notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the beneficiary's new provider upon request and facilitate the beneficiary's transfer of care at no charge to Carolina Complete Health or the beneficiary.

Carolina Complete Health will notify affected beneficiaries in writing of a provider's termination, within thirty (30) calendar days prior to the effective date of termination and no more than fifteen (15) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Carolina Complete Health will assign the beneficiary to a new PCP and notify the beneficiary their rights to change their PCP.

Providers must continue to render covered services to beneficiaries who are existing patients at the time of termination until the later of sixty (60) days, the anniversary date of the beneficiary's coverage, or until Carolina Complete Health can arrange for appropriate healthcare for the beneficiary with a participating provider.

Upon request from a beneficiary undergoing active treatment related to a chronic or acute medical condition, Carolina Complete Health will reimburse the provider for the provision of covered services for up to ninety (90) days from the termination date. In addition, Carolina Complete Health will reimburse providers for the provision of covered services to beneficiaries who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Beneficiaries requiring only routine monitoring

- Providers unwilling to continue to treat the beneficiary or accept payment from Carolina Complete Health

Carolina Complete Health will also provide written notice to a beneficiary within thirty (30) days, prior to the effective date of termination and no more than fifteen (15) calendar days of receipt of the termination notice from the provider, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

CULTURAL COMPETENCY

Cultural competency within Carolina Complete Health is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective that values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Carolina Complete Health is committed to the development, strengthening and sustaining of healthy provider/ beneficiary relationships. Beneficiaries are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, beneficiaries are at risk for sub-optimal care. Beneficiaries may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of its credentialing Carolina Complete Health will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist providers in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Beneficiaries understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the beneficiary's race/ethnicity and language and its impact/influence on the beneficiary's health or illness
- Office staff that routinely interact with beneficiaries have access to and participate in cultural competency training and development
- Office staff that are responsible for data collection make reasonable attempts to collect race- and language-specific beneficiary information. Staff will also explain race/ethnicity categories to a beneficiary so that the beneficiary is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the beneficiary's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the beneficiary's perspective on healthcare
- Office sites have posted and printed materials in English and Spanish, and if required by Department of Health and Human Services, any other required non-English language

BENEFIT EXPLANATION AND LIMITATIONS

Carolina Complete Health Benefits

Carolina Complete Health network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this ProviderManual, please contact Provider Services at 1-833-552-3876 from 8:00 a.m. to 5:00 p.m. (CST) Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

The following list is not intended to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Service	Medicaid Coverage	Health Choice Coverage	Benefit Limitation	Comments
ADDITIONAL BENEFITS	YES	YES	NO BENEFIT LIMITS	
ADULT PREVENTIVE MEDICINE ANNUAL HEALTH ASSESSMENT	YES	NO	SERVICE LIMITED TO 1 PER YEAR. COVERED FOR BENEFICIARIES AGED 21 YEARS OLD AND OLDER	
ALLERGY IMMUNOTHERAPY	YES	YES	No Age restrictions, benefit limits dependent on services rendered	
ALLERGY TESTING	YES	YES	No Age restrictions, benefit limits dependent on services rendered	
AMBULANCE SERVICES	YES	YES	NO BENEFIT LIMITS, NO AGE RESTRICTIONS	NON EMERGENT TRANSPORTATION IS NOT COVERED FOR HEALTH CHOICE
ANESTHESIA SERVICES	YES	YES	NO BENEFIT LIMITS, NO AGE RESTRICTIONS	
AUDIOLOGY EVALUATION	YES	YES	NO BENEFIT LIMITATIONS	
CARDIAC EVENT MONITORS	YES	YES	LIMITED TO 1 PER 30 DAYS.	
CHIROPRACTIC SERVICES	YES	YES	COVERED BENEFIT FOR BENEFICIARIES 12 YEARS OF AGE AND OLDER. MANIPULATIONS ARE LIMITED TO 1 PER DATE OF SERVICE.	

COCHLEAR AND AUDITORY IMPLANT	YES	YES	No Age restrictions, benefit limits dependent on services rendered	
CORONARY INTRAVASCULAR ULTRASOUND	YES	YES	MUST BE BILLED ON THE SAME DAY AS TRANSESOPHAGEAL ECHOCARDIOGRAPHY	
DIAGNOSTIC ASSESSMENT	YES	YES	LIMITED TO ONE PER FISCAL YEAR WITHOUT AN AUTHORIZATION.	
DIALYSIS	YES	YES	NO BENEFIT LIMITATIONS	
DIETARY EVALUATION AND COUNSELING-INITIAL ASSESSMENT	YES	YES	LIMITED TO 4 PER 9 MONTHS	
DIETARY EVALUATION AND COUNSELING-RE ASSESSMENT	YES	YES	LIMITED TO 4 PER DATE OF SERVICE AND UP TO 20 FOR THE FISCAL YEAR	
DOPPLER ECHOCARDIOGRAPHY	YES	YES	MUST BE BILLED ON THE SAME DAY AS TRANSESOPHAGEAL ECHOCARDIOGRAPHY	
DURABLE MEDICAL EQUIPMENT	YES	YES	VARIABLE LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	
ELECTROCARDIOGRAM	YES	YES	LIMITED TO 4 PER DATE OF SERVICE	
EPSDT	YES	NO	BENEFIT LIMITS MAY APPLY-DEPENDENT ON SERVICES RENDERED. BENEFICIARIES UNDER 21 YEARS OLD.	
FAMILY BASED CRISIS SERVICE FOR ADULTS	YES	NO	LIMITED TO 112 UNITS WITHOUT AN AUTHORIZATION. LIMITED TO 16 UNITS PER DATE OF SERVICE.	
FAMILY BASED CRISIS SERVICE FOR CHILDREN AND ADOLESCENTS	YES	YES	LIMITED TO BENEFICIARIES UNDER 21 YEARS OLD. LIMITED TO 24 UNITS PER DAY AND UP TO 720 UNITS PER FISCAL YEAR.	
FAMILY PLANNING	YES	YES	LIMITED TO 6 VISITS PER FISCAL YEAR.	
FETAL ECHOCARDIOGRAPHY	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
HEARING AID SERVICES	YES	YES	COVERED FOR MEMBERS UNDER 21 YEARS OLD	
HIV CARE MANAGEMENT	YES	YES	LIMITED TO 16 UNITS PER	

			MONTH.	
HOLTER MONITOR	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
HOME HEALTH AIDE	YES	YES	LIMITED TO 100 VISITS PER FISCAL YEAR.	
HOME HEALTH HOME INFUSION THERAPY	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
HOME HEALTH HOME INFUSION THERAPY TERMINATION	YES	YES	LIMITED TO 7 PER DATE OF SERVICE.	
HOME HEALTH PRIVATE DUTY NURSING	YES	NO	NO BENEFIT LIMIT OR AGE RESTRICTIONS	
HOME HEALTH SKILLED NURSING	YES	YES	LIMITED TO 1 VISIT PER DAY OF SERVICE. LIMITED TO 75 VISITS PER FISCAL YEAR.	
HOME HEALTH THERAPIES	YES	YES	LIMITED TO 1 VISIT PER DAY OF SERVICE	
HOSPICE	YES	YES	NO BENEFIT LIMITATIONS	
HYSTERECTOMY	YES	YES	LIMITED TO ONCE IN A LIFETIME.	
INPATIENT HOSPITAL	YES	YES	NO BENEFIT LIMITATIONS	
INTRACARDIAC ECHOCARDIOGRAPHY	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
LABORATORY	YES	YES	VARIABLE LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	
MEDICAL LACTATION-ASSESSMENT	YES	YES	LIMITED TO 6 UNITS PER DATE OF SERVICE. LIMITED TO 1 VISIT PER BENEFICIARY LIFETIME.	
MEDICAL LACTATION-SERVICE	YES	YES	LIMITED TO 6 UNITS PER DATE OF SERVICE. LIMITED TO 36 VISITS PER BENEFICIARY LIFETIME.	
MEDICALLY SUPERVISED DETOXIFICATION CRISIS STABILIZATION	YES	NO	AGE LIMIT, NOT COVERED FOR MEMBERS UNDER 21 YEARS OLD. LIMITED TO 1 PER DAY OF SERVICE AND UP TO 30 PER FISCAL YEAR.	
MICROVOLT-WAVE ALTERNANS	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
MOBILE CRISIS MANAGEMENT	YES	YES	LIMITED TO 32 UNITS WITHOUT AN AUTHORIZATION. LIMITED TO TOTAL 96 UNITS PER	

			DAY OF SERVICE.	
NON HOSPITAL DETOXIFICATION	YES	NO	LIMIT TO 1 PER DATE OF SERVICE. LIMITED TO 30 PER FISCAL YEAR	
OPHTHALMOLOGICAL	YES	YES	VARIABLE LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	
OPIOID TREATMENT	YES	YES	AGE RESTRICTION, NOT COVERED FOR MEDICAID BENEFICIARIES UNDER 21 OR NCHC BENEFICIARIES UNDER 18. LIMITED TO ONE PER DATE OF SERVICE.	
OUTPATIENT BEHAVIORAL HEALTH	YES	YES	VARIABLE LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	
OUTPATIENT CARDIAC REHABILITATION	YES	YES	NO BENEFIT LIMITATIONS	
OUTPATIENT HOSPITAL	YES	YES	NO BENEFIT LIMITATIONS	
PARTIAL HOSPITALIZATION	YES	YES	LIMITED TO ONE PER DATE OF SERVICE.	
PHYSICIAN FLORIDE VARNISH	YES	NO	SERVICE LIMITED TO BENEFICIARIES UNDER 37 MONTHS OLD. LIMITED TO 6 PER LIFETIME.	
PRESCRIPTION DRUGS	YES	YES	BENEFIT LIMITS MAY APPLY-DEPENDENT ON SERVICES RENDERED.	
RADIOLOGY	YES	YES	VARIABLE AGE RESTRICTIONS AND LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	
REFUGEE HEALTH ASSESSMENT	YES	NO	SERVICE LIMITED TO 1 PER LIFETIME. COVERED FOR BENEFICIARIES AGED 21 YEARS OLD AND OLDER	
RESPIRATORY THERAPY TREATMENT	YES	YES	LIMITED TO BENEFICIARIES UNDER 21 YEARS OLD. LIMITED TO 15 THERAPIES PER 6 MONTHS	2 THERAPIES ALLOWED IN SCHOOL OR OTHER LOCATION
RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS	YES	YES	CORE ENCOUNTERS LIMITED TO 1 PER DAY FOR MEDICAL, 1 PER DAY FOR BEHAVIORAL HEALTH AND 1 FOR A	

			SEPARATE ENCOUNTER	
SEXUALLY TRANSMITTED DISEASE TREATMENT	YES	YES	LIMITED TO 4 PER DAY OF SERVICE.	
SKILLED NURSING FACILITY	YES	NO	NO BENEFIT LIMIT OR AGE RESTRICTIONS	
STERILIZATION	YES	YES	NO BENEFIT LIMITS.	
SUBSTANCE ABUSE-OUTPATIENT TREATMENT	YES	NO	LIMIT TO 60 VISITS WITHOUT AN AUTHORIZATION	
SUBSTANCE ABUSE-TARGETED CARE MANAGEMENT	YES	YES	LIMITED TO ONE PER 7 DAYS.	
TELEMEDICINE AND TELEPSYCHIATRY	YES	YES	LIMITATIONS DEPENDENT ON SERVICES BILLED.	
THERAPY (OT,PT,ST)	YES	YES	COVERED FOR BENEFICIARIES UNDER 21 YEARS OLD. NO BENEFIT LIMITATIONS	
TRANSCRANIAL DOPPLER STUDIES	YES	NO	LIMITED TO 1 PER DATE OF SERVICE	
TRANSESOPHAGEAL ECHOCARDIOGRAPHY	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
TRANSPLANT	YES	YES	NO BENEFIT LIMITATIONS	
TRANSTHORACIC ECHOCARDIOGRAPHY	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
VENTRICULAR ASSIST DEVICES	YES	YES	LIMITED TO 1 PER DATE OF SERVICE	
VISION	YES	YES	VARIABLE LIMITATIONS APPLICABLE BASED ON THE SERVICE BILLED.	

Non-Contracted and Non-Covered Services

Service	Medicaid Coverage	Health Choice Coverage
Assertive Community Treatment	NO	NO
Assistive Technology Equipment	NO	NO

Community Living and Support	NO	NO
Community Navigator	NO	NO
Community Transition	NO	NO
Crisis Services: Intervention and Consultation	NO	NO
DAY SUPPORTS	NO	NO
DEVELOPMENTAL DAY	NO	NO
EMPLOYER SUPPLIES	NO	NO
FINANCIAL SUPPORT SERVICES	NO	NO
HOME MODIFICATIONS	NO	NO
HOSPICE DISCHARGE STATUS 20	NO	NO
IN HOME SKILL BUILDING	NO	NO
INDIVIDUAL GOODS AND SERVICES	NO	NO
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES TARGETED CARE MANAGEMENT	NO	NO
PERSONAL CARE SERVICES	NO	NO
PSYCHOSOCIAL REHABILITATION	NO	NO
RESIDENTIAL SUPPORTS	NO	NO
RESPIRE	NO	NO
SPECIALIZED CONSULTATION SERVICES	NO	NO
SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM	NO	NO
SUBSTANCE ABUSE-DAY TREATMENT FOR CHILD	NO	NO
SUBSTANCE ABUSE-INTENSIVE IN HOME SERVICES	NO	NO
SUBSTANCE ABUSE-MEDICALLY MONITORED COMMUNITY	NO	NO
SUBSTANCE ABUSE-MULTISYSTEMIC THERAPY	NO	NO

SUBSTANCE ABUSE-NON MEDICAL COMMUNITY RESIDENTIAL TREATMENT	NO	NO
SUPPORTED LIVING	NO	NO
VEHICLE MODIFICATIONS	NO	NO

Non-Emergent Medical Transportation

Carolina Complete Health will provide non-emergent transportation for covered services requested by the beneficiary or someone on behalf of the beneficiary. At the time of transport, the beneficiary must be eligible with Carolina Complete Health through a medical eligibility code that includes this benefit. Carolina Complete Health requests its participating providers including its transportation vendor to inform our Beneficiary Services Department when a beneficiary misses a transportation appointment so that it can monitor and educate the beneficiary on the importance of keeping medical appointments.

Language Assistance

The initial message on our Beneficiary Services Call Center is recorded in English and Spanish, and callers can choose a separate line to hear the full recording in their preferred language. After hours and for calls that become clinical in nature, Nurse Advice Line, our after-hours nurse advice line, provides Spanish-speaking Customer Service Representatives and Registered Nurses. For calls during or after business hours in languages for which bilingual staff are not available, Nurse Advice Line staff has access to Language Services Associates, which provides interpretation for 250 languages. Carolina Complete Health provides support services for hearing impaired beneficiaries through Telecommunications Device for the Deaf (TDD). This is achieved primarily through the use of Telecommunication Relay Services via three-way calling. Pertinent information regarding the beneficiary's needs is exchanged between Carolina Complete Health, the beneficiary and the Telecommunication Relay Service Representative. Provider Services Department 1-833-552-3876 TDD/TTY 800-735-2962.

In-Person Services

Carolina Complete Health provides oral interpreter and American Sign Language services free of charge to beneficiaries seeking health care-related services in a provider's service location, 24/7, and as necessary to ensure effective communication on treatment, medical history, health education, and any Contract-related matter. Beneficiaries are educated about these support services, and how to obtain them, through the New Member Welcome Packet and our Member Newsletter. We maintain a list of certified interpreters who provide services on an as-needed basis, including for urgent and emergency care, when beneficiaries request services. Carolina Complete Health responds to beneficiary requests for telephonic interpreters immediately, and within five (5) business days for requests for services at provider offices.

NETWORK DEVELOPMENT AND MAINTENANCE

Carolina Complete Health will ensure the provision of covered services as specified by the State of North Carolina. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the network adequacy requirements for the Medicaid Managed Care Organization networks. Carolina Complete Health will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its beneficiaries, both adults and children, without excessive travel requirements, and that is in compliance with Carolina Complete Health access and availability requirements.

Carolina Complete Health offers a network of primary care providers to ensure every beneficiary has access to a medical home within the required travel distance standards (thirty (30) minutes or thirty (30) miles for at least 95% of members in rural regions; and thirty (30) minutes or ten (10) miles for at least 95% of members in urban regions). Physicians who may serve as PCPs include Internists, Pediatricians, Obstetrician/Gynecologists, Family and General Practitioners, Nurse Practitioners, and Physician Assistants. (More information on Primary Care Physicians and their responsibilities can be found in this manual). In addition, Carolina Complete Health will have available, at a minimum, the following specialists for beneficiaries on at least a referral basis:

Allergy	Gastroenterology
Dermatology	Hematology/Oncology
Family Medicine	Infectious Disease
General Practice	Nephrology
Internal Medicine	Pulmonary Disease
Cardiology	Rheumatology
Endocrinology	Neurology
Obstetrics	Podiatry
Ophthalmology	Psychiatrist-Adult/General
Optometry	Psychiatrist-Child/Adolescent
Orthopedics	Psychologist/Other Therapies
Otolaryngology	Surgery/General
Pediatric (General)	Urology
Pediatric (Subspecialties)	Vision Care/Primary Eye care
Physical Medicine and rehab	

In the event Carolina Complete Health network is unable to provide medically necessary services required under the contract, Carolina Complete Health shall ensure timely and adequate coverage

of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a Carolina Complete Health beneficiary, please contact our Medical Management team at 833-238-7689 and we will identify a provider to make the necessary referral.

Non-Discrimination

Carolina Complete Health does not limit the participation of any Provider or facility in the network, and/or otherwise discriminate against any Provider or facility based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, we do not have and have never had a policy of terminating any provider who:

- Advocated on behalf of a Participant
- Filed a complaint against us
- Appealed a decision of ours

If a provider believes that Carolina Complete Health has discriminated against them, they should file a formal complaint following the process outlined in the Provider Grievances section of this manual. If the complaint and resolution process does not resolve the issue to the provider's satisfaction, they should notify DHHS of the incident utilizing the process outlined on the DHHS website located at <https://www.ncdhhs.gov/>.

Tertiary Care

Carolina Complete Health offers a network of tertiary care providers, including level one and level two trauma centers, burn centers, neonatal intensive care units, perinatology services, rehabilitation facilities, comprehensive cancer services, comprehensive cardiac services and medical sub specialists available twenty-four (24) hours per day in the geographical service area. In the event Carolina Complete Health network is unable to provide the necessary tertiary care services required, Carolina Complete Health shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

Network Adequacy and Access Standards

Carolina Complete Health will contract a network that complies with the following standards and will reassess the adequacy of the network at least quarterly to ensure on an ongoing basis that beneficiaries have appropriate access to care. In order to ensure that all Members have timely access to all covered health care services, Carolina Complete Health will ensure its network meets the following time and distance standards as measured from the Member's residence for adult and pediatric providers separately through geo-access mapping at least annually.

In the table below "urban" is defined as non-rural counties with average population densities of two hundred fifty (250) or more people per square mile. This includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or

suburban counties” or “urban counties.” “Rural” is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

Service Type	Urban Standard	Rural Standard
Primary Care	≥ Two (2) providers within thirty (30) minutes or ten (10) miles for at least 95% of beneficiaries	≥ Two (2) providers within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries
Specialty Care*	≥ Two (2) providers (per specialty type) within thirty (30) minutes or fifteen (15) miles for at least 95% of beneficiaries	≥ Two (2) providers (per specialty type) within sixty (60) minutes or sixty (60) miles for at least 95% of beneficiaries
Hospitals	≥ One (1) hospitals within thirty (30) minutes or fifteen (15) miles for at least 95% of beneficiaries	≥ One (1) hospitals within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries
Pharmacies	≥ Two (2) pharmacies within thirty (30) minutes or ten (10) miles for at least 95% of beneficiaries	≥ Two (2) pharmacies within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries
OB/GYN	≥ Two (2) providers within thirty (30) minutes or ten (10) miles for at least 95% of beneficiaries	≥ Two (2) providers within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries
Occupational, Physical, or Speech Therapists	≥ Two (2) providers of each type within thirty (30) minutes or ten (10) miles for at least 95% of beneficiaries	≥ Two (2) providers of each type within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries
Outpatient Behavioral Health Services	≥ Two (2) providers of each outpatient behavioral health service within thirty (30) minutes or thirty (30) miles of residence for at least 95% of beneficiaries	≥ Two (2) providers of each outpatient behavioral health service within forty-five (45) minutes or forty-five (45) miles of residence for at least 95% of beneficiaries
Location-Based Services (Behavioral Health)	≥ Two (2) providers of each service within thirty (30) minutes or thirty (30) miles of	≥ Two (2) providers of each service within forty-five (45) minutes or forty-five (45) miles

	residence for at least 95% of beneficiaries	of residence for at least 95% of beneficiaries
Crisis Services (Behavioral Health)	≥ One (1) provider of each crisis service within each PHP Region	
Inpatient Behavioral Health Services	≥ One (1) provider of each inpatient behavioral health service within each PHP Region	
Partial Hospitalization (Behavioral Health)	≥ One (1) provider of partial hospitalization within thirty (30) minutes or thirty (30) miles for at least 95% of beneficiaries	≥ One (1) provider of specialized services partial hospitalization within sixty (60) minutes or sixty (60) miles for at least 95% of beneficiaries
Clinically Managed Low-Intensity Residential Treatment Services (Behavioral Health)	≥ Two (2) providers of clinically managed low-intensity residential treatment services within each PHP Region.	
All State Plan LTSS (except nursing facilities)	≥ Two (2) LTSS provider types, identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county served by Carolina Complete Health.	≥ Two (2) providers accepting new patients available to deliver each State Plan LTSS in every county served by Carolina Complete Health; providers are not required to live in the same county in which they provide services.

*Specialty care providers adhering to this standard include: Allergy/Immunology, Anesthesiology, Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Infectious Disease, Hematology, Nephrology, Neurology, Oncology, Ophthalmology, Optometry, Orthopedic Surgery, Pain Management (Board Certified), Psychiatry, Pulmonology, Radiology, and Rheumatology.

MEDICAL MANAGEMENT

Overview

Carolina Complete Health Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays). After normal business hours, Envolve staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, care management, disease management, and quality review. The department clinical services are overseen by the Carolina Complete Health medical director (“Medical Director”). The VP of Medical Management has

responsibility for direct supervision and operation of the department.
To reach the Medical Director or VP of Medical Management contact:

Medical Management
Phone: 1-833-552-3876
Fax: 1-833-238-7689

Utilization Management

The Carolina Complete Health Utilization Management Program (UMP) is designed to ensure that beneficiaries of Carolina Complete Health receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible beneficiaries across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Carolina Complete Health UMP seeks to optimize a beneficiary's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for beneficiaries that are at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Carolina Complete Health beneficiaries establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with beneficiaries/providers to enhance cooperation and support for UMP goals

See the section on Specialty Therapy and Rehabilitation Services for information about authorization of outpatient and home health occupational, physical and speech therapy services.

Referrals - PCPs should coordinate the healthcare services for Carolina Complete Health beneficiaries. PCPs can refer a beneficiary to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters. To better coordinate a beneficiary's healthcare, Carolina Complete Health encourages specialists to communicate to the PCP the results of the consultant and subsequent treatment plans.

Notifications - A provider is required to promptly notify Carolina Complete Health when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the beneficiary with prenatal care coordination of services.

Prior Authorizations - Some services require prior authorization from Carolina Complete Health in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, call:

**Carolina Complete Health
Medical Management/Prior Authorization Department**

Telephone: 1-833-552-3876

Fax: 1-833-238-7689

<https://www.carolinacompletehealth.com/>

Prior Authorization requests may be done electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

Carolina Complete Health
C/O Centene EDI Department
1-800-225-2573, extension 25525 or by e-mail at: EDIBA@centene.com

Self-Referrals

The following services do not require prior authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women's health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Testing and treatment of communicable disease
- General optometric services (preventive eye care) with a participating provider

Note: Except for emergency services, family planning services, and treatment of communicable disease, the above services must be obtained through Carolina Complete Health network providers.

Prior Authorization and Notifications

Prior authorization is a request to the Carolina Complete Health Utilization Management (UM) department for approval of services on the prior authorization list before the service is delivered.

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified. Services that require

authorization by Carolina Complete Health are noted in the table below. The PCP should contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization. Below is a Table reflecting those services that require prior authorization. The below list is not all inclusive. Please visit Carolina Complete Health’s web site at <https://www.carolinacompletehealth.com/> and utilize the Prior Authorization Tool to determine if prior authorization is required.

	FOR MEMBERS	FOR PROVIDERS	FIND A HEALTHCARE PROVIDER																								
FOR PROVIDERS																											
Why Join the Team? +																											
Our Programs																											
Login																											
Practice Improvement Resource Center (PIRC) +																											
Pre-Auth Needed?																											
ICD-10 Overview +																											
Drug Diversion Toolkit																											
		<h3>Pre-Auth Needed?</h3> <p>DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.</p> <p>Vision Services need to be verified by Opticare. Dental Services need to be verified by Dental Health and Wellness. Biopharmacy and Vaccines are carved out to MO HealthNet. Behavioral Health/Substance Abuse need to be verified by Cenpatico. Non-participating providers must submit Prior Authorization for all services. For non-participating providers, Join Our Network Important Information for Out of Network Providers</p> <p>Are Services being performed in the Emergency Department or Urgent Care Center, Public Health or Public Welfare Agency, or Family Planning services billed with a contraceptive management diagnosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1"> <thead> <tr> <th>Types of Services</th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>Is the member being admitted to an inpatient facility?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Is the member having observation services?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Are anesthesia services being rendered for pain management?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Are services for a facility billing with Dental Diagnosis?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Are oral surgery services being provided in the office?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Is the member receiving hospice services?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>		Types of Services	YES	NO	Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>	Is the member having observation services?	<input type="radio"/>	<input type="radio"/>	Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>	Are services for a facility billing with Dental Diagnosis?	<input type="radio"/>	<input type="radio"/>	Are oral surgery services being provided in the office?	<input type="radio"/>	<input type="radio"/>	Is the member receiving hospice services?	<input type="radio"/>	<input type="radio"/>	Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
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Procedures/Services	Inpatient Authorization	Ancillary Services
All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)	All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn	Air Ambulance Transport (non-emergent fixed wing airplane)
Potentially Cosmetic including but not limited to: <ul style="list-style-type: none"> • bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures 	All services performed in out- of network facility	DME purchases costing \$500 or more or rental of \$250 or more
Experimental or investigational	Hospice care	Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
High Tech Imaging (i.e. CT, MRI, PET)	Rehabilitation facilities	Orthotics/Prosthetics billed with an "L" code costing \$500 or more or rental of \$250 or more
Hysterectomy	Skilled nursing facility	
Oral Surgery	Transplant related support services including pre-surgery assessment and post-transplant follow up care	Hearing Aid devices including cochlear implants
Pain Management	<ul style="list-style-type: none"> • Notification for all Urgent/Emergent Admissions: • Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes 	<ul style="list-style-type: none"> • Genetic Testing

Emergency department and post stabilization services never require prior authorization. Providers should notify Carolina Complete Health of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Providers should **notify Carolina Complete Health of emergent inpatient admissions (including observation) within one business day** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. Carolina Complete Health providers are contractually prohibited from holding any Carolina Complete Health beneficiary financially liable for any service administratively denied by Carolina Complete Health for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

Carolina Complete Health decisions are made as expeditiously as the beneficiary's health condition requires. For standard service authorizations, the decision will be made within two (2) business days from receipt of necessary medical information and notification within one (1) business day after the decision is made (not to exceed a total fourteen (14) calendar days from receipt of the request unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. For urgent/expedited requests, a decision and notification is made within twenty-four (24) hours of the receipt of the request. Approval or denial of non-emergency services, when determined as such by emergency department staff, shall be provided within thirty (30) minutes of request. Involuntary detentions ninety-six (96) hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect. For concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care, decisions are made within twenty-four (24) hours of receipt of necessary information, and notification within one (1) business day after the decision is made. Written or electronic notification includes the number of days of service approved, and the next review date.

Transplant Authorizations

The Centralized Transplant Unit (CTU) is responsible for medical necessity review for all transplant services. Prior authorization requests for transplant services should be submitted by the provider rendering the beneficiary's transplant care (i.e., transplant coordinator from the facility where the evaluation and listing services will be performed). In the event a prior authorization request is received by Carolina Complete Health, the request should be redirected to the CTU fax number 1-866-753-5659.

The transplant review process begins when a request is received by the CTU. Requests are reviewed by a CTU clinical nurse coordinator. The transplant review process is complete when written notification of a determination for the request is sent to the beneficiary and requesting provider.

The CTU does not review requests for corneal transplant, pancreatic islet cell auto-transplant after pancreatectomy, or parathyroid auto-transplant after thyroidectomy; or CAR-T therapy. HLA Typing/Stem Cell Collection/Donor Search and Transplant Consultation at an in-network facility (1 visit) will be approved by the CTU without medical necessity review.

Transplant Centers

All organ transplant providers should meet the CMS Conditions of Participation (CoP)s for clinical experience, data submission and outcome and process requirements. These criteria focus on the transplant program's ability to perform successful transplants and deliver quality patient care.

Transplant Evaluations

Transplant evaluations are pre-transplant diagnostic testing and services that determine a beneficiary's candidacy for transplantation.

A transplant evaluation request by an in-network provider can be approved after nurse review if all necessary documentation has been provided. If all necessary documentation has not been provided the case is referred to the Carolina Complete Health medical director for review and determination. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide at 1-866-447-8773

To avoid delay in authorization, all required clinical documentation must accompany the request.

If the request is from an out of network provider (OON) provider, the case is referred to the Carolina Complete Health medical director for review and determination.

Transplant evaluations are authorized for a total of twelve (12) visits to be completed within a six (6) month time frame. At times, additional visits may be necessary and should be requested by the provider prior to the authorization expiration. If additional visits are requested after the authorization expiration; the provider must submit new clinical documentation for review and determination.

Transplant Listings

Once the beneficiary has completed the transplant evaluation process, the provider may request the beneficiary be listed for the transplant. Transplant listing requests must be accompanied by clinical documentation that supports the need for the type of organ(s) requested. Please contact the CTU for a copy of the Transplant Services Required Clinical Information Guide.

To avoid delay in authorization, all required clinical documentation must accompany the request.

A transplant listing requested by an in-network provider may be approved by the nurse coordinator if all necessary documentation has been provided and if it meets all aspects of the pertinent Clinical Policy or appropriate medical necessity criteria. If all necessary documentation has not been provided, or if the documentation submitted does not support medical necessity, the nurse coordinator will refer the case to the Carolina Complete Health medical director for review and determination.

If the request is from an out of network provider, the nurse coordinator will refer the case to the Carolina Complete Health medical director for review and determination.

Once approved, transplant listings are authorized for a period of twelve (12) months. If the candidate has not received the transplant within the twelve (12) month time-frame; the provider must submit a request for a new authorization with updated clinical documentation.

Out of Network (OON) Transplant Providers

All Transplant Evaluation and Transplant Listing requests from OON providers, or from facilities that do not meet CMS approval requirements must be approved by the Carolina Complete Health medical director regardless of the outcome of the CTU medical necessity review process.

Adverse Determinations

All adverse determinations will be issued by the Carolina Complete Health Medical Director.

If additional and/or clarifying information is needed due to insufficient or conflicting information obtained during the Level I review, the Carolina Complete Health Medical Director may discuss the case with the managing physician. Only the treating physician/provider may participate in this peer-to-peer discussion.

Treating practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer.

At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the CTU nurse notifies the requester of the opportunity for the treating physician to discuss the case directly with the CTU Medical Director or applicable practitioner reviewer making the determination. The peer to peer process is also included in the written denial notification.

Out of Network Transplant Financial Determinations

The CTU will work with the Carolina Complete Health to coordinate contract negotiations for payment of transplant services rendered out of network.

If a financial agreement cannot be reached, or if a facility is denied for any other reason, it is the responsibility of the CTU and the Carolina Complete Health medical director to work with the requesting provider to coordinate services at an approved facility.

Transplant Continuity of Care Requests

Requests for authorization for transplant services through continuity of care (COC) must be accompanied by appropriate documentation and requested within the COC timeframe specified by the contract. Continuity of Care Requests will be initially reviewed by the nurse coordinator. In the event that determinations are not able to be made with the information provided, it will be sent to the Carolina Complete Health medical director for review and determination. Requests for continuity of care authorization must include the following:

- Documentation of previous insurer coverage, such as if previously covered by state Medicaid fee for service.

- Documentation of authorization for coverage of transplant evaluation or listings by previous insurer.

- Copy of beneficiary's United Network for Organ Sharing (UNOS) listing.

Duration of Authorizations

Providers not considered in-network for transplant services for Carolina Complete Health must reach a payment agreement. If a financial agreement cannot be made, the CTU will help to identify an in-network provider that can ensure the beneficiary's health care needs are met.

Request Type	Timeframe
Prospective/Urgent	Seventy-two (72) hours [three (3) calendar days]
Prospective/Non-Urgent	Ten (10) business days

Multiple Listing

Coverage is not provided for authorizations for transplant services at multiple facilities for a single beneficiary.

Second and Third Opinions

Beneficiaries or a healthcare professional with the beneficiary's consent may request and receive a second opinion from a qualified professional within the Carolina Complete Health network. If there is not an appropriate provider to render the second opinion within the network, the beneficiary may obtain the second opinion from an out-of-network provider at no cost to the beneficiary. Beneficiaries have a right to a third surgical opinion when the recommendation of the second surgical opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the beneficiary desires the third opinion. Out-of-network and in-network providers require prior authorization by Carolina Complete Health when performing second and third opinions.

Clinical Information

Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a Carolina Complete Health nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

Carolina Complete Health clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Carolina Complete Health is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the beneficiary.

Information necessary for authorization of covered services may include but is not limited to:

- Beneficiary's name, Beneficiary ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

Carolina Complete Health affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Carolina Complete Health does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

The treating physician, in conjunction with the beneficiary, is responsible for making all clinical decisions regarding the care and treatment of the beneficiary. The PCP, in consultation with the Carolina Complete Health Medical Director, is responsible for making utilization management (UM) decisions in accordance with the beneficiary's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Peer to Peer Discussions

In the event of an adverse determination, including a denial, reduction, or termination of coverage, the provider may request a peer-to-peer discussion with the medical director. At the time of notification of denial, the provider will be notified of this right, and has two (2) business days to initiate a peer-to-peer discussion.

Medical Necessity

Medical necessity is defined for Carolina Complete Health beneficiaries as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines;
- Not primarily for the personal comfort or convenience of the beneficiary, family, or provider;
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the beneficiary;
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the beneficiary's medical symptoms or conditions require that the services cannot be safely provided to the beneficiary as an outpatient service;
- Not experimental or investigational or for research or education.

Review Criteria

Carolina Complete Health has adopted utilization review criteria developed by McKesson InterQual[®] products to determine medical necessity for physical healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the beneficiary's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Carolina Complete Health also utilizes InterQual[®] for psychiatric service reviews, American Society for Addiction Medicine (ASAM) criteria for substance use service reviews, and state specific criteria for community based service reviews.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-833-552-3876. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling the Carolina Complete Health main toll-free phone number and asking for the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Beneficiaries or healthcare professionals with the beneficiary's consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Carolina Complete Health Plan
Complaint and Grievance Coordinator

10101 David Taylor Dr. Suite 300

Charlotte, NC 28262

Phone: 1-833-552-3876

Fax Numbers:

Medical Necessity Appeals: 1-833-238-7689

Beneficiary Grievances: 1-833-537-2330

Concurrent Review: 1-833-238-7692

Prior Authorization: 1-833-238-7694

Inpatient Notification: <To Be Added>

New Technology

Carolina Complete Health evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Carolina Complete Health population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-833-552-3876.

Notification of Pregnancy

Beneficiaries that become pregnant while covered by Carolina Complete Health may remain a Carolina Complete Health beneficiary during their pregnancy. The managing or identifying physician should notify the Carolina Complete Health prenatal team by completing the Notification of Pregnancy (NOP) form within five days of the first prenatal visit or confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our Start Smart for Your Baby[®] program and our 17-P program for women with a history of early delivery.

Abortions

The PHP shall require providers to follow the Abortion clinical coverage policy 1E-2, complete and submit the Abortion Statement outlined in Attachment B of the policy to the PHP, (https://files.nc.gov/ncdma/documents/files/1E-2_1.pdf) and maintain records of completed consent form consistent with the PHP contract and federal statute.

Sterilization

The PHP shall require providers to follow Clinical Coverage Policy 1E-3 which includes the completion and submission to the PHP of the Sterilization Consent Form outlined in Attachment B (https://files.nc.gov/ncdma/documents/files/1E-3_3.pdf) and maintain completed consent forms consistent with the PHP contract and federal statute.

Concurrent Review and Discharge Planning

Nurse Care Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the beneficiary's attending physician. The Care Manager will review the beneficiary's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of necessary information, and notification within one (1) business day after the decision is made. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Carolina Complete Health within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a beneficiary, but for which authorization and/or timely notification to Carolina Complete Health was not obtained due to extenuating circumstances (i.e. beneficiary was unconscious at presentation, beneficiary did not have their Carolina Complete Health Plan card or otherwise indicated, services authorized by another payer who subsequently determined beneficiary was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within thirty (30) calendar days following receipt of the request, not to exceed one-hundred eighty (180) calendar days from the date of service.

Opioid Misuse Prevention Program Policy

This program aligns with NCDHHS Opioid Action Plan to tackle opioid abuse by monitors pharmacological prescribing patterns, and offering education and treatment. The Plan employs the Strengthen Opioid Misuse Prevention Act (STOP) measures as well as the Screening, Brief Intervention and Referral to Treatment (SBIRT) and Lock-In program to support the reduction in abuse of Opioids.

SPECIALTY THERAPY AND REHABILITATION SERVICES

Carolina Complete Health offers beneficiaries access to all covered, medically necessary outpatient physical, occupational and speech therapy services. Carolina Complete Health has partnered with National Imaging Associates, Inc. (NIA) to ensure that the physical medicine services (physical, occupational, and speech therapy) provided to Carolina Complete Health beneficiaries are consistent with nationally recognized clinical guidelines.

Therefore, physical, occupational, and speech therapy services claims will be reviewed by NIA peer consultants to determine whether the services met/meet Carolina Complete Health's policy criteria for medically necessary and medically appropriate care. These determinations are based on a review of the objective, contemporaneous, clearly documented clinical records. These reviews help us determine whether such services (past, present, and future) are medically necessary and otherwise eligible for coverage. You can access clinic guidelines at <http://www1.radmd.com/solutions/physical-medicine.aspx>.

NIA may request clinical documentation to support the medical necessity and appropriateness of the care. **There is no need to send patient records with your initial claim.** NIA will notify you if records are needed and your options for submitting them directly to NIA. If records are necessary, it is important you know that Carolina Complete Health cannot adjudicate your claims until the necessary information is received. If the documentation received fails to establish that care is/was medically necessary Carolina Complete Health may deny payment for services and future related therapy services thereafter. If requested records are not received, claims will be denied due to lack of information.

Please keep in mind you will need to ensure that the beneficiary has not exhausted his/her PT/OT/ST benefit and/or has a habilitative benefit prior to providing services. The purpose of NIA is to review medical necessity of PT/OT/ST services, and not to manage the beneficiary's benefits. Non-Network Providers must obtain prior authorization for all services. Carolina Complete Health does not retroactively authorize treatment.

Prior authorization for home health occupational, physical or speech therapy services, as well as comprehensive day rehabilitation, should be submitted to Carolina Complete Health using the Outpatient Prior Authorization form located at <https://carolinacompletehealth.com>.

Carolina Complete Health Home Health Therapies Prior Authorization

833-238-7694

IMPORTANT: Hi Tech Radiology Services

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our beneficiaries, Carolina Complete Health utilizes National Imaging Associates (NIA) to provide prior authorization and utilization management services. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. Prior authorization is required for the following outpatient radiology procedures:

CT /CTA

MRI/MRA

PET Scan

Myocardial Perfusion Imaging – Nuclear Cardiology

MUGA Scan

Transthoracic Echocardiology

Transesophageal Echocardiology

Stress Echocardiography

If a convenient, cost-effective, in-network imaging facility is not selected at intake for MR and CTs, NIA will assign one that is closest to the beneficiary's zip code. Exceptions will be made in situations where there is a clinical reason why the test must take place at a specific, higher cost facility. The finalized authorization will reflect the imaging facility selected. In addition, the imaging provider selected or assigned pursuant to this process will become the **provider of record for claims payment**. Any claim billed with an imaging provider's Tax ID that differs from the imaging provider's Tax ID selected or assigned during this process will be denied. Claim denial reasons are:

EXNo-DENY Procedure code and Provider does not match auth

EXNq-DENY Provider and DOS does not match auth

EXNs-Deny Did not use authorized provider in network

EXy1- Deny: Services Rendered by Non Authorized Non Plan Provider

Please communicate to your patient which facility is on the authorization and the importance of them having the imaging study conducted there to ensure proper payment of the claim.

Key Provisions

- Emergency department, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

NIA provides an interactive website to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department at 1-833-552-3876. To reach NIA for urgent requests or other questions, please call 800-424-4889 and follow the prompt for high tech imaging authorizations.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Carolina Complete Health's comprehensive and preventive child health program for individuals under the age of 21, which includes NC Health Choice children provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision dental and hearing services. The need to corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan. Carolina Complete Health will cover services, products, or procedures for a Medicaid Member under the age of 21 if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness; or, a condition or health problem identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). In addition, coverage is not limited to curing a recipient's condition, rather coverage includes procedures that are medically necessary to improve or maintain a recipient's overall health.

Carolina Complete Health and its providers will provide the full range of EPSDT services as defined in, and in accordance with, North Carolina Department of Health and Human Services, Division of Social Services policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics (AAP) periodicity schedule for pediatric preventive care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

- a) Comprehensive health and development history (including assessment of both physical and mental development and/or delays at each visit through the 5th year; and Autistic Spectrum Disorder per AAP)
- b) Comprehensive unclothed physical examination
- c) Immunizations appropriate to age and health history
- d) Assessment of nutritional status
- e) Laboratory procedures appropriate for age and population groups, including blood lead screening
- f) Blood testing is mandatory at 12 and 24 months or annually if residing in a high risk area as defined by the Department of Health and Human Services regulation
- g) Development assessment and behavioral screening
- h) An ASD screen may be administered at a "catch-up" visit if the 18- or 24-month visit was missed. Providers may screen for developmental risk for ASD at ages greater

than 30 months when the provider or caregiver has concerns about the child.

Findings supporting use of a developmental screen for ASD may include:

- a) observed difficulties in responsiveness, age-appropriated interaction or communication
 - b) a report by parent or caregiver
 - c) diagnosis of an ASD in a sibling
-
- i) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
 - j) Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommend that preventive dental services begin at age six (6) through 12 months and be repeated every six (6) months
 - k) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and
 - l) Health education and anticipatory guidance

PCP's must clearly document provision of all components of EPSDT services in the medical records of each beneficiary.

Carolina Complete Health requires that providers cooperate to the maximum extent possible with efforts to improve the health status of North Carolina citizens, and to participate actively in the increase of percentage of eligible beneficiaries obtaining EPSDT services in accordance with the adopted periodicity schedules. Carolina Complete Health will cooperate and assist providers to identify and immunize all beneficiaries whose medical records do not indicate up-to-date immunizations.

For EPSDT and immunization billing guidelines please visit our Website at <https://www.carolinacompletehealth.com/> for Carolina Complete Health Provider Billing Manual.

EMERGENCY CARE SERVICES

Carolina Complete Health defines an emergency medical condition as a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairments of bodily functions;
3. Serious dysfunction of any bodily organ or part; Serious harm to self or others due to an alcohol or drug abuse emergency;
4. Injury to self or bodily harm to others; or
5. With respect to a pregnant woman having contractions: that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn.

Beneficiaries may access emergency services at any time without prior authorization or prior contact with Carolina Complete Health. If beneficiaries are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Carolina Complete Health 24-hour Nurse Triage Line (Envolve) for assistance; however, this is not a requirement to access emergency services. Carolina Complete Health contracts with emergency services providers as well as non-emergency providers who can address the beneficiary's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Carolina Complete Health when furnished by a qualified provider, including non-network providers, and will be covered until the beneficiary is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Carolina Complete Health. Emergency services are covered and reimbursed regardless of whether the provider is in Carolina Complete Health provider network as long as the provider is located within the United States. Emergency services obtained outside the United States are not covered by the State or Carolina Complete Health Plan. Payment will not be denied for treatment obtained within the United States under either of the following circumstances:

1. A beneficiary had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the Plan instructs the beneficiary to seek emergency services.

Once the beneficiary's emergency medical condition is stabilized, Carolina Complete Health requires Notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

24-HOUR NURSE ADVICE LINE

Our beneficiaries have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help beneficiaries proactively manage their health needs, decide on the most appropriate care, and encourage beneficiaries to talk with their physician about preventive care.

Envolve is our twenty-four (24) hour, nurse advice line for beneficiaries. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the Envolve service. Our staff often answer basic health questions, but are also available to triage more complex health issues using nationally-recognized protocols. Beneficiaries with chronic problems, like asthma or diabetes, are referred to care management for education and encouragement to improve their health.

Beneficiaries may use Envolve to request information about providers and services available in the community after hours, when the Carolina Complete Health Beneficiary Services department is closed. The Envolve staff are available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our beneficiaries access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or Envolve at 1-833-552-3876.

WOMEN'S HEALTHCARE

Carolina Complete Health will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive health care services in addition to the beneficiary's PCP if the provider is not a women's health specialist. Beneficiaries are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, beneficiaries will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and interconception care services. Carolina Complete Health will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out-of-network.

PUBLIC HEALTH PROGRAMS

Women, Infants and Children (WIC) Program

Women, Infants and Children (WIC) is a special supplemental nutrition program which provides services to pregnant women, new mothers, infants and children up to their fifth (5th) birthday based on nutritional risk and income eligibility. The primary services provided are health screening, risk assessment, nutrition education and counseling, breastfeeding promotion and referrals to health care. Supplemental food is provided at no cost to participants.

Eligibility

Eligibility is based on three things: category, income and nutritional risk.

Category Definitions:

- Women – pregnant women, postpartum breastfeeding women up to one year after delivery while nursing, and postpartum non-breastfeeding women up to six months after delivery or termination of the pregnancy.
- Infants – from birth up to one year of age.
- Children – from one year of age up to their 5th birthday.

Income:

Calculated on the family income at 185% or less of federal poverty level.

Carolina Complete Health requires providers to provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five (5), as indicated, to the WIC Program as part of the initial assessment of the beneficiary, and as a part of the initial evaluation of newly pregnant women.

Parents as Teachers (PAT)

PAT is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources.

PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three than comparison children, ninety-nine point five percent (99.5%) of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests.

The PAT program is administered at the local level by the public school districts in the State of North Carolina. Families interested in PAT may contact their local district directly. PAT also

accepts referrals from other sources including medical providers. Carolina Complete Health encourages providers to refer beneficiaries to their local PAT program.

Clinical Practice Guidelines

Carolina Complete Health clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Carolina Complete Health adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Carolina Complete Health providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by Carolina Complete Health.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health

For links to the most current version of the guidelines adopted by Carolina Complete Health, visit our website at <https://www.carolinacompletehealth.com> .

CARE MANAGEMENT PROGRAM

Carolina Complete Health care management model is designed to help your Carolina Complete Health beneficiaries obtain needed services, whether they are covered within the Carolina Complete Health array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help beneficiaries achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible beneficiaries, needs assessment, and development and implementation of an individualized care plan that includes beneficiary/family education and actively links the beneficiary to providers and support services as well as outcome monitoring and reporting back to the PCP. Our care management team will integrate covered and non-covered services and provide a holistic approach to a beneficiary's medical, functional, social and other needs. We will coordinate access to services such as behavioral health, dental and pharmacy services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A care management team is available to help all providers manage their Carolina Complete Health beneficiaries. Listed below are programs and components of services that are available and can be accessed through the care management team. We look forward to hearing from you about any Carolina Complete Health beneficiaries that you think can benefit from the addition of a Carolina Complete Health care management team beneficiary.

To contact a care manager call:

Carolina Complete Health
Care Management Department
1-833-552-3876

High Risk Pregnancy Program

The OB CM Team will implement our **Start Smart for Your Baby® Program** (Start Smart), which incorporates care management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant beneficiaries and providing care management to high and moderate risk beneficiaries through the postpartum period and infants through the first year of life. A care manager with obstetrical nursing experience will serve as lead care manager for beneficiaries at high risk of early delivery or who experience complications from pregnancy.

An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain beneficiaries. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk beneficiaries, and recommending interventions. These physicians will provide input to Carolina Complete Health Medical Director on obstetrical care standards and use of newer preventive treatments such as **17 alpha-hydroxyprogesterone caproate (17-P)**.

Carolina Complete Health offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a beneficiary is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Carolina Complete Health care manager who will check for eligibility. The care manager can coordinate the ordering and delivery of the 17-P directly to the physician's office or coordinate home care for administration, if needed. A prenatal care manager will contact the beneficiary and do an assessment regarding compliance. The nurse will remain in contact with the beneficiary and the prescribing physician during the entire treatment period. Contact the Carolina Complete Health high risk pregnancy department for enrollment in the 17-P program.

Complex Teams

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Carolina Complete Health complex teams will manage care for beneficiaries whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care beneficiaries and children with special health care needs are at special risk and are also eligible for enrollment in care management. Carolina Complete Health will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist beneficiaries in making better health care choices.

A **Transplant Coordinator** will provide support and coordination of pre-surgery and post follow up care for beneficiaries who need organ transplants. All beneficiaries considered as potential transplant candidates should be immediately referred to the Carolina Complete Health care management department for assessment and care management services. Each candidate is evaluated for coverage requirements. Carolina Complete Health will coordinate coverage for transplant services with the state agency.

Member Connections® Program

Member Connections is Carolina Complete Health outreach program designed to provide education to our beneficiaries on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our care management program in order to link Carolina Complete Health and the community served. The program recruits staff from the local community being served to establish a grassroots support and awareness of Carolina Complete Health within the community. The program has various components that can be provided depending on the need of the beneficiary.

Beneficiaries can be referred to Member Connections through numerous sources. Beneficiaries who phone Carolina Complete Health to talk with Carolina Complete Health Beneficiary Services department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify beneficiaries who would benefit from one of the many Member Connections components and complete a referral request. Providers may request Member Connections referrals directly to the Connections Representative or their assigned care manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to groups during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what coordinated care is all about, overview of services offered by Carolina Complete Health, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Carolina Complete Health.

Home Connections: Connection Representatives are available on a full-time basis whenever a need or request from a beneficiary or provider arises. All home visits are pre-scheduled with the beneficiary unless the visit is a result of being unable to locate a beneficiary. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Connection Representatives may contact new beneficiaries or beneficiaries in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

**To contact the Member Connections Team call: Carolina Complete Health
Care Management
1-833-552-3876**

Chronic Care/Disease Management Programs

As a part of Carolina Complete Health services, Disease Management Programs (DM) are offered to beneficiaries. Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrated care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Envolve, Centene's disease management subsidiary, will administer Carolina Complete Health disease management program. Envolve's programs promote a coordinated, proactive, disease-specific approach to management that will improve beneficiaries' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Carolina Complete Health programs include but are not limited to: asthma, diabetes and depression.

All beneficiaries identified as having a targeted diagnoses such as, but not limited to, the following: major depression, asthma, and diabetes will be offered the opportunity to enroll in a Disease Management/Population Health program. For those Members receiving Prevention and Population Health Program support, Carolina Complete Health will notify their AMH/PCP by letter, email, fax, or via a secure web portal of their patient's involvement, unless the Member notifies us not to inform their PCP. Beneficiaries with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk beneficiaries with co-morbid or complex conditions will be referred for care management program evaluation.

To refer a beneficiary for disease or care management call: Carolina Complete Health Care Management at 1-833-552-3876

PROVIDER PARTNERSHIP MANAGEMENT

Provider Orientation

Carolina Complete Health Provider Partnership Management department is designed around the concept of making your experience a positive one by being your advocate within Carolina Complete Health. Upon credentialing approval by Carolina Complete Health, each provider/practitioner is assigned a dedicated provider partnership associate. Within thirty (30) days of the provider's effective date, the provider relations representative will contact the provider to schedule an orientation.

Responsibilities

The Provider Partnership Management Department is responsible for providing the services listed below which include but are not limited to:

- Maintenance of existing Carolina Complete Health Provider Reference Manual
- Conducting quarterly joint operating committee meetings
- Conduct in person provider visits
- Network performance profiling
- Individual physician performance profiling
- Physician and office staff orientation
- Hospital and ancillary staff orientation
- Ongoing provider education, updates, and training

The goal of the department is to furnish you and your staff with the necessary tools to provide the highest quality of healthcare to Carolina Complete Health enrolled beneficiary.

To contact the provider partnership associate for your area contact our Provider Services toll-free help line at 1-833-552-3876. Provider Services Representatives work with Provider Partnership Associates to serve as your advocates to ensure that you receive necessary assistance and maintain satisfaction with Carolina Complete Health.

Top 10 Reasons to Contact a Provider Partnership Associate

1. To schedule an in-service training for new staff
2. To conduct ongoing education for existing staff
3. To obtain clarification of policies and procedures
4. To obtain clarification of a provider contract
5. To request fee schedule information
6. To obtain responses to beneficiary list questions

7. To learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility.
8. To assist with quality performance scores
9. To receive training on use of the online provider analytics tool
10. To schedule monthly or quarterly provider performance meetings

CREDENTIALING AND RE-CREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by the Carolina Complete Health, as well as government regulations and standards of accrediting bodies.

Note: In order to maintain a current provider profile, providers are required to notify Carolina Complete Health if any relevant changes to their credentialing information in a timely manner.

Providers must submit at a minimum documentation to the state Medicaid program and credentialing determinations will be based off Medicaid provider data credentialing file provided to all contracted MCOs.

Note: As of January 1, 2018, according to federal regulation 42 CFR 438.602, states must screen and enroll, and periodically revalidate, all network providers of Managed Care Organizations (MCOs). This requirement applies to Ordering Prescribing and Referring (OPR) providers in the Medicaid Managed Care setting, as well.

This requirement does not cause Medicaid Managed Care network providers to see Fee-For-Service (FFS) Medicaid clients. Providers who are already enrolled as a FFS or OPR provider do not need to submit another application as a MCO Network Provider.

Medicaid Audit & Compliance has created two enrollment application forms for MCO network providers to enroll as a non-participating provider.

Carolina Complete Health will use **the NC Medicaid CVO data to make objective quality decisions at re-credentialing.**

Once the application is completed, the Carolina Complete Health Credentialing Committee (“Credentialing Committee”) will render a final decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating beneficiaries. PCPs cannot accept beneficiary assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits are performed at practitioner offices within sixty (60) days of identification of two or more beneficiary complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner’s site visit score is less than eighty (80) percent, the practitioner may be subject to termination and/or continued review until

compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, Carolina Complete Health conducts the re-credentialing process for providers at least every thirty-six (36) months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Carolina Complete Health network. As part of the re-credentialing process, Carolina Complete Health will review records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine if the provider is adhering to Carolina Complete Health advance directive policy as stated in this manual.

In between credentialing cycles, Carolina Complete Health conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate North Carolina State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Carolina Complete Health reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Carolina Complete Health Credentialing Committee that credentialing requirements are no longer being met.

In order to ensure a balanced distribution of credentialing cycles amongst providers participating in North Carolina Medicaid, some providers DHHS will implement a Provider Credentialing Transition period. During this time, Carolina Complete Health will apply Objective Quality Standards to contracted providers no less frequently than every five (5) years consistent with the Department policy and procedure.

Carolina Complete Health Plan will promptly notify the State agency of any denial of provider credentialing or re-credentialing. This is in addition to reporting provider terminations on a quarterly fraud and abuse report. The state agency shall, pursuant to 42 CFR 100.3 (b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state agency; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051.

Right to Review and Correct Information

All providers participating within the Carolina Complete Health network have the right to review information obtained by Carolina Complete Health to evaluate their credentialing and/or re-

credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the Carolina Complete Health credentialing department. Upon receipt of this information, the provider will have thirty (30) days to provide a written explanation detailing the error or the difference in information to the Carolina Complete Health Credentialing Committee. The Carolina Complete Health Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join Carolina Complete Health have the right to be informed of the status of their application upon request. To obtain status, contact the Carolina Complete Health Provider Relations department at 1-833-552-3876.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within thirty (30) days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Carolina Complete Health network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than thirty (30) days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

Providers on Review

It is the policy of Carolina Complete Health that providers who do not pass the credentialing process and/or who lose their license to practice medicine will not be reimbursed for services rendered to Carolina Complete Health beneficiaries. These providers will be set up or modified in Carolina Complete Health systems so that all claims are denied and an appropriate denial EX code appears on the provider Explanation of Payment (EOP).

RIGHTS AND RESPONSIBILITIES

Member Rights

Carolina Complete Health members have the following rights to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told where, when and how to get the services they need from Carolina Complete Health
- Be told by their PCP what health issues they may have, what can be done for them and what will likely be the result, in language they understand
- Get a second opinion about their care
- Give their approval of any treatment
- Give their approval of any plan for their care after that plan has been fully explained to them
- Refuse care and be told what they may risk if they do
- Get a copy of their medical record and talk about it with their PCP
- Ask, if needed, that their medical record be amended or corrected
- Be sure that their medical record is private and will not be shared with anyone except as required by law, contract or with their approval
- Use the Carolina Complete Health complaint process to settle complaints.
- Use the State Fair Hearing system
- Appoint someone they trust (relative, friend or lawyer) to speak for them if they are unable to speak for themselves about their care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Member Responsibilities

Carolina Complete Health member have the responsibility:

- Work with their PCP to protect and improve their health
- Find out how their health plan coverage works
- Listen to their PCP's advice and ask questions
- Call or go back to their PCP if they do not get better or ask for a second opinion

- Treat health care staff with the respect
- Tell us if they are having problems with any health care staff by calling Member Services at 1-833-552-3876.
- Keep their appointments. If they must cancel, call as soon as they can.
- Use the emergency department only for emergencies
- Call their PCP when they need medical care, even if it is after hours

Provider Rights

Carolina Complete Health providers have the right to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for beneficiaries' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the provider's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in beneficiaries' treatment plans
- Expect beneficiaries to follow their directions, such as taking the right amount of medication at the right times
- Make a grievance or file an appeal against Carolina Complete Health and/or a beneficiary
- File a grievance with Carolina Complete Health on behalf of a beneficiary, with the beneficiary's consent
- Have access to information about Carolina Complete Health quality improvement programs, including program goals, processes, and outcomes that relate to beneficiary care and services
- Contact Carolina Complete Health Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of beneficiaries
- Not be discriminated against by Carolina Complete Health based solely on any characteristic protected under state or federal non-discriminate laws

Provider Responsibilities

As an extension of the Carolina Complete Health Participating Provider Agreement, all Carolina Complete Health contracted providers are obligated to comply with the requirements stipulated in this Provider Manual.

Carolina Complete Health providers have the responsibility to:

- Help beneficiaries or advocate for beneficiaries to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
 - Recommend new or experimental treatments
 - Provide information regarding the nature of treatment options
 - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
 - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat beneficiaries with fairness, dignity, and respect
- Not discriminate against beneficiaries on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of beneficiary's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give beneficiaries a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide beneficiaries with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow beneficiaries to request restriction on the use and disclosure of their personal health information
- Provide beneficiaries, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to beneficiaries, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the beneficiary to participate in the decision-making process
- Tell a beneficiary if the proposed medical care or treatment is part of a research experiment and give the beneficiary the right to refuse experimental treatment

- Tell a beneficiary, prior to the medical care or treatment, that the service(s) being rendered are not a covered benefit. Inform the beneficiary of the non-covered service and have the beneficiary acknowledge the information. If the beneficiary still request the service, obtain the acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the beneficiary about private payment, that agreement becomes null and void if a claim is submitted to the health plan.
- Allow a beneficiary who refuses or requests to stop treatment the right to do so, as long as the beneficiary understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect beneficiaries' advance directives and include these documents in the beneficiary's medical record
- Allow beneficiaries to appoint a parent, guardian, family beneficiary, or other representative if they can't fully participate in their treatment decisions
- Allow beneficiaries to obtain a second and third opinion, and answer beneficiary questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Carolina Complete Health data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of performance data for QI activities
- Review clinical practice guidelines distributed by Carolina Complete Health
- Comply with Carolina Complete Health Medical Management program as outlined in this Manual.
- Disclose overpayments or improper payments to Carolina Complete Health and promptly return overpayments within sixty (60) days of identifying the overpayment.
- Provide beneficiaries, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- Obtain and report to Carolina Complete Health information regarding other insurance coverage
- Notify Carolina Complete Health in writing if the provider is leaving or closing a practice
- Notify Carolina Complete Health of any changes in address, phone number, or other key contact information that could impact beneficiary access to care
- Contact Carolina Complete Health to verify beneficiary eligibility or coverage for services, if appropriate

- Invite beneficiary participation, to the extent possible, in understanding any medical or behavioral health problems that the beneficiary may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide beneficiaries, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with American Sign Language
- Not be excluded, penalized, or terminated from participating with Carolina Complete Health for having developed or accumulated a substantial number of patients in the Carolina Complete Health with high cost medical conditions
- Coordinate and cooperate with other service providers who serve beneficiaries such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Carolina Complete Health, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Carolina Complete Health and the physician or physician group
- Report all suspected physical and/or sexual abuse and neglect
- Carolina Complete Health requires providers to follow the Child Medicaid Evaluation and Medical Team Conference for Child Maltreatment Policy and bill according to 1A-5 Attachment A. (<https://files.nc.gov/ncdma/documents/files/1A-5.pdf>)
- Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse
- Monitor and report on provider preventable conditions including:
 - Reporting of Never Events and Hospital-Acquired Conditions
 - Procedures to Follow for Reporting Avoidable Errors (Never Events)
 - Procedures to Follow for Report POA and HAC Indicators
- Retain patient records for the mandated period
- Ensure that all documentation regarding services provided is timely, accurate, and complete
- Be available for or provide on-call coverage through another source 24-hours a day for management of beneficiary care
- Ensure Carolina Complete Health is the payer of last resort

GRIEVANCES AND APPEALS PROCESS

A beneficiary, a beneficiary's authorized representative or a beneficiary's provider (with written consent from the Beneficiary), may file an appeal or grievance either verbally or in writing.

Carolina Complete Health gives beneficiaries reasonable assistance in completing all forms and taking other procedural steps in the appeal and grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.

Carolina Complete Health values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a beneficiary behalf. Carolina Complete Health will provide assistance to both beneficiary and provider with filing a grievance by contacting our Beneficiary/Provider Services Department at 1-833-552-3876.

Beneficiary Grievance Process

A beneficiary grievance is defined as any beneficiary expression of dissatisfaction about any matter other than an "adverse action."

The grievance process allows the beneficiary, the beneficiary's authorized representative acting on behalf of the beneficiary or Provider acting on the beneficiary's behalf with the beneficiary's written consent, to file a grievance either orally or in writing at any time.

Carolina Complete Health will acknowledge, in writing within five (5) calendar days of receipt of each grievance. For grievances related to the denial of an expedited appeal request, Carolina Complete Health will acknowledge the receipt of the grievance, in writing via trackable mail, within twenty-four (24) hours of receipt of the grievance.

Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case, where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, Carolina Complete Health shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the beneficiary's condition or disease. [42 CFR § 438.406]

Carolina Complete Health resolves the grievance as expeditiously as the beneficiary's condition warrants and will provide written notice of resolution of the grievance to the beneficiary and, as applicable, the beneficiary's authorized representative within thirty (30) calendar days of the receipt of the grievance. Carolina Complete Health may extend the timeframe for resolution of the grievance up to fourteen (14) calendar days if the beneficiary requests the extension or Carolina Complete Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the beneficiary's best interest. For any extension not requested by the Beneficiary, Carolina Complete Health will provide written notice to the Beneficiary within two (2) calendar days of the reason for the delay and the right to file a grievance if they disagree with the decision.

For grievances related to the denial of an expedited appeal request, Carolina Complete Health will resolve the grievance and provide notice to the Beneficiary and, as applicable, the beneficiary's authorized representative within five (5) days calendar days of the receipt of the grievance.

Supplementary to the procedures outlined here, providers may act on behalf of Carolina Complete Health members. If they wish to file a grievance on behalf of a member, they should use the process outlined in the Carolina Complete Health Member Handbook.

Beneficiary Appeal Process

An appeal is the request for Carolina Complete Health to review an adverse benefit determination.

The appeal process allows the beneficiary, the beneficiary's authorized representative acting on behalf of the Beneficiary or Provider acting on the beneficiary's behalf with the beneficiary's written consent, to file an appeal either orally or in writing, within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination. Oral appeals must be followed by a written, signed appeal unless the beneficiary requests an expedited resolution.

Carolina Complete Health will acknowledge, in writing within five (5) calendar days of receipt of each standard appeal request, whether it was received either orally or in writing.

Carolina Complete Health will provide written notice of resolution of the appeal to the Beneficiary and/or authorized representative as expeditiously as the beneficiary's health condition requires and within thirty (30) calendar days of the receipt of the standard appeal request. Carolina Complete Health may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the Beneficiary requests the extension or Carolina Complete Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the beneficiary's best interest. For any extension not requested by the Beneficiary, Carolina Complete Health will provide written notice to the Beneficiary within two (2) calendar days of the reason for the delay and the right to file a grievance if they disagree with the decision.

Expedited Appeal Process

An expedited appeal may be filed when there is an immediate need for health services because a standard appeal could jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The appeal process allows the beneficiary, the beneficiary's authorized representative acting on behalf of the beneficiary or Provider acting on the beneficiary's behalf with the beneficiary's written consent, to file an appeal either orally or in writing, within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination. For expedited appeal requests made by Providers on behalf of beneficiaries, Carolina Complete Health presumes an expedited appeal resolution is necessary and will grant the request for expedited resolution. No punitive action will be taken against a provider that requests an expedited resolution or supports a beneficiary's appeal. In instances where the beneficiary's request for an expedited appeal is denied, the appeal will be immediately transferred to a standard appeal timeframe and provide written notice to the

Beneficiary, and when applicable, an authorized representative, if the denial of the expedited resolution request.

Carolina Complete Health will acknowledge, in writing, receipt of each expedited appeal request within twenty-four (24) hours of receipt.

Decisions for expedited appeals are issued as expeditiously as the beneficiary's health condition requires, and will provide written notice, and make reasonable efforts to provide oral notice, of the resolution no later than seventy-two (72) hours from the initial receipt of the appeal. Carolina Complete Health may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the beneficiary requests the extension or Carolina Complete Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the Beneficiary's best interest. For any extension not requested by the beneficiary, Carolina Complete Health will provide written notice to the Beneficiary within two (2) calendar days of the reason for the delay and the right to file a grievance if they disagree with the decision.

How to File a Beneficiary Grievance or Appeal

Appeals and grievances can be filed several ways:

- Call Beneficiary Services. The phone number is toll-free at 833-552-3876.
- Send electronically by fax. The fax number is 833-318-7256.
- Send by email to QOC_CIR@CarolinaCompleteHealth.com
- In person or by mail at:

Carolina Complete Health
Appeals and Grievances
10101 David Taylor Drive
Charlotte, NC 28262

State Fair Hearing Process

If a Beneficiary is not satisfied with the outcome of a Carolina Complete Health appeal decision, they have the right to request a State Fair Hearing. The State Fair Hearing process allows the Beneficiary, the Beneficiary's authorized representative acting on behalf of the Beneficiary or Provider acting on the Beneficiary's behalf with Beneficiary's written consent to file for a State Fair Hearing within one hundred and twenty (120) calendar days from the date on the Notice of Resolution issued by Carolina Complete Health. Beneficiaries must exhaust the internal appeals process with Carolina Complete Health before they may file a request for a State Fair Hearing. Beneficiaries have the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of the request for a State Fair Hearing with the North Carolina Office of Administrative Hearings (OAH).

Carolina Complete Health will comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an

Administrative Law Judge.

Continuation of Benefits

The beneficiary, or the beneficiary's authorized representative, may request for the continuation of benefits during an appeal and or State Fair Hearing within ten (10) calendar days of Carolina Complete Health sending the adverse benefit determination or on the intended effective date of the proposed adverse benefit determination, whichever comes later. Providers may not request continuation of benefits on behalf of a beneficiary. North Carolina Health Choice, Beneficiaries are not eligible to receive continuation of benefits during the appeal process.

IMPORTANT: If the final determination of the appeal or State Fair Hearing is adverse to the beneficiary, that is, upholds Carolina Complete Health's adverse benefit determination, Carolina Complete Health may recover the cost of services furnished to the beneficiary while the appeal and State Fair Hearing was pending to the extent that they were provided during the appeal and State Fair Fearing process.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the Carolina Complete Health or State Fair Hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, Carolina Complete Health will authorize the disputed services promptly and as expeditiously as the beneficiary's health condition requires and no later than seventy-two (72) hours from the date it received notice of reversing the determination. Additionally, in the event that services were continued while the appeal was pending, Carolina Complete Health will provide payment for those services in accordance with the terms of the contract.

How to File a State Fair Hearing

If a member is unsatisfied with the results of an appeal or grievance to Carolina Complete Health, they may initiate a State Fair Hearing via the contact information below:

Attn: Clerk
6714 Mail Service Center
Raleigh, NC 27699-6700
Phone: 1-919-431-3000
Fax: 1-919-431-3100

Provider Grievance and Appeals

A **Grievance** is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, claims, or any aspect of Carolina Complete Health functions.

- Carolina Complete Health logs and tracks all grievances whether received verbally or in writing. For instructions on how to file a grievance, please see the How to File a

Provider Grievance or Appeal subsection at the end of the Grievance and Appeals Processes section of this manual.

- A provider has ten (10) days from the date of the incident, such as the original remit date, to file a grievance.
- After the complete review of grievances **not** related to claims Carolina Complete Health shall open communication with the provider to review the status of the grievance. If the grievance cannot be resolved in fifteen (15) days, the Plan will provide a status update at that time, and will fully resolve all grievances within thirty (30) calendar days from the date the grievance was received.
- After the complete review of grievances related to claims we will open communication with the provider to review the status of the grievance, provide updates every fifteen (15) days, and resolve grievances fully within ninety (90) days.
- Providers must exhaust the Grievance process before submitting a claim appeal outlined in the process below.

Appeal is the mechanism following the exhaustion of the grievance process that allows providers the right to appeal actions of Carolina Complete Health such as a claim denial, prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Carolina Complete Health.

A provider has thirty (30) calendar days from Carolina Complete Health notice of action. The Plan will extend this timeframe by an additional thirty (30) days for good-cause, which may include, but is not limited to, the voluminous nature of required evidence or supporting documentation; or an appeal of an adverse quality decision as determined by the Plan. Carolina Complete Health will acknowledge receipt of each appeal within five (5) calendar days after receiving an appeal.

Carolina Complete Health will accept a written request for an appeal from the provider within thirty (30) calendar days if the Provider receives written notice from the Carolina Complete Health of the decision giving rise to the right to appeal; or if Carolina Complete Health should have taken a required action and failed to take such actions.

Types of Actions Eligible for Appeal

The table below represents the reasons for which the Carolina Complete Health will allow a provider to appeal an adverse decision made by the plan.

For Network Providers

- a. Program Integrity related findings or activities
- b. Finding of fraud, waste, or abuse by the PHP
- c. Finding of or recovery of an overpayment by the PHP
- d. Withhold or suspension of a payment related to fraud, waste, or abuse concerns
- e. Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in the PHP's Objective Quality Standards as described

in Section V.D. Providers of the RFP, as provided under Section 5.(6)d. of Session Law 2015-245, as amended

- f. Termination of, or determination not to renew, an existing contract for LHD care/case management services
- g. Determination to lower an AMH provider's Tier Status
- h. Violation of terms between the PHP and provider

For Out-of Network Providers

- a) A determination to not initially credential and contract with a provider based on objective quality reasons outlined in the PHP's Objective Quality Standards as described in Section V.D. Provider, and as provided under Section 5.(6)d. of Session Law 2015-245, as amended
- b) An out-of-network payment arrangement
- c) Finding of waste or abuse by the PHP
- d) Finding of or recovery of an overpayment by the PHP

Resolution of Appeals addresses the process by which Carolina Complete Health reviews provider appeals and determines the most appropriate course of action in response. Carolina Complete Health will work to resolve appeals to the mutual satisfaction of both the health plan and the provider in accordance with the standards laid out in this Provider Manual and other health plan documents.

Carolina Complete Health will establish and maintain a committee to review and decide on provider appeals. The committee will be made up of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction which led to the appeal. The committee will also include an external peer reviewer when the issue on appeal involves whether the provider met Objective Quality Standards.

For appeals **not** related to payment withhold, Carolina Complete Health shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the beneficiary's health condition requires, but shall not exceed thirty (30) calendar days from the date Carolina Complete Health receives the appeal. Please see the Appeals on Behalf of a Member section below for further details on this process.

For appeals related to payment withhold, the Plan will resolve each appeal within fifteen (15) business days. If the review of an appeal related to payment results in the determination that the Plan did not have good-cause for withholding or suspending payment, and withheld or suspended payments will be made to the provider within five (5) business days, and the Plan will pay interest in accordance with the provider contract.

Carolina Complete Health will allow providers to be represented by an attorney during the appeals process.

Suspension or Withhold of Provider Payment addresses nonpayment of an appealed claim by Carolina Complete Health.

In cases of a suspended or withheld payment, Carolina Complete Health will limit its consideration to whether there existed good-cause to withhold or suspend provider payment. Carolina Complete Health will not address whether the provider has or has not committed fraud or abuse.

Carolina Complete Health will offer the provider an in-person or telephonic hearing when the provider is appealing whether Carolina Complete Health had good cause to withhold or suspend payment to the provider.

Carolina Complete Health will pay interest and penalties for overturned denials, underpayment, or other determinations that did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

Appeals on Behalf of a Member

Expedited Appeals may be filed when either Carolina Complete Health or the beneficiary's provider determines that the time expended in a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a beneficiary's appeal. In instances where the beneficiary's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Expedited appeals will be acknowledged within twenty-four (24) hours, and determinations will be made as expeditiously as the beneficiary's health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal.

In order to file an appeal on behalf of a member (such as for prior authorization or adverse benefit determination), please follow the instructions in the Beneficiary Appeal section of this manual.

How to File a Provider Grievance or Appeal

Appeals and grievances can be filed several ways:

- Call Provider Services. The phone number is toll-free at 1-833-552-3876
- Send electronically by fax. The fax number is <To Be Added>
- Send by email to <To Be Added>@CarolinaCompleteHealth.com
- In person or by mail at:

Carolina Complete Health
Attn: Appeals and Grievances
P.O. Box 8040
Farmington, MO 63640-8040

1-833-552-3876 (phone)
<To Be Added> (fax)

Provider Ombudsman

If a provider wishes to issue a complaint about any aspect of Carolina Complete Health's business operations, they may contact the Provider Ombudsman for support in submitting their complaint via the contact channels below

Provider Ombudsman Email: <To Be Added>

Provider Ombudsman Phone: <To Be Added>

FRAUD, WASTE AND ABUSE

Fraud, Waste and Abuse (FWA)

Carolina Complete Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste and Abuse (FWA) program that complies with state and federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes “reckless disregard” of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the provider or subcontractor and office staff is educated on proper billing requirements and/or claim submission.

Abuse means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive..

Carolina Complete Health instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Carolina Complete Health, successfully operates a Special Investigations Unit (SIU), with dedicated staff that reside in North Carolina. This unit routinely inspects claims submitted to assure that Carolina Complete Health is paying appropriately for covered services. Carolina Complete Health performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic prepayment review audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this handbook. The Special Investigation Unit (SIU) performs retrospective audits that, in some cases, may result in taking actions against those providers, individually or as a practice, commit fraud, waste and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Unannounced onsite audit
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Carolina Complete Health requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all Carolina Complete Health members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, Physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Carolina Complete Health auditors request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Carolina Complete Health will recover all amounts paid for the services in question.

Carolina Complete Health auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the beneficiary's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a beneficiary receiving inappropriate services, please call OIG's Hotline at 1-800-447-8477 directly to a Fraud Control Unit, or our anonymous and confidential FWA hotline at 1-866-685-8664. Carolina Complete Health and

Centene take all reports of potential fraud, waste and abuse very seriously and investigate all reported issues.

Please Note: Due to the evolving nature of wasteful, abusive and fraudulent billing, Carolina Complete Health and Centene may enhance the FWA program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.

Authority and Responsibility

The Carolina Complete Health Director of Regulatory Affairs & Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Carolina Complete Health is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Carolina Complete Health provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

QUALITY IMPROVEMENT

Carolina Complete Health culture, systems and processes are structured around its mission to improve the health of all enrolled beneficiaries. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all beneficiaries, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Carolina Complete Health recognizes its legal and ethical obligation to provide beneficiaries with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Carolina Complete Health will provide for the delivery of quality care with the primary goal of improving the health status of its beneficiaries. Where the beneficiary's condition is not amenable to improvement, Carolina Complete Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the beneficiary. This will include the identification of beneficiaries at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Carolina Complete Health QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its beneficiaries.

Program Structure

The Carolina Complete Health Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to beneficiaries. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to beneficiaries. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve beneficiary outcomes, and the education of beneficiaries, providers and staff regarding the QI, UM, and Credentialing programs. Carolina Complete Health maintains policies and procedures for quality assessment, utilization management, and continuous quality improvement. These policies and procedures are evaluated periodically to determine impact and effectiveness.

The following sub-committees report directly to the Quality Improvement Committee:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- CLAS Task Force
- HEDIS Steering Committee
- Performance Improvement Team
- Beneficiary, Provider, Hospital and Community Advisory Committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

Practitioner Involvement

Carolina Complete Health recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Carolina Complete Health encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as but not limited to, the QIC, Credentialing Committee and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the Carolina Complete Health beneficiaries. Carolina Complete Health QAPI Program incorporates all demographic groups, benefit packages, care settings, providers and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care and ancillary services, and operations.

Carolina Complete Health primary QAPI Program goal is to improve beneficiaries' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the Carolina Complete Health QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with beneficiary confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Data collection, analysis, and reporting
- Delegated entity oversight

- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Beneficiary enrollment and disenrollment
- Beneficiary Grievance System
- Beneficiary satisfaction
- Beneficiary Services
- Network Performance
- Organizational structure
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan accessibility
- Provider availability
- Provider Grievance System
- Provider network adequacy and capacity
- Provider satisfaction
- Provider Services
- Quality management
- Records management
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

Patient Safety and Quality of Care

Patient Safety is a key focus of Carolina Complete Health QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a beneficiary. Carolina Complete Health employees (including medical management staff, beneficiary services staff, provider services,

grievance coordinators, etc.), panel practitioners, facilities or ancillary providers, beneficiaries or beneficiary representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Carolina Complete Health QIC reviews and adopts an annual QAPI Program and Work Plan based on Medicaid Managed Care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Carolina Complete Health to monitor improvement over time.

Annually, Carolina Complete Health develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Results, conclusions, recommendations, and implemented system changes are reported to the QIC quarterly. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Carolina Complete Health communicates activities and outcomes of its QAPI Program to both beneficiaries and providers through avenues such as the beneficiary newsletter, provider newsletter and the Carolina Complete Health web portal at <https://www.carolinacompletehealth.com/>.

At any time, Carolina Complete Health providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Carolina Complete Health progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the North Carolina State Medicaid contract.

As both the state and federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. North Carolina purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its beneficiaries. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of quality indicators such as HEDIS.

How Are HEDIS Rates Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data.

Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using only administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of beneficiary medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see Carolina Complete Health website and HEDIS brochure for more information on reducing HEDIS medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Carolina Complete Health will only use a hybrid reporting approach for measures as appropriate and will develop a consistent reporting approach to minimize any burden to providers. Carolina Complete Health will base all hybrid reporting models on guidelines provided by DHHS and will seek prior Department approval before utilizing these models.

Conducting the Medical Record Reviews (MRR) for HEDIS

Carolina Complete Health will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any

of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the beneficiary/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Carolina Complete Health which allows them to collect PHI on our behalf.

Carolina Complete Health will ensure minimal interference with day-to-day activities at the provider's office by incorporating the following best practices:

- Contracting with a reputable medical record retrieval vendor
- Providing the vendor with complete and accurate provider data (address, phone and fax data) to ensure no inadvertent PHI concerns occur due to bad demographic data
- Ensuring the vendor is trained appropriately on collecting medical records necessary for HEDIS hybrid measures
- Vendor will support retrieval efforts which are compatible with the provider's medical record management practices, such as fax, mail, secure portals, third-party release of information vendors, and onsite collections.
- Vendor will not make more than three follow-up attempts to the provider to finalize medical record collection activities

Our goal is to conduct the project with minimal interruption, with the utmost professionalism and respect for the provider and office staff.

What Can Be Done to Improve My HEDIS Scores?

- Understand the technical specifications established by NCQA for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-833-552-3876.

Provider Satisfaction Survey

Carolina Complete Health conducts an annual provider satisfaction survey that includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Carolina Complete Health, and the participants are kept anonymous, unless you grant the survey vendor permission to disclose your name and comments for follow-up purposes. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a beneficiary satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to beneficiaries by an NCQA certified survey vendor. The survey provides information on the experiences of beneficiaries with health plan and practitioner services and gives a general indication of how well we are meeting the beneficiary's expectations. Beneficiary responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

Provider Profiling and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the quality and cost-effectiveness of care. Carolina Complete Health currently uses a pay-for-performance program that includes physician profiling to improve care and services provided to Carolina Complete Health beneficiaries.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA and NQF. Additionally, Carolina Complete Health will provide an opportunity for financial reward to PCPs and specialists using an incentive payment that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

Carolina Complete Health's quality measures for all primary care providers, as well as AMHs, will reflect the DHHS Quality Strategy and identified priority measures. The P4P program will also include health plan-specific measures that are determined following an evaluative period of at least six months based on identified performance gaps observed in the provider network.

The goals of Carolina Complete Health P4P program are to:

- Increase provider awareness of his/her performance in key areas
- Motivate providers to establish measurable performance improvement processes relevant to Carolina Complete Health beneficiary populations in their practices
- Use peer performance data and/or other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance
- Increase opportunities for Carolina Complete Health to partner with providers to achieve measurable improvement in health outcomes by developing, implementing, and monitoring practice-based performance improvement initiatives
- Accelerate adoption of value-based payment arrangements and align Advanced Medical Home and other Provider Incentive Programs with the Quality Strategy and related measures.

Carolina Complete Health will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Carolina Complete Health and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Carolina Complete Health beneficiary populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with profiled providers related to performance improvement.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Carolina Complete Health in publications such as newsletters, bulletins, press releases, and recognition in our provider directories as well as being eligible for applicable financial incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting Carolina Complete Health Contracting and/or Provider Relations departments.

PHARMACY

Carolina Complete Health adheres to The North Carolina Medicaid Pharmacy Program which offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.

Carolina Complete Health provides pharmacy benefits through its Pharmacy Benefit Manager, Envolve Pharmacy Solutions.

Carolina Complete Health adheres to the State Preferred Drug List (PDL) to determine medications that are covered under the pharmacy benefit, as well as which medications may require prior authorization. Please visit the Carolina Complete Health website at (enter link), for a link to the State's current PDL and criteria.

Some beneficiaries may have copayment or cost share when utilizing their prescription benefits.

Preferred Drug List (PDL)

The Carolina Complete Health PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Providers may contact Carolina Complete Health with questions at 833-552-3876

The PDL does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the provider or pharmacist
- Relieve the provider or pharmacist of any obligation to the beneficiary or others

Unapproved Use of Preferred Medication

Medication coverage under this program is limited to non-experimental indications as approved by the FDA. Other indications may also be covered if they are accepted as safe and effective using current medical and pharmaceutical reference texts and evidence-based medicine.

Reimbursement decisions for specific non-approved indications will be made by Carolina Complete health, following requirements in Social Security Act 1927. Experimental drugs and investigational drugs are not eligible for coverage.

Prior Authorization Process

The Carolina Complete Health PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the approved list for their patients. Some drugs will require PA and that requirement will be indicated on the PDL. If a request for prior authorization is needed the information should be submitted by the physician, clinician, or pharmacy. This document is located on the Carolina Complete Health Website <https://www.carolinacompletehealth.com/>.

Carolina Complete health will cover the medication if it is determined that:

- The request meets all approved criteria
- Depending on the medication, other medications on the PDL have not worked

All prior authorization reviews are performed by a licensed clinical pharmacist using the clinical criteria provided by the state. Once approved, Envolve Pharmacy Solutions notifies the physician/clinician of the approval. If the clinical information provided does not meet the coverage criteria for the requested medication Carolina Complete Health we will notify the beneficiary and physician/clinician of alternatives and provide information regarding the appeal process.

If a patient requires a medication that does not appear on the PDL, the physician/clinician can request a PA for the medication. A phone, fax, and electronic portal process is available for PA requests. Please see Envolve Pharmacy Solutions Contact Information Section below.

Envolve Pharmacy Solutions Contacts - Prior Authorization

Fax: 1-866-399-0929

Web: <https://pharmacy.envolvehealth.com/>

Phone: 1-844-330-7852 (Monday - Friday 8:00 a.m.-8 p.m. CST)

Mailing Address:

Envolve Pharmacy Solutions
<Address is TBD, location in North Carolina>

72-Hour Emergency Supply Policy

State and federal law require that a pharmacy dispense a seventy-two (72) hour (three-day) supply of medication to any patient awaiting a PA determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee for the 72- hour supply of medication, whether or not the PA request is ultimately approved or denied.

The pharmacy may call the Help Desk for a prescription override assistance to submit the 72-hour medication supply for payment.

Please call <xxx-xxx-xxxx> for the Pharmacy Help Desk.

Prospective Drug Utilization Review (DUR) Response Requirements

Carolina Complete Health is committed to providing a safe and quality pharmacy benefit. Our pharmacy program will utilize prospective and concurrent drug utilization review (DUR) edits to detect potential problems at the point-of-service. All DUR messages appear in the claim response utilizing NCPDP standards. This allows the provider to receive and act on the appropriate DUR conflict codes. Pharmacy providers can find detailed instructions on the DUR system by accessing provider manual.

Benefit Exclusions

The following drug categories are not part of the Carolina Complete Health PDL and are not covered:

- OTC products, unless they are specifically listed on the PDL
- Any drug manufactured by a company that has not signed a CMS rebate labeler agreement. Exception shall be made for CroFab
- Fertility drugs
- Drugs used for cosmetic indications
- Medical supplies and devices
- Diaphragms, which are a family planning service
- Intravenous (IV) fluids (Dextrose 500 ml or greater) and irrigation fluids; except for living arrangement codes 10 (Private Living Arrangement (not 1/3 reduction), 11 (Private Living Arrangement (with 1/3 reduction) (Medicaid Only), 13 (Living with Supplemental Security Income (SSI) Beneficiary), 52 (Domiciliary care, Six or More Beds (Special Assistance for the Aged (SAA), Special Assistance for the Disabled (SAD), 53 (Foster Care (Medicaid for Families (MAF), Medicaid for Infants and Children (MIC), State Foster Home Fund (HSF), Medicaid with IV-E Adoption Subsidy and Foster Care (IAS)) or 80 (Adoptive Home (MAF, MIC, MRF (Refugee Medical Assistance), HSF, IAS))
- Erectile dysfunction drugs
- Weight loss and weight gain drugs
- Drug samples
- Drugs obtained from any patient assistance program
- Drugs used for the symptomatic relief of cough and colds that contain expectorants or cough suppressants
- Legend vitamins and mineral products

- All DESI drugs and combinations equivalent to a DESI drug in compounded prescriptions. Drugs described by the FDA as DESI are products that the FDA has found to be less than effective or not proven to be as effective as indicated. Drug products that are identical, related or similar to DESI drugs are considered DESI. Updates and corrections are published in the Pharmacy Newsletters on Medicaid's website
- A compounded prescription which is equivalent to an OTC product.

Physician Administered Drug Program

The Physician Administered Drug Program covers drugs purchased for use in an outpatient office setting. Medicaid covers the cost of the drug when it is purchased by the same provider administering the drug.

- All drugs are not automatically covered in the Physician Administered Drug Program
- Drugs and biological medications must be approved by the Food and Drug Administration as reasonable and necessary for the diagnosis and treatment of the illness or injury
- Experimental drugs or drugs for investigational use are not covered by the Medicaid program

Covered medications include:

- Injectable drugs
- Intravenous administrations
- Chemotherapy
- Vaccines/toxoids
- Immune globulins
- Radiopharmaceuticals

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum thirty-four (34) day supply for each new or refill non-controlled substance. A total of seventy-five percent (75%) of the prior fill days supplied must have elapsed before the prescription can be refilled. Opioid prescriptions can't be filled until eighty-five percent (85%) of the prior fill day supplied has elapsed.

Carolina Complete Health may limit how much of a medication you can get at one time. Some medications may have age limits. Age limits are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns and quality standards of care. The age limit aligns with current FDA alerts for the appropriate use of pharmaceuticals.

Dispensing outside the quantity limit (QL) or age limit (AL) requires prior authorization. If the physician/clinician feels a beneficiary has a medical reason for getting a larger amount, submit a prior authorization.

Mandatory Generic Substitution

When generic drugs are available, the brand name drug will not be covered without prior authorization unless specifically allowed on the Carolina Complete Health PDL. Generic drugs have the same active ingredient and work the same as brand name drugs. If the physician/clinician thinks a brand name drug is medically necessary, the physician/clinician can ask for prior authorization or must indicate on a Prescription order in their own handwriting "Brand Medically Necessary". The brand name drug will be covered according to our clinical guidelines if there is a medical reason the beneficiary needs the particular brand name drug

Working With the Pharmacy Benefit Manager (PBM)

Carolina Complete Health works with Envolve Pharmacy Solutions to administer pharmacy benefits, including the prior authorization process. Certain drugs require prior authorization to be approved for payment.

These include:

- All medications not listed on the PDL
- Some Carolina Complete Health preferred and formulary drugs (designated prior authorization (PA) on the PDL and formulary)

Drug Prior Authorization request are available at Envolve Pharmacy Solutions through phone, fax or online.

Complete the Carolina Complete Health/Envolve Pharmacy Solutions prior authorization form: Medication Prior Authorization Request Form is found on the website at www.carolinacompletehealth.com

Online Prior Authorization

CoverMyMeds is an online drug prior authorization tool offered through Envolve Pharmacy Solutions that allows prescribers to begin the prior authorization process electronically. Prescribers locate the correct form, complete the online form, and submit the form to Envolve Pharmacy Solutions via fax. CoverMyMeds simplifies the prior authorization submission process by automating drug prior authorizations

CoverMyMeds can be found at <https://pharmacy.envolvehealth.com/pharmacists/cmm-widget.html>

Envolve Pharmacy Solutions Contacts - Prior Authorization

Fax: 1-866-399-0929

Web: <https://pharmacy.envolvehealth.com/>
Phone: 1-844-330-7852 (Monday - Friday 8:00 a.m.-8 p.m. CST)

Mailing Address:

Envolve Pharmacy Solutions
<Address is TBD, location in North Carolina>

When calling, please have beneficiary information, including Medicaid ID number, beneficiary date of birth, complete diagnosis, medication history, and current medications readily available. If the request is approved, information in the online pharmacy claims processing system will be changed to allow the specific beneficiary to receive the specific drug.

If the request is denied, the beneficiary and physician/clinician will be notified and provided information regarding the appeal process.

Providers are requested to utilize the PDL when prescribing medications for their beneficiaries. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the provider to request a change to a product included on PDL.

In the event that a provider or beneficiary disagrees with the decision regarding coverage of a medication, the beneficiary or the provider, on the beneficiary's behalf, may submit an appeal.

Pharmacy Portal and Provider Links

(This section will be compiled when links are designated)

MEDICAL RECORDS REVIEW

Medical Records

Carolina Complete Health providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to beneficiaries. They will also enable Carolina Complete Health to review the quality and appropriateness of the services rendered. To ensure the beneficiary's privacy, medical records should be kept in a secure location. Carolina Complete Health requires providers to maintain all records for beneficiaries for at least seven (7) years. See the Beneficiary Rights section of this handbook for policies on beneficiary access to medical records.

Required Information

Medical records means the complete, comprehensive beneficiary records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the beneficiaries participating primary care physician or provider, that document all medical services received by the beneficiary, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for beneficiaries in accordance with the following standards:

- Beneficiary's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric beneficiaries or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Carolina Complete Health practice guidelines.
- Appropriate subjective and objective information pertinent to the beneficiary's presenting complaints is documented in the history and physical.
- Past medical history (for beneficiaries seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and

- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the beneficiary.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For beneficiaries ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for beneficiaries seen three (3) or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the beneficiary is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of beneficiary information and records protected.
- Evidence that an advance directive has been offered to adults eighteen (18) years of age and older.
- Any corrections, additions, or change in any medical record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

Medical Records Release

All beneficiaries' medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

NOTE: When beneficiaries enroll, they sign a waiver to release medical records and other requested participant protected health information to the State of North Carolina and to agents of the State, such as Carolina Complete Health.

Medical Records Transfer for New Beneficiaries

When a beneficiary changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the beneficiary's medical record attempts to obtain historical medical records for all newly assigned Carolina Complete Health beneficiaries. If the beneficiary or beneficiary's guardian is unable to disclose the names and/or addresses of providers who delivered prior care, then this should also be noted in the medical record.

Medical Records Audits

Carolina Complete Health will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to beneficiaries, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Carolina Complete Health will provide written notice prior to conducting a medical record review.

TELEMEDICINE AND TELEPSYCHIATRY

Carolina Complete Health is committed to transforming the health care experience for beneficiaries and providing increased access to care through telemedicine services. Our approach for the use of telemedicine services is aligned with North Carolina Department of Health and Human Services (NCDHHS) goals and requirements. (RFP 30-190029-DHB V.C.1.f).

Carolina Complete Health will provide services via telemedicine to all beneficiaries as an alternative service delivery model in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Select provider offices have, and offer, the ability to conduct a two-way, real-time, interactive audio and video consultation with beneficiaries. This allows providers to support a member in a different geographic location with greater medical or psychiatric expertise. Contracted providers may refer to other providers with telemedicine and telepsychiatry capabilities in order to address specialty care gaps for members in urban, rural, or underserved areas in order to enhance timely access to specialists and provide an alternative service delivery model of care. Beneficiaries are not required to participate in telemedicine or telepsychiatry.

Carolina Complete Health uses telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within its network. However, Carolina Complete Health does not require a beneficiary to seek services through telemedicine and will allow the beneficiary to access a face-to-face service through an out-of-network provider, if that is the beneficiary's preference.

Telemedicine Covered Services

Carolina Complete Health will cover procedures, products, and services related to telemedicine when they are medically necessary, and:

- The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

Carolina Complete Health will cover Telemedicine and Telepsychiatry services when medically necessary under the following conditions:

- The beneficiary will be present at the time of consultation
- The medical examination of the beneficiary must be under the control of the consulting provider

- The distant site of the service(s) must be of a sufficient distance from the originating site to provide service(s) to a beneficiary who does not have readily available access to such specialty services
- The consultation must take place by encrypted two-way real-time interactive audio and video telecommunications system

Telemedicine Appeals

Providers wishing to submit a grievance or appeal related to telemedicine decisions should follow the instructions outline in the Provider Grievance and Appeal section of this manual.