carolina complete health

2025 Provider Manual

carolinacompletehealth.com

INTRODUCTION

Welcome to Carolina Complete Health

Thank you for being part of the Carolina Complete Health network of participating physicians, hospitals, and other healthcare professionals committed to serving Medicaid members in North Carolina. As the only Provider-Led Entity (PLE) in North Carolina's Medicaid Managed Care plan, we value our partnerships with providers to support Medicaid Transformation in North Carolina in Regions 3, 4 and 5. We are committed to improving quality, cost-efficiency, and patient and provider satisfaction. Carolina Complete Health is locally based with offices in Charlotte, Durham, and Wilmington to serve the unique needs of each region and community.

About Us: Doctors Leading the Way to Better Health Care

Carolina Complete Health is a Prepaid Health Plan (PHP) contracted with the North Carolina Department of Health and Human Services (NC DHHS). What makes Carolina Complete Health different is that we are a designated Provider-Led Entity (PLE) through an innovative joint venture among the Centene Corporation (Centene), the North Carolina Medical Society (NCMS), and the North Carolina Community Health Center Association (NCCHCA).

- Centene Corporation: With over 30 years of Managed Care experience, Centene is a Fortune 50 company serving over 25 million members across 50 states with the mission to transform the health of the communities it serves, one person at a time.
- North Carolina Medical Society: The NCMS is the oldest professional member organization in North Carolina, representing physicians and physician assistants who practice in the state, providing leadership in medicine by uniting, serving and representing physicians and their health care teams to enhance the health of North Carolinians.
- North Carolina Community Health Center Association: The NCCHCA is a private, non-profit membership association that represents Federally Qualified Health Centers (FQHCs) and aspiring health centers across North Carolina.

We believe that physicians are the key to success for Medicaid Transformation and should have a leadership role in developing and approving the plan's medical policies to ensure they are in the best interest of patients and providers. That's why you will see local provider representation within our leadership team and board of directors, invested in every decision we make.

Mission

At Carolina Complete Health, our mission is to transform the health of our community, one person at a time. Working with providers, we do this by:

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

- Partnering with doctors, hospital systems, specialists and other providers to ensure that our health plan benefits, services, network, and support truly meet the needs of North Carolina Medicaid beneficiaries.

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 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 in the "Resources" section of our website at: www.network.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 Reconsideration and Grievance Processes
- 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 1701 North Graham St, Suite 101, Charlotte, NC 28206 https://www.carolinacompletehealth.com/	
Department	**Telephone Number**	**Fax Number**
Provider Services	1-833-552-3876 TDD/TYY: 711	1-844-915-0459
Member Services		1-833-537-2330
Physical Health Authorization Request	1-833-552-3876 TDD/TYY: 711	1-833-238-7694
Concurrent Review		1-833-238-7692
Care Management		1-833-706-0238
Nurse Advice Line (24/7 Availability)	1-833-552-3876 TDD/TYY: 711	1-866-399-0929
Face Sheets		1-833-238-7690
Behavior Health Prior Authorization		Inpatient: 1-833-596-2768 Outpatient: 1-833-596-2769
Census Reports		1-844-975-1325
Assessments		1-833-238-7691
Medical Records		1-833-238-7693
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

Most NC Medicaid beneficiaries receive the same Medicaid services through NC Medicaid Managed Care. Most people get health care coverage from a Standard Plan. Some people must get coverage from their Tailored Plan or can choose to enroll in a Tailored Plan. Health care options (choices) are specific to each person's needs and situation.

Who qualifies for a Carolina Complete Health Standard Plan?

- Most families and children
- Pregnant women up to twelve (12) months post-partum
- People who are blind or disabled and do not get Medicare
- Federally recognized tribal members or others who qualify for services through Indian Health Service (IHS)

Who qualifies for the EBCI Tribal Option?

- Federally recognized tribal members or others who qualify for services through Indian Health Service (IHS) who live in the following counties: Buncombe, Clay, Cherokee, Graham, Haywood, Henderson, Jackson, Macon, Madison, Swain, Transylvania

Who qualifies for a Tailored Plan?

- People who get Innovations Waiver services
- People who get Traumatic Brain Injury (TBI) Waiver services
- People who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI)

Tailored Plans will start at a later date. Some people will be automatically enrolled in a Tailored Plan based on their needs. For example, individuals receiving Innovations waiver or TBI waiver services will be enrolled in a Tailored Plan. Others may have the option to choose a Tailored Plan. If you are enrolled in the Tailored Plan or have the option to choose the Tailored Plan, you will get a notice in the mail to tell you. To learn more, go to Tailored Plan services.

Who qualifies for NC Medicaid Direct?

- Children/youth in foster care
- Children/youth who get adoption assistance
- Children who get Community Alternatives Program for Children (CAP/C) services
- Federally recognized tribal members or others who qualify for services through Indian Health Service (IHS)
- Former foster care youth
- People in the Health Insurance Premium Payment (HIPP) program
- People in the Program for All-Inclusive Care for the Elderly (PACE)
- People who are medically needy

- People who get Community Alternatives Program for Disabled Adults (CAP/DA) services
- People who get Family Planning Medicaid only
- People who get Medicaid and Medicare
- People who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI)

TAILORED PLANS

A Tailored Plan is an integrated health plan for individuals with mental health needs, substance use disorders, intellectual/developmental disabilities (I/DDs) or traumatic brain injuries (TBIs). It offers physical health, pharmacy, care management and behavioral health services. Tailored Plans offer added services for members who qualify such as:

- People who get Innovations Waiver services
- People who get Traumatic Brain Injury (TBI) Waiver services
- People who may have a mental health disorder, substance use disorder, intellectual/developmental disability (I/DD) or traumatic brain injury (TBI)

With the implementation of North Carolina's Behavioral Health I/DD Tailored Plans, Partners and Trillium will contract with Carolina Complete Health as a Standard Plan partner. Carolina Complete Health will assist with care management, utilization management, and network contracting and provider relations – primarily related to physical health – to individuals with serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/developmental disability, and traumatic brain injury.

Partners Health Management and Trillium Health Resources maintain an open networks for all physical health providers and will enter into a good faith contracting effort with any willing provider of physical health services via partnership with Carolina Complete Health.

Behavioral Health Providers requesting to join the Tailored Plans with either Partners Behavioral Health and/or Trillium Health Resources should visit their websites:

- Partners Health Management: https://www.partnersbhm.org/
- Trillium Health Resources https://www.trilliumhealthresources.org/

Partners Provider Resources

Partners Provider Portal	ProviderCONNECT: https://providers.partnersbhm.org/category/providerconnect/
Partners Pre-Auth Lookup Tool	https://providers.partnersbhm.org/benefits/#lookuptool
Partners Tailored Plan Quick Reference Guide	https://www.partnersbhm.org/wp-content/uploads/partners-quick-reference-guide.pdf
Partners Provider Manual	https://www.partnersbhm.org/tailoredplan/providers/manuals-forms-and-policies/
Partners Billing Guidance	https://providers.partnersbhm.org/claims-information/

Trillium Provider Resources

Trillium Provider Portal	Trillium Physical Health Portal https://provider.trilliumhealthresources.org/
Trillium Physical Health Pre-Auth Tool	https://www.carolinacompletehealth.com/trillium-preauth.html
Trillium Tailored Plan Quick Reference Guide	https://www.trilliumhealthresources.org/sites/default/files/docs/Medicaid-Transformation-Provider/Trillium-Tailored-Plan-Quick-Reference-Guide.pdf
Trillium Tailored Plan Provider Resources and Provider Manual	https://www.trilliumhealthresources.org/for-providers/tailored-plans-information-for-providers
Trillium Medicaid Direct & Tailored Plan Claims Submission Protocol	https://www.trilliumhealthresources.org/for-providers/provider-documents-forms

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:

Verify Recipient Eligibility on NCTracks at https://www.nctracks.nc.gov/. Using the NCTracks portal, a provider can check beneficiary eligibility.

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.

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.

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) can access a list of eligible beneficiaries who have selected them as their assigned Advanced Medical Home (AMH) at the time of enrollment or who were auto-assigned to them. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, or a missed Early Periodic Screening. 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.

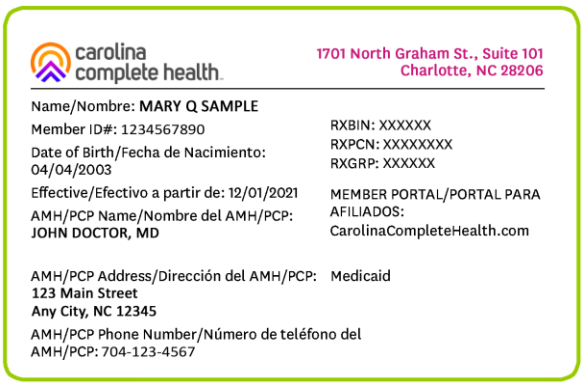
All new Carolina Complete Health beneficiaries receive a Carolina Complete Health beneficiary ID card. A new card is issued only when the information on the card changes, if a beneficiary loses a card, or if a

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 ID 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 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.


carolina complete health

1701 North Graham St., Suite 101
Charlotte, NC 28206

Name/Nombre: **MARY Q SAMPLE**
Member ID#: 1234567890
Date of Birth/Fecha de Nacimiento: 04/04/2003
Effective/Efectivo a partir de: 12/01/2021
AMH/PCP Name/Nombre del AMH/PCP: **JOHN DOCTOR, MD**

RXBIN: XXXXXX
RXPCN: XXXXXXXX
RXGRP: XXXXXX

MEMBER PORTAL/PORTAL PARA AFILIADOS:
CarolinaCompleteHealth.com

AMH/PCP Address/Dirección del AMH/PCP:
123 Main Street
Any City, NC 12345

Medicaid

AMH/PCP Phone Number/Número de teléfono del AMH/PCP: 704-123-4567


IMPORTANT CONTACT INFORMATION / INFORMACIÓN IMPORTANTE DE CONTACTO
Members/Afiliados:
Call **1-833-552-3876** (TTY: 711) for **Member Services** / Servicios para afiliados and
24/7 Nurse Advice Line / Línea de consejo de enfermería que atiende 24/7
Call **1-855-798-7093** for **Behavioral Health Crisis Line** / Línea de crisis de salud mental

Providers: Call **1-833-552-3876 for**
Provider Service Line • Prescriber Service Line • Prior Authorization
Pharmacy Help Desk: XXX-XXX-XXXX **Pharmacy Prior Authorization:** 1-833-585-4309
Pharmacy Paper Claims: P.O. Box 989000, West Sacramento CA 95798
All Medical Claims: Carolina Complete Health, PO Box 8040, Farmington, MO 63640-8040

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.**

Si sospecha que un médico, clínica, hospital, servicio de atención médica en el hogar o cualquier otro tipo de proveedor médico está cometiendo fraude contra Medicaid, infórmelo. Llame al 1-919-881-2320. Algunos servicios están excluidos. Puede encontrar una lista completa de beneficios en el Manual para afiliados de **CarolinaCompleteHealth.com.**

CAROLINA COMPLETE HEALTH WEBSITE

Carolina Complete Health Website

Please use the Carolina Complete Health website to find information. 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 Engagement Administrator 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 by clicking 'For Providers':

- Provider Manual
- Provider Billing Manual
- Prior Authorization List

- Forms
- Carolina Complete Health News
- Clinical Guidelines
- Provider Bulletins
- Check to see if an Authorization is Required
- Known Issues Tracker

Known Issues Tracker

Carolina Complete Health notifies its providers of any Known System Issues via its provider website at https://network.carolinacompletehealth.com. The Known Issues Tracker includes any identified system issues that could impact claim payment, eligibility, prior authorizations, etc. This tracker is updated weekly and contains information on the scope of impact and timeline for resolution.

Secure Provider Portal

The Carolina Complete Health Secure Provider Portal allows providers to obtain information at their convenience (24/7) without having to make a phone call. Carolina Complete Health contracted providers and their office staff can register for our secure provider portal. Here, we offer tools which make obtaining and sharing information easy. It's simple and secure! Go to https://provider.carolinacompletehealth.com/ to register. Select 'Create New Account' 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, submit claim corrections, reconsiderations, and grievances.
- View payment history
- View and submit Prior Authorizations
- Contact us securely and confidentially

Providers using the secure portal agree 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.

Carolina Complete Health is 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 Engagement Administrator for a tutorial on the secure site.

GUIDELINES FOR PROVIDERS

Primary Care Providers (PCPs)

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 if 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:

a) **Beneficiary history with a PCP.** The algorithm will first attempt to match a beneficiary to their previous PCP. If there is no previous PCP assignment, claims 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.

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.

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.

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.

PCP Change Request for Members

Without Cause

Medicaid Beneficiaries can change their PCP up to two times a year. The members may change within 30 days of AMH assignment for any reason and one additional time a year "without cause". If your office notices the PCP listed on a member's ID card is no longer with your practice or if the member asks for help changing their PCP to your practice, you have two options:

- Let them know that they can call Member Services at 833-552-3876.
- Give them a copy of the PCP Change Request Form: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Change-of-PCP-Fax-Form-ENG-SPN.pdf

With Cause

Members may request a "with cause" PCP change at any time by calling Member Services at 833-552-3876. Requests received by calling Member Services will be processed at the time of the call and will be effective the 1st of the following month.

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. 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
- The Department maintains an Advanced Medical Home Provider Manual to be used a resource for Primary Care Providers (PCPs) as well as Clinically Integrated Networks (CINs) and Other Partners working with AMHs. This manual can be found on the AMH Webpage: https://medicaid.ncdhhs.gov/advanced-medical-home

Provider Self-Audits

- Carolina Complete Health recommends that providers conduct periodic, voluntary self-audits to identify instances where claims may have been incorrectly paid based on your Participating Provider Agreement or applicable State and federal requirements. In addition to your duty to monitor and report any findings of fraud, waste and abuse, providers must report and promptly return overpayments made to the provider by Carolina Complete Health within sixty (60) days of identifying the overpayment. (42 C.F.R. § 438.608(d)(2).
- If you identify any overpayments, you may notify Carolina Complete Health in the following ways:
- Notifying Carolina Complete Health's Network Support Specialist team via email at NetworkRelations@cch-network.com
- Contacting the Ethics and Compliance Helpline at 800.345.1642 or www.centene.ethicspoint.com

Tobacco-free Policy Requirement

Beginning July 1, 2025, Carolina Complete Health shall require contracted Medicaid Providers, except for residential provider facilities as described below, to implement a tobacco-free policy covering any portion of the property on which the Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to individuals they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

The following partial tobacco-free policy shall be required in Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services subject to the Home and Community Based Final Rule and in adult care homes, family care homes, residential hospices, skilled nursing facilities, long term nursing facilities:

1. Use of tobacco products is prohibited indoors when the building or home in which the provider operates is under the provider's control as owner or lessee.
2. Outdoor areas of the property under the provider's control as owner or lessee must:

a. Ensure access to common outdoor space(s) free from exposure to tobacco use; and
b. Prohibit staff/employees from using tobacco products anywhere on the property.
c. Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

Provider Monitoring.
Carolina Complete Health (CCH) shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. CCH shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The PHP shall initiate technical assistance to address grievance related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

For more information about the North Carolina Standard Plan Tobacco-Free Requirement, view the NC Medicaid Blog published January 25th, 2022

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 behavioral/emotional health and SDoH screens (including brief screens for substance and/or tobacco screens) to determine the need for behavioral health and other interventions;
- 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 North Carolina's 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; including but not limited to the collection of performance measurement data and participation in Carolina Complete Health's clinical and service measure quality improvement 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.

Referrals

Carolina Complete Health does not require referrals for members to seek care from an in-network specialist. Prior authorizations may apply. Please see the Prior Authorization section of this manual for more information. For additional information and clarification, please see the NC Medicaid Bulletin: Specialty Care Referrals in NC Medicaid Reminder: NC Medicaid does not require referrals for specialty care. This bulletin provides information about referrals for specialty care for NC Medicaid beneficiaries.

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.

Care Coordination

As promoted by the Medical Home concept, PCPs are encouraged to coordinate the healthcare services for Carolina Complete Health beneficiaries. When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs can initiate and coordinate the care members receive from specialist providers. 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.

As a participating PCP with Carolina Complete Health, it is important to understand the requirements for Prior Authorization process to ensure your patients do not experience any disruption in care, and claims are paid in a timely and accurate manner

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.

Please refer to the Utilization Management section of the Provider Manual for information on how to submit Prior Authorizations.

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. 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 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 and No-Reject Requirement

Carolina Complete Health considers mainstreaming of its beneficiaries an important component of the delivery of care. Participating Medicaid providers who are open to accepting new patients cannot reject members based on 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 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

Providers must accept members for the purpose of providing care and managing their health care needs in accordance with the care they provide and within the appointment availability standards outlined in this manual. Medicaid participating providers shall not bill an NC Medicaid beneficiary for services furnished to a beneficiary who the provider has accepted as a Medicaid patient in accordance with 10A NCAC 22J .0106 and the Provider Participation Agreement.

If a provider must terminate the provider-patient relationship, it must be done so in accordance with the North Carolina Medical Board (see position statement). Patient termination must be accompanied by appropriate written notice provided to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured.

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.

Appointment Wait Time Standards in Accordance with Standard Plan Contract Section VII Attachment F :

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 two (2) hours
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 fourty-eight (48) hours
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, Providers should update and maintain accurate demographic information in NCTracks. NCTracks is the "system of record" for provider enrollment data, which is then shared with health plans to inform contracting and provider directories. If provider information is not current, then the data that flows forward to the health plans and the enrollment broker will not be accurate.

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 can 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. For a termination to be considered valid, providers are required to send written termination notices via email to networkrelations@cch-network.com, or certified mail (return receipt requested), United States mail, or overnight courier to the following address:

Carolina Complete Health, Inc.
ATTN: Contracting Department
1701 N. Graham St., Suite 101
Charlotte, NC 28206-3571

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 a terminated provider is an AMH/PCP for a Member, the PHP shall notify the Member within seven (7) calendar days of the following:

1. Procedures for selecting an alternative AMH/PCP.
2. That the Member will be assigned to an AMH/PCP if they do not actively select one within thirty (30) calendar days

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.

Electronic Visit Verification (EVV)

The 21st Century Cures Act requires NC Medicaid to begin using an Electronic Visit Verification (EVV) system for Home Health Care Services (HHCS) and Personal Care Services (PCS).

To ensure that the provider community complies with the Cures Act mandate requirements, Carolina Complete Health partners with HHAeXchange as its EVV solution.

All PCS and HHCS providers are expected to be fully compliant with EVV requirements. EVV data must be validated prior to claims adjudication. Claims without required EVV criteria will deny.

Claims including Home Health (HH) services and supplies must be split. HH services must be billed through EVV, while HH supplies should be billed directly to Carolina Complete Health. If providers submit a claim including HH services and supplies, the claim will deny.

View our Home Health and Personal Care Services page for more information regarding EVV requirements and HHAeXchange.

Provider Hardship Advance Payments

Hardship Payment: An advanced payment from the CCH to a provider to address a situation in which the provider is experiencing a significant drop in PHP claims payments due to issues beyond the control of the provider.

A provider may submit a Hardship Advance Payment request only after attempts to resolve the open claims issues have not been successful and must receive approval from the CEO and CFO from Carolina Complete Health. The Provider's request must include documentation that supports the hardship need. The following criteria must be met for the provider request to be approved for a hardship advance:

- Delay or nonpayment of provider claims is due to CCH configuration or other system issues.
- The amount owed exceeds $10,000, or a lesser amount when the provider is unable to meet immediate financial obligations.
- A promissory note that stipulates terms of Advance payment is executed and signed by the provider entity before any disbursement of funds unless otherwise determined by CCH CFO or CEO.

Provider Submission: Provider advance requests will have a sequential process flow as outlined below.

1. The Provider should submit a formal electronic (networkrelations@cch-network.com) or written request to the CCHN Provider Experience team.
2. CCHN will initiate the review of the request with the CCH Operations and Claims leadership teams for analysis and recommended action. Review and analysis will be completed by the following: CCH VP, Operations, CCH Sr. Director Claims, CCH VP, Network Operations, CCHN Chief, Provider Operations, CCH Chief Operating Officer, CCH Chief Financial Officer.
3. Upon approval of the hardship request, and prior to the disbursement of funds, the Provider must sign a promissory note that stipulates the terms of the advance payment.

Please Note: All advance payments must be refunded within 30 days of the eventual adjudication of the claim(s) that caused the hardship.

Timeline for Standard and Urgent Requests: The targeted turnaround time for the claims review to be completed is 7 business days. In urgent hardship circumstances, exceptions can be made to complete within 3 days and require CCH CEO and CFO approval.

For additional details, please view an FAQ on the Administrative Policy page.

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. 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.

Carolina Complete Health will 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

Covered Services, Additional Benefits and Carved-out Services

Carolina Complete Health providers supply a variety of medical benefits and services, some of which are itemized in Appendix I in the table labeled Covered Services. For specific information not covered in this Provider Manual, please contact Provider Services at 1-833-552-3876 from 7:00 a.m. to 6:00 p.m. (EST) Monday through Saturday, including holidays. 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. For details, view the Clinical Coverage Policies: https://network.carolinacompletehealth.com/resources/clinical-policies.html

Carved Out Services

Members can get these services from a provider outside of the health plan's network, if the provider takes NC Medicaid:

- Dental services
- Services provided by Local Education Agencies that are included in your child's:
    - Individualized Education Program (IEP)
    - Individualized Family Service Plan (IFSP)
    - Section 504 Accommodation Plan (504 Plan)
    - Individual Health Plan (IHP)
    - Behavior Intervention Plan (BIP)

- Services provided by Children's Developmental Services Agencies (CDSAs) or providers contracted with CDSAs that are included in your child's Individualized Family Service Plan (IFSP)
- Services provided before NC Medicaid eligibility determination
- The making of eyeglasses, including Medicaid frame and prescription lenses.

Non-Contracted and Non-Covered Services

- NORTH CAROLINA INNOVATIONS WAIVER SERVICES (Clinical Coverage Policy 8P)*
- Traumatic Brain Injury Waiver Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- ASSERTIVE COMMUNITY TREATMENT
- Community Support Team
- HOSPICE DISCHARGE STATUS 20
- INTELLECTUAL AND DEVELOPMENTAL DISABILITIES TARGETED CARE MANAGEMENT
- PSYCHOSOCIAL REHABILITATION
- CHILD AND ADOLESCENT DAY TREATMENT
- INTENSIVE IN-HOME SERVICES
- Residential Treatment Facility Services
- Psychiatric Residential Treatment Facilities (PRTF)
- 1915i services (Clinical Coverage Policies 8H-1 – 8H-6)
- SUBSTANCE ABUSE MEDICALLY MONITORED COMMUNITY RESIDENTIAL TREATMENT
- MULTISYSTEMIC THERAPY
- SUBSTANCE ABUSE-ON-MEDICAL COMMUNITY RESIDENTIAL TREATMENT

*For a list of NC Innovations Services, please see Clinical Coverage Policy 8P: https://medicaid.ncdhhs.gov/behavioral-health-clinical-coverage-policies

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.

For more information about Carolina Complete Health's transportation Vendor, visit our Transportation Resources page online: network.carolinacompletehealth.com/transportation

Value-Added Services (VAS)

We are proud to offer coverage for a variety of value-added services (VAS) for eligible members, which are extra benefits not provided via fee-for-service Medicaid. Carolina Complete Health's value-added services are subject to review and approval by DHHS, and we routinely assess market need to add new VAS to the currently offered list as needed.

For more information about Carolina Complete Health's Value-Added Services, please visit the website at www.carolinacompletehealth.com/vas or call Member Services at 1-833-552-3876 (TTY: 711).

Carolina Complete Health offers the following Value-Added Services:

Value-Added Service	Description	Eligibility Requirements	How to Get this Value-Added Service
Child Education Support	$50 per member per year for school supplies	Members enrolled in grades Pre-K – 12.	For School Supplies, parent/guardian must fill out a request form on Carolina Complete Health's website or call Member Services. Eligible members will receive a backpack with school supplies via mail.
General Educational Development (GED) Support	Financial assistance with GED study materials and the exam.	Members eligible for GED.	For GED Support, members must fill out a request form on Carolina Complete Health's website or call Member Services. Eligible members will receive a voucher for GED support after request is processed.
Child Education Support	Up to 24 hours of Online Tutoring in reading and/or math	Eligible members grades K-6	For Online Tutoring, parent/guardian must fill out a request form on Carolina Complete Health's website or call Member Services. Eligible members will receive online tutoring through Educational Tutorial Services (ETS) after request is processed.
New Mother's Support	Up to $100 per member per year including choice of infant car seat, breast pump, OR diaper bag. Members will also receive access to Start Smart for Baby® educational materials.	Members who are expecting a baby or who have had a baby	For New Mother's Support, the member must fill out a request form on Carolina Complete Health's website or call Member Services. Eligible members will receive their choice of a car seat, breast pump, OR diaper bag.

Youth Development Activity Support	Up to $75 per member per year for members to use at participating organizations/activities listed on the Carolina Complete Health website.	Members age 6 -17.	For Youth Development Activity Support, parent or guardian must fill out request form on website or call Member Services. Eligible members will receive a voucher via mail that can be presented at participating organizations and/or activities.
Weight Management Support	Up to 14 weeks of WW™ (formerly Weight Watchers) online classes.	Members age 13+ with Body Mass Index (BMI) of 30+ and PCP referral form.	For Weight Management Support, members must complete a Care Needs Screening and receive a referral from their Primary Care Physician based on BMI of 30+.
YMCA Pre-Diabetes and/or High Blood Pressure Management Support	One-year program through the YMCA to help adults lower their risk of diabetes by learning about physical activity and nutrition leading to weight loss and risk reduction. A trained Lifestyle coach will teach a small group of members how healthy eating, exercise, and behavior changes can help lower their risk for diabetes and improve their overall health.	Members age 18+ with prediabetes, a Body Mass Index (BMI) of 25+ (Asian individual(s) with BMI of 23+) and have an A1c between 5.7% - 6.4. Members who currently have diabetes would not be eligible since this program is preventive.	For Pre-Diabetes and/or High Blood Pressure Management Support, member must fill out request form on website or call Member Services. Member must also meet eligibility requirements and provide a PCP referral form.
Over-the-Counter (OTC) Pharmacy Support	Up to $120 per household per year ($30 per quarter) to get supplies such as pain relievers, first aid supplies, and cold medicine.	All members are eligible for this Value-Added Service.	To order OTC supplies by phone, call 1-844-962-0694 (TTY: 711). You will need your Member ID card number. The phone order line is open from Monday – Friday from 8 a.m. to 8 p.m. Members can also order by downloading a mobile app or through the member portal.

My Health Pays ® Rewards Card	Up to $120 per member per year for completing various healthy activities. For a comprehensive description of activities, please visit Carolina Complete Health website.	All members are eligible for this Value-Added Service.	Members receive a My Health Pays Card within two weeks of enrollment. The rewards will be automatically loaded onto the card when the member completes specific healthy activities.
My Healthy Balance Food Rewards Card	Up to $120 per member per year for healthy foods at Walmart®.	Members who complete a Care Needs Screening and meet food insecurity screening guidelines.	For My Healthy Balance Food Rewards, $20 will be loaded on the card.
Vision Support	Up to $125 credit for glasses.	Members age 21 and older.	For Vision Support, call Member Services or visit a contracted vision provider.
Cell Phone Support	Pre-programmed cell phone allowing calls to and from doctors, care managers, pharmacies, important family contacts, 24/7 nurse advice line, and 911.	Eligibility based on Care Management risk assessment. Members are limited to one cell phone. Lost phones may be replaced at the discretion of the Care Manager. Members may keep the phone at the end of Care Management, but will be responsible for their own minutes thereafter.	For Cell Phone Support, member must fill out request form on website or call Member Services.

myStrength Mobile App	Carolina Complete Health offers online, member-directed behavioral health resources through www.myStrength.com, a website that offers a range of personalized e-Learning programs to help overcome depression, anxiety or overuse of drugs or alcohol supported by tools, weekly exercises and daily inspiration in a safe and confidential environment.	All members	Members can find out how to access the mobile app on the website.
Room to Breathe	This Carolina Complete Health program supports members with asthma. This includes providing eligible members with items like air filters and mattress covers. Asthma management education will also be provided by a clinical professional.	All members under age 16 with a diagnosis of asthma and frequent ED visits.	Member must fill out the request form on the website or call Member Services.

Language Assistance

The initial message on our Member Services Call Center is recorded in English and Spanish, and callers can choose a separate line to hear the full recording in Spanish. The Nurse Advice Line provides Spanish-speaking assistance for members with non-emergency medical questions. Nurse Advice Line staff has access to Language Services Associates, which provides interpretation for most languages. Carolina Complete Health provides support services for hearing impaired beneficiaries through calling TTY 711.

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 locations 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. Providers are educated about these support services and how to obtain them through the Provider Welcome Packet and New Provider Orientation.

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/Immunology, Anesthesiology, Cardiology, Dermatology, ENT/Otolaryngology, Endocrinology, Family Medicine, Gastroenterology, General Practice, General Surgery, Hematology/Oncology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Obstetrics/Gynecology, Oncology, Ophthalmology, Optometry, Orthopedics, Orthopedic Surgery, Otolaryngology, Pain Management (Board Certified), Pediatric (General), Pediatric (Subspecialties), Physical Medicine and rehab, Podiatry, Psychiatrist-Adult/General, Psychiatrist-Child/Adolescent, Psychologist/Other Therapies, Pulmonary Disease, Radiology, Rheumatology, Surgery/General, Urology, Vision Care/Primary Eye care. 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 1-833-552-3876and 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. 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.

For purposes of network adequacy standards physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.

For purposes of network adequacy standards for behavioral health providers/services, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

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.

Certain service types are not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

Network Time and Distance Standards:

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
Obstetrics[1] [1]Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included to satisfy OB access requirements.	≥ 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 Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard	≥ 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 Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): Not subject to standard
Location-Based Services (Behavioral Health)	≥ Two (2) providers of each service within thirty (30) minutes or thirty (30) miles of residence for at least 95% of beneficiaries	≥ Two (2) providers of each service within forty-five (45) minutes or forty-five (45) miles 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
All State Plan LTSS* (except nursing facilities)	≥ Two (2) LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), 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.
Nursing Facilities*	PHP must have at least 1 nursing facility accepting new patients in every county.	PHP must have at least 1 nursing facility accepting new patients in every county.

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., EST (excluding holidays). After normal business hours, Nurse Advice Line 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 Population Health 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 NUMBER REFERENCE GUIDE	
833-238-7690	Carolina Complete Health Medicaid Face Sheets
833-238-7691	Carolina Complete Health Medicaid Assessments
833-238-7692	Carolina Complete Health Medicaid Inpatient Requests
833-238-7693	Carolina Complete Health Medicaid Medical Records
833-238-7694	Carolina Complete Health Medicaid Prior Authorization
844-975-1325	Carolina Complete Health Medicaid Census Reports
833-596-2768	Carolina Complete Health Inpatient Behavioral Health PA
833-596-2769	Carolina Complete Health Outpatient Behavioral Health PA

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.

Carolina Complete Health's Utilization Management Program Policy is available on the Administrative Policy page: https://network.carolinacompletehealth.com/resources/administrative-policies.html.

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

Referrals – Referrals are not required for members to seek care with in-network specialists. It is encouraged that PCPs 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. 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. All non-emergency inpatient admissions require prior authorization from Carolina Complete Health.

Prior Authorizations - Some services require prior authorization from Carolina Complete Health for reimbursement to be issued to the provider. All out-of-network services require prior authorization inclusive of observation stays. 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: 833-238-7694
https://www.carolinacompletehealth.com/

Please visit Carolina Complete Health's web site at https://network.carolinacompletehealth.com/resources/prior-authorization.html and utilize the Prior Authorization Tool to determine if prior authorization is required.

Medicaid Pre-Auth

Behavioral Health UM Prior Authorization

For Behavioral Health, please see state bulletin regarding COVID-19 flexibilities for specifics related to BH prior authorizations.

BEHAVIORAL HEALTH SERVICE FLEXIBILITIES SPECIAL BULLETIN #265

Pharmacy Prior Authorization

For Pharmacy or Medication related authorizations including:

- Home Infusion Therapy
- Physician Administer Drug Program
- Outpatient Pharmacy Medication

PLEASE REFER TO PHARMACY WEBPAGE FOR MORE INFORMATION

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

Vision Services need to be verified by Envolve Vision.
Dental Services are administered by the State. Please click here to verify.
Complex imaging, MRA, MRI, PET, and CT scans need to be verified by NIA.

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?		
Are services being rendered for pain management?		
Are oral surgery services being provided in the office?		
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?		
Is the member receiving hospice services?		

To submit a prior authorization Login Here.

Prior Authorization requests can be submitted on the secure provider portal, by phone, or by fax.

The following services do not require prior authorization:

- 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 fourteen (14) 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, except for emergency services, family planning, and post stabilization services.

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://network.carolinacompletehealth.com/resources/prior-authorization.html and utilize the Prior Authorization Tool to determine if prior authorization is required.

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 14 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: • 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 andauditory implants
Pain Management	• Notification for all Urgent/Emergent Admissions: • Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes	• 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 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. Note that for Behavioral Health Inpatient Admissions, authorization is not required upon admission through the first 72 hours of service as noted in policy 8B. In order to assist with discharge planning as needed, CCH requests that providers submit

a notice of admission within 48 hours of a member's admission via the usual Prior Authorization form submission.

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, prior authorization is required at least fourteen (14) business days prior to the scheduled admission date or as soon as the need for service is identified. For standard service authorizations, the decision will be made within fourteen (14) calendar days. "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 emergent inpatient admissions, including Involuntary Commitments (IVC), providers must notify within one (1) business day of the admission for ongoing concurrent review and discharge planning. For urgent/expedited requests, a decision and notification is made within seventy-two (72) 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. For concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care, decisions are made within seventy-two (72) 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. If 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.

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, telephone number, and Taxonomy/NPI numbers
- Facility name, if the request is for an inpatient admission or outpatient facility services (also include Taxonomy/NPI numbers)
- 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 five (5) 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.
- For information on the medical necessity "EPSDT Guarantee" please see the "Early Periodic Screen, Diagnostic and Treatment Services" section

All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through:

1. scientifically validated clinical studies
2. medical literature research and
3. qualified medical experts.

Experimental studies and related guidance that you reference is found in the following:

- Clinical Policy: Experimental Technologies
- Clinical Policy: Medical Necessity Criteria

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 decide in accordance with currently accepted medical or healthcare practices, considering special circumstances of each case that may require deviation from the norm in the screening criteria.

Carolina Complete health utilizes NC Clinical Coverage Policies for behavioral health service reviews, American Society of Addiction Medicine (ASAM) criteria as applicable for substance use services reviews,

and state approved criteria for CCH In-Lieu of services. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-833-552-3876. Practitioners can also 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

1701 North Graham Street, Suite 101

Charlotte, NC 28206

Phone: 1-833-552-3876

Fax Numbers:

Medical Necessity Appeals	1-833-318-7256
Beneficiary Grievances	1-833-318-7256
Concurrent Review:	1-833-238-7692
Prior Authorization	1-833-238-7694
Inpatient Notification	1-833-238-7692
Behavioral Health Outpatient Authorizations	833-596-2769
Behavioral Health Inpatient Authorizations	833-596-2768

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 decides 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 Care Management team within seven days of the first prenatal visit or confirmation of pregnancy. Early notification of pregnancy allows the health plan to assist the beneficiary with prenatal care coordination of services. To notify CCH of pregnancy, please complete the Pregnancy Risk Screening Tool from NC DHHS available through the link below and fax to Carolina Complete Health Care Management Notification of Pregnancy:833-417-0446 and your Local Health Department (LHD) . NC DHHS Provider Forms: Reproductive Health Forms For billing guidance, view the NC DHHS Medicaid Clinical Coverage Policy 1E-6: Pregnancy Management Program. Providers can continue sending the Pregnancy Risk Screening Form to the Local Health Department to refer pregnant members into the Care Management for High-Risk Pregnancies (CMHRP). Additionally, CCH also reimburses for the postpartum visit using HCPCS code S0281 in accordance with Clinical Policy 1E-6. Providers can access NOP forms on the secure provider portal under 'Assessments' or on our website: https://network.carolinacompletehealth.com/forms. 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. 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 per instructions outlined in Attachment B of the policy to the PHP, (https://medicaid.ncdhhs.gov/1e-2-therapeutic-and-non-therapeutic-abortions/download?attachment) 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 per instructions outlined in Attachment B (https://medicaid.ncdhhs.gov/1e-3-sterilization-procedures/download?attachment) and maintain completed consent forms consistent with the PHP contract and federal statute.

Concurrent Review and Discharge Planning

Concurrent review nurses, or licensed behavioral health (BH) clinicians for BH services, perform ongoing concurrent review for inpatient admissions through telephonic, fax, or web request methods received from the hospital's Utilization and Discharge Planning departments and when necessary, with the beneficiary's attending physician. The concurrent review nurse, or BH clinician in the case of BH admissions, 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 72 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, or denied and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, unless the inpatient stay extends beyond the federal benefit limit, 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 and the discharge summary, with the discharge date once available.

Retrospective Review

Retrospective Review Definition:

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. Examples of extenuating circumstances include, but are not limited to the following:

- Member unable or refused to provide eligibility information (i.e. member unconscious)
- Services authorized by another payer who subsequently determined member was not eligible at the time of service or services occurred during a transition of care period.
- Catastrophic event/natural disaster interfered with normal business operations.
- Service/procedure change due to unavoidable circumstance.
- Late eligibility notification from DHHS.

How should Providers submit retrospective review requests?

Providers may request a retrospective review up to 90 days after the date of service (DOS) or date of admission (DOA) in the case of an inpatient request.

Retrospective review requests may be submitted to CCH using one of the following prior authorization submission processes:

- Secure Provider Portal (Preferred and most efficient method)
- Phone: 1-833-552-3876 (Follow the prompts for Provider Services, then Utilization Management)
- Fax: 1-833-238-7694*
  *If faxing, providers should use the Prior Authorization form located online: https://network.carolinacompletehealth.com/forms

What should be included in the Retrospective Request?

Retrospective review requests must contain:

1. Clinical documentation that illustrates specific clinical evidence supportive of the request and demonstrates alignment with the applicable definition of medical necessity.
2. Specific details as to why an authorization was not obtained (preferably on the cover page of the request).

When can the provider expect to hear back from Carolina Complete Health?

The health plan will have 30 calendar days to review and finalize a decision. If the request lacks clinical information, Carolina Complete Health may extend the retrospective review time frame for up to 15 calendar days (total 45 calendar days for review).

How are Retrospective Requests reviewed?

- If the retrospective review request is received after 90 days of the DOS/DOA, the retrospective request will not be reviewed and will deny for lack of timely notification.

- If the request is received timely and extenuating circumstances are not clearly defined, the request will not be reviewed and will be denied due to failure to follow authorization procedures (administrative denial).
- If the request is received timely and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity.

If the providers disagrees with the Retrospective Review determination:
Providers may then file their claim and follow the Claim Reconsideration/Grievance process. (Completion of the retrospective review process as defined above must be completed; a denied authorization must be on file). Upon receipt, the request will be reviewed to determine if the retrospective process and/or beneficiary appeal process was followed.

Opioid Misuse Prevention Program Policy

This program aligns with NCDHHS Opioid Action Plan to tackle opioid misuse by monitoring 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. The plan also uses the Opioid Risk Classification Algorithm (ORCA) proprietary risk stratification scoring system to identify high and at-risk members for care management outreach. Outreach and intervention is conducted by care managers experienced in behavioral health and substance misuse.

HIGH TECH RADIOLOGY

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members Carolina Complete Health is using Evolent, formerly National Imaging Associates (NIA), to provide prior authorization services and utilization. Evolent 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

Key Provisions

- Emergency room, 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.

To reach Evolent and obtain authorization, please call 1-800-424-4889. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Carolina Complete Health, in collaboration with Evolent, formerly National Imaging Associate (NIA), will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent :

- Inpatient advanced radiology services
- Observation setting advanced radiology services

- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 1-800-424-4889. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health and medical treatment. Carolina Complete Health adheres to and offers or arranges for the full scope of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, per the periodic schedule established by the state of North Carolina. Early Periodic Screening services include physical exams, up to date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices.).

CCH requires all primary care providers (PCPs) to include the following components in each medical screening:

a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.":

b) 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)

c) Comprehensive unclothed physical examination

d) Immunizations appropriate to age and health history, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices

e) Assessment of nutritional status

f) Laboratory procedures appropriate for age and population groups, including blood lead screening. Blood lead screening is required for infants/toddlers at age 12 and 24 months. Blood lead screening is also appropriate whenever the provider suspects exposure or when they live in high risk environments/areas.

g) Routine blood assay, including hemoglobin and hematocrit levels is required at 12 months and should be performed whenever clinical findings indicate medical necessity

h) Assessment of growth and development and administration of brief, scientifically validates developmental, emotional, behavioral, SDoH and risk screens during preventative visits

i) 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:

- observed difficulties in responsiveness, age-appropriated interaction or communication
- a report by parent or caregiver
- diagnosis of an ASD in a sibling

j) Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses

k) 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

l) Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and

m) Health education and anticipatory guidance

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

"EPSDT Guarantee"

CCH does not require prior authorization for preventative care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age, however, prior authorization may be required for other diagnostic and treatment products and services provided under EPSDT. If a provider request a service for a member that is not a covered benefit, providers are required to submit a prior authorization. (See section: "Prior Authorization and Notifications" for prior authorization details).

Upon receipt of the request, it will be reviewed for medical necessity under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. The medical necessity criteria specific to EPSDT is defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and:

- Must be made on a case-by-case basis, taking into account the particular needs of the child.
- Should consider the child's long-term needs, not just what is required to address the immediate situation.
- Should consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders.
- May not contradict or be more restrictive than the federal statutory requirement
- Must correct or ameliorate a defect, physical or mental illness

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap are not consistent with EPSDT requirements.

Upon conclusion of an individualized review of medically necessary services, CCH will cover medically necessary services that are included within the categories of mandatory and optional services listed in 42

U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan.

Medically necessary care and treatment to 'correct or ameliorate' health problems must be provided directly or arranged by referral, even when a Medicaid coverable service is not available under the North Carolina Medicaid plan. CCH will provide referral assistance for non-medical treatment not covered by the plan but found to be needed due to conditions disclosed during screenings and diagnosis.

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 NC DHHS EPSDT Guidelines: https://medicaid.ncdhhs.gov/epsdt

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 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:

- 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
- 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.

EMERGENCY PREPAREDNESS

Carolina Complete Health maintains a comprehensive Disaster Preparedness plan. In the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease, CCH Care Managers will identify high needs members to contact. Care managers will evaluate services and supports that members may need in the event they have limited access to medical care and/or medication.

CCH expects Providers to maintain their own disaster preparedness plans as well in order to assess and evaluate the needs of their members and guide them in how to access care, medications, and other supports in the event of an emergency.

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.

, nurse advice line for beneficiaries. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the Nurse Advice Line service. Our staff often answer basic health questions and 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 Nurse Advice Line to request information about providers and services available in the community after hours, when the Carolina Complete Health Beneficiary Services department is closed. The Nurse Advice Line 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 Nurse Advice line 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

Care Management for High-Risk Pregnancies (CMHRP)

Care Management for High-Risk Pregnancies (CMHRP) is a program available to all pregnant women ages 14 to 44 years (until the end of the month of her 44th birthday) enrolled with Carolina Complete Health who may be at risk for adverse birth outcomes. A key feature of the program is the continued use of the standardized screen tool to identify and refer women at risk for an adverse birth outcome to the CMHRP program; a more intense set of care management services that is coordinated and provided by Local Health Departments (LHDs). With a focus on healthy moms and babies, pregnant beneficiaries receive comprehensive, coordinated maternity care services, ensuring social drivers of health are addressed with a focus on preventing pre-term birth.

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 (ages 0-4 + 364 days) 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

Providers who administer vaccines to Medicaid enrolled children under 21 will participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, under 19 years of age, who might not otherwise be vaccinated because of an inability to pay. The Centers for Disease Control and Prevention purchases vaccines at a discounted rate and distributes them to grantees, who in turn, distributes them to VFC enrolled public and private health care providers. The North Carolina Immunization Branch in the Division of Public Health is the state's VFC

awardee. Because VFC vaccines are federally purchased, enrolled providers cannot bill for the cost of the vaccine. Providers, however, can bill for vaccine administration fees. VFC providers must maintain adequate stock of all vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP) as appropriate for their specific patient population. Non-VFC enrolled providers who choose to use private stock to vaccinate Medicaid-covered children will not be reimbursed for the cost of the vaccine. Visit https://www.immunize.nc.gov/providers/enrollmentrequirements.htm for more information or contact the NC Immunization Branch at (919) 707-5598 to begin the VFC enrollment process.

You must report all immunizations administered to the North Carolina Immunization Registry (NCIR), https://www.immunize.nc.gov/providers/ncir.htm. To request access, contact the NC Immunization Branch at 1-877-873-6247.

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. Foster families with qualifying individuals may be eligible to receive WIC benefits. 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

Live in North Carolina

Meet WIC Income Guidelines

Talk with a WIC nutritionist about health and nutrition habits

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. A person receiving Medicaid, Temporary Assistance for Needy Families (TANF), or assistance from the NC Food and Nutrition Services automatically meets the income eligibility requirement.

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.

To find your local WIC office and apply for the program, contact the local WIC agency that serves the residents of the county in which you live. You can:

- Look up your local WIC agency.
- Call or text: 1-844-601-6881 Text: wic12345 (wic + your zip code)
- Fill out the WIC Referral Form.

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, 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 through our **Start Smart for Your Baby® Program** (Start Smart), 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 Care Manager 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.

Care Management Teams

These teams will be led by clinical licensed nurses or licensed Social Workers 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 to develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our care management program to link Carolina Complete Health and the community served. The program recruits Community Health Workers (CHWs) from local neighborhoods 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 contact Carolina Complete Health's Member 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 referrals for program services and supports directly to our CHWs or through the member's assigned care manager. Community groups may request CHWs 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: Community Health Workers are available to present to groups during events initiated by state entities, community groups, clinics, or any other stakeholder. 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 topics such as what coordinated care is, the importance of obtaining primary preventive care, and other valuable information related to obtaining supports and services from providers and Carolina Complete Health.

Home Connections: Community Health Workers 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 initiated due to an inability 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: Community Health Workers may contact new beneficiaries or beneficiaries in need of more personalized information to review the health plan material over the telephone. CHWs will discuss all previous topics, value-added service (VAS) options, and address any questions.

To contact the CHW 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.

Centene's shared services department will administer Carolina Complete Health disease management program. The 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, COPD, diabetes, heart failure and depression.

All beneficiaries identified as having a targeted diagnoses such as, but not limited to, the following: major depression, asthma, COPD, heart failure 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 ENGAGEMENT AND NETWORK SUPPORT

Provider Orientation

Carolina Complete Health Network's Provider Engagement and Provider Relations teams are designed around the concept of making your experience a positive one by being your advocate within Carolina Complete Health. Upon contracting with Carolina Complete Health, all providers and health systems are assigned a dedicated Provider Engagement and Provider Relations Coordinator within thirty (30) days of the provider's effective date, providers will receive information about attending a New Provider Orientation. You can also access this information via our website under Education and Training, New Provider Orientation: https://network.carolinacompletehealth.com/resources/education-and-training.html

Responsibilities

Provider Engagement Coordinator (PEC) will support you with:

- Provider education and orientation
- HEDIS/care gap reviews and monitor performance patterns with Standard Plan quality measures and P4P
- Financial analysis on P4P or risk arrangement in VBC
- AMH oversight in partnership with Care Management Transformation team with CCH
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Secure Portal registration and Pay Span

Provider Relations Coordinators (PRC) will support you with:

- Network status inquiries
- Contract questions related to standard contracts and can facilitate support for non-standard contract questions
- Claims questions
- Inquiries related to administrative policies and procedures, and other general questions

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

Provider Engagement Coordinators are assigned to providers, across specialty types, based on county. To view assignments by county, along with PEC contact information, via the team page at: https://network.carolinacompletehealth.com/about-us/provider-engagement-team.html

To contact the Network Relations team, email NetworkRelations@cch-network.com. Learn more about our teams via our website: https://network.carolinacompletehealth.com/about-us.html

CREDENTIALING AND RECREDENTIALING

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. Carolina Complete Health will assume any credentialing decision as indicated on the NC Medicaid Provider Enrollment File by the NC Medicaid program and does not have any additional Decision requirements.

Note: To maintain a current provider profile, providers are required to notify NC Medicaid Program, via NC Tracks, 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 Provider Enrollment File (PEF) to confirm.

Providers must be credentialed on the NC Medicaid Provider Enrollment File (PEF)prior to accepting or treating beneficiaries. PCPs cannot accept beneficiary assignments until they have completed their process with NC Medicaid.

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.

Recredentialing Process

During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment process, the PHP shall evaluate a contracted provider's continued eligibility for contracting every 5 years by confirming the appearance of the provider on the daily Provider Enrollment File.

After the Provider Credentialing Transition Period, the PHP shall evaluate a contracted provider's continued eligibility for contracting every 3 years by confirming the appearance of the provider on the daily Provider Enrollment File.

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 will be directed to the NC Medicaid program to resolve any issues with their NC Medicaid Status.

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 within one business day of receipt of notice from the Dept. that the provider is terminated as a Medicaid provider 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. They can also contact the NC Medicaid Ombudsman any time they feel they were not fairly treated.
- 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 themself about their care and treatment
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints
- Make recommendations about their rights and responsibilities

Member Responsibilities

Carolina Complete Health members have the following responsibilities:

- 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
- Not be discriminated against by Carolina Complete Health if they service high-risk populations or specialize in conditions that require costly treatment.

Interest

- The PHP shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract. Carolina Complete Health shall not be subject to interest payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k)

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

- Actively participate in and cooperate with all Carolina Complete Health quality initiatives and programs; including but not limited to the collection of performance measurement data and participation in Carolina Complete Health's clinical and service measure quality improvement programs.
- 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
- Update NCTracks via a Managed Change Request (MCR) with 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 Medical Evaluation and Medical Team Conference for Child Maltreatment Policy and bill according to 1A-5 Attachment A. (https://medicaid.ncdhhs.gov/1a-5-child-medical-evaluation-and-medical-team-conference-child-maltreatment/download?attachment))
- 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 must provide written consent of the member and 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.

General consents signed by the beneficiary, such as consent of financial liability, consent for treatment, or consent to disclose PHI do not meet compliance standards for appeals. It is recommended the Appointment of Authorized Representative form or the appeal form contained within the notice of denial be used. However, in cases that form is not used, or the provider utilizes their own form, the written consent must specifically authorize a person or facility to act as an authorized representative for the member and include, at a minimum, the member's name, DOB, date and signature. Software that allows electronic or remote signing of documents, such as DocuSign, are acceptable only when they can be authenticated by including a unique signature ID (usually below or beside the name).

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.

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 (Non-Claim):

Appeals and grievances can be filed several ways:

Call Beneficiary Services. The phone number is toll-free at 1-833-552-3876.

Send electronically by fax. The fax number is 1-833-318-7256.

Send by email to CCHGrievancesAppeals@carolinacompletehealth.com

In person or by mail at:

Carolina Complete Health
Appeals and Grievances
1701 North Graham St, Suite 101
Charlotte, NC 28206

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 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.

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 to Carolina Complete Health, they may initiate a State Fair Hearing by writing or calling via the contact information below:

Attn: Clerk
Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609
*Phone: **984-236-1860***
*Fax: **984-236-1871***

To file a request for state fair hearing, call 1-984-236-1860.

For Medicaid questions, call 1-984-236-1850

Provider Grievance and Appeals (non-claims)

A Grievance is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, or any aspect of Carolina Complete Health functions, such as health plan policy, health plan information systems, or referral processes. Carolina Complete Health's Grievance and Appeal Department will acknowledge, resolve, log and track all grievances whether received verbally or in writing. Providers may submit grievances via the secure provider portal, by phone at 833-552-3876 or via email to: CCHGrievancesAppeals@carolinacompletehealth.com.

HSO Grievances related to the Healthy Opportunities Pilot

Carolina Complete Health permits filling of Pilot-related HSO grievances directly to the plan or HSO's Network Lead within thirty (30) calendar days of the issue causing the grievance. Pilot related HSO grievances may include:

a. Payment disputes for denied Pilot service invoices

b. Payment errors; and

c. Overpayments or underpayments due to fraud, waste, or abuse.

Carolina Complete Health shall handle HSO grievances related to the Healthy Opportunities Pilot promptly, consistently, fairly, and in compliance with requires in this Section.

Carolina Complete Health will acknowledge receipt of each grievance with the HSO and Network Lead within five (5) calendar of receipt of the grievance from the HSO or the HSO's Network Lead. Carolina Complete Health will provide notice of the outcome of the grievance to the HSO and the HSO's Network Lead within thirty (30) calendar days of receiving a grievance.

Types of Actions Eligible for Appeal

Below represent reasons for which 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 for LHD care/case management services

f. Determination to lower an AMH provider's Tier Status

g. Violation of terms between the PHP and provider

For Out-of-Network Providers

a) An out-of-network payment arrangement

b) Finding of waste or abuse by the PHP

Carolina Complete Health shall provide written notice of provider's right to appeal with the notice of decision giving rise to the provider's right to appeal. Carolina Complete Health will accept a written request for an appeal from the provider within thirty (30) calendar days on which:

a. Provider receives written notice from Carolina Complete Health of the decision giving rise to the right to appeal; or

b. Carolina Complete Health should have taken a required action and failed to take such actions. .

The Plan will extend the timeframe of appeal request 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.

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.

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 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 appeal 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.

Provider Ombudsman

Office of the Ombudsman

Providers may contact the NCDHHS Ombudsman Program established to assist Providers with submitting a complaint about Carolina Complete Health.

Providers may submit a complaint to Managed Care Provider Ombudsman Program by phone 866-304-7062or by email:

- Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Provider Claim Reconsiderations and Grievances

Claim Reconsideration

A Claim Reconsideration is a formal expression by a Provider, which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service. Contracted providers must submit requests for claim reconsideration within 365 calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA). Non-Contracted providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA. Providers must complete a claim reconsideration prior to submitting a claim grievance.

Claim reconsiderations may be submitted via provider secure web portal or to the address below.

Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms

Claim Grievance

A Claim Grievance is the mechanism following the exhaustion of the claim reconsideration process that allows providers the right to express dissatisfaction regarding the amount reimbursed or the denial of a particular service. All claim grievances must be submitted from the provider within thirty (30) calendar days from the date of the EOP or ERA.

NOTE: Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process:

- If services were provided to a beneficiary but for which authorization and/or timely notification to Carolina Complete Health was not obtained due to extenuating circumstances, the request may be reviewed retrospectively.
- The Beneficiary Appeal process allows the 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.
- Additional Information about the retrospective review and beneficiary appeals process can be found on the Prior Authorization Guide and in this manual.
- Administrative Rules for Retrospective Review and Beneficiary Appeals apply.

Please submit eligible claim grievances via provider secure web portal or to the address below:

Claim Grievances
Carolina Complete Health

P.O. Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration or grievance through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms.

A decision will be made, and appropriate notification of the decision must be received by the Provider within 30 calendar days of Carolina Complete Health's receipt of the request.

Providers must exhaust the Claim Reconsideration Process prior to pursing the Claim Grievances Process.

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.

To help ensure program integrity and payment accuracy, CCH's Prepayment Review team routinely reviews provider claims data to identify any instances of irregular, improper, or erroneous billing. When such instances of potential FWA are identified, the SIU Prepay team may request additional documentation prior to the payment of claims or services to better understand the basis for the billing activity and to ensure service met applicable medical necessity, policy, and coding requirements.

Prior to placing a Provider on prepayment review, a letter notifying the Provider of the prepayment review will be sent via first-class postage prepaid mail service. The prepayment review notice informs the provider that the prepayment review was initiated to verify the extent and nature of the services rendered for the patient's condition, and to confirm that the claim is coded correctly for the services billed to meet applicable medical necessity, policy, and coding requirements. The notice also details the process for submitting supporting documentation, a list of documents to be submitted, and timeframe to submit the requested documentation.

Prepayment review shall be instituted no less than 20 calendar days from the date of the mailing or written notification. After review of submitted documentation by the SIU clinical review team, the Provider will receive written notification of any missing or deficient documentation for every claim reviewed. Providers can not appeal review determinations (i.e., denied claims or the act of placing a provider on Prepayment Review). Only the Health Plan's final determination, such as provider terminations or sanctions, can be appealed.

A Provider will remain on prepayment review for the code(s) of concern outlined in the initial Prepay Analyst request as approved by CCH and OCPI until they have successfully met the clean claims rate as outlined below.

In order to be removed from review, a provider must meet 3 consecutive months on prepay with a minimum of 70% clean claim rate, provided that the number of claims submitted per month is no less than 50% of the provider's average monthly submissions of Medicaid claims for the 3-month period prior to the Provider being placed on prepay. Supplemental claims data will also be analyzed to identify any shifts in billing behaviors that may warrant expansion to the scope of the active Prepayment Review.

If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted.

If the provider does not meet the seventy percent (70%) clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review, the Health Plan may take administrative action, up to and including termination (subject to applicable Regulatory Requirements).

If there is immediate concern the claims reviewed are fraudulent or there is a concern regarding member safety, the Health Plan may pursue immediate administrative action, up to and including termination (subject to applicable Regulatory Requirements).

Prepayment claims review shall not continue longer than 24 consecutive months unless the Health Plan has initiated the termination or other sanction against the Provider and the Provider has appealed that termination or other sanction. If the Health Plan has initiated the termination or other sanction of the Provider and the Provider has appealed that termination or sanction, then the Provider shall remain on prepayment review until the final disposition of the Department's termination or other sanction of the provider.

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 have30 days 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 conducts audits that may result in extrapolation of results for all services and provider types subject to a post-processing claims audit. Except as required by federal agency, law, or regulation, or instances of credible allegation of fraud, Providers shall be subject to audits which result in the extrapolation of results for a time period of up to 36 months from the date of payment of a Provider's claim.

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. You may also report FWA directly via email: Special_Investigations_Unit@centene.com, 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 Vice President of 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 identifying beneficiaries at risk of developing conditions, implementing appropriate interventions and designating adequate resources to support them. When possible, the Carolina Complete Health QAPI Program supports these processes and activities designed to achieve demonstrable and sustainable improvement in its beneficiaries' health status.

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 Management Committee (QMC) is a senior management committee with physician representation accountable to the BOD. The purpose of the QMC 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 Management Committee:

- Medical Management Committee
- Performance Improvement Team and Advisory Committees
- Joint Operations Delegation Oversight Committee
- 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 the Quality Management Committee, Medical Management 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
- Medical records review and supplemental data 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 are 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 or critical incidents may also be identified through claims-based reporting. Potential quality of care issues and/or critical incidents 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 and critical incidents received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level. Providers must also follow all state reporting regulations regarding the documentation, reporting and follow-up of critical incidents.

Critical Incident Reporting

Carolina Complete Health's Critical Incident Management Program complies with all health, safety and welfare monitoring and reporting of critical incidents as required by North Carolina and federal statutes and regulations and meets all CMS and NCQA requirements. The Critical Incident Management Program will safeguard the health, safety, and welfare of members by establishing protocols, procedures, and guidelines for consistent monitoring and trend analysis for all Critical Incidents as defined by state and federal regulations and accreditation requirements.

A Critical Incident is defined as any happening not consistent with the routine operation of a facility or service or the routine care of a member and likely to lead to adverse effects on a member. Critical Incidents may include events or occurrences that cause harm to an LTSS member or indicate risk to a member's health and welfare, such as abuse, neglect, and exploitation. Critical Incidents are defined specifically by DHHS; other events impacting LTSS members' health and wellness, or potential risk, may be addressed through the quality-of-care process as noted above.

Critical Incidents involving persons receiving publicly funded mental health, developmental disabilities, and/or substance abuse (MH/DD/SA) services are reported through the NC Incident Response Improvement System (IRIS) system. Providers enter reports into the IRIS system, which CCH can monitor. Carolina Complete Health's Quality staff will monitor the worklist within the IRIS system to review any incidents received. Carolina Complete Health will review any further information needed and ensure all appropriate agencies have been informed. Carolina Complete Health staff, affiliated providers and subcontractors have

training available surrounding Critical Incidents, which will be updated as applicable per DHHS guidance. Critical Incident training can include, but is not limited to:

- Identifying Abuse, Neglect, Exploitation and Fraud
- Preventing Abuse, Neglect, Exploitation and Fraud
- Reporting suspected or alleged Abuse, Neglect, Exploitation and Fraud
- Reporting requirements for Critical Incidents, as defined in the state contract.

Performance Improvement Process

Carolina Complete Health QMC reviews and adopts an annual QAPI Program and Work Plan based on Medicaid Managed Care appropriate industry standards. The QMC 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 Quality Improvement 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 continuously. The work plan integrates QMC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QMC and requirements for external reporting. Results, conclusions, recommendations, and implemented system changes are reported to the Quality Management Committee 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 network.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, weight assessment and counseling for nutrition and physical activity, diabetic HbA1c and eye exam, controlling high-blood pressure, cervical cancer screening, and prenatal 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 Experience Survey

Provider experience is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with services such as claims, communications, utilization management, and other administrative services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor and meet specific requirements outlined. The participants are kept anonymous, unless they grant the survey vendor permission to disclose their name and comments for follow-up purposes. Carolina Complete Health will analyze the findings and assess an appropriate course of action to sustain strengths and identify opportunities for improvement. We

encourage providers to respond to the survey in a timely manner, as the results of the survey are analyzed and used as a basis for developing provider-related quality improvement initiatives.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a beneficiary satisfaction survey included as 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 the overall health plan, practitioner services, and gives a general indication of how well Carolina Complete Health is meeting the members' 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 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 pharmacy page at (https://network.carolinacompletehealth.com/resources/pharmacy.html), 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 Preferred Drug List (PDL) is a list of medications covered by Carolina Complete health and 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 1-833-552-3876.

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

Carolina Complete Health works with our PBM to administer pharmacy benefits. The Carolina Complete Health PDL includes a broad spectrum of brand name and generic drugs. Clinicians are encouraged to prescribe from the preferred drug list for their patients. Some drugs will require PA such as.

- Medications not listed on the PDL or formulary
- Some Carolina Complete Health preferred and formulary drugs (designated prior authorization (PA) on the PDL and formulary)
- If a request for prior authorization is needed the information should be submitted by the physician or clinician. For more information on this process, please visit our Outpatient Pharmacy Page https://network.carolinacompletehealth.com/resources/pharmacy/outpatient-pharmacy-benefit.html
- 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, Pharmacy Services 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/Pharmacy Services 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 or is not covered by Carolina Complete Health, the physician/clinician can request a PA for the medication. A phone, fax, and electronic portal process is available for PA requests. Please see the contact information below.

Pharmacy Services - Prior Authorization

Fax: 1-833-404-2393
Cover My Meds Portal: https://www.covermymeds.com/main/prior-authorization-forms/
Phone: 1-833-585-4309 (Monday - Friday 8:00 a.m.-8 p.m. CST)

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.

If 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.

Online Prior Authorization

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

CoverMyMeds can be found at https://www.covermymeds.com/main/prior-authorization-forms/

72-Hour Emergency Supply Policy

State and federal law require the health plan to have a pathway available for a pharmacy to 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 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 1-833-750-4461 for the Pharmacy Help Desk.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum ninety (90) day supply for new or refill non-controlled maintenance medications. 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

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 NC Medicaid Clinical Coverage Policy 9 or 9A
- 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*;
- 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, except prenatal vitamins, fluoride, and calcitriol (vitamin-D) when the calcitriol is being used for predialysis beneficiaries, dialysis beneficiaries, and hypoparathyroidism beneficiaries as outlined in Clinical Coverage Policy 9
- 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.
- A compounded prescription which is equivalent to an OTC product.
- *Living arrangements may impact exclusion

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 the provider manual.

Physician Administered Drug Program

The Physician Administered Drug Program covers certain drugs that are purchased and administered by a medical professional in an outpatient office setting. Medicaid covers the cost of the drug when it is purchased by the same provider administering the drug.

- Covered medications include:
    - Injectable drugs
    - Intravenous administrations
    - Chemotherapy
    - Vaccines/toxoids
    - Immune globulins
    - Radiopharmaceuticals
- 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
- A prior authorization is not required for a Carolina Complete Health provider administering a PDP drug for an FDA approved indication. However, off-label use, where not listed on the PDP catalog, requires a case-by-case review via PA request

- Providers who determine the indications or dosing for a particular drug is medical necessary for a member, but those parameters fall outside of the predetermined standards for that drug, may submit member medical records, official compendia or peer-reviewed medical literature supporting its use to Carolina Complete Health.

Providers may submit Physician Drug Program off-label use medication requests via:

  - CCH Provider Portal (https://provider.carolinacompletehealth.com/) under the service type, "BIOPHARMACY"
  - By fax: 1-833-465-1703
  - By phone: 1-833-552-3876

Pharmacy Portal and Provider Links

- CoverMyMeds PA Requests: https://www.covermymeds.com/main/prior-authorization-forms/
- Find a provider: https://findaprovider.carolinacompletehealth.com/location
- Preferred Drug List: https://www.carolinacompletehealth.com/members/medicaid/resources/handbooks-forms.html
- Clinical Policy Criteria and Forms: https://network.carolinacompletehealth.com/resources/pharmacy.html

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.

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 (telehealth, virtual communications and remote patient monitoring) when medically necessary under the following conditions:

- Provider(s) shall ensure that services can be safely and effectively delivered using telehealth, virtual communications, or remote patient monitoring.
- Provider(s) shall consider a beneficiary's behavioral, physical and cognitive abilities to participate in services provided using telehealth, virtual communications, or remote patient monitoring.

- The beneficiary's safety must be carefully considered for the complexity of the services provided.

- In situations where a caregiver or facilitator is necessary to assist with the delivery of services via telehealth, virtual communications, or remote patient monitoring, their ability to assist and their safety must also be considered.

- Delivery of services using telehealth, virtual communications, or remote patient monitoring must conform to professional standards of care: ethical practice, scope of practice, and other relevant federal, state and institutional policies and requirements, such as Practice Act and Licensing Board rules;

- Provider(s) shall obtain and document verbal or written consent. In extenuating circumstances when consent is unable to be obtained, this must be documented.

- Beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the beneficiary requests;

- Provider(s) shall verify the beneficiary's identity using two points of identification before initiating service delivery via telehealth, virtual communications, or remote patient monitoring.

- Provider(s) shall ensure that beneficiary privacy and confidentiality is protected to the best of their ability.

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.

CENTENE VISION SERVICES HELP AT A GLANCE

The following chart includes several important telephone and fax numbers available to contracted **Centene Vision Services** provider offices. When calling **Centene Vision Services**, please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID Number (TIN) number
- Member's Carolina Complete Health ID number or Medicaid ID number

Members under 21 are eligible for:

- a routine eye exam with refraction or a refraction only once every year (365 days)
- medically necessary contact lenses
- fitting and dispensing of visual aids
- one pair of eyeglasses once every year (365 days)

Members 21 and older are eligible for:

- a routine eye exam with refraction or refraction-only once every two years (730 days)
- medically necessary contact lenses
- fitting and dispensing of visual aids
- one pair of eyeglasses once every two years (730 days*)*

SERVICE	FYI
Centene Vision Services Provider Web Portal	https://www.envolvevision.com/logon Eye Health Manager (available 24/7) • Verify member eligibility and benefits • File claims and review claim status • Use audit tools • Download, research, and reprint EOPs
Centene Vision Services Provider Customer Service *Member Eligibility and Claims Inquiries*	1-833-224-0516
Centene Vision Services Fraud, Waste, and Abuse	866-685-8664

Centene Vision Services Paper Claims	**Centene Vision Services**, Attn: Claims PO Box 7548 Rocky Mount, NC 27804
Electronic Claims Submission	Change HealthCare Payer ID#56190
Centene Vision Services Provider Claim Appeals	**Centene Vision Services**, Attn: Claim Appeal Committee PO Box 7548 Rocky Mount, NC 27804
Medicaid Eyeglass Dispensing	North Carolina Medicaid contracts with the State optical laboratory, Nash Optical Plant, to fabricate fee-for-service Medicaid eyeglasses for members. Therefore, providers continue to obtain prior approval through NCTracks for Medicaid eyeglasses. However, after the eyeglasses are dispensed to the member, providers are to submit claims for the dispensing fee to **Centene Vision Services** **Although carved-out, providers who supply eye exams and eyeglasses in their office must also supply Medicaid eye exams and fee-for-service eyeglasses to members* * Opticians are qualified providers for visual aids (eyeglasses and contact lenses).
Centene Vision Services Value Added Eye Care Benefit	All eligible adult members, 21 years old and older, receive an additional eye exam and up to a $125 allowance towards an additional pair of eyeglasses once every two years (730 days). Providers are to submit claims for the Medicaid Value Add Eyewear Benefit to **Centene Vision Services** only after the standard DHHS optical laboratory has been dispensed to the member.

Vision Program

- NCDHHS pays for one pair of Medicaid fee-for-service eyeglasses per year for children ages 0 through 20.
- NCDHHS pays for one pair of Medicaid fee-for-service eyeglasses every two years for adults 21 and older
- Although carved-out, providers who supply eye exams and eyeglasses in their office must also supply the following:
    - Medicaid eye exams
    - Medicaid fee-for-service eyeglasses

    - NOTE: Providers bill **Centene Vision Services** for the dispensing fee for Medicaid fee-for-service eyeglasses.
- *If offering an* **Centene Vision Services** *Value Add Eyewear Benefit:*
    - The **Centene Vision Services** Value Added Eyewear may only be provided AFTER the Medicaid fee-for-service eyeglasses have been dispensed to the member.
    - NOTE: Providers bill **Centene Vision Services** for Value Add Eyewear.
- Covered services shall include:
    - Routine eye exams
    - Medically necessary contact lenses
    - Fitting and dispensing visual aids
- Opticians are qualified providers for visual aids (eyeglasses and contact lenses)

Appendix I: COVERED SERVICES

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. For details, view the Clinical Coverage Policies:
https://network.carolinacompletehealth.com/resources/clinical-policies.html

COVERED SERVICES		
Service	Description	Covered by CCH Medicaid
Inpatient hospital services	Services that – Are ordinarily furnished in a hospital for the care and treatment of inpatients; Are furnished under the direction of a physician or dentist; and Are furnished in an institution that - (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66. Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to Subsection 1.1.1, above) may use beds for either	Yes

	inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a). Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven (7)-consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	

Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that— Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program	Yes
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	Yes
Nursing facility services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.	Yes

	Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility	
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.	Yes
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through: 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that	Yes

	would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.	
Rural health clinic services	Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for "physician services" and "physician-directed services" whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	Yes
Federally qualified health center services	Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program. Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.	Yes

Telemedicine	The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.	Yes
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	Yes
Family planning serv ices	Regular Medicaid Family Planning (Medicaid FP) services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. If the State specifies qualifications for family nurse practitioners, the practitioner must - • Be currently licensed to practice in the State as a registered professional nurse; and • Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must -	Yes

	• Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and • Have a family nurse practice limited to providing primary health care to individuals and families.	
Certified pediatric and family nurse practitioner services.	Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section: If the State specifies qualifications for pediatric nurse practitioners, the practitioner must – i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. If the State specifies qualifications for family nurse practitioners, the practitioner must - Be currently licensed to practice in the State as a registered professional nurse; and Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must -	Yes

	• Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and • Have a family nurse practice limited to providing primary health care to individuals and families.	
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	Yes
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	Yes
Ambulance Services	Ambulance services provide medically necessary treatment. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary.	Yes
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	Yes
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	Yes
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist. (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an	Yes

	eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
Physical therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.	Yes
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	Yes
Speech, hearing and language disorder services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a	Yes

	competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists	
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policies	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.	Yes
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	Yes
Other diagnostic, screening, preventive and rehabilitative services	(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of	Yes

	physical or mental disability and restoration of an individual to the best possible functional level	
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, "is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less."	Yes
Optometry services	Medicaid shall cover the following optical services when provided by ophthalmologists and optometrists: a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids. Opticians may dispense approved visual aids.	Yes
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	Yes
Private duty nursing services	Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. § 440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.	Yes

	Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing and employed by a licensed home care agency. A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.	
Personal Care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified in Clinical Coverage Policy No: 3L In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.	Yes

Hospice Services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina. Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities	Yes
Durable Medical Equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: 1. Inexpensive or routinely purchased items 2. Capped rental/purchased equipment 3. Equipment requiring frequent and substantial servicing 4. Oxygen and oxygen equipment 5. Related medical supplies 6. Service and repair 7. Other individually priced items 8. Enteral nutrition equipment	Yes

Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	Yes
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy	Yes
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems. *IMD exclusion is waived for Medicaid beneficiaries receiving treatment for substance use disorders.	Yes
Inpatient psychiatric services for individuals under age 21.	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.	Yes
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.	Yes
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.	Yes

Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.	Yes
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. c. The clinical management of the patient unconscious from whatever cause. d. The evaluation and management of acute or chronic pain. e. The management of problems in cardiac and respiratory resuscitation. f. The application of specific methods of respiratory therapy. g. The clinical management of various fluid, electrolyte, and metabolic disturbances.	Yes
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device’s ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	Yes
Burn Treatment and Skin Substitutes	Provides treatment for burns.	Yes
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	Yes
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary’s diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes	Yes

Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity	Yes
Maternal Support Serv ices	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	Yes
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	Yes
Ophthalmological Services	General ophthalmologic services include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.	Yes
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	Yes
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	Yes
Vision Services.	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.	Yes
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual patient communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal	Yes

	health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.	

COVERED SERVICES	
Service	Description
Inpatient hospital services	Services that – Are ordinarily furnished in a hospital for the care and treatment of inpatients; Are furnished under the direction of a physician or dentist; and Are furnished in an institution that - (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: Swing Bed Hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66. Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural

	areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to Subsection 1.1.1, above) may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a). Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven (7)-consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that— Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

	(ii) Meets the requirements for participation in Medicare as a hospital; and May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program
Early and periodic screening, diagnostic and treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
Nursing facility services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.

Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. All medical services performed must be medically necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through: 4) scientifically validated clinical studies 5) medical literature research and 6) qualified medical experts. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.
Rural health clinic services	Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. The specific health care encounters that constitute a core service include the following face to face encounters: b. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician’s services, including drugs and biologicals that cannot be self-administered b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.
Federally qualified health center services	Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program.

	Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. The specific health care encounters that constitute a core service include the following face to face encounters: a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. services provided by physician assistants and incident services supplied; c. nurse practitioners and incident services supplied; d. nurse midwives and incident services supplied; e. clinical psychologists and incident services supplied; and f. clinical social workers and incident services supplied.
Telemedicine	The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.
Family planning serv ices	Regular Medicaid Family Planning (Medicaid FP) services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. If the State specifies qualifications for family nurse practitioners, the practitioner must - • Be currently licensed to practice in the State as a registered professional nurse; and • Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services.

	If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - • Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and • Have a family nurse practice limited to providing primary health care to individuals and families.
Certified pediatric and family nurse practitioner services.	Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section: If the State specifies qualifications for pediatric nurse practitioners, the practitioner must – iii. Be currently licensed to practice in the State as a registered professional nurse; and iv. Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. (Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section. If the State specifies qualifications for family nurse practitioners, the practitioner must - Be currently licensed to practice in the State as a registered professional nurse; and Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must - • Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

	• Have a family nurse practice limited to providing primary health care to individuals and families.
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.
Ambulance Services	Ambulance services provide medically necessary treatment. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary.
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: (a) Services furnished at the clinic by or under the direction of a physician or dentist. (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.

Physical therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.
Speech, hearing and language disorder services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policies	There must be a current diagnosis reflecting the need for treatment. All covered services must be medically necessary for meeting specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary. Standard Plan Covered BH Services: • Outpatient BH Medication Mangement, Therapy Services, Assessments, and Psychological Testing (policy 8C) • Ambulatory Detoxification (policy 8A) • Behavioral Health Urgent Care (In-Lieu of Service) • Facility-Based Crisis Services (policies 8A and 8A-2) • Inpatient Hospitalization (policy 8B), to include IMD in-lieu of service • Medically Supervised or ADATC Detoxification Crisis Stabilization (policy 8A)

	• Mobile Crisis Management (policy 8A) • Non-Hospital Medical Detoxification (policy 8A) • Opioid Treatment Program Service (policy 8A-9) • Partial Hospitalization (policy 8A) • Peer Support Services (policy 8G) • Substance Abuse Intensive Outpatient Program (policy 8A) • Substance Abuse Comprehensive Outpatient Treatment (policy 8A) • Research-Based Behavioral Health Treatment for Autism Spectrum Disorders (policy 8A)
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.
Other diagnostic, screening, preventive and rehabilitative services	(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; (C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, “is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less.”
Optometry services	Medicaid shall cover the following optical services when provided by ophthalmologists and optometrists:

	a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids. Opticians may dispense approved visual aids.
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.
Private duty nursing services	Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. § 440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing and employed by a licensed home care agency. A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.
Personal Care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable

	them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care. PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified in Clinical Coverage Policy No: 3L In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.
Hospice Services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina. Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North

	Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities
Durable Medical Equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: 1. Inexpensive or routinely purchased items 2. Capped rental/purchased equipment 3. Equipment requiring frequent and substantial servicing 4. Oxygen and oxygen equipment 5. Related medical supplies 6. Service and repair 7. Other individually priced items 8. Enteral nutrition equipment
Prosthetics, orthotics and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems. *IMD exclusion is waived for Medicaid beneficiaries receiving treatment for substance use disorders.
Inpatient psychiatric services for individuals under age 21.	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.

Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.
Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. c. The clinical management of the patient unconscious from whatever cause. d. The evaluation and management of acute or chronic pain. e. The management of problems in cardiac and respiratory resuscitation. f. The application of specific methods of respiratory therapy. g. The clinical management of various fluid, electrolyte, and metabolic disturbances.
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device’s ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.
Burn Treatment and Skin Substitutes	Provides treatment for burns.
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.
Dietary Evaluation and Counseling and Medical	Offers direction and guidance for specific nutrient needs related to a beneficiary’s diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes

Lactation Services	
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity
Maternal Support Serv ices	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.
Ophthalmological Services	General ophthalmologic services include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.
Vision Services.	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual patient communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types

	of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.