Provider Manual

State of North Carolina
Department of Health and Human Services
Division of Health Benefits
2025 State Submission

AmeriHealth Caritas
North Carolina

Table of Contents

Welcome

Welcome to AmeriHealth Caritas North Carolina – a mission-driven prepaid health plan organization located in North Carolina, and serving members of North Carolina Medicaid, through North Carolina's Medicaid Managed Care program. By providing unparalleled access, focusing on seamless care coordination, and leveraging the strength and success of current North Carolina Department of Health & Human Services' (NCDHHS) initiatives, we work to drive quality health outcomes for the North Carolina Medicaid Program.

This *Provider Manual* was created to assist you and your office staff with providing services to our members, your patients. As a provider, you agree to use this *Provider Manual* as a reference pertaining to the provision of medical services for members of AmeriHealth Caritas North Carolina.

This Provider Manual may be changed or updated periodically and when required by NCDHHS. AmeriHealth Caritas North Carolina provides you with timely communications through multiple channels outlined under Plan-Provider-Communications. Providers are also responsible for checking ACNC's website, www.amerihealthcaritasnc.com regularly for updates.

Thank you for your participation in the AmeriHealth Caritas North Carolina provider network.

Sharing Our Mission

As our provider partner, we invite you to share our mission: To help people get care, stay well, and build healthy communities.

SECTION I
GETTING STARTED

I. Getting Started

Who We Are

AmeriHealth Caritas North Carolina Inc., ("AmeriHealth Caritas North Carolina", "ACNC" or "the Plan") is a Prepaid Health Plan (PHP) and a member of the AmeriHealth Caritas Family of Companies – an industry leader in the delivery of quality health care to populations covered by publicly funded programs, including Medicaid, Medicare, and State Children's Health Insurance programs. We are proud to partner with the state of North Carolina to provide health care coverage for enrollees of:

- Medicaid - The program that provides services through a managed care delivery system to individuals who receive temporary assistance for needy families (TANF), (including children who qualify for Title IV-E foster care and adoption assistance and pregnant women), individuals who receive SSI but are not eligible for Medicare, adults age 19 to 64 who are not eligible for Medicare with income levels up to 133% Federal Poverty Level (FPL), Aged, Blind and Disabled (ABD) all ages.

Excluded Populations

The following populations are permanently excluded from enrollment:

- Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid Coverage is limited to the coverage of Medicare premiums and cost sharing;
- Qualified aliens subject to the five-year bar for means-tested public assistance under
  - 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
- Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
- Medically needy Medicaid beneficiaries;
- Presumptively eligible beneficiaries, during the period of presumptive eligibility;
- Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program;
- Beneficiaries enrolled under the Medicaid Family Planning program;
- Beneficiaries who are inmates of prisons;
- Beneficiaries being served through the Community Alternatives Program for Children (CAP/C);
- Beneficiaries being served through Community Alternative Program for disabled Adults (CAP/DA) (includes beneficiaries receiving services under CAP/Choice); and
- Beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE).

Through our partnership with you – our dedicated providers – we intend to help our members achieve healthy lives and build healthy communities.

About Our Program

North Carolina's Medicaid programs are administered through the North Carolina Department of Health and Human Services (NCDHHS), Division of Health Benefits (DHB). AmeriHealth Caritas North Carolina has been contracted by NCDHHS to provide covered services for enrollees of the Medicaid Managed Care Program, which includes the TANF/ and ABD eligible.

Plan and NCDHHS Contact Information

AmeriHealth Caritas North Carolina
AmeriHealth Caritas North Carolina
Mailing Address: 8041 Arco Corporate Drive, Raleigh, NC 27617
Provider Services Phone: **1-888-738-0004**

AmeriHealth Caritas North Carolina Member Services Line: 1-855-375-8811, 24/7 and State of North Carolina holidays.

NCDHHS/DHB
Medicaid General Mailing Address
2501 Mail Service Center
Raleigh, NC 27699-2501
Medicaid Customer Service Center
1-888-245-0179

For a complete listing of important contact information, refer to Provider homepage of our website.

Member Enrollment & Health Plan Selection

NCDHHS employs an Enrollment Broker who performs outreach, education, enrollment, transfer, and disenrollment of members. Potential members may enroll via the Enrollment Broker by contacting: **1-833-870-5500 (TTY: 1-833-870-5588).**

The Enrollment Broker explains the benefits offered by AmeriHealth Caritas North Carolina and other North Carolina Medicaid pre-paid health plans. The Enrollment Broker helps members choose a health plan that best meets their needs; if no health plan is chosen within 60 calendar days, the member will be auto assigned to a health plan by the state.

New members can change health plans during the first 90 calendar days following the date of enrollment with ACNC.

Accepting AmeriHealth Caritas North Carolina Members

AmeriHealth Caritas North Carolina expects network providers to accept all voluntary and assigned members without restriction and in the order in which they enroll. AmeriHealth Caritas North Carolina providers will not discriminate against or use any policy or practice that has the effect of discriminating against, an individual on the basis of health status or need for services, or race, color, or national origin, sex, sexual orientation, gender identity, or disability.

Primary Care Selection & Assignment

The Medicaid Enrollment Broker provides managed care education, and supports PHP and AMH/PCP selection to beneficiaries eligible for Medicaid Managed Care. If the member is automatically assigned to AmeriHealth Caritas North Carolina and the Member does not select a PCP, AmeriHealth Caritas North Carolina will assign the Member to an Advanced Medical Home/Primary Care practitioner (AMH/PCP) within 24 hours of effectuation date of enrollment in AmeriHealth Caritas North Carolina. If no PCP is selected via the Enrollment Broker, AmeriHealth Caritas North Carolina will:

- Inform the member of their right to choose a PCP.
- Assist the member in selecting a PCP.
- Inform the member that each eligible family member has the right to choose his/her own PCP.
- Automatically assign a PCP to members who do not proactively choose a PCP within 24 hours of enrollment with ACNC.

ACNC considers the following when assigning a PCP:

a) Prior AMH/PCP assignment;

b) Member claims history;

c) Family member's AMH/PCP assignment;

d) Family member's claims history;

e) Geographic proximity;

f) Special medical needs; and

g) Language/cultural preference.

Members can change their AMH/PCP without cause twice per year. Members will be given thirty (30) days from receipt of notification of their AMH assignment to change their AMH/PCP without cause (1st instance) and will be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance).

NCDHHS will consider the following as appropriate "cause" for Members to change their AMH/PCP:

The provider has failed to furnish accessible and appropriate medical care, services or supplies to which the Member is entitled under the terms of the contract under which AmeriHealth Caritas North Carolina has agreed to provide services.

This includes, but is not limited to, the failure to:

1. Provide primary care services;
2. Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
3. Arrange for consultation appointments;
4. Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
5. Arrange for services with qualified licensed or certified providers;
6. Coordinate the Member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;

Members have the right to change their PCP more than once a year; however, need to have a good reason (good cause). The following list represents reasons a member has the right to change their Primary Care Provider (PCP):

1. Your PCP does not provide accessible and proper care, services, or supplies (e.g., does not set up hospital care or consults with specialists when required for treatment).
2. You disagree with your treatment plan.
3. Your PCP moves to a different location that is not convenient for you.
4. Your PCP changes the hours or day that patients are seen.
5. You have trouble communicating with your PCP because of a language barrier or another issue.
6. Your PCP is not able to accommodate your special needs.
7. You and your PCP agree that a new PCP is what is best for your care.

Newly enrolled members receive a welcome packet from ACNC that includes a Member Handbook. Members also receive an AmeriHealth Caritas North Carolina Member Identification (ID) Card that lists the member's PCP and telephone number. Information about the opportunity and procedures to change PCPs is included in the member welcome packet.

Verifying Member Eligibility

As a participating provider, you are responsible for verifying member eligibility with AmeriHealth Caritas North Carolina before rendering services, except when a member requires emergency services.

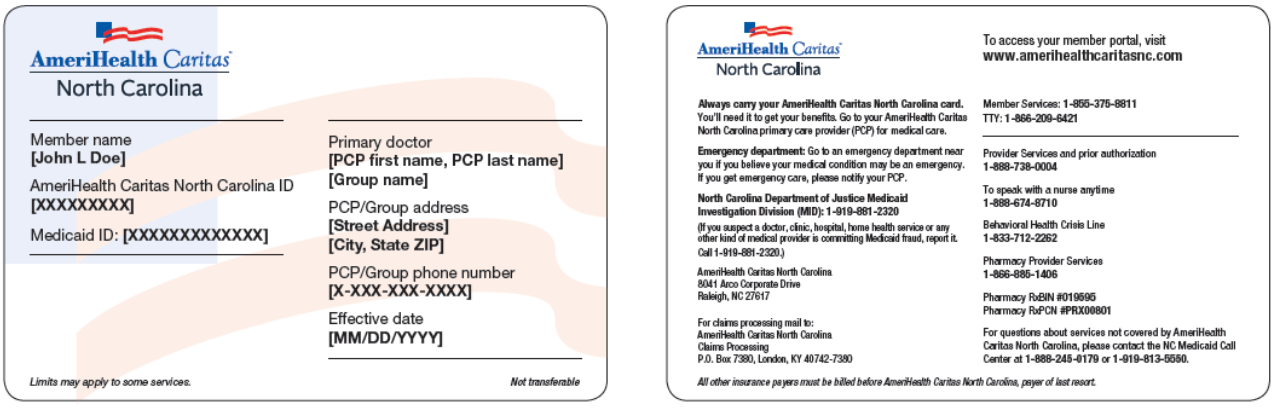
Depending on your clearinghouse or practice management system, eligibility may be verified by:

- Visiting the provider home page, to access NaviNet, a free, web-based application for electronic transactions and information through a secure multi-payer portal.
- Calling Provider Services at **1-888-738-0004** and utilize the automated real time eligibility service without speaking to a representative, just follow the prompts for Member Eligibility.
- Asking to see the member's Plan ID card. Members are instructed to always keep their ID card with them. The member's ID card includes:

The member's ID card includes:

- Member's name
- Effective date of enrollment
- AmeriHealth Caritas North Carolina ID number
- Medicaid ID number
- Primary Care Physician Name, Address and Phone Number
- Pharmacy Bin and PCN numbers are located on the back of the pharmacy card
- Services lines
  - Pharmacy Service Line
  - Behavioral Health Crisis Line
  - Provider Services
  - ACNC's 24-hour nurse advice/nurse triage telephone number
- Procedures to be followed for emergency services.

Member Medicaid ID card



NOTE: AmeriHealth Caritas North Carolina Medicaid ID cards are not returned to ACNC when a member becomes ineligible. Presentation of an AmeriHealth Caritas North Carolina ID card is not proof that an individual is currently a member of ACNC. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member's ID card, please report the occurrence to our Fraud, Waste and Abuse Hotline at **1-866-833-9718.**

Important Phone Numbers

Service Line Name	Phone Number	Hours of operation
Member Services	**1-855-375-8811** **TTY: 1-866-209-6421**	• Non-Emergency and Emergency Member issues: open twenty-four (24) hours a day / seven (7) days a week/365 days a year • Open all State holidays
Pharmacy Service Line	**1-866-885-1406** **TTY: 1-866-209-6421**	• Monday – Saturday: 7a.m. – 6 p.m. ET • Open all State holidays
Nurse Line	**1-888-674-8710** **TTY: 1-866-209-6421**	• Twenty-four (24) hours a day / seven (7) days a week / 365 days per year
Provider Services	**1-888-738-0004** **TTY: 1-866-209-6421**	• Monday – Saturday: 7AM – 6PM ET • Open all State holidays
Behavioral Health Crisis Line	**1-833-712-2262** **TTY: 1-866-209-6421**	• Twenty-four (24) hours per day / seven (7) days per week / 365 days a year
An Automated Voice Response System (AVRS):	**1-855-375-8811** **TTY: 1-866-209-6421**	• Interacts with the Member through voice and/or numeric prompts and allows our members to perform self-service activities and resolve simple inquiries without the need to interact with a live person;

Member Rights and Responsibilities

These are rights and responsibilities that have been shared with our members in the member's handbook:

Member Rights
As a member of AmeriHealth Caritas North Carolina, you have a right to:

- Receive information about the organization, its practitioners, and providers, your rights and responsibilities, benefits and services, and the cost of health care.
- Receive information on where, when, and how to get the services, you need from AmeriHealth Caritas North Carolina.
- Be treated with respect and recognition of your dignity and your right to privacy, without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation, or gender identity.
- Receive considerate and respectful care in a clean and safe environment.
- Request materials and/or assistance in languages and formats other than written English, such as Braille, audio, or Sign language, if necessary.
- Be furnished with health care services consistent with applicable state and federal law.
- Receive health care services in a timely manner from a provider that meets your care needs.
- Be told by your primary care provider (PCP) what health issues you may have, what can be done for you and what will likely be the result, in language you understand.
- Candid discussion and information with your health care provider about appropriate or medically necessary treatment options and alternatives for your conditions, regardless of cost or benefit coverage, in a manner that you understand.
- Participate with practitioners in making decisions about your health care.
- Get a second opinion about your care.
- Give your approval of any plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free to exercise your rights and know that the exercising of those rights does not adversely affect the way AmeriHealth Caritas North Carolina, its network providers, or the NC Department of Health and Human Services will treat you.
- Request and receive a copy of your medical record as allowed by applicable state and federal law.

- Use the AmeriHealth Caritas North Carolina grievance process to resolve grievances (complaints) and the right to file an appeal. You can also contact the Medicaid Managed Care Ombudsman Program any time you feel you were not treated fairly.

- Ask, if needed, that your medical record be amended or corrected.

- Be sure that your personal and health information and medical records are private and confidential.

- Approve or deny the release of identifiable medical or personal information, except when the release is permissible and/or required by Law.

- Request an Accounting of Disclosures of Protected Health Information (PHI).

- Expect that AmeriHealth Caritas North Carolina will provide the Notice of Privacy Practices upon enrollment, annually, and upon your request.

- Request that any mailing or communication with PHI from AmeriHealth Caritas North Carolina be sent by alternate means or to an alternate address or phone number.

- Make recommendations regarding the organization's member rights and responsibilities policy and other policies and procedures.

- Use the AmeriHealth Caritas North Carolina grievance process to resolve grievances (complaints) and the right to file an appeal. You can also contact the Medicaid Managed Care Ombudsman Program any time you feel you were not treated fairly.

- Use the State Fair Hearing system

- Provide an advance health care directive.

- Appoint someone you trust (relative, friend or lawyer) to speak for you if you are unable to speak for yourself about your care and treatment.

Member Rights if they are a Minor

Minors have the right to agree to *some* treatment and services *without the consent* of a parent or guardian:

- Treatment for sexually transmitted diseases.

- Services related to pregnancy.

- Services to help with alcohol and/or other substance use disorders.

- Services to help with emotional conditions.

Member Responsibilities
As a member of AmeriHealth Caritas North Carolina, you agree to:

- Find out how your health plan coverage works and follow plan guidelines.
- Supply information (to the extent possible) that the organization and its practitioners and providers need to provide care.
- Notify AmeriHealth Caritas North Carolina and your health care providers of any changes that may affect your participation, healthcare needs or benefits, such as:
    - Pregnancy
    - Birth of a new baby
    - Change of address or phone number
    - Other health insurance
    - Special medical conditions
    - Change in primary care provider (PCP)
    - Change in family size
    - Relocation to another county or state
- Use the emergency department only for emergencies.
- Call your PCP when you need medical care, even if it is after hours.
- Follow plans and instructions for care that you have agreed to with your health care providers.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible, including:
    - Making appointments with your PCP and keeping appointments
    - Cancelling appointments when you cannot make the appointment. If you must cancel, call as soon as you can.
- Make sure your information is up to date with your local Department of Social Services.
    - Call or go back to your PCP if you do not get better or ask for a second opinion.
- Treat health care staff with respect and dignity.
- Contact AmeriHealth Caritas North Carolina when you have questions or tell us if you have problems with any health care staff by calling Member Services at 855-375-8811.

Plan Privacy and Security Procedures

AmeriHealth Caritas North Carolina complies with all federal and North Carolina regulations regarding member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Standards for Privacy of Individually Identifiable Health Information as outlined in 45 CFR Parts 160 & 164. All member health and enrollment information is used, disseminated and stored according to Plan policies and guidelines to ensure its security, confidentiality, and proper use. As an AmeriHealth Caritas North Carolina provider, you are expected to be familiar with your responsibilities under HIPAA and 42 CFR, Part 2, which governs the confidentiality of alcohol and drug treatment information, and to take all necessary actions to fully comply.

AmeriHealth Caritas North Carolina providers are required to assist with privacy and security investigations, including providing attestations of destruction in a timely manner, to ensure that contractual requirements are met.

SECTION II
PROVIDER AND NETWORK INFORMATION

II. Provider and Network Information

This section provides information for maintaining network privileges and sets forth expectations and guidelines for PCPs, specialists, and facility providers. Please note that, in general, the responsibilities and expectations outlined in this section pertain to all providers, including behavioral health providers and long-term services and supports providers (LTSS).

Becoming an ACNC Provider

AmeriHealth Caritas North Carolina maintains and adheres to all applicable state and federal laws and regulations, North Carolina Medicaid requirements. AmeriHealth Caritas North Carolina will align with the Department on a long-term model for credentialing to meet the National Committee on Quality Assurance (NCQA) compliance. All providers enrolled with AmeriHealth Caritas North Carolina must also be enrolled with North Carolina Medicaid.

Examples of Participating Network Provider Types

- Primary Care Providers (PCPs)
- Physician Specialists
- Maternal and Child Health Centers
- Long-Term Services and Supports (LTSS) Providers
- Home Health Agencies
- Behavioral Health Providers
- Ancillary and Hospital Providers
- Allied Health Providers
- AIDs Providers
- Acute Care Providers
- Other Safety Net Providers and Community Partners
- Indian Health Services
- FQHCs and RHCs for Behavioral Health Services
- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- County Health Department
- Nurse Midwives
- Nurse Practitioners
- Transportation Providers

Provider Credentialing and Re-Credentialing

NCDHHS has established a centralized credentialing process including a uniform provider enrollment application and qualification verification process.

North Carolina Centralized Application and Credentialing Process

AmeriHealth Caritas North Carolina adheres to the North Carolina Department of Health and Human Services' (the "Department") Medicaid managed care program streamlined approach for the credentialing and re-credentialing of providers. AmeriHealth Caritas North Carolina will rely on a provider's presence on the Medicaid Provider Enrollment File (PEF) for credentialing/re-credentialing purposes. A provider's presence on the PEF extended version replaces a quality determination that would have been made by AmeriHealth Caritas North Carolina in accordance with the revised direction provided by NCDHHS. Through this standardized credentialing/re-credentialing approach, AmeriHealth Caritas North Carolina will not outreach to in-state, bordering (i.e., providers that reside within forty (40) miles of the North Carolina state line), or out-of-state providers about credentialing/re-credentialing in accordance with the direction from NCDHHS in Attachment M.6 Revised and Restated Uniform Credentialing and Re-Credentialing Policy. PHPs must negotiate in good faith with, and include in the network, all qualified willing providers, except when the PHP is unable to negotiate rates.

ACNC will not contract with Providers/Contractors/Organizational Providers who are not enrolled with the Department as North Carolina Medicaid Providers, consistent with provider disclosure, screening, and enrollment requirements. AmeriHealth Caritas North Carolina will partner with the Department on a long-term model for credentialing to meet National Committee for Quality Assurance (NCQA) compliance.

AmeriHealth Caritas North Carolina is prohibited from employing or contracting with providers excluded from participation in federal health care programs under the Social Security Act. ACNC shall develop and implement as part of its Credentialing and Re-credentialing Policy, written policies and procedures for the section and retention of network providers and will meet the requirements specified in 42 C.F.R § 438.214. ACNC is also prohibited from discriminating against providers that service high-risk populations or specialize in conditions that require costly treatment. This includes, prohibiting discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely based on that license or certification. 42 C. F. R § 438.12.

AmeriHealth Caritas North Carolina credentialing staff abide by policies and procedures for the collection, use, transmission, storage, access to and disclosure of confidential information to protect the privacy and confidentiality rights of AmeriHealth Caritas North Carolina's Members and Providers and to ensure the appropriate and legitimate use of the information. AmeriHealth Caritas North Carolina is prohibited from using, disclosing, or

sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.

Initial Credentialing

AmeriHealth Caritas North Carolina will accept the PEF extended version as the source for provider eligibility and credentialing status purposes. AmeriHealth Caritas North Carolina matches the provider to the active Medicaid provider record by using the NPI, location code, and effective date methodology provided by the Department.

Recredentialing

- Providers/Contractors/Organizational Providers are re-credentialed no less frequently than every 5 years by the Department during the Provider Credentialing Transition period.

- AmeriHealth Caritas North Carolina will suspend claims payments to any non-compliant provider for dates of services after the suspension effective date provided by the Department. Claims payment suspension will occur within one (1) business day of receipt of notice from the Department that Provider payment should be suspended for failing to submit re-credentialing documentation to the Department, or for otherwise failing to meet Department requirements.

- AmeriHealth Caritas North Carolina will reinstate provider payments upon notice of compliance from the Department.

- If the provider does not come into compliance within the fifty (50) day suspension period, the Department will terminate the provider from Medicaid, and AmeriHealth Caritas North Carolina will terminate the provider from its network within one (1) business day of notice of termination from Medicaid.

- After the Provider Credentialing Transition period, re-credentialing will be every three (3) years.

AmeriHealth Caritas North Carolina will not be liable for interest or penalties for payment suspension at recredentialing.

Note: Any provider found to be excluded from Medicare or Medicaid will be terminated immediately from the PHP.

For additional information, please reference the AmeriHealth Caritas North Carolina Credentialing/Recredentialing policy with effective date March 12, 2025 on our website.

On-going Monitoring

- Through the uniform credentialing process, the Department will screen and enroll, and revalidate all providers as participating and non-sanctioned Medicaid Providers.
- AmeriHealth Caritas North Carolina will reconfirm providers' Medicaid eligibility upon receipt of every PEF extended file.
- AmeriHealth Caritas North Carolina will monitor provider performance against Quality data on an ongoing basis, as outlined in the Quality Improvement Program Description.

Access to Care

AmeriHealth Caritas North Carolina must establish a provider network that meets standard guidelines as outlined in this publication to help ensure that Plan members have timely access to care.

AmeriHealth Caritas North Carolina endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. ACNC establishes mechanisms for measuring compliance with existing standards and identifies opportunities for the implementation of interventions for improving accessibility to health care services for members.

Ratios & Geographic Access Standards

To ensure network adequacy, ACNC will monitor the standards below on a quarterly basis, utilizing Geo Access report for NC Medicaid members.

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.

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 (child/children or adolescent) services are those provided to a member who is less than 18 years of age.

Network Adequacy Standards		
Service Type	**Urban Standard**	**Rural Standard**
Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of Members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of Member

Network Adequacy Standards		
Service Type	**Urban Standard**	**Rural Standard**
Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of Members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of Members
Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
Outpatient Behavioral Health Services	• ≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of Members • Research-based behavioral health treatment for autism spectrum disorder (ASD): Not subject to standard	• ≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of Members • Research-based behavioral health treatment for autism spectrum disorder (ASD): Not subject to standard
Location-Based Services (Behavioral Health)	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members
Crisis Services (Behavioral Health)	≥ 1 provider of each crisis service within each PHP Region	
Inpatient Behavioral Health Services	≥ 1 provider of each inpatient BH service within each PHP Region	
Partial Hospitalization (Behavioral Health)	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of specialized services partial hospitalization within 60 minutes or 60 miles for at least 95% of Members
All State Plan LTSS (except nursing facilities) *	PHP must have at least 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.	PHP must have at least 2 providers accepting new patients available to deliver each State Plan LTSS in every county; 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.

[1] Measured on members who are female and age 14 or older.

Specialty Care Providers Services Type
Allergy/Immunology
Anesthesiology
Cardiology
Dermatology
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Gynecology[2]
Infectious Disease
Hematology
Nephrology
Neurology
Oncology
Ophthalmology
Optometry
Orthopedic Surgery
Pain Management (Board Certified)
Psychiatry
Pulmonology
Radiology
Rheumatology
Urology

Behavioral Health Service Category Definitions	
Service Type	**Definition**
Outpatient Behavioral Health Services	• Outpatient behavioral healthservices provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
Location-Based Services (Behavioral Health)	• Outpatient Opioid treatment program (OTP) (adult) • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program
Crisis Services (Behavioral Health)	• Professional treatment services in a facility-based crisis program (adult) • Facility-based crisis services for children and adolescents • Ambulatory withdrawal management without extended on-site monitoring • Ambulatory withdrawal management with extended on-site monitoring • Medically Monitored Inpatient Withdrawal Services • Clinically Managed Residential Withdrawal Services (Social Setting Detox)

[2] Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included TO SATISY OB success requirements. .

	• Mobile Crisis Management
Inpatient Behavioral Health Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult Medically Managed Intensive Inpatient Withdrawal Management Services beds. • Acute care hospitals with adult Medically Managed Intensive Inpatient Services beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent/child Medically Managed Intensive inpatient Services beds. • Acute care hospitals with child inpatient psychiatric beds.
Partial Hospitalization (Behavioral Health)	• Partial hospitalization (adults and children)

Included below are zip codes from contiguous states that are within 40 miles of the NC border. Providers who are within these zip codes and within the 40-mile range can be considered in-network Medicaid providers and will contribute to ACNC network adequacy if enrolled in the PEF and are appropriately credentialed and contracted.

ZIP Codes Within 40 Miles of the North Carolina Border						
23320	23321	23322	23323	23324	23325	23327
23328	23430	23432	23434	23435	23437	23438
23439	23450	23451	23452	23453	23454	23455
23456	23457	23458	23459	23460	23461	23462
23463	23464	23465	23466	23467	23471	23479
23487	23501	23502	23503	23504	23505	23506
23507	23508	23509	23510	23511	23512	23513
23514	23517	23518	23519	23520	23521	23523
23529	23541	23551	23601	23602	23603	23604
23605	23606	23607	23608	23609	23612	23651
23661	23665	23666	23668	23669	23670	23701
23702	23703	23704	23705	23707	23708	23709
23827	23828	23837	23847	23851	23857	23866
23867	23868	23872	23879	23887	23888	23890
23917	23919	23924	23927	23944	23970	23974
24054	24068	24073	24076	24078	24091	24112
24113	24114	24115	24126	24133	24141	24142
24143	24148	24151	24165	24171	24201	24202
24203	24210	24236	24301	24317	24328	24330
24333	24343	24348	24352	24354	24363	24378

ZIP Codes Within 40 Miles of the North Carolina Border						
24379	24382	24528	24531	24540	24541	24543
24557	24558	24577	24589	24592	24651	29009
29010	29031	29055	29065	29067	29101	29301
29302	29303	29304	29305	29306	29307	29316
29318	29319	29322	29323	29330	29331	29335
29338	29340	29341	29342	29348	29349	29353
29356	29364	29365	29373	29379	29388	29501
29502	29503	29504	29505	29506	29511	29512
29520	29525	29526	29527	29528	29532	29536
29540	29541	29543	29544	29545	29550	29551
29563	29565	29566	29568	29569	29570	29571
29572	29574	29575	29576	29577	29578	29579
29581	29582	29583	29587	29588	29592	29593
29596	29597	29598	29601	29602	29603	29604
29605	29606	29607	29608	29609	29610	29611
29612	29615	29616	29621	29627	29631	29633
29635	29640	29641	29642	29644	29650	29651
29652	29657	29661	29671	29672	29678	29679
29680	29681	29687	29690	29691	29693	29702
29706	29707	29708	29709	29710	29714	29715
29716	29717	29718	29720	29721	29727	29728
29730	29731	29732	29743	29745	30143	30512
30513	30514	30525	30528	30531	30533	30535
30537	30540	30546	30552	30555	30559	30560
30562	30577	30582	30708	30719	30720	30721
30722	37303	37310	37311	37312	37317	37320
37323	37326	37331	37333	37364	37371	37385
37391	37601	37602	37603	37604	37605	37615
37616	37618	37620	37621	37625	37641	37643
37644	37650	37658	37659	37660	37662	37663
37664	37665	37681	37683	37684	37687	37692
37701	37711	37722	37725	37738	37743	37744
37745	37753	37760	37771	37774	37777	37801
37802	37804	37809	37813	37814	37815	37816
37818	37821	37830	37831	37843	37853	37862
37863	37864	37868	37874	37876	37878	37882
37886	37890	37901	37902	37909	37912	37914
37915	37916	37917	37918	37919	37920	37921

ZIP Codes Within 40 Miles of the North Carolina Border						
37922	37923	37924	37927	37928	37929	37930
37931	37932	37933	37938	37939	37940	37950

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Appointment scheduling and wait times for members should comply with the access standards defined below. The standards below apply to health care services and medical, Behavioral Health and LTSS providers; AmeriHealth Caritas North Carolina monitors the following access standards on an annual basis per North Carolina guidelines. If a provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Network Account Executive or the Provider Services department at **1-888-738-0004.**

Appointment Wait Time Standards

Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms, and pap smears.	Within thirty (30) Calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) Calendar days for Member less than six (6) months of age Within thirty (30) Calendar days for Members six (6) months of age and older.
2	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts	Within twenty-four (24) hours

Appointment Wait Time Standards			
		and wounds, sudden onset of stomach pain and severe, non-resolving headache.	
3	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar days
4	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar days
Specialty Care			
6	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
7	Routine/Check-up without symptoms	Non-symptomatic visits for health check	Within thirty (30) calendar days
8	After-Hours Access Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days per year}

Appointment Wait Time Standards			
Behavioral Health Care			
9	Mobile Crisis Management Services	Mobile Crisis Management Services: Mobile crisis services, for adults and children are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.	Within two (2) hours
10.	Urgent Care Services for Mental Health	Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.	Within twenty-four (24) hours
11.	Urgent Care for SUD	Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the	Within twenty-four (24) hours

Appointment Wait Time Standards			
		person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.	
12.	Routine Services for Mental Health	Services to treat a person who describes signs and symptoms resulting in impaired behavioral functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards. Services to treat a person who describes signs and symptoms resulting in impaired mental functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards. Services to treat a person who describes signs and symptoms resulting in impaired emotional functioning, which has impacted person's ability to participate in daily living or markedly decreased person's quality of life	Within fourteen (14) calendar days

Appointment Wait Time Standards			
		for the purposes of the BH appointment wait-time standards.	
13.	Routine Services for SUD	Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.	Within forty-eight (48) hours
14.	Emergency Services for Mental Health	Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
15.	Emergency Services for SUDs	Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.	Immediately {available twenty-four (24) hours a day, three-hundred sixty-five (365) days a year}

Missed Appointment Tracking

If a member misses an appointment with a provider, the provider should document each missed appointment in the member's medical record. Providers should make at least three documented attempts to contact the member and determine the reason for a missed

appointment. The medical record should reflect any reasons for delays in providing health care, because of missed appointments, and should also include any refusals by the member. Providers are encouraged to advise AmeriHealth Caritas North Carolina's Rapid Response team at **1-833-808-2262** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.

After-Hours Accessibility
AmeriHealth Caritas North Carolina members have access to quality, comprehensive health care services **24 hours a day, seven days a week.** PCPs must have either an answering machine or an answering service for members during after-hours for non-emergent issues. The answering service must forward calls to the PCP or to the on-call provider or instruct the member that the provider will contact the member within 30 minutes. When an answering machine is used after hours, the answering machine must provide the member with a process for reaching a provider after hours. PCPs may have a different after-hours phone number other than the office's daytime phone number.

For emergent issues, both the answering service and answering machine must direct the member to call **911** or go to the nearest emergency room. AmeriHealth Caritas North Carolina will monitor access to after-hours care on an annual basis by conducting a survey of PCP offices after normal business hours.

Monitoring Appointment Access and After-Hours Access
AmeriHealth Caritas North Carolina will monitor appointment waiting times and after-hours access using various mechanisms, including:

- Reviewing provider records during site reviews;
- Monitoring administrative complaints and grievances; and,
- Conducting an annual *Access to Care* survey to assess member access to daytime appointments and after-hours care**.**

Corrective Action for Non-Compliant Providers
Non-compliant providers will be subject to corrective action and/or termination from the Network, as follows:

- Non-compliant providers who have been non-compliant for two consecutive years will be visited by the Account Executive to discuss submission of a corrective action plan to come into compliance with the accessibility standards within 30 days. The Account Executive is responsible for monitoring the provider's timely compliance with the corrective action plan.
- The Account Executive will follow up with the non-compliant provider at the end of 30 days and re-assess whether the provider has come into compliance. Providers who are still non-compliant after the corrective action plan time period will be referred to the Quality Service Committee, the Director of Provider Network Management, the Market Chief Medical Officer, and the Director of Compliance for

review of the non-compliance, and determine possible disciplinary action, including termination of the provider's contract.

Panel Capacity & Notification
When members choose a provider as their PCP, they are assigned to the provider's panel of members.

The panel remains open unless the following occurs:

- The PCP is under sanction;
- The PCP has voluntarily closed his/her AmeriHealth Caritas North Carolina panel; or,
- The panel is closed by AmeriHealth Caritas North Carolina due to member access issues.

AmeriHealth Caritas North Carolina PCPs must have adequate capacity as this term is defined by the standard of care, prevailing industry norms and community standards including CMS and/or North Carolina guidance on this issue. PCPs are required to provide AmeriHealth Caritas North Carolina with a quarterly report of current caseload, including non-Plan-member patients.

In evaluating the capacity of PCPs, AmeriHealth Caritas North Carolina will take into consideration both a PCP's existing AmeriHealth Caritas North Carolina member load, overall member load (across all programs), Medicaid patient load, as well as its total patient load and will assess the overall patient load against community standards for any specialty involved.

AmeriHealth Caritas North Carolina will also consider whether the provider is in compliance with the Access Standards set forth in this *Provider Manual*. AmeriHealth Caritas North Carolina will not assign additional members to a single PCP if ACNC believes that PCP has reached the capacity to provide high quality services to Plan members.

Practitioner and Provider Responsibilities

Responsibilities of All Providers

AmeriHealth Caritas North Carolina is regulated by North Carolina and federal laws. Providers who participate in AmeriHealth Caritas North Carolina have responsibilities, including but not limited to:

- Provider must adhere to all terms and conditions agreed upon in their signed contract with AmeriHealth Caritas North Carolina and be compliant with all applicable federal and/or North Carolina regulations.
- Treat AmeriHealth Caritas North Carolina members in the same manner as other patients.

- Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., vaccines for children (VFC), communications regarding management of infectious or reportable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.
- Comply with all disease notification laws in North Carolina.
- Provide information to AmeriHealth Caritas North Carolina and/or the NCDHHS as required.
- Inform members about all treatment options, regardless of cost or whether such services are covered by ACNC or other programs.
- Maintain a communication network providing necessary information to any Mental Health/Substance Abuse (MH/SA) services provider as frequently as necessary based on the member's needs.
- As appropriate, work cooperatively with specialists, consultative services, and other facilitated care situations for special needs members such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDs, self-referrals for women's health services, family planning services, etc.

- Not refuse an assignment or transfer a member or otherwise discriminate against a member solely on the basis of religion, gender, sexual orientation, race, color, age, national origin, creed, ancestry, political affiliation, personal appearance, health status, pre-existing condition, ethnicity, mental or physical disability, participation in any governmental program, source of payment, or marital status or type of illness or condition, except when that illness or condition may be better treated by another provider type.
- Ensure that ADA requirements are met, including use of appropriate technologies in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the member's special needs.
- Abide by and cooperate with the policies, rules, procedures, programs, activities, and guidelines contained in your Provider Agreement (to which this *Provider Manual* and any revisions or updates are incorporated by reference).
- Accept AmeriHealth Caritas North Carolina payment or third-party resource as payment- in-full for covered services.
- Comply fully with AmeriHealth Caritas North Carolina's Quality Improvement, Utilization Management, Integrated Care Management, and Audit Programs.
- Comply fully with the NCTracks Enrollment process found at www.nctracks.nc.gov/public/providers/provider-recredentialing.html.
- Comply with all applicable training requirements as required by AmeriHealth Caritas North Carolina, North Carolina and/or CMS.
- Promptly notify AmeriHealth Caritas North Carolina of claims processing payment or encounter data reporting errors.
- Maintain all records required by law regarding services rendered for the applicable period of time, making such records and other information available to AmeriHealth Caritas North Carolina or any appropriate government entity.

- Treat and handle all individually identifiable health information as confidential in accordance with all laws and regulations, including HIPAA Administrative Simplification and HITECH requirements.
- Immediately notify AmeriHealth Caritas North Carolina of adverse actions against license or accreditation status.
- Maintain liability insurance in the amount required by the terms of the Provider Agreement.
- Notify AmeriHealth Caritas North Carolina of the intent to terminate the Provider Agreement as a participating provider within the timeframe specified in the Provider Agreement and provide continuity of care in accordance with the terms of the Provider Agreement.
- Verify member eligibility immediately prior to service.
- Obtain all required signed consents prior to service.
- Obtain prior authorization for applicable services.
- Maintain hospital privileges when hospital privileges are required for the delivery of the covered service.
- Provide prompt access to records for review, survey or study if needed.
- Report known or suspected child, elder or domestic abuse to local law authorities and have established procedures for these cases.
- Inform member(s) of the availability of AmeriHealth Caritas North Carolina's interpretive services and encourage the use of such services, as needed.
- Notify AmeriHealth Caritas North Carolina of any changes in business ownership, business location, legal or government action, or any other situation affecting or impairing the ability to carry out duties and obligations under the Provider Agreement.
- Maintain oversight of non-physician practitioners as mandated by North Carolina and federal law.
- Agreeing that claims data, medical records, practitioner and provider performance data, and other sources of information, may be used by ACNC to measure and improve the health care delivery services to members.

Primary Care Provider (PCP) Responsibilities

PCPs must adhere to all terms and conditions agreed upon in their signed contract with AmeriHealth Caritas North Carolina and be compliant with all applicable federal and/or North Carolina regulations.

The Primary Care Provider is defined as any 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 all the Member's health care needs and to initiate and monitor referrals for specialized services, when required.

A PCP is responsible to AmeriHealth Caritas North Carolina and its members for diagnostic services, care planning and Treatment Plan development. The PCP is expected to work with ACNC to monitor treatment planning and provision of treatment.

All new AmeriHealth Caritas North Carolina adult and child members with a newly assigned PCP, who has not previously cared for the member, must receive a comprehensive initial examination and a screening for mental health and substance abuse. The mental health and substance abuse screening must be completed using a scientifically validated screening tool.

For the initial examination and assessment of a child, the PCP is required to perform the relevant screenings and services, as well as any additional assessment, using the appropriate tools to determine whether or not a child has special health care needs. All Medicaid-covered children under 21 years of age receive EPSDT services.

For on-going care, the mental health and substance abuse screening must also be administered as a routine part of every child and adult preventive health examination.

AmeriHealth Caritas North Carolina PCPs are also expected to assist members with accessing substance abuse, mental health services, and long-term services and supports as needed. The Rapid Response team is available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling **1-833-808-2262.**

In addition, the PCP is responsible for:

- Providing continuous access to PCP services and necessary referrals of urgent or emergent nature available 24 hours, seven days per week.
- Managing and coordinating the health care of a member with a participating specialist(s), and/or behavioral health provider;
- Providing covered services to all assigned members and complying with all requirements for prior authorization.
- Providing assigned members with a medical home including, when medically necessary, coordinating appropriate referrals to services that typically extend beyond those services provided by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services and other community-based agency services.
- Adhering to North Carolina's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule for members under age 21.
- All in-network primary care providers are required to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with NCDHHS's Oral Health Periodicity Schedule.

- Early identification of all members, including children, with special health care needs or behavioral health needs and notification to the Rapid Response team and/or referral to PROMISE regarding any such identification as soon as possible;
- Collaboration with AmeriHealth Caritas North Carolina's Integrated Care Management programs to facilitate member care;
- Use of a valid and standardized developmental screening tool, approved by ACNC, to screen for developmental delays during well-child visits, episodic visits or as a stand-alone service;
- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a comprehensive developmental evaluation;
- Documentation of all diagnoses and care rendered in a timely, complete, and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas North Carolina's medical record documentation requirements;
- Providing follow-up services for members who have been seen in the Emergency Department;
- Promptly and accurately reporting all member encounters to AmeriHealth Caritas North Carolina;
- Releasing medical record information upon written consent or request of the member;
- Ensuring the release of medical records when a member changes PCPs. His/her medical records or copies of medical records should be forwarded to the new PCP within 10 business days from receipt of request. The State is not required to obtain written approval from a member before requesting the member's record from the PCP or any other participating provider.
- Providing preventive healthcare to members according to established preventive health care guidelines;
- Advising the Rapid Response team at **1-833-808-2262** if outreach assistance is needed when a member does not keep appointment and/or when a member cannot be reached during an outreach effort.
- Advising AmeriHealth Caritas North Carolina ninety (90) days in advance of the effective date if they elect to decline accepting additional members.
- Advising AmeriHealth Caritas North Carolina at least 60 days in advance of any addition or change in office location.

OB/GYN Practitioner as a PCP

All OB/GYN Practitioners must adhere to all terms and conditions agreed upon in their signed contract with AmeriHealth Caritas North Carolina and be compliant with all applicable federal and/or North Carolina regulations.

Participating Obstetricians are responsible for medical services during the course of the member's pregnancy, and for coordinating testing and referral services. Obstetricians may also provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma.

- Treatment of minor physical injuries.
- Preventive health screenings and maintenance.
- Routine gynecological care.

The OB/GYN is also responsible for notifying the Bright Start® Care Managers at **1-833-475-2262** for assistance with support services needed to help a member during pregnancy.

Prenatal care providers are expected to complete the Pregnancy Medical Home Risk Screening form to assess risk for each pregnant member. The completed screening tool must be submitted to AmeriHealth Caritas North Carolina as part of the authorization for obstetric services. To access the form, go to the forms section of the AmeriHealth Caritas North Carolina website: www.amerihealthcaritasnc.com.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks. Pregnancies that are considered high-risk due to physical, social, or behavioral conditions must also be reported to ACNC at the time of the first visit or at the time when the high-risk situation is identified during the pregnancy. All high-risk conditions should be reported to a Bright Start® Care Manager at **1-833-475-2262.** Providers can fax reports to Bright Start® at: **1-833-463-2262.**

Specialist Responsibilities
All Specialists must adhere to all terms and conditions agreed upon in their signed contract with AmeriHealth Caritas North Carolina and be compliant with all applicable federal and/or North Carolina regulations.

An AmeriHealth Caritas North Carolina specialist is responsible for:

- Providing specialty care as indicated by the referring practitioner;
- Reporting clinical findings to the referring PCP;
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the member, as requested by the referring practitioner;
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for Plan members that meets AmeriHealth Caritas North Carolina's medical record documentation requirements;
- Refraining from referring members to other specialists without the intervention of the member's PCP;
- Verifying a member's eligibility prior to the provision of services.

Compliance Responsibilities

Providers are required to comply with all applicable Plan policies and procedures, applicable federal and state regulations, and applicable contractual requirements set by our state Medicaid agency partners.

Although not an exclusive list, the primary areas of compliance with policies and regulations for Plan providers are:

- Americans with Disabilities Act (ADA) / Rehabilitation Act
- Health Insurance Portability and Accountability Act (HIPAA)
- Program Integrity/Fraud, Waste & Abuse (FWA)
- False Claims Act
- Fraud Enforcement and Recovery Act
- Advance Directives
- Marketing Activities Guidelines
- The Nondiscrimination Rule set forth in Section 1557 of the Patient Protection and Affordable Care Act
- Tobacco-Free Policy Requirement

The Americans with Disabilities Act (ADA) and the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973 ("Rehabilitation Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require ACNC's providers to make their services and facilities accessible to all individuals. AmeriHealth Caritas North Carolina expects its network providers to be familiar with the requirements of the Rehabilitation Act and the ADA and to fully comply with the requirements of these statutes.

Health Insurance Portability and Accountability Act (HIPAA)

AmeriHealth Caritas North Carolina is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA), as well as all applicable state and federal regulations governing the privacy and security of health information. AmeriHealth Caritas North Carolina expects its practitioners and providers to be familiar with their HIPAA responsibilities and to take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other identifying information on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

Program Integrity/Fraud, Waste and Abuse

AmeriHealth Caritas North Carolina is obligated to ensure the effective use and management of public resources in the delivery of services to its members. AmeriHealth Caritas North Carolina does this in part through its Program Integrity department, whose programs are designed to ensure the accuracy of claims payments and to detect and prevent fraud, waste, and abuse. In connection with these programs, you may receive written communications from or on behalf of AmeriHealth Caritas North Carolina, regarding payments or the recovery of potential overpayments. You may be asked to provide supporting documentation including the medical record or itemized bill to support the review of the claim. In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer's

submission of similar claims; if this were to occur you would be notified and additional action may be required on your behalf. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract, and with state and federal law. Examples of these Program Integrity initiatives include:

1. **Prospective (Pre-claims payment)**
    a. Claims editing – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services ("CMS"), the American Medical Association ("AMA"), state regulatory agencies or AmeriHealth Caritas North Carolina medical/claim payment policy) are applied to prepaid claims.
    b. Medical Record/Itemized Bill review – a medical record and/or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.
    c. Provider must submit an itemized bill with any claim type with a total billed amount greater than:

Please note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested time frame.

Claim Type	Threshold amount
Hospital Inpatient claims	$250,000
Hospital Outpatient claims	$75,000
Professional claims	$25,000

i. To simplify the submission process, ACNC has added functionality for network providers to submit electronic attachments to support medical claims via electronic data interchange clearinghouses. See more on our Claims and Billing webpage.
ii. ACNC's medical claims review vendor will prospectively review any submitted claims and itemized bills and submit findings to ACNC for claim adjudication. The remittance advice will reflect any payment differences resulting from the review. Within 20 business days of the date of the remittance advice, ACNC will mail a facility packet to the provider including a Forensic Review Report that contains any identified billing issues.

iii. General questions regarding the prospective reviews should be directed to the contact information found on the Forensic Review Report. The medical claims review vendor can answer inquiries regarding the report's findings or the documentation and explanations and clarify the charges in question.

a. Coordination of Benefits ("COB") - Process to verify third party liability to ensure that AmeriHealth Caritas North Carolina is only paying claims for

members where AmeriHealth Caritas North Carolina is responsible, i.e., where there is no other health insurance coverage.

b. Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

2. **Retrospective (Post-claims payment)**
   a. Third Party Liability ("TPL")/Coordination of Benefits ("COB")/Subrogation – As a Medicaid plan, AmeriHealth Caritas North Carolina is by federal statute the payor of last resort. The effect of this rule is that AmeriHealth Caritas North Carolina may recover its payments if it is determined that a member had other health insurance coverage at the time of the service.
   2. a. i. Please also see Section XI Claims Submission Protocols and Standards for further description of TPL/COB/Subrogation.
   b. Data Mining – Using paid claims data, AmeriHealth Caritas North Carolina identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
   c. Medical Record /Itemized Bill Review – a medical record and/or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. The scope of the validation may encompass any or all of the procedures, diagnosis, or diagnosis-related group ("DRG") billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.

Please note if medical records are not received within the requested timeframe, AmeriHealth Caritas North Carolina will recoup funds from the provider. Your failure to provide the necessary medical records to validate billing creates a presumption that the claim as submitted is not supported by the records.

3. **Credit Balance Issues**
   a. Credit balance review service may be conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
   b. Overpayment Collections – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you may be requested to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas North Carolina reserves the right to adjust any payment made following a review of the medical records or other documentation and/or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided.

Federal False Claims Act

The Federal False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors, including state Medicaid agencies, for payment or approval. Additionally, the FCA prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When AmeriHealth Caritas North Carolina submits claims data to the government for payment (for example, submitting Medicaid claims data to NCDHHS) we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to ensure compliance.

The FCA, through amendments made under the Fraud Enforcement and Recovery Act of 2009, also prohibits knowingly concealing or knowingly and improperly avoiding the return of identified overpayments.

Penalties for violating the FCA include civil monetary penalties (CMPs) ranging from $11,181 to $22,363 (as adjusted by the DOJ under the Federal Civil Penalties Inflation Adjustment Act of 1990) per false claim, and/or exclusion from federally funded programs. In addition, violators are subject to three times the amount of damages sustained by the Federal government because of the illegal act(s) unless the violator has voluntarily disclosed the FCA violation under certain conditions.

North Carolina False Claims Act

The North Carolina False Claims Act (NC FCA) allows private individuals to file a lawsuit on behalf of the State of North Carolina. These lawsuits are known as qui tam lawsuits and the private individuals who file them are known as whistleblowers. The qui tam lawsuit is filed against a person or business for submitting or causing the submission of false claims to the state or becoming aware of mistakenly submitted claims and failing to submit repayment. The purpose of the NC FCA is to deter persons from knowingly causing or assisting in causing the State to pay claims that are false or fraudulent and to provide remedies in the form of treble damages and civil penalties when money is obtained from the State by reason of a false or fraudulent claim.

The NC FCA specifically makes liable any person who: (1) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (3) conspires to commit a violation of subdivision (1), (2), (4), (5), (6), or (7) of this section; (4) has possession, custody, or control of property or money used or to

be used by the state and knowingly delivers or causes to be delivered less than all of that money or property; (5) is authorized to make or deliver a document certifying receipt of property used or to be used by the state and, intending to defraud the state, makes or delivers the receipt without completely knowing that the information on the receipt is true; (6) knowingly buys, or receives as a pledge of an obligation or debt, public property from any officer or employee of the state who lawfully may not sell or pledge the property; or (7) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State.

Damages for violating the NC FCA may include treble damages and significant fines. The NC FCA rewards whistleblowers by allowing a whistleblower to receive a percentage of any recovery. The NC FCA also provides whistleblower protection against workplace retaliation by employers, which may include loss of pay, demotion, suspension, firing, harassment, threats, as well other retaliations.

The Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 (FERA) increases the government's power to investigate and prosecute any financial fraud against the government and expands liability under the False Claims Act (FCA). FERA expanded potential liability under the FCA in several ways, most notably by:

- Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like AmeriHealth Caritas North Carolina**.**
- Expands the scope of liability for reverse false claims to include the knowing retention of overpayments.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

Program Integrity Operations Team

Program Integrity Operations is responsible for the identification, reporting, and collection of FWA recoveries. The teams use real-time data to identify overpayments, provide specific state or contractual reporting, and collect outstanding balances from providers. This team is made up of three subgroups: Claims Cost Management, Inventory and Recovery, and Credit Balance.

The Internal Claims Cost Management team performs prospective (pre-payment) and retrospective (post-payment) analysis to validate the accuracy of claims payments.

- **Prospective analysis** - This analysis includes the development of front-end edits to identify inaccurate payments, prior to payment of the claim. The team coordinates the correction of the claim payment with the AmeriHealth Caritas North Carolina claims processing unit.

- **Retrospective analysis -** The team performs first-pass retrospective review of paid claims. Retrospective edits help us identify potential overpayments of professional, outpatient, and facility claims; we then submit these for recovery of the overpayment.

Inventory and Recovery

The Inventory and Recoveryteam acts as the gatekeeper of all FWA inventory accountable for intake, management, and monitoring of overpayment recovery projects. This team uses a system called CORS (claim overpayment recovery system) to track and report all related activity.

The Credit Balance team pursues outstanding provider credit balances that exist for more than 60 calendar days. They perform provider outreach through outbound calls and letter mailings.

Claims Cost Containment Unit

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Program Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from providers causing overpayment.
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system.
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments.
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility.

The Claims Cost Containment Unit is also responsible for the manual review of provider-initiated overpayments. Providers who self-identify claim overpayments may submit their inquiries for review to the following address:

Claims Cost Containment
PO Box 7380
London, Kentucky 40742-7380

Refunds for Claims Overpayments or Errors

AmeriHealth Caritas North Carolina and NCDHHS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to make arrangements within 60 days to return the funds to AmeriHealth Caritas North Carolina or follow the NCDHHS protocol for returning improper payments or overpayments:

1. Contact AmeriHealth Caritas North Carolina Provider Services at **1-888-738-0004** to arrange the repayment. There are two ways to return overpayments to AmeriHealth Caritas North Carolina:

    - Have AmeriHealth Caritas North Carolina deduct the overpayment/improper payment amount from future claims payments, or

    - Return the overpayments directly to AmeriHealth Caritas North Carolina:

      Use the Claim Refund form when submitting return payments to AmeriHealth Caritas North Carolina. The form is available on the Provider Manuals, Policies and Forms webpage.

    - Include the Member's name and ID, date of service, and Claim ID. Mail the completed form and refund check for the overpayment/improper payment amount to:

      AmeriHealth Caritas North Carolina
      Claims Processing Department
      PO Box 7380
      London, KY 40742-7380

Special Investigations Unit – Preventing, Detecting, and Investigating Fraud, Waste and Abuse

The Special Investigations Unit (SIU) is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claim's payment processes for AmeriHealth Caritas, including AmeriHealth Caritas North Carolina. The SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Registered Nurses, Certified Fraud Examiners, and Accredited Health Care Fraud Investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste, and abuse.
- Implements corrective actions for any supported allegations after thorough investigation, which may include recovery of identified overpayments, placing providers on pre-payment review of claims, and making referrals to appropriate agencies in compliance with contractual obligations.

Definitions of Fraud, Waste and Abuse (FWA)

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or

some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid Program.

Examples of fraudulent, wasteful, and abusive activities:

- Billing for services not rendered or not medically necessary
- A physician ordering excessive diagnostic tests.
- Alteration or forgery of documentation.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not medically necessary.
- A doctor prescribes a brand-name drug when there's a lower-cost generic option that works the same way.
- Misrepresenting the services rendered.
- Submitting a claim for provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failing to perform services required under a capitated contractual arrangement.
- Misrepresenting dates and times of service.
- Misusing Electronic Medical Records, such as by cloning and copying so records are identical, not unique, and/or specific as required.
- Failing to have supporting documentation for billed services.

Reporting and Preventing FWA

AmeriHealth Caritas North Carolina receives state and federal funding for payment of services provided to our members. In accepting claims payment from AmeriHealth Caritas North Carolina, providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse

against the medical assistance program. Compliance with federal laws and regulations is a priority of AmeriHealth Caritas North Carolina.

If you, or any entity with which you contract to provide health care services on behalf of AmeriHealth Caritas North Carolina beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact AmeriHealth Caritas North Carolina by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**.
- Emailing to fraudtip@amerihealthcaritas.com; or
- Mailing a written statement to:

  Special Investigations Unit
  AmeriHealth Caritas North Carolina
  200 Stevens Drive
  Philadelphia, PA, 19113

Below are examples of information that will assist ACNC with an investigation:

- Information (e.g., name of individual making the allegation, address, number). Name and Identification Number of the suspected individual.
- Approximate Dollars involved (if known).
- Place of Service
- Description of the Alleged Fraudulent or Abuse Activities
- Timeframe/Date of the Allegation(s)

Report suspected Provider fraud, waste, and abuse directly to the North Carolina's Attorney General's Medicaid Investigations Division by calling **1-919-881-2320**

North Carolina Department of Justice
Medicaid Investigations Unit
5505 Creedmoor Rd.
Suite 300
Raleigh, NC 27612
Fax: **919-571-4837**

Medicaid recipient fraud should be reported to the North Carolina Division of Medical Assistance at 1-800-662-7030. Their fax number is **1-919-571-4837.**

What to Expect as a Result of SIU Activities

The Special Investigations Unit (SIU) utilizes the prepayment pending of claims as a corrective action tool. As part of its oversight responsibilities associated with the North Carolina Medicaid Program, AmeriHealth Caritas North Carolina has the authority in accordance with N.C.G.S § 108C-7, 10A NCAC 22F.0104(c) and Parts 455, 456 and 457 of Title 42 of the Code of Federal Regulations, to implement a prepayment review process

whereby medical records are requested and reviewed prior to the timely adjudication of claims submitted by providers participating in the North Carolina Medicaid Program. Compliance with requests to submit medical records is a requirement of your provider agreement/contract with AmeriHealth Caritas North Carolina.

The SIU will send a Prepayment Review Notification Letter advising a provider that prepayment review has been implemented. The letter includes: the reason the provider was placed on prepayment review, the effective date of prepayment review, 20 calendar days from the mailed date of the Notification Letter, a description of the prepayment review process, a specific list of supporting documentation/medical records the provider needs to submit to the prepayment review vendor for all claims subject to prepayment review, the process for submitting claims and documentation and the standard evaluation to determine when a provider's claims will no longer be on prepayment review.

Optum Insight, Inc. (Optum), on behalf of AmeriHealth Caritas North Carolina (ACNC) Special Investigations Unit (SIU), will perform the prepayment review of claims. This review will begin no less than 20 calendar days from the date of the Notification Letter. Only claims submitted after the 20th day will be subject to prepayment review.

The documentation submitted must follow the process outlined in the Prepayment Review Notification Letter and be complete, legible, and clearly identify the provider to which the documentation applies. If the provider failed to provide any of the specifically requested supporting documentation necessary to process a claim, Optum shall send the provider written notification of the lacking or deficient documentation within 15 calendar days of the due date of requested supporting documentation. Optum shall have an additional 20 days to process a claim upon receipt of the provider documentation.

Claims for services will be pended during the review process and reviews will be conducted by coding specialists, nurses and physicians using nationally recognized published guidelines. The review will be completed within 20 calendar days from receipt of your documentation. The review will determine if the billed codes are supported. If the billed codes are not supported, the claims will be denied. If claims are submitted without the requested documentation, they will be denied. Providers can re-file claims denied for no medical records with the appropriate supporting medical records. Monthly prepayment review status letter(s) will be sent to the provider, which includes a description of the findings of completed reviews.

The SIU Investigator will monitor the provider's billing accuracy while the provider is on prepayment review. When a provider's billing accuracy falls into compliance for a minimum of three (3) consecutive months, SIU management can remove the provider from prepayment review. The standard of evaluation used to determine when a provider's claims will no longer be subject to prepayment claims review is as follows: the provider's claims will remain subject to the prepayment claims review process until the provider achieves and maintains a claims submission accuracy rate of 70% for three (3) consecutive calendar months provided that the number of claims submitted per month is no less than fifty percent (50%) of the average monthly submission of claims for the three-month

period before being placed on prepayment review. If providers do not submit any claims within a month while on prepayment review, the claims accuracy rate will be zero percent (0%). Providers shall not withhold claims to avoid the claims review process.

The accuracy rate is determined by the total number of claims and detail line items determined as approved or denied within each month in which the claims are submitted for payment. This means that 70% of all claim detail lines submitted by the provider's agency must be identified as containing no error(s). A single claim may contain one or more procedures billed on the same or different dates of service. In the prepayment review process, the methodology for calculating a provider's accuracy rate is to take all claim detail lines with no identified errors divided by the total number of claim detail lines submitted for review. Prepayment review will not continue more than 24 months unless termination or other sanction has been initiated.

Providers cannot appeal the action of being placed on prepayment review.

See Attachment A: Prepayment Review Policy No. 106.100.010.

Advance Directives

All participating Plan providers are required to facilitate advance directives for individuals as defined in 42 C.F.R 489.100 and to comply with all federal and state laws and regulations related to advance directives, including 42 C.F.R. 489.100 and Article 23 of Chapter 90 of the General Statutes. The Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under federal law to decide what health care that he/she wants to receive, if in the future the member is unable to make his/her wishes known about medical treatment. Providers are required to document in the member's medical record and plan of care whether or not the member has executed an Advance Directive. The member has the right to choose a person to act on his or her behalf to make health care decisions for him/her if the member cannot make the decision for him or herself. North Carolina Advance Directives information is found on the NCDHHS website . The forms are available on Provider Manuals, Policies and Forms webpage under Forms.

AmeriHealth Caritas North Carolina requires its contracted providers to maintain written policies and procedures concerning advance directives with respect to all adults receiving care. The information regarding advance directives must be furnished by providers and/or organizations as required by federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled Nursing Facility - At the time of the individual's admission as a resident.
- Home Health Agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about Advance

Directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

- Hospice Program - At the time of initial receipt of hospice care by the individual from the program.

Additionally, providers and/or organizations are not required to:

- Provide care that conflicts with an advance directive.
- Implement an advance directive if doing so would violate an attending physician's conscience or the conscience-based policy of the facility at which a patient is being treated. However, the physician must cooperate in the transfer of the patient to a facility or physician who will honor the directive.
- Implement an advance directive if, after reasonable inquiry, there are reasonable grounds to question the genuineness or validity of a declaration.

Provider Marketing Activities Guidelines

- As a contracted provider, you are permitted to share the following with Plan members:
    - General and factual information about AmeriHealth Caritas North Carolina and your participation in ACNC's network.
    - Plan-provided member education materials that have been approved by ACNC and the NCDHHS.
    - Contact information for the North Carolina Department of Health and Human Services' contracted Enrollment Broker.
- As a contracted provider, you are prohibited from participating in the following activities:
    - Conducting any marketing, including mass marketing, to individuals or the general public with the intention of inducing patients to join a particular Medicaid plan or to transfer from one plan to another.
    - Mass marketing includes use of any mass media outlets such as radio, television, newspaper, billboards, bus posters, and social media advertisements.
    - Using written or oral methods of communication with members to assert or imply that the member must enroll in a specific Medicaid health plan to obtain Medicaid benefits or in order not to lose Medicaid benefits.
    - Using written or oral methods of communication with members to compare benefits or other aspects of Medicaid Prepaid Health Plan (PHP).
    - Using written or oral methods of communication to share false or misleading information regarding ACNC or the provision of services, including suggesting that any particular Medicaid plan is uniquely endorsed by a government entity.
    - Performing direct marketing activities or solicitation on behalf of ACNC, including the sale or offering of any incentives such as private insurance, or gifts.
    - Using marketing materials, strategies, or activities that discriminate against or target potential members or potential members based on health status, geographic residence, location of possible services, or income.

- Performing or permitting any marketing activities on behalf of ACNC at your office location.
- Using marketing materials that have not been approved by ACNC and NCDHHS.
- Assisting with or making recommendations for enrollment with ACNC, except to refer prospective members to the North Carolina Department of Health and Human Services' contracted Medicaid Managed Care Enrollment Broker.
- Using written or oral methods of communications with members in health care settings *other than* common areas. Common areas where marketing activities are permitted include hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. Marketing activities will not be conducted in areas where patients primarily intend to receive health care services, including but not limited to emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.

Provider Support and Accountability

Provider Network Management

AmeriHealth Caritas North Carolina's Provider Network Account Executives function as a provider relations team to advise and educate AmeriHealth Caritas North Carolina providers. Provider Network Account Executives assist providers in adopting new business policies, processes, and initiatives. From time to time, providers will be contacted by Plan representatives to conduct meetings that address topics including, but not limited to:

- Contract Terms
- NCDHHS Processes for Credentialing or Re-credentialing
- Population Health Programs
- Orientation, Education, and Training
- Program Updates and Changes
- Provider Complaints
- Provider Responsibilities
- Quality Enhancements
- Self-Service Tools

New Provider Orientation and Training

AmeriHealth Caritas North Carolina is committed to partnering with its providers and the North Carolina Department of Health and Human Services to promote quality and accessible care to its members. As part of this commitment, AmeriHealth Caritas North Carolina requires that all providers be familiar with ACNC's administrative and clinical procedures, policies, programs, and requirements, as well as relevant Federal and State regulations, including but not limited to applicable Medicaid Managed Care Rule requirements.

The AmeriHealth Caritas North Carolina Provider Network Management department is responsible for conducting provider orientations and ongoing training. The Account Executive is responsible for building, nurturing, and maintaining positive working relationships between AmeriHealth Caritas North Carolina and its contracted providers. The Account Executive conducts orientation sessions, educational visits, functions as a proactive practice account manager, and coordinates resolution of provider issues. The Account Executive is responsible for documenting all provider orientation and education sessions as established by department standards. Providers who do not complete the orientation and required trainings will be subject to progressive discipline and removal from AmeriHealth Caritas North Carolina Provider Network.

Upon completion of AmeriHealth Caritas North Carolina's contracting processes, each provider will receive a welcome letter within five (5) business days of executing the contract, which will include the effective date, AmeriHealth Caritas North Carolina provider ID, and the Provider Network Account Executive's contact information. The welcome letter will refer all Plan providers to online resources, including AmeriHealth Caritas North Carolina provider orientation and training information and this *Provider Manual*. The *Provider Manual* serves as a source of information regarding ACNC's covered services, policies and procedures, selected statutes and regulations, telephone access and special requirements intended to support provider compliance with all provider contract requirements. The welcome letter explains how to request a hard copy of this *Provider Manual* by contacting the Provider Services department at **1-888-738-0004.**

Orientation Training

AmeriHealth Caritas North Carolina will conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status upon request. Orientation training topics will include:

- Billing, Claims Filing, and Encounter Data Reporting
- Co-Pays
- Covered Services, Benefit Limitations, and Value-Added Service
- Cultural Competency, bias, diversity, equity, and inclusion including considerations for Gender Affirming Care and Tribal populations. Materials are available for download at the website hyperlinks provided.
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements
- Electronic Funds Transfer and Electronic Remittance Advice
- Managed Care
- Medicaid Compliance
- Medical Necessity Criteria, Clinical Practice Guidelines, and Screening Tools
- Member Access Standards
- NCDHHS Centralized Credentialing Process
- Plan Policies and Procedures
- Population health management goals

- Provider Grievance and Appeal Processes
- Provider Responsibilities (including Advance Directives, Fraud, Waste & Abuse, Reporting Requirements, HIPAA, and Privacy, etc.)
- Quality Enhancement Programs/Community Resources
- Telemedicine
- Utilization Management, Quality Improvement and Population Health Management Programs
- Value Based Programs

Additional Provider Trainings & Meetings

At a minimum, AmeriHealth Caritas North Carolina will provide training on the following topics as required by NCDHHS:

- Development and implementation of provider practices that support wellness, disease management, and health education for members.
- North Carolina Opportunities for Health.
- Sensitivity to the special needs of the Medicaid population.
- Advanced Medical Homes
- LTSS provider training, as applicable.
- Into the Mouths of Babes (IMB) training

Provider Education and On-Going Training

AmeriHealth Caritas North Carolina's training and development are fundamental components of continuous quality and superior service. ACNC offers on-going educational opportunities for providers and their staff. ACNC is committed to offering appropriate training and education to help providers achieve compliance with Plan standards, and federal and state regulations. Provider training and educational programs are based on routine assessments of provider training and educational needs. This training may occur in the form of an on-site visit or in an electronic format, such as online or interactive training sessions. Detailed information is shared in advance of training opportunities and is available on the AmeriHealth Caritas North Carolina website at www.amerihealthcaritasnc.com.

Plan-to-Provider Communications

Providers will receive or have access to regular communications from AmeriHealth Caritas North Carolina including, but not limited to the following:

- Provider Manual
- Provider Newsletters
- Website Updates and Information
- Provider Notices and Announcements

- Surveys
- Faxes
- Emails
- Miscellaneous Other Materials

Business Continuity Planning

AmeriHealth Caritas North Carolina follows an all-hazards approach (e.g., fire, flood, terrorist event, hurricane/tornado, winter storm, technology failure, pandemic, public health emergency, etc.), meaning that business continuity plans are executed for any risk or threat that affects critical business services or key assets.

In the event of an emergency, providers both within and outside of the affected area will continue to be able to access all needed services and information. Providers should consult the AmeriHealth Caritas North Carolina website (www.amerihealthcaritasnc.com) or contact Provider Services at **1-888-738-0004**.

AmeriHealth Caritas North Carolina may issue additional guidance in response to the emergency via fax blast or email communication.

Providers within an Affected Area

AmeriHealth Caritas North Carolina Provider Services will continue to be available in an emergency situation. Provider Network Management Account Executives will be assigned and available to providers who are affected by the emergency. AmeriHealth Caritas North Carolina will provide outreach to providers following an emergency to identify providers who are closed temporarily. Provider Network Management will assist providers who are temporarily discontinuing services to redirect members to an alternate provider as needed. Alternate providers nearest the member(s) will be identified based on the successful contacts made to providers that identify themselves as open or, when necessary, members may be linked with providers located in the non-affected area(s). Provider outreach will continue post-disaster to help ensure that the needs of members are being addressed and to assure that provider demographic information is maintained accurately.

Providers outside an Affected Area

Staff outside of the affected area will be able to assist providers in answering questions and providing information. For those providers outside of the affected area, there will be no disruption to the day-to-day operations or usual service levels available.

Provider Grievances and Appeals

Please see Section VII “Provider Grievances and Appeals “of this provider manual.

PerformPlus Value Based Program Participation

As a participating provider with AmeriHealth Caritas North Carolina, the Members assigned to the participating provider's associated Plan will be included in the applicable PerformPlus® value-based program(s), as determined by provider type and specialty. The provider-specific program will be implemented pursuant to a written addendum to, and will thereby become incorporated to, the provider's Agreement. For the initial contract period, there will be no downside risk as the program will qualify as meeting state-based requirements. For ongoing participation in a PerformPlus value-based program beyond the first year, the parties agree to negotiate in good faith to agree to terms for a value-based model that may include an element of downside risk.

AmeriHealth Caritas North Carolina will offer provider support and services to help ensure provider success in our value-based payment programs. Provider support includes, but is not limited to, practice transformation support, access to reporting and analytics, and ongoing opportunities to collaborate on value-based program design.

Tobacco-Free Policy Requirement

Effective January 1, 2027, unless the provider is a residential facility, all in-network providers are required to comply with NCDHHS's tobacco free policy. Providers shall implement a tobacco-free policy and are encouraged to review NCDHHS blog post, dated March 21, 2024, for more information.

Provider shall develop and implement a tobacco-free policy covering any portion of the property on which Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting Provider from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients Provider serves.

Contracts with facilities that are owned or controlled by the provider, and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

(1) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by Provider.
(2) For outdoor areas of campus, Provider shall:
i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
ii. Prohibit staff/employees from using tobacco products anywhere on campus.

SECTION III
PROVISION OF SERVICES

III. Provision of Services

This section provides a summary of the covered services offered to AmeriHealth Caritas North Carolina members under the Medicaid Managed Care Program.

No content found in this publication or in ACNC's participating Provider Agreement is intended to prohibit or otherwise restrict a provider from acting within the lawful scope of his or her practice, or to encourage providers to restrict medically necessary covered services or to limit clinical dialogue with patients. Providers are not prohibited from advising or advocating on behalf of a member who is his or her patient and may discuss the member's health status, health care, treatment options (including any alternative treatment that may be self-administered), information the member needs to make a decision between relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. Regardless of benefit coverage limitations, providers are encouraged to openly discuss all available treatment options with Plan members.

Covered Services

Basic covered services include inpatient; outpatient and ambulatory medical and surgical services; gynecological, obstetric, and family planning services; limited behavioral health services, LTSS and a variety of other services. Plan members may also be eligible to receive other services covered by North Carolina's fee-for-service Medicaid program.

All services must be medically necessary, and some services may have limitations or require authorization. For information on Prior Authorization requirements, see the "Utilization Management" section of this *Provider Manual*.

For the most complete and up-to-date benefit information please contact AmeriHealth Caritas North Carolina Provider Services at **1-888-738-0004.**

For additional information regarding the North Carolina Medicaid program policies and benefits, please go to https://medicaid.NCDHHS.gov/providers

Please note: Covered benefits vary by program. Providers should verify eligibility before rendering services. Please refer to "Verifying Eligibility" in Section I for how to confirm eligibility.

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
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 will 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).	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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 will 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. 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			

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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			
Limited inpatient and outpatient behavioral health services	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. Please refer to NC Clinical Coverage Policies and services listed.	Yes		Yes
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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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].	Yes		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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. § 440.70.	Yes		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;	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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 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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. Child health assistance in RHCs is authorized for NC Medicaid beneficiaries in 42 U.S.C. 1397jj(a)(5). 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.			
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. Child health assistance in FQHCs is authorized for NC Medicaid beneficiaries in U.S.C. 1397jj(a)(5). The specific health care encounters that constitute a core service include the following face to face encounters:	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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.	Yes		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		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
Family planning services	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.	Yes		Yes
Certified pediatric and family nurse practitioner services	(a) 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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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.	Yes		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. Medicaid only pays for the least expensive means suitable to the recipient's needs.	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program beneficiaries. 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		Yes
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	Yes		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		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 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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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 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.	Yes		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		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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			

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
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		Yes
Optometry services	Medicaid will 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 are qualified providers for visual aids.	Yes		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.			
Private Duty Nursing	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 will be rendered by a licensed	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c. 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	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.	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by: Medicaid		ACNC
	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	Yes		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by: Medicaid		ACNC
	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	Yes		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. *ACNC Note: IMD exclusion is waived for Medicaid beneficiaries receiving treatment for substance use disorders.	Yes		No
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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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.	Yes		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		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		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,	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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 cochlear, auditory brainstem, and bone anchored hearing aid implant to maintain 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. Only device manufacturers are qualified providers.	Yes		Yes
Burn Treatment and Skin Substitutes	Provides treatment for burns.	Yes		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		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
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		Yes
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories, supplies, repairs, and dispensing fees when there is medical necessity.	Yes		Yes
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	Yes		Yes
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	Yes		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	included under general ophthalmological services or in which special treatment is given.			
Pharmacy Services	Provides a comprehensive prescription drug benefit.	Yes		Yes
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	Yes		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, including medically necessary contact lenses when an eye disease or condition cannot be managed by eyeglasses. Providers who supply eye exams and eyeglasses in their office must also supply Medicaid eye exams and fee-for-service eyeglasses to members.	Yes		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	Yes		Yes

COVERED SERVICES				
Service	Description	Covered by:		
		Medicaid		ACNC
	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.			

Pre-Operative Test Requirements

It is the surgeon's responsibility to provide information to the member on the hospital's requirements for pre-operative physical examination, laboratory, and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work up.

Covered Behavioral Health Services

Ambulatory Detoxification Services	Outpatient behavioral Health Emergency Services
Clinically managed residential withdrawal management (Social setting Detox)	Outpatient Behavioral Health Services
Diagnostic Assessment Services	Outpatient behavioral health services provided by direct-enrolled providers
EPSDT Authorized Services	Outpatient Opioid Treatment
Facility-based Crisis Services for Children and Adolescents	Partial Hospitalization
Inpatient behavioral Health Services	Professional Treatment Services in a Facility-Based Crisis Program
Medically supervised Alcohol and Drug Abuse Treatment Center Detoxification, Crisis Stabilization	**Substance Abuse Comprehensive Outpatient Treatment (SACOT)**
Mobile Crisis Management Services	**Substance Abuse Intensive Outpatient Treatment (SAIOP)**
Non-hospital Medical Detoxification Services and partial hospitalization	

See the ACNC Opioid Misuse Prevention Program Description on the Provider Manuals, Policies and Forms webpage.

AmeriHealth Caritas North Carolina will refer members to local resources for services that are not covered by ACNC, as appropriate. Providers may contact the Rapid Response team at **1-833-808-2262** for assistance with coordination of non-covered services.

Services Carved out of Medicaid Managed Care

Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT

codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

AmeriHealth Caritas North Carolina Managed Care Cost Sharing (Co-pays)

AmeriHealth Caritas North Carolina imposes the same cost-sharing amounts as NCDHHS and does not require Members to pay for any covered services other than the co-payment amounts as specified by NCDHHS.

Medicaid Managed Care Cost Sharing			
INCOME LEVEL	**ANNUAL ENROLLMENT FEE**	**SERVICE**	**COPAY**
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency	$4/visit $4/visit $4/visit $4/prescription $4/visit $4/visit $4/visit $4/visit

Exceptions to Cost Sharing
Medicaid
Medicaid cost-sharing does not apply to subset of the population including: • members under age twenty-one (21) members who are pregnant • members receiving hospice care • federally recognized tribal members • NC Breast and Cervical Cancer Control Program (NC BCCCP) beneficiaries Children in foster care • People living in an institution who are receiving coverage for cost of care Behavioral health services • Intellectual or developmental disability (I/DD) services • Traumatic brain injury (TBI) services

Private Pay for Non-Covered Services

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas North Carolina prior to rendering such services. Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Emergency Services

Members requiring emergency care should be advised to call 911.

AmeriHealth Caritas North Carolina ensures the availability of emergency services and care **24 hours a day, 7 days a week** and is responsible for coverage and payment of emergency and post-stabilization care services regardless of whether the provider who furnishes the services has a contract with AmeriHealth Caritas North Carolina. Post-stabilization services remain covered until AmeriHealth Caritas North Carolina contacts the emergency room and takes responsibility for the member.

AmeriHealth Caritas North Carolina will not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have placed the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulted in serious impairment to bodily functions, or resulted in serious dysfunction of any bodily organ or part.

AmeriHealth Caritas North Carolina will not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider, AmeriHealth Caritas North Carolina or applicable state entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Any provider of emergency services who does not have a contract in effect with AmeriHealth Caritas North Carolina must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that the provider could collect if the member received medical assistance under Title XIX or Title XXI through an arrangement other than enrollment in AmeriHealth Caritas North Carolina.

Definitions and requirements regarding urgent/emergent care are as follows:

Emergency Medical Condition. A medical 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 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services. Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an Emergency Medical Condition.

Urgent Care. Treatment of a condition that is potentially harmful to a patient's health and for which it is medically necessary for the patient to receive treatment within 48 hours to prevent deterioration.

Out-of-Network Use of Non-Emergency Services

AmeriHealth Caritas North Carolina will provide timely approval or denial of requests for authorization of out-of- network service(s) through the assignment of a prior authorization number, which refers to and documents the determination. Written follow-up documentation of the determination will be provided to the out-of- network provider within one business day after the decision.

Providers are required to inform Medicaid members about the costs associated with services that are not covered under AmeriHealth Caritas North Carolina prior to rendering such services and to coordinate with out-of-network providers for payment of services to ensure the cost to the Member is not greater than it would be if the services were furnished within the network.

Should the patient and provider agree the services will be rendered as a private pay arrangement; the provider must obtain a signed document from the member to validate the private payment arrangement.

Second Opinions

AmeriHealth Caritas North Carolina members have the right to request a second opinion from a qualified, participating network provider. If a network provider is not available within a reasonable distance of a member's home, AmeriHealth Caritas North Carolina will arrange for the member to obtain a second opinion outside of the network, at no cost to the member. "Reasonable distance" for this purpose is determined according to the time and distance standards for the specific provider type found in the Network Adequacy Standards under Access to Care in Section II.

Inpatient at Time of Enrollment

The managed care plan responsible for a member's inpatient care depends upon the timing of the member's Medicaid enrollment. If a member, transferring from another Medicaid plan to AmeriHealth Caritas North Carolina is hospitalized at the time of enrollment, the originating health plan is responsible for inpatient facility coverage until discharge; but AmeriHealth Caritas North Carolina is responsible for covering professional services as of the member's enrollment date and is responsible for coverage of all benefits upon discharge.

Likewise, if a member transfers from AmeriHealth Caritas North Carolina to another Medicaid plan during an inpatient stay, AmeriHealth Caritas North Carolina is responsible for inpatient facility coverage until discharge.

Newborn Coverage

Newborns born to mothers who are covered by AmeriHealth Caritas North Carolina at the time of birth will be enrolled for coverage with AmeriHealth Caritas North Carolina. ACNC will provide covered services to eligible newborns retroactive to the date of birth.

AmeriHealth Caritas North Carolina will not limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section, unless the attending provider, in consultation with the mother makes the decision to discharge the mother or the newborn child before that time. A participating provider is not required to obtain prior authorization for stays up to the forty-eight (48) or ninety-six (96) hour periods.

Sterilizations

Sterilizations are not covered for members less than 21 years of age. A Member seeking sterilization must voluntarily give informed consent on the NCDHHS Sterilization Consent form. The Member must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

Providers must submit the consent form at the same time as the claims submission for these services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by ACNC.

NCDHHS Sterilization Consent forms in English and Spanish are located on the NCDHHS website under Reproductive Health Forms. The direct link also can be found at https://www.amerihealthcaritasnc.com/ on our Provider Manuals, Policies and Forms page under Forms.

Preventive Care/Immunizations

Preventive care includes a broad range of services (including screening tests, counseling, and immunizations/vaccines).

- Providers are required to administer childhood immunizations in accordance with CDC's Advisory Committee on Immunization Practices" published schedules, or when medically necessary for the member's health.
- Providers are required to prepare for the simultaneous administration of all vaccines for which a member under the age of 21 is eligible at the time of each visit.
- Providers are encouraged to participate in the Vaccines for Children Program (VFC).

AmeriHealth Caritas North Carolina has adopted the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services [childhood and adolescent immunization schedule approved by: the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP)/Bright Future, and the American Academy of Family Physicians (AAFP)], and the adult immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP).

Immunization Schedules (Childhood, Adolescent and Adult)

- Center for Disease Control (CDC) 2023 recommend: Immunization for Child and Adolescent and Adult Immunization Schedule by Age

Vaccines for Children (VFC) Program

Providers are strongly encouraged to 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, distribute 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 NC Immunization Branch for more information or contact **1-919-707-5598** to begin the VFC enrollment process.

You must report all immunizations administered to the North Carolina Immunization Registry (NCIR), to request access, contact the NC Immunization Branch at **1-877-873-6247**.

Additional North Carolina Resources

North Carolina Immunization Branch

The North Carolina Immunization Branch https://www.immunize.nc.gov/ promotes public health through the identification and elimination of vaccine preventable diseases like polio, hepatitis B, measles, chickenpox, whooping cough, rubella (German measles), and mumps. In 2001, the Branch incorporated an adult education component into the program to raise awareness of the agelessness of immunizations.

North Carolina Immunization Registry (NCIR)

The North Carolina Immunization Registry (NCIR) is a secure, web-based clinical tool which is the official source for North Carolina immunization information. The NCIR takes the place of outdated handwritten charting of immunizations administered in the state. Immunization providers may access all recorded immunizations administered in North Carolina, regardless of where the immunizations were given.

Access to the NCIR via the North Carolina Identity Management (NCID) system is limited to North Carolina Immunization Program medical providers and affiliates. Access to the immunization information contained within the NCIR is meant for health care providers in the prevention and control of vaccine preventable diseases and is not intended for general public use.

The primary purposes of the NCIR are:

- To give patients, parents, health care providers, schools and childcare facilities timely access to complete, accurate and relevant immunization data;
- To assist in the evaluation of a child's immunization status and identify children who need (or are past due for) immunizations;
- To assist communities in assessing their immunization coverage and identifying areas of under-immunization; and
- To fulfill federal and state immunization reporting needs.

More information on Immunization Information Systems (IIS) can be found on the CDC's IIS webpage.

The NCIR stores immunization records that are client-specific and created by the client's health care provider or through our data feed with NC Vital Records. If you find there is an error in your child's or client's NCIR record, please contact your health care provider or Vital Records directly. The Immunization Branch cannot alter those records because we

cannot confirm the identity of the client and do not provide treatment to clients in the NCIR.

Important Forms

- Confidentiality Agreement (PDF, 40 KB)
- Contingency Forms
  - New Client Form (English, Spanish) (PDF, 6 KB, 721 KB)
  - Mass Clinic Form (English, Spanish) (PDF, 72 KB, 73 KB)
- Blank Inventory Form (PDF, 157 KB)

NCIR Education

The North Carolina Immunization Branch has developed a series of educational resources for NCIR users. Access NCIR training resources here.

Data Exchange

Information on data exchange between the NCIR and electronic medical records can be found here.

NCIR Help Desk Staff

- Phone: **1-877-873-6247**
- Fax: **1-800-544-3058**
- Email: ncirhelp@dhhs.nc.gov

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health and medical treatment. AmeriHealth providers offer or arrange for the full range of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, on a periodic schedule established by the state of North Carolina. Early Periodic Screening services include unclothed 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. 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 state Medicaid plan. Our Pediatric Wellness team works to improve the health of Medicaid members from birth to under age 21 by increasing participation in comprehensive Early Periodic Screening (wellness) visits and allows for early detection of health problems before they become more complex and difficult to treat. When conducting Early Periodic Screenings, providers will adhere to best practice guidelines published by the American Academy of Pediatrics in their Bright Futures publication.

All Plan PCPs are responsible to provide EPSDT services to AmeriHealth Caritas North Carolina members from birth to under age 21 according to the American Academy of

Pediatrics Periodicity Schedule or upon request at other times to determine the existence of a physical or mental condition. Find the most current periodicity schedules online.

For the initial examination and assessment of a child, PCPs are required to perform the relevant EPSDT screenings and services, as well as any additional assessment, using the appropriate tools to determine whether a child has special health care needs.

Participating PCPs are required to include all the following components in each medical screening:

- 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".
- Screening for developmental delay at each visit through the 5th year; and
- Screening for Autistic Spectrum Disorders per AAP guidelines.
- Comprehensive, unclothed physical examination.
- All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
- Laboratory testing (including blood lead screening appropriate for age and risk factors).
- Health education and anticipatory guidance for both the child and caregiver.
- Health History
- Growth and Development Assessment
- Vision and Hearing Screening
- Dental Screening and Education
- Developmental, Emotional/Behavioral, Opportunities for Health and Risk Screening
- Nutrition Assessment and Education
- Anticipatory Guidance
- Referral for Further Diagnostic and Treatment Services, if needed.

EPSDT providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to AmeriHealth Caritas North Carolina members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris teenagers. This explanation of EPSDT services should occur on the member's first visit and quarterly thereafter and must include distribution of appropriate EPSDT educational tools and materials. Please refer to the Claims and Billing manual for proper coding requirements.

Screening Timeframes

EPSDT providers (PCPs) are contractually obligated to provide EPSDT screenings within 30 days of the scheduled due date for children under the age of two years and within 60 days of the scheduled due date for children aged two and older, or within no more than six calendar

weeks after the initial request. Inter-periodic exams must also be promptly provided, as needed.

Initial EPSDT screenings must be offered to new members within 60 days of becoming an AmeriHealth Caritas North Carolina member, or at an earlier time if needed to comply with the periodicity schedule. At the latest, the initial EPSDT screening must be completed within three months of the member's enrollment date with AmeriHealth Caritas North Carolina. Appointments for EPSDT services must be scheduled within six (6) calendar weeks from the date of the request for an appointment.

Plan PCPs are expected to assist members with accessing substance abuse and mental health services, as needed. ACNC's Rapid Response team is also available to members and providers to support care coordination and access to services. Members and providers may request Rapid Response support by calling **1-833-808-2262.**

Medical Necessity

EPSDT requests for service are reviewed for medical necessity on a case-by-case basis, utilizing medical necessity criteria specific to EPSDT and the individual needs of the member. These criteria include evaluating whether the requested service is necessary to prevent further advancement of a condition (maintenance or control), ameliorative or corrective, including when a service is needed to help a child reach an age-appropriate developmental level.

- Utilization Management staff and the Market Chief Medical Officers consider the available medical information along with the child's individual needs, the preventive nature of EPSDT and the medical necessity criteria specific to EPSDT.
- EPSDT federal criteria are considered in the course of the service authorization review process for Medicaid Members under twenty-one (21) years of age, including whether the requested service is safe and effective to treat the Member's medical condition and problems and whether the service will improve the Member's health condition, maintain the Member's health in the best condition possible, prevent the Member's health condition from worsening or preventing the development of more health problems.
- Requests for medically necessary services are covered when an individualized review is completed for services that are included in the categories of mandatory and optional services, regardless of whether the services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such.

Pharmacy Services

Pharmacy services covered by AmeriHealth Caritas North Carolina are managed by ACNC's delegated vendor, PerformRx. For the most current and complete information on the provision of pharmacy services, please visit www.amerihealthcaritasnc.com. For questions regarding pharmacy services, Plan members and providers may contact:

PerformRx Pharmacy Member Services
1-800-855-375-8811 (TTY-1-866-209-6421)

PerformRx Pharmacy Provider Services
1-866-885-1406

Formulary

AmeriHealth Caritas North Carolina utilizes the NCDHHS Medicaid Preferred Drug List (PDL), which allows our members access to the most commonly prescribed therapeutic drug categories. The pharmacy benefit design provides for outpatient prescription services that are appropriate, medically necessary, and are cost effective for NCDHHS Medicaid. Prescribers are encouraged to write prescriptions for "preferred" products but may prescribe medications that are not on the PDL. For formulary information on generic and brand medications, step therapy, age limits and prior authorization, refer to the website links below.

The most up-to-date preferred drug list is available online at the NCDHHS website and the ACNC Medication Look-Up Tool.

NCDHHS Medicaid PDL is updated quarterly in January, April, July and October each year.

Pharmacy Prior Authorization

The Pharmacy Services Department at AmeriHealth Caritas North Carolina issues Prior Authorizations for drugs that require clinical review based on NCDHHS clinical criteria requirements. Contact Pharmacy Provider Services at **1-866-885-1406** between 7am – 6pm ET Monday through Saturday and Holidays.

A Pharmacy Prior Authorization can be submitted multiple ways:

- Electronically submit pharmacy prior authorization (ePA) via any of the following options:
    - Your Electronic Health Record (EHR) tool software
    - CoverMyMeds Portal
- Surescripts PortalDownload and complete the appropriate prior authorization form from the pharmacy prior authorizations website, then faxi to **1-877-234-4274**.
- For additional questions, call Pharmacy Services at 1-866-885-1406, Monday through Saturday, 7 a.m. to 6 p.m. On Sunday and holidays, call Member Services at **1-855-375-8811 (TTY 1-866-209-6421)**.

Providers are encouraged to access the ACNC Pharmacy website for more information on pharmacy prior authorization. Providers are to use the pharmacy prior authorization process for medications that are required to meet clinical criteria for coverage or for medication exception requests. This includes requesting coverage of a non-covered medication or for a medication dose exceeding quantity limits.

When completing the prior authorization form:

- Provide relevant clinical information to support the member's need for a medication.
- Complete the specific ACNC Prior Authorizations form for the requested medication if applicable

Emergency Supply

In the event a member needs to begin therapy with a medication before prior authorization can be obtained, pharmacies are authorized to dispense 72-hour emergency supplies.

Over-the-Counter Medications

Select over-the-counter (OTC) medications and products will be covered by ACNC based on NCDHHS OTC covered products, with a prescription from the prescribing physician. A list of current covered OTC products can be found at the Program Specific Clinical Coverage Policies section of the NCDHHS website or by contacting Provider Services at **1-866-885-1406.**

Durable Medical Equipment (DME) and Pharmacy Claims

For a list of covered diabetic supplies and testing equipment, that can be submitted as a pharmacy point-of-sale claim, refer to the NCDHHS Preferred Drug List and the Medication Look Up Tool.

All other products, non-preferred diabetic supplies and other DME supplies, such as, spacers, incontinence supplies, enteral feedings, etc. should be submitted to AmeriHealth Caritas North Carolina as DME claims, on a medical claim form. Here are the key things pharmacies need to know when submitting DME claims:

- PerformRx is not able to process DME claims through their pharmacy POS system.
- Pharmacies that provide DME supplies must submit claims to AmeriHealth Caritas North Carolina for claims to be processed.
- To submit a DME claim, pharmacies and/or DME suppliers can use the CMS-1500 professional claim form and submit electronically or via paper. Electronic claims can be submitted to one of our clearinghouses listed on the Claims and Billing webpage,or pharmacies can use another clearinghouse.
    - AmeriHealth Caritas North Carolina's electronic data interchange (EDI) payer ID# is **81671**
- **Paper claims can be submitted to:**
  AmeriHealth Caritas North Carolina
  Attn: Claims Processing Department
  P.O. Box 7380
  London, KY 40742-7380

A list of participating network DME suppliers can be viewed in the online provider directory at www.amerihealthcaritasnc.com, or visit State DME information

Pharmacy Copays
See Medicaid Managed Care Cost Sharing (Copays) on page 80.

Pharmacy Lock-In Programs
To support the reduction of fraud, waste, and abuse within the Medicaid system, and to better support our members with complicated drug regimens who see multiple physicians, AmeriHealth Caritas North Carolina utilizes recipient restriction (lock-in) programs for pharmacy and primary care services. Through data analysis ACNC identifies members who may need additional support or who may have misused, abused, or committed possible fraud in relation to the receipt of prescription drug services.

A member may be identified for review when any of the following criteria is met:

- Have filled ten or more prescriptions for covered substances in a period of two consecutive months, when not medically necessary.
- Have received prescriptions for covered substances from four or more providers in a period of two consecutive months.

AmeriHealth Caritas North Carolina accepts referrals of suspected fraud, misuse, or abuse from a number of sources, including physician/pharmacy providers, ACNC's Pharmacy Services, Member/Provider Services, the Special Investigations Unit, Case Management/Care Coordination, Special Care Unit, Quality Management, Medical Affairs and the NCDHHS. If you suspect member fraud, misuse, or abuse of services, you are encouraged to make a referral by calling the Fraud and Abuse Hotline at **1-866-833-9718.**

If a member is placed in the Pharmacy Lock-In program, the member's assigned prescriber and pharmacy will receive a letter from AmeriHealth Caritas North Carolina identifying the restricted member by name and ID number, and as appropriate, the pharmacy where the member must receive his/her prescription medications.

North Carolina Controlled Substances Reporting System (CSRS)
AmeriHealth Caritas North Carolina providers are required to follow all requirements of the North Carolina Controlled Substances Reporting System including mandatory registration to access the CSRS.

The CSRS collects information on all controlled substances (schedules II-V) prescriptions. Prescribers registered with the CSRS may obtain immediate access to an online report of their current or prospective patient's controlled substance prescription history. Pharmacies and prescribers are not permitted to distribute prescription history reports from the CSRS to patients.

AmeriHealth Caritas North Carolina providers must query the CSRS to view information about our member's usage before prescribing Schedule II or III controlled substances to them. All CSRS users must comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule requirements.

Vision Services

Comprehensive Eye Care

1. NCDHHS pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, per year for children ages 0 through 20.
2. NCDHHS pays for one pair of fee-for-service eyeglasses, fabricated by the NCDHHS optical laboratory, every two years for adults 21 and older.
3. Providers who supply eye exams and eyeglasses in their office must also supply Medicaid eye exams and fee-for-service eyeglasses to members.
4. Enhanced vision benefit provided by AmeriHealth Caritas North Carolina:
    a. AmeriHealth Caritas North Carolina is offering the **enhanced benefit** of an additional pair of eyeglasses and an eye exam (including the fitting and dispensing of eyeglasses) for adults age 21-64 every 2 years. Inquiries regarding this ACNC value added benefit should be directed to Provider Services at 1-888-738-0004.
    b. The enhanced vision benefit may only be provided AFTER the NCDHHS fee-for-service eyeglasses have been dispensed to the member.
5. Covered services shall include:
    a. Routine eye exams
    b. Medically necessary contact lenses
    c. Fitting and dispensing visual aids
6. Providers obtain Medicaid fee-for-service eyeglasses through the traditional NCDHHS process and bill AmeriHealth Caritas North Carolina for dispensing fees, after the fee-for-service eyeglasses have been dispensed to the member.
7. Opticians are qualified providers for visual aids (eyeglasses and contact lenses)

For additional information on the NCDHHS eyeglass benefit, reference the special bulletin issued by NCDHHS in December 2018.

Dental Services

Except for the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program, all Dental Services, as defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, **are carved out** of Medicaid Managed Care, and should be billed to the North Carolina Medicaid Fee-for-Service program.

Upon enrollment, AmeriHealth Caritas performs an initial health screening to identify Members who are due for a preventive dental visit. In North Carolina, our Care Connectors will help interested Members access North Carolina Medicaid fee-for-service (FFS)

enrolled dentists. We will provide PCPs and pediatricians with information about screening and referring children for routine dental services, and we will provide guidance to OB/GYNs and other providers who serve pregnant Members to encourage scheduling routine dental exams. We will also coordinate with dental schools that serve Medicaid beneficiaries and other low-income populations to deliver whole-person care for dental services not otherwise covered by the Medicaid program.

All in-network primary care providers are required to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with NCDHHS' Oral Health Periodicity Schedule.

All in-network primary care providers are required to refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of NCDHHS's Oral Health Periodicity Schedule.

The exception will be Into the Mouth of Babes (IMB): IMB is a clinical program that trains medical providers to deliver preventive oral health services to young children insured by North Carolina Medicaid. Services are provided from the time of tooth eruption until age 3½ (42 months), including oral evaluation and risk assessment, parent/caregiver counseling, fluoride varnish application, and referral to a dental home.

For mandatory training on "Into the Mouths of Babes", please visit our website at www.amerihealthcaritasnc.com, under "Training."

Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our members, AmeriHealth Caritas North Carolina members may receive laboratory services from laboratories at our contracted hospital facilities. The Centers for Medicare and Medicaid Services (CMS) CLIA regulations apply to laboratory testing in all settings including commercial, hospital and physician office laboratories. Claims submitted for laboratory services ***without*** the appropriate Clinical Laboratory Improvement Amendments (CLIA) Identification number will be denied.

Also, AmeriHealth Caritas North Carolina has made an agreement with the following laboratories:

Laboratory	Type	Phone	Website
LabCorp	General Lab Services	See website for locations and contact information	www.labcorp.com

Laboratory	Type	Phone	Website
Quest Diagnostics	General Lab Services	See website for locations and contact information	www.questdiagnostics.com

To quickly establish an account with one or more of these labs please visit the websites listed above. For more information about individual labs, please visit their website.

- Network Physicians are encouraged to perform venipuncture in their office whenever possible.
- Providers should contact the laboratory provider in question to arrange a pick-up service.
- AmeriHealth Caritas North Carolina highly recommends that pre-admission laboratory testing be completed by the PCP. However, testing can be completed at the hospital where the procedure will take place and does not require a referral from AmeriHealth Caritas North Carolina.
- STAT labs must only be utilized for urgent problems. The ordering physician may give the member a prescription form or AmeriHealth Caritas North Carolina procedure confirmation form to present to the participating facility.

Hospice Services

A hospice provides palliative and supportive services to meet the physical, psychological, social, and spiritual needs of a terminally ill member, including the family or other persons caring for the member regardless of where the member resides. Below are some of the covered services:

- Nursing Care
- Medical Social Services
- Physician Services
- Counseling Services
- Short-Term Inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards
- Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the member's terminal illness and related conditions
- Physical therapy, occupational therapy, and speech-language pathology

Hospice Services in a Nursing Facility

Hospice services can occur in the home or in a nursing facility. When services occur in a nursing facility, the facility can be considered the residence of the member. When the

member resides in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

- The member is terminally ill.
- The member has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

Notification and Coverage for Hospice Benefits

AmeriHealth Caritas North Carolina covers hospice services provided to members who are certified as terminally ill when there is no Part A, commercial, or any other coverage. The member must have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and the member must elect hospice care rather than active treatment for the illness.

When a member is in need of hospice services – including home hospice, inpatient hospice, continuous care, or respite – the primary care practitioner, attending physician, or hospice agency must notify the AmeriHealth Caritas North Carolina Utilization Management department at **1-833-900-2262.** ACNC will coordinate the necessary arrangements between the primary care practitioner and the hospice provider in order to assure continuity and coordination of care.

It is the responsibility of hospice to obtain certification from the physician that the member is terminally ill.

Interpretation and Translation Services

Interpretation and translation services for members for whom English is not their primary language, and auxiliary aids and services for the hearing and visually impaired are free to AmeriHealth Caritas North Carolina members. To access any of these services, providers may contact Member Services toll-free at: **1-855-375-8811, TTY 1-866-209-6421.**

Visit the Your Benefits webpage for the most up to date Value-Added Services and Benefits for Members.

CARE Card

Category	Incentives	Details	Reward Amount
Well Screenings	Infant and child well visits	Infant and child well visits	$20
		Annual well visits (ages 3 -21)	$20
	Adult well visits	Annual well visits	$20
	Cervical cancer screening	Women (ages 21 – 65) once every three years	$15
Prenatal Exams			
	Prenatal visit	Rewards offered for every other prenatal visit (up to 7 per pregnancy)	$10
Postpartum exams	Postpartum visit	7 – 84 days after delivery	$15
Diabetic screenings	Dilated eye exam	Once a year for members diagnosed with diabetes	$10
	A1c blood test	For members diagnosed with diabetes with HbA1C results of 9.0 or less	$10
Other	Care needs screening	Complete screening within 90 days of enrolling with ACNC	$25
	Behavioral health follow-up	Follow-up visit (for qualified members) with a doctor who treats behavioral health issues within 7 calendar days after discharge from a behavioral health hospitalization	$10
	Flu Vaccination	Children 2 years of age and under, limit once yearly	$50

Rewards earned in a fiscal year (July 1 – June 30) cannot exceed $75.

Prenatal rewards are loaded to the CARE Card after the claim for maternity care is received.

Members can access value-added services by contacting **Member Services at 1-855-375-8811 (TTY 1-866-209-6421).**

Providers who have inquiries regarding AmeriHealth Caritas North Carolina value-added services should contact **Provider Services at 1-888-738-0004.**

SECTION IV
Medical Management Programs

IV. Medical Management Programs

The following information is in regard to AmeriHealth Caritas North Carolina's Population Health (PH) program as part of our Medical Management programs, which includes an integrated model of Care & Disease Management and Care Coordination for physical and behavioral health services provided to Plan members.

Population Health Management Program Overview

ACNC's Population Health Management (PHM) program improves the health of North Carolinians by focusing on the implementation of core PHM programs and development of organization competencies necessary to promote improved population health. In addition to the core PHM programs presented here, we augment our approach with targeted population health improvement initiatives identified through deep analytics, stakeholder input, our annual population assessment, and the implementation of an annual population health work plan which leverages the collective impact of ACNC resources to achieve our population health goals.

The overall objective of the PHM program is to proactively identify and intervene with ACNC members with potential avoidable health care needs and empowers at-risk members to regain optimum health or improved functional capability. At-risk members are identified through population assessments which include a focus on social determinants of health. Members for each population are segmented by criteria which include age, clinical conditions, utilization patterns, and adherence to evidence based clinical practice guidelines.

ACNC's PH team includes nurses, behavioral health clinicians, licensed social workers, utilization clinical reviewers, non-clinical Care Connectors, community health navigators, clinical pharmacists, plan medical and behavioral health directors, primary care providers (PCPs), specialists, community agencies, members, caregivers, parents, or guardians. This multi-disciplinary approach works with our members' needs at all levels in a proactive manner with a process designed to maximize health outcomes and quality of life. Our Population Health program applies to all AmeriHealth Caritas North Carolina's members. Additional information about AmeriHealth Caritas North Carolina's LTSS Population Health programs can be found in the LTSS section of this manual.

AmeriHealth Caritas North Carolina will provide the care management services directly or will subcontract with an Advanced Medical Home (AMH) Tier 3 or /Clinically Integrated Network (CIN)to provide care coordination and care management.

Population Health Management Components

Practitioners can refer members, via multiple avenues to any of the six core components of our Population Health (PH) Program. The Population Health

Management program consists of the following core components that focus on the Member's level of need:

- Wellness and Prevention
    - Tobacco Cessation
    - Opioid Misuse Prevention Program
    - Pediatric Preventive Health Care
- Member Safety Management
- Member Transition Management
    - Bright Start® (maternity management)
    - Rapid Response and Outreach Team (RROT)
- Condition/Diagnosis Management
    - Long-Term Services and Supports (LTSS)
- Care Coordination
- Complex Care Management

Within each of these categories there are programs targeting specific populations, such as Early, Periodic, Screening, Diagnostics and Treatment (EPSDT) and the AmeriHealth Bright Start Maternity management program. Each population health program level incorporates features to address physical health (PH), behavioral health (BH), SDoH, and Member outreach and engagement.

Pediatric Preventive Health Care – Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The EPSDT program is designed to improve the health of Medicaid Managed Care members from birth to 21 years by increasing adherence to EPSDT guidelines. This is accomplished by identifying and coordinating preventive services for these members. Program approach combines scheduled member outreach and point-of-contact notification for Plan staff and providers when a member is due or overdue for an EPSDT Periodic Screening.

Local Health Department (LHD)
AmeriHealth Caritas North Carolina contracts with each Local Health Department (LHD) in the region(s) in which we operate, and that meet the benchmark specifications of NCDHHS to provide care management services to High-Risk Pregnant Women. If an individual lives in a county where the LHD does not provide these services, the member can still be enrolled in Bright Start.

A "high-risk pregnancy" is one in which some condition puts the mother, the child, or both, at higher-than-normal risk for complications during or after the pregnancy and birth, including but not necessarily limited to the following:

- Multifetal gestation
- Fetal complications (current)
- Chronic condition (diabetes, hypertension, asthma, mental illness, HIV, seizure disorder, renal disease, lupus)
- Current drug or alcohol use/substance use disorder
- Cervical insufficiency (current/history of)
- Gestational diabetes (current/history of)
- Hypertensive disorders of pregnancy (current/history of)
- History of previous preterm birth (<37 weeks completed gestation)
- At least one (1) spontaneous preterm labor and/or rupture of membranes
- Member-reported domestic violence (current)

The care management requirements that LHDs are expected to carry out with High-Risk Pregnant Women are consistent with NCDHHS' Care Management for High-Risk Pregnancy Policy, set forth in of the NCDHHS Program Guide. By agreeing to provide care management services to High-Risk Pregnant Women, LHD providers agree to comply with this Policy.

Bright Start® (Maternity Management)

This program is designed to assist pregnant members by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG). As pregnant members are identified by new member assessments, claims data, routine member outreach and provider reporting; our Plan staff work to ensure that each pregnant member is aware of the services and support offered through the Bright Start® program.

High-Risk Pregnancies
The Care Management for High-Risk Pregnancies (CMHRP) Program is available to pregnant and postpartum individuals who have or may qualify for Medicaid. Examples of potential social and/or medical factors that qualify an individual for CMHRP services are listed on the High-Risk Pregnancy Referral Form found on pages 32-43 of the NCDHHS Program Guide.

Under this program and state guidelines, prenatal care providers are expected to complete and submit the Care Management for High-Risk Pregnancies (CMHRP) Pregnancy Risk Screening Form found on pages 32-43 of the NCDHHS Program Guide as part of the authorization for obstetric services. Each pregnant member needs a separate form submitted to **the local health department (LHD)**. Submit the form to the LHD following the process they request.

It is the provider's responsibility to address identified risk factors upon contact with the member and to develop appropriate action items in collaboration with the member to resolve the identified risks.

"Let Us Know" Program

Providers are encouraged to refer members to the Population Health (PH) program as needs arise or are identified. If you recognize a member with a special, chronic, complex health condition, or who may need the support of one of our programs, please contact the Rapid Response Outreach Team **1-833-808-2262.**

Members are also referred to the PH program through internal Plan processes. Identified issues and diagnoses that result in a referral to the PH program may include:

Multiple diagnoses (three or more actual or potential major diagnoses)

- Risk score indicating over- or under-utilization of care and services
- Pediatric members requiring assistance with EPSDT
- Pediatric members in foster care or receiving adoption assistance
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively challenged
- Members with a special health care need
- Members with polypharmacy use
- Pregnant members
- Members with high trauma exposure
- Members in need of long-term services and supports to avoid hospital or institutional admission

Providers can also complete a Member Intervention Request form, available on the Provider Manuals, Policies and Forms webpage. Fax to our Rapid Response Outreach Team fax line **1- 833-816-2262** for members that have missed appointments, need transportation services, or further education on their treatment plan, chronic condition, or need assistance with Value-added benefits.

Rapid Response and Outreach Team (RROT)

This contact center is designed to assist Members and Providers with accessing needed health care services and remove barriers to care. The team assists Members with urgent and or short-term, episodic care coordination needs. The contact center services are short-term in nature. For extended assistance and or if the Member requires more care coordination and

or complex care management, a referral is made to the relevant Population Health Management Programs.

This team performs the following functions on behalf of Plan members and providers:

- Assist with decreasing barriers to care
- Educate and help address identified gaps in care
- Provide care coordination support
- Coordinate value added services.
- Complete health risk assessments
- Assists with Provider Member/Panel updates

Members and providers may request RROT support by calling **1-833-808-2262.**

Transitional Care Management

This program coordinates services for adult and pediatric members with transitions of care needs. Care Managers are licensed registered nurses (RN) or licensed clinical social workers (LCSW). Program staff supports members by providing resolution for issues relating to access, care coordination and follow up care with the provider after hospital discharge. Program staff will monitor a member's condition(s) for a short-term period of time, if program staff feels the member's condition requires long term/complex care a referral is made to program staff in Complex Care Management (CCM).

Complex Care Management (CCM)

The organization has multiple avenues for members to be considered for complex care management services. This program serves members identified and referred as needing comprehensive and disease-specific assessments, and re-assessments, along with the development of member- centered prioritized goals that are incorporated into the member-centered plan of care, developed in collaboration with the member, the member's caregiver(s), and the member's primary care provider (PCP) and supporting service providers when applicable with appropriate consents. Program staff includes Care Managers who are licensed registered nurses (RN) or Licensed Clinical Social Workers (LCSW).

Members in the Complex Care Management program are screened for the following as part of standard protocol:

- All members receive a comprehensive initial assessment that meets NCQA requirements**.**
- Adolescents ages 11 through 17 and adult members aged 18 and older receive a depression screening to assess for symptoms of depression. Based on the depression score, the member is offered education and referred to the appropriate behavioral health services.

- Subsequent detailed reassessments are performed for any item that screens positive in the initial assessment.

Care Management Team

Members who have or are at risk of frequent hospital admissions, readmissions and complex needs including both physical and behavioral or are difficult to contact via telephone may be targeted for engagement by Care Management. Care Management provides a high-touch, telephonic or virtual face-to-face engagement through a community-based team of nurses, social workers, and community health workers to help members navigate and increase their access to needed medical, behavioral health, and social services. Care Management also supports the development of member self-management skills through encouragement and coaching for chronic disease management.

In addition to improving the care and health outcomes of members, this community-based team provides valuable information for, and coordination with, other health plans, staff and services as well advancing integrated care through a person-centered approach and close collaboration with other providers, agencies, and care givers in the community.

Care Coordination

Triggered through ongoing data mining or in-person referrals, Care Coordination programs address member's healthcare needs while assessing for and addressing social needs and barriers.

Program Participation

Participation in the PH program is offered to all Plan members, with the ability for members to opt out upon request. Members may also self-refer into a program by contacting ACNC.

Members are initially identified for specific PH needs upon joining ACNC through systematic risk stratification. ACNC will systematically re-stratify members on a quarterly basis. Members are also identified through material and telephonic outreach by ACNC. Members are encouraged to let ACNC know if they have a chronic health condition, special health need or if they are receiving on-going care. A new member assessment is included in the members' welcome packet to identify current health conditions and health care services. Based upon their responses to the initial health assessment, members are identified for participation in the appropriate care management program.

Care Coordination with the Advanced Medical Home/Primary Care Physician (AMH/PCP)

AmeriHealth Caritas North Carolina recognizes that the Advanced Medical Home Primary Care Physician (AMH/PCP) will be the cornerstone of the member's care coordination and delivery system. Care management contacts each AMH/PCP during a member's initial

enrollment into a complex care management program, as part of the comprehensive assessment and member- centered plan of care development process.

A care manager creates the member's member-centered plan of care. Program staff complements the PCP's recommendations in the development of an enhanced and holistic plan of care specific to the members' needs. Care management remains in close communication with the PCP during the implementation of the plan of care, should issues or new concerns arise.

Care Coordination with Other Providers

Care managers also contact the member's key and/or current providers of care, such as the member's behavioral health care providers, to determine the best process to support the member. This process eliminates redundancies and supports efficiencies for both programs. Care managers may also engage key providers to be part of the development of the member-centered plan of care if the member agrees. As the member is reassessed, a copy of the care plan goals is supplied to both the provider and member.

Referrals

To effectively manage the care of its Members, AmeriHealth Caritas North Carolina will establish and maintain a referral and prior authorization process with the Member-selected or assigned AMH/PCP at its center.

AmeriHealth Caritas North Carolina will make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees for referrals. AmeriHealth Caritas North Carolina will also make use of other public health, mental health, and education and related programs, (such as Head Start, and Social Services) and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.

Integrating Behavioral and Physical Health Care

Members with mental health, substance use disorders, and social needs often experience physical health conditions that complicate the treatment and diagnosis of both behavioral and physical health conditions. AmeriHealth Caritas North Carolina understands that coordination of care for these members is imperative. To meet this need, member and provider support services are implemented with a 360-degree view of physical health, behavioral health, and social needs. We do this through collaborative, integrated solutions that recognize inter-dependence and impact on health, and are based on flexible, team-based care that adapts to member needs.

Plan staff will work with the involved primary care and behavioral health providers to develop an integrated plan of care for members in need of physical and behavioral health care coordination. Care Managers will also assure that communication between the two disciplines, providers, and organizations, occurs routinely for all members with physical and behavioral health issues. Care Managers will also work to coordinate with substance use disorder treatment providers and community resources with the appropriate member

consent as needed. Care Managers will proactively and regularly follow-up on required physical and behavioral health services, joint treatment planning and provider-to-provider communication to ensure that member needs are continuously reviewed, assessed, and updated.

Person-Centered Plan of Care

Through the Population Health program, AmeriHealth Caritas North Carolina works with practitioners, members, their natural supports and outside agencies as appropriate to develop person-centered plans of care for members with special or complex health care needs. Our methodology is to empower the member to take the lead in identifying and prioritizing their goals and interventions. AmeriHealth Caritas North Carolina's plan of care

specifies mutually agreed- upon goals, medically necessary physical and behavioral health services, as well as any support services necessary to carry out or maintain the plan of care, and planned care coordination activities. The person-centered plan of care also takes into account the cultural values and any special communication needs of the member, family and/or the child. Additionally, social determinants of health as identified by the member are addressed.

AmeriHealth Caritas North Carolina care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member, and his or her family or caregiver, as clinically appropriate and legally permissible, and as determined by the member's practitioner and standards of practice.

AmeriHealth Caritas North Carolina also utilizes EPSDT guidelines in the development of Treatment Plans for members under age 21. AmeriHealth Caritas North Carolina works with practitioners to coordinate care with other treatment services provided by state agencies.

Through AmeriHealth Caritas North Carolina's Population Health program, the member is assisted in accessing any support needed to maintain the plan of care. ACNC and the PCP are expected to ensure that members and their families (as clinically appropriate) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. To make treatment decisions and give informed consent, available treatment for members will include the option to refuse treatment and will include all treatments that are medically available, regardless of whether AmeriHealth Caritas North Carolina provides coverage for those treatments.

Member-centered plans of care for members with special health care needs are reviewed and updated at every contact, every 12 months, at a minimum, or as determined by the member's PCP based on the PCP's assessment of the member's health and developmental needs. The revised plan of care is expected to be incorporated into the member's medical record following each update.

Coordinating Care through Transitions and Discharge Planning

One of the most important functions of a Prepaid Health Plan is to assist in coordination of care during transitions. This includes, but is not limited to:

- Changes in care settings such as from hospital to home or hospital to rehab;
- Changes in health status due to presentation of a new chronic, acute, or life-threatening condition;
- Temporary or permanent changes in the fulcrum of care when a patient is referred by their primary care physician to a specialist due to a surgical need or exacerbation of a chronic condition;
- Changes in a living situation to obtain more independence or because of a need for greater support; or,
- Caregiver and family changes.

During inpatient transitions, members are supported through the PH department. Members receive, at minimum three outreach calls, starting within 24-48 business hours of discharge. These calls are strategically placed to ensure the member has the appropriate resources in place and has a follow up appointment scheduled and kept with their provider.

Priority Populations

Identifying Children with Special Health Care Needs

PCPs are required to use a valid and standardized developmental screening tool to screen for developmental delays during well child visits or episodic care visits (stand-alone visits qualify as episodic visits). If a child is identified as having a delay that is significantly different than an expected variation, within the norm of age-appropriate development, the PCP is required to refer the child for a comprehensive developmental evaluation.

AmeriHealth Caritas North Carolina contracts with each Local Health Department (LHD) in the region(s) in which we operate, to provide care management services to At-Risk Children, to the extent that each LHD choose to provide these services. An "at-risk child" is aged birth to 4 years and 364 days, who meets any of the following conditions:

- Child with special health care needs (at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who requires health and related services of a type or amount beyond that required by children generally)
- Child in foster care who needs to be linked to a medical home
- Infant in NICU needing help transitioning to community/medical home care
- Child exposed to Toxic Stress – including but not limited to:
    - Extreme poverty in conjunction with continuous family chaos
    - Current domestic/family violence, recurrent physical or emotional abuse

- Caregiver unable to meet infant's health and safety needs/neglect
- Parent(s) has history of parental rights termination
- Parental/caregiver substance abuse, neonatal exposure to substances
- CPS Plan of Safe Care referral for "Substance Affected Infant"
- Unstable home
- Unsafe where child lives
- Parent/guardian suffers from depression or other mental health condition
- Homeless or living in a shelter

At Risk Children

The care management requirements that LHDs are expected to carry out with at-risk children are consistent with NCDHHS' Care Management for At-Risk Children Policy. By agreeing to provide care management services to At-Risk Children, LHD providers agree to comply with this Policy.

As a reminder, practitioners are expected to contact ACNC's Rapid Response team at **1-833-808-2262** to support coordination of services for children who may be eligible or who have been identified as eligible for supports through the educational system, including the development of an Individualized Education Plan (IEP).

Once the need for evaluation is established, the evaluation appointment must be scheduled as soon as possible to meet federal guidelines on the timing of referral, evaluation, treatment planning and the initiation of rehabilitative service for children identified as having special needs.

Once the evaluation is completed, a multidisciplinary case meeting will be arranged, as appropriate, to discuss the findings and treatment recommendations. Upon the recommendations, the Care Connector and/or Care Manager will help to arrange medically necessary services consistent with the treatment plan and as covered by AmeriHealth Caritas North Carolina. For recommended services not covered by ACNC, the Care Connector and/or Care Manager will assist in locating services and assisting in coordination as needed.

After the initiation of recommended services, the provider and/or Care Manager should receive progress updates periodically. The provider and/or Care Manager will work to assist the PCP with receiving regular progress updates. Progress monitoring continues until the child has demonstrated substantial progress and is released from the program.

Examples of children with behavioral health issues who may require a referral include, but are not limited to, those listed below:

- Children diagnosed with attention deficit hyperactivity disorders, autism spectrum disorder, severe attachment disorders, or other behavioral health disorders that impair their functioning.
- Children with delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability

to communicate emotional needs, or ability to tolerate frustration.
- Children with persistent failure to initiate or respond to most social interactions.
- Children with fearfulness or other distress that does not respond to comforting by caregivers.
- Children with indiscriminate sociability, for example, excessive familiarity with relative strangers; or self-injurious or other aggressive behavior.
- Children who have experienced substantiated physical/emotional abuse, sexual abuse, or other environmental situations that raise significant concern regarding the children's emotional being.

Examples of clinical conditions or environmental situations that warrant potential referral for evaluation:

Clinical Conditions:
- Chromosomal Abnormality or Genetic Disorder
- Metabolic Disorder
- Infectious Disease
- Neurological Disease
- Congenital Malformation
- Sensory Disorder (vision and hearing)
- Toxic Exposure
- ATOD (alcohol, tobacco, and other)
- Exposure to HIV

Neonatal Conditions:
- Birth weight 2000 grams - Infant's Birth weight less than 2000 grams.
- Premature birth – Gestational age less than or equal to 34 weeks.
- Respiratory Distress - Infant experienced respiratory distress requiring mechanical ventilation for more than 6 hours.
- Asphyxia -Infant experienced Asphyxia using APGAR score as an indicator.
- Hypoglycemia - Newborn has a serum glucose level less than 25 mg/dl.
- Hyperbilirubinemia - Newborn has had a bilirubin blood level of greater than 20 mg/dl
- Intracranial Hemorrhage - Newborn or infant has had a subdural, subarachnoid, intraparenchymal or intraventricular hemorrhage (grade II-IV).
- Neonatal Seizures Newborn or infant has had neonatal seizures.
- Major Congenital Abnormalities - Various genetic dysmorphic, or metabolic disorders; including anatomic malfunctions involving the head or neck (e.g., atypical appearance, including syndromal and non-syndromal abnormalities, overt or submucous cleft palate, morphological abnormalities of the pinna), Spina Bifida, congenital heart defects.
- Central Nervous System (CNS) Infection or trauma - Bacterial or viral infection of the brain, such as encephalitis or meningitis; or clinical evidence of central nervous system abnormality, abnormal muscle tone (persistent hypertonia or hypotonia),

multiple apneic episodes inappropriate for gestational age, or inability to feed orally in a full-term infant or sustained in a premature infant.
- Congenital Acquired Infection - Congenital or prenatal acquired infection (i.e., cytomegalo-virus, rubella, herpes, toxoplasmosis, HIV, syphilis).

Post-Neonatal Conditions:
- Suspected Visual Impairment - Infant is not able to make eye contact or to track visually after the first few weeks of life.
- Suspected Hearing Impairment - Infant 1) fails newborn hearing screen, 2) presents with unresolved otitis media, or 3) presents with physical abnormality of the ear or oral-facial anomalies.

Newborn Situations:
- Delayed first well-care visit and/or delayed first immunization visit
- Frequently missed well care visits within the first year of life
- Expression of parental concern
- Suspicion of abuse/neglect/exploitation

Childhood Situations:
- Frequently missed well care visits
- Expression of parental concern
- Screening failure demonstrated on administration of developmental assessment tool (Ages and Stages is recommended however practitioners may use Denver Developmental Tool)
- Physical and/or laboratory results findings (example lead result >10 ng/dl)
- Inappropriate adaptation to school environment; schoolteacher or counselor expresses concerns about child's ability to adapt to school environment or learning
- Report/suspicion of abuse/neglect/exploitation

Adolescence Situations:
- Expression of concern from child, parent, or school authority
- Behavioral risk assessment indication
- Failing grades or difficulty learning
- Demonstration of behavior significantly different from the usual norm
- Report suspicion of abuse /neglect
- Suspected drug, alcohol, or tobacco usage

Providers are encouraged to refer for further evaluation when any of the above conditions and/or situations, or other conditions and/or situations are present. Especially when the concern varies significantly from what is expected at the member's age or stage of development. If the provider detects what he or she considers a minor variation, the provider may use discretion in the timing of the referral. If the provider perceives that the

area of concern may be due to a normal variation in development, the provider may choose to have the child return within a specified timeframe and re-administer the screening tool.

However, when choosing to re-administer the screening, providers are expected to consider factors that may impact the child's return to the office:

- Ability and desire of the parent to return
- Transportation
- Competing priorities of parent that may prohibit return on the scheduled date
- Eligibility issues

Health & Lifestyle Education

AmeriHealth Caritas North Carolina PCPs are expected to provide Plan members with education and information about lifestyle choices and behaviors that promote and protect good health. AmeriHealth Caritas North Carolina will support Plan providers in this effort by developing and distributing state-approved health education materials for Plan members, from time to time and as needed to address specific health education needs.

Additionally, AmeriHealth Caritas North Carolina PCPs are expected to help educate Plan members regarding:

- Appropriate use of Urgent Care and Emergency Services, including how to access such care when necessary.
- How to access services such as vision care, behavioral health care and substance use disorder services.
- Recommendations for self-management of health conditions and self-care strategies relevant to the member's age, culture, and conditions.
- Opportunities for advance care planning regarding their wishes for their care at the end of life.

Advanced Medical Homes (AMH)

North Carolina Advanced Medical Homes (AMH) were developed as an advanced model of care to build on Carolina ACCESS. It has been designed to expand access to primary care services for Medicaid enrollees, and to strengthen the role of primary care in care management and care coordination. AMH allows providers to assume more advanced care responsibilities.

Health plans are required to delegate care management functions to certain AMHs and to establish value-based payment arrangements with AMHs for a defined set of quality measures. The AMH program is designed to, over time, support increased provider responsibility for overall population health and total cost of care.

Practice Eligibility and Requirements

Practices will be eligible to participate in the AMH program if they are primary care practices as defined by the current requirements for participation in the Carolina ACCESS program. NCDHHS has developed a centralized process for designating practices into the appropriate tier.

Eligibility requirements are found via the AMH-specific, Fact Sheet Advanced Medical Home (AMH) Program Provider Playbook online.

In addition, if Provider is a Tier 3 AMH, the additional requirements are as indicated below:

	Tier 1 and Tier 2	Tier 3
Payment	Same as Carolina ACCESS I & II	Payment at the Carolina ACCESS II level plus additional care management.
Practice requirements	Review NC Medicaid 2022 Provider Playbook Fact Sheet online	In addition to Carolina ACCESS requirements – take on responsibility for additional care management responsibilities

	Tier 1 and Tier 2	Tier 3
Care Management responsibility	PHP retains primary responsibility for care management	PHP delegates primary responsibility for delivering care management to the practice. Practices can provide care management in-house or through a single Clinically Integrated Network (CIN) across all of their Tier 3 PHP contracts Practices must: • Risk Stratify all patients • Provide care management to high-need patients • Develop Care Plan for all patients receiving high-need care management • Provide short-term transitional care management and medication management support when members are at high risk of readmission or other poor outcomes • Receive claim data feeds (directly or via a CIN/partner) and meet state security standards for storage and use • Demonstrate that, at a minimum, they have active access to an Admission, Discharge, Transfer (ADT) data source that correctly identifies specific empaneled Medicaid managed care members' admissions, discharges or transfers to/from an ED or hospital in real time or near real time

A 4th tier may be developed in later years of the contract.

For more information about Advanced Medical Homes, contact your AmeriHealth Caritas North Carolina Provider Services at **1-888-738-0004** or your account executive.

SECTION V
UTILIZATION MANAGEMENT

V. Utilization Management

The AmeriHealth Caritas North Carolina Utilization Management (UM) program establishes processes for an effective, efficient utilization management system. Utilization Management decision-making is based only on appropriateness of care and services and existence of coverage. AmeriHealth Caritas North Carolina does not reward health care professionals/providers or other individuals conducting utilization review for issuing denials of coverage or services. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

UM Criteria is available upon request and is most easily located on our website below.

A. Manuals, Policies and Forms webpage
B. ACNC Clinical Policies webpage

If you are a practitioner without fax, email, or internet access:

A. Call 1-833-900-2262 to reach our Utilization Management department
B. In person: AmeriHealth Caritas North Carolina
5th Floor
8041 Arco Corporate Drive
Raleigh NC 27617

Per the provider agreement with AmeriHealth Caritas North Carolina providers are required to comply fully with ACNC's medical management programs.

This includes:

- Obtaining authorizations and/or providing notifications, depending upon the requested service;
- Providing clinical information to support medical necessity when requested;
- Permitting access to the member's medical information;
- Involving ACNC's medical management nurse and/or licensed clinician in discharge planning discussions and meetings;
- Providing ACNC with copies of plan of treatment, progress notes and other clinical documentation, as required.

Prior Authorization Policy and Procedure

1. Applies to all services and providers except pharmacy. Pharmacy providers must follow AmeriHealth Caritas North Carolina's pharmacy prior authorization processes regardless of network status. For information on the pharmacy prior authorization process, see Pharmacy Services in Section III, Provision of Services or visit our Pharmacy webpage for more information.

2. Prior authorizations with AmeriHealth Caritas North Carolina are required for certain services for participating providers. Use our Prior Authorization Lookup tool for immediate guidance on prior authorizations. And refer to the

list of services on our Prior Authorization Webpage for the most up to date requirements.

3. For out of network providers, prior authorization is required for all services except emergency services.

4. For services approved by ACNC, a Prior Authorization call center is available for prior authorization requests and education. Our Prior Authorization call center is open Monday – Friday, 8:00 am to 5:00 pm EST. Please call 1-833-900-2262 to reach our Utilization Management department.

5. After hours and on weekends and holidays, please call the AmeriHealth Caritas North Carolina Member Services department at **1-855-375-8811** to be connected with the on-call prior authorization nurse or licensed clinician. Our staff will be able to answer questions and help assist you with your prior authorization request, including requests for inpatient hospitalizations.

6. For members new to AmeriHealth Caritas North Carolina, for a period of ninety (90) days post-enrollment to our plan (or until treatment is completed, if shorter than 90 days), we will cover a member's medical or behavioral health condition that is currently being treated at the time of the member's enrollment to our plan or honor an existing prior authorization, whichever is lesser. If the member was enrolled in a full Medicaid program while pregnant, they are eligible for the 12-month postpartum extension regardless of any changes in circumstances or if the pregnancy ends for any reason.

7. For members new to ACNC, AmeriHealth Caritas North Carolina will receive a list of existing prior authorizations for its members and will have a record of those on file.

8. AmeriHealth Caritas North Carolina offers information on its prior authorization policies to reduce the risk of recovery for claims paid when the service is determined to not be medically necessary. Prior Authorization requirements are listed in detail in this section of the *Provider Manual*, and in the new provider orientation program.

9. Determination of lack of medical necessity is considered an adverse action and may be appealed.

10. AmeriHealth Caritas North Carolina will provide comprehensive, ongoing provider training and outreach to contracted providers. Training will include prior authorization and billing processes to help providers treating our members to avoid delays in payment or member service delivery.

11. AmeriHealth Caritas North Carolina offers additional training materials on its website and these materials are accessible for both in-network and out-of-network providers.

12. A retrospective/post-service Utilization Management (UM) review will only be performed in the following circumstances:

- When the member obtains retroactive eligibility
- When pertinent coverage information is not available, or is incorrect, upon admission or at the time of the service (i.e., member presented as self-pay or with altered level of consciousness)
- When an out-of-state facility treats the member emergently/urgently
- When a provider can show that attempts were made to submit the request prior to the service, but the plan did not receive the request

ACNC will follow the Utilization Management Post-Service Review (Retrospective) Policy and Procedure and requests that do not meet the policy requirements will be denied.

Prior Authorization Process and Contact Information

The most up-to-date list of services requiring prior authorization can be found by using our Prior Authorization Lookup Tool. Please consult the tool before submitting your request. Review our Prior Authorization Webpage for the most up to date requirements.

Submit authorizations electronically

The fastest way to submit medical prior authorizations is electronically in NaviNet, via **Medical Authorizations** located on the **Workflows menu**.

In addition to submitting and inquiring on existing authorizations, you will also be able to:

- Verify if **No Authorization is Required.**
- Receive **Auto Approvals**, in some circumstances.
- Submit **Amended Authorization.**
- **Attach supplemental documentation.**
- Sign up for **in-app status change notifications** directly from the health plan.
- Access a **multi-payer Authorization log.**
- Review inpatient admission notifications and provide supporting clinical documentation.

ACNC's UM department hours of operation are 8:00 a.m. to 5:00 p.m., Monday through Friday, except for State of North Carolina holidays, and they handle some physical health, behavioral health and Long-term Services and Supports (LTSS) services. Review our Prior Authorization Webpage for the most up to date requirements.

- Fax a completed Prior Authorization Request form (PDF) to **1-833-893-2262**
- For inpatient admission notifications and concurrent review fax **1-833-894-2262**
- For prior authorizations assistance after hours, weekends and holidays, call Member Services at **1-855-375-8811**

Pharmacy Prior Authorization

Pharmacy prior authorization forms can be found in the Providers Section of our website.

Payment Adjustments
Prior authorization is not a guarantee of payment for the service authorized. AmeriHealth Caritas North Carolina reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued, and the service was provided.

Referrals
AmeriHealth Caritas North Carolina does not require referrals.

Peer-to-Peer Telephone Line
Providers may reach the Peer-to-Peer telephone line by following the prompts at 1-833-900-2262 to discuss a medical determination with a physician in the AmeriHealth Caritas North Carolina Medical Management department. Provider must call within five (5) days of the verbal/faxed notification of the determination.

Note: The purpose of the Peer-to-Peer process is to address medical determinations regarding health care services. This process is not intended to address denied claims or other issues. For information on filing a grievance, please refer to the "Provider Grievances and Appeals" section of this Provider Manual. For information on disputing a claim, please refer to the "Claims Submission Protocols and Standards" section of this Provider Manual.

For the most up-to-date guidance on medical and behavioral health Prior Authorizations, use our Prior Authorization Lookup tool. Visit the ACNC Prior Authorization webpage for the most up to date guidance on process submission.

LTSS Services Requiring Prior Authorization

AmeriHealth Caritas North Carolina will authorize LTSS based upon a Member's current needs assessment. Treatment will be consistent with their person-centered service care plan. For the most up-to-date guidance on LTSS Prior Authorizations, use our Prior Authorization Lookup tool. Visit the ACNC Prior Authorization webpage for the most up to date guidance on process submission.

Organization Determinations

An organization determination is any determination (i.e., approval or denial) by AmeriHealth Caritas North Carolina regarding the benefits a member is entitled to receive from ACNC. Examples include:

- Payment for emergency services, post-stabilization care or urgently needed services;
- Payment for any other health service furnished by a non-contracted provider and the member believes:
    - The services are covered under Medicaid program; or,
    - If not covered under the Medicaid program, should have been furnished, arranged for or reimbursed by AmeriHealth Caritas North Carolina.
- Refusal to authorize, provide or pay for services – in whole or in part – including the type or level of services, which the member believes should be furnished, arranged for, or reimbursed by ACNC.
- Reduction or premature discontinuation of a previously authorized on-going course of treatment; or,
- Failure of ACNC to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, if the delay adversely affects the health of the member.

The procedures for appealing an organization determination are described in the "Member's Grievances, Appeals and Fair Hearings" section of this *Provider Manual*.

Standard Determination Decision Turnaround Time

AmeriHealth Caritas North Carolina must notify the member of its determination as expeditiously as the member's health condition requires, or no later than 14 calendar days after AmeriHealth Caritas North Carolina receives the request.

The timeframe may be extended up to 14 additional calendar days if:

- The provider or the member requests an extension; and,
- ACNC justifies the need for additional information and the extension is in the member's best interest.

Expedited Determination Decision Turnaround Time

The member's physician may request an expedited determination, including authorizations, from AmeriHealth Caritas North Carolina when the member or physician

believes waiting for a decision under the standard timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function.

In situations where a provider indicates or AmeriHealth Caritas North Carolina determines that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, AmeriHealth Caritas North Carolina will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

AmeriHealth Caritas North Carolina may extend the 72 hours by up to fourteen (14) calendar days if the member or the provider requests an extension or ACNC justifies a need (to the State agency, upon request) for additional information and how the extension is in the best interest of the member. AmeriHealth Caritas North Carolina will provide its justification to the NCDHHS upon request.

Untimely service authorizations constitute an Adverse Benefit Determination, and the Health Plan treats these as appealable adverse actions. An Adverse Benefit Determination will be issued if a determination or need for an extension is not communicated to the provider within the required timeframes.

Medical Necessity of Services

"Medically Necessary" or "Medical Necessity" is defined as services or supplies that are needed for the diagnosis or treatment of the member's medical condition according to generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. The need for the item or service must be clearly documented in the member's medical record.

In accordance with Utilization Management Program Description 2021, AmeriHealth Caritas North Carolina uses the following medical necessity criteria as guidelines for determinations related to medical necessity:

1. North Carolina DHHS Clinical Coverage Policies including but not limited to:
    a. 8A: Enhanced Mental Health and Substance Abuse Services
    b. 8A-2: Facility-based Crisis Services for Children and Adolescents
    c. 8B: Inpatient Behavioral Health Services
    d. 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers
    e. 8Q: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder AmeriHealth Caritas North Carolina Utilization Management Program Description 2021 13
    f. 1E-7: Family Planning Services
    g. 1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment
    h. 1A-23: Physician Fluoride Varnish Services
    i. 1A-36: Implantable Bone Conduction Hearing Aids (BAHA)
    j. 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions

   k. 13A: Cochlear and Auditory Brainstem Implant External Parts replacement and Repair
   l. 13b: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
2. InterQual® Adult Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
3. InterQual® Pediatric Criteria (Condition Specific- Responder, Partial Responder, Non-responder)
4. InterQual® Outpatient Rehabilitation and Chiropractic Criteria
5. InterQual® Home Care Criteria
6. InterQual® Procedures Criteria
7. InterQual® DME Criteria
8. InterQual® Criteria for Behavioral Health Adult and Geriatric Psychiatry Criteria
9. InterQual® Criteria for Behavioral Health Child and Adolescent Psychiatry Criteria
10. InterQual® Criteria for Behavioral Health Residential and Community Based Treatment
11. American Society of Addiction Medicine (ASAM) Patient Placement (except for members aged 0 through 6; EPSDT criteria will be used for members in this age range)
12. Behavioral Health Screening Tools:
    a. Level of Care Utilization System (LOCUS) for members aged 18 and older
    b. Child and Adolescent Level of Care Utilization System (CALOCUS) for members aged 6 through 17
    c. Early Childhood Services Intensity Instrument (ECSII) or Child and Adolescents Needs and Strengths (CANS) for infant, toddler, and preschool aged members (ages 0 through5)
    d. Supports Intensity Scale (SIS) for I/DD services for members aged 5 and older (SIS Children version required for members between the ages of 5 through 16 and the SIS Adult version required for members aged 17 and older)
13. North Carolina Administrative Code & Rules
14. Evolent Radiology Guidelines
15. AmeriHealth Caritas Corporate Clinical Policies

When applying these criteria, ACNC staff also consider the individual member factors and the characteristics of the local health delivery system, including:

Member Considerations:

- Age, comorbidities, complications, progress of treatment, psychosocial situation, home environment.

Local Delivery System:

- Availability of sub-acute care facilities or home care in the AmeriHealth Caritas
  - North Carolina service area for post-discharge support.
- AmeriHealth Caritas North Carolina benefits for sub-acute care facilities or home care where needed.

- Ability of local hospitals to provide all recommended services within the estimated length of stay.
- Availability of the medically necessary behavioral health level of care.

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Market Chief Medical Officer/Behavioral Health Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure, or extension of stay, based on medical necessity, or to approve a service in an amount, duration or scope that is less than requested, is made by ACNC's Market Chief Medical Officer/Behavioral Health Medical Director under the clinical direction of the AmeriHealth Caritas Corporate VP, Utilization Management Physician/Corporate Behavioral Health Medical Director. The Medical Directors and their designee(s) have no history of disciplinary action or sanctions taken or pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

Medical Necessity decisions made by ACNC's Market Chief Medical Officer/Behavioral Health Medical Director or designee are based on North Carolina's definition of Medically Necessary Services, in conjunction with the Member's benefits and, medical/behavioral expertise. At the discretion of ACNC's Market Chief Medical Officer/Behavioral Health Medical Director or designee, participating board-certified physicians from an appropriate specialty, other qualified healthcare professionals or the requesting Practitioner/Provider may provide input to the decision. ACNC's Market Chief Medical Officer or designee makes the final decision. If a decision requires specialized judgement, ACNC contracts with External Independent Review Organizations with sub-specialist physicians available to participate in utilization review. The ACNC Medical/Behavioral Health Medical Director or designee makes the final decision. Only a medical director may issue an adverse benefit determination of medical or behavioral health services based on medical necessity.

Prior authorization is not a guarantee of payment for the service authorized. ACNC reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued, and the service was provided.

Clinical guidelines are made available to/members/practitioners/providers on the ACNC website. Members/Practitioners may request copies of guidelines used for a Medical Necessity Determination at any time by contacting ACNC.

ACNC will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from ACNC or an agent of ACNC unless there was material misrepresentation or fraud in obtaining the authorization. AmeriHealth Caritas North Carolina will not arbitrarily deny or reduce the

amount, duration, or scope of required services solely because of the diagnosis, type of illness or condition of the member.

The Utilization Management staff involved in Medical Necessity decisions is assessed for consistent application of review criteria, a minimum of two times a year as outlined in Policy UM.708NC Inter-rater Reliability Testing for Utilization Management Staff. An action plan is created and implemented for any variances among staff outside of the specified range. Clinical and non-clinical staff members are audited for adherence to policies and procedures.

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Provider Appeals telephone line by following the prompts at **1-855- 375-8811**

SECTION VI
Member's Grievances, Appeals and Fair Hearings

VI. Member's Grievances, Appeals and Fair Hearings

Member Grievance Process

If a member has a concern or question regarding the health care services, he/she has received under AmeriHealth Caritas North Carolina he/she should contact Member Services at the toll-free number on the back of the member ID card. A Member Services representative will answer questions or concerns. The representative will try to resolve the problem. If the Member Service representative does not resolve the problem to the member's satisfaction, the member has the right to file a grievance.

A *grievance* expresses dissatisfaction about the health care services he or she has received from AmeriHealth Caritas North Carolina or a provider. The member may file a grievance in writing or by telephone at the information below. It may be filed at any time either orally or in writing. It may be filed by the treating provider or primary care provider (or another authorized representative) on behalf of the member.

A grievance may be filed about issues such as the quality of the care the member receives from AmeriHealth Caritas North Carolina or a provider, rudeness from an ACNC employee or a provider's employee, a lack of respect for their rights by AmeriHealth Caritas North Carolina or any service or item that did not meet accepted standards for health care during a course of treatment.

To file a grievance:

Telephone:
Member Services: **1-855-375-8811** TTY: **1-866-209-6421**
Member Services Hours of Operation: 24 hours per day, 7 days per week.

Write To:
AmeriHealth Caritas North Carolina
Attn: Complaints and Grievances
PO Box 7382
London, KY 40742-7382

If the member needs assistance in filing his/her grievance or needs the help of an interpreter, the member may call Member Services and, if needed, interpretation services will be made available to the member free of charge. AmeriHealth Caritas North Carolina will send the member an acknowledgement letter within five (5) business days of receiving the grievance. ACNC will send a decision letter within thirty (30) calendar days of receiving the request. In some cases, ACNC may need additional time to obtain more information. If ACNC needs more time, the member will be informed of the reason for the extension in writing and within fourteen (14) calendar days of receiving the request.

Appeals Process

Notice of Adverse Benefit Determination

If AmeriHealth Caritas North Carolina decides to deny, reduce, limit, suspend, or terminate a service the member is receiving, or if ACNC fails to act in a timely manner, the member will receive a written "Notice of Adverse Benefit Determination." In most cases, the Notice of Adverse Benefit Determination will be sent within 10 calendar days from receipt of the request.

If the member does not agree with AmeriHealth Caritas North Carolina's determination as outlined in the Notice of Adverse Benefit Determination, he/she may file an appeal. With the written consent of the member, an "authorized representative" (i.e., his/her physician, a family member, friend, or provider) may file the appeal for them.
The member, or an authorized representative with the written consent of the member, may ask for a Fair Hearing after the appeals process has been exhausted. Additional information on requesting a Fair Hearing is available in this section of the *Provider Manual*.

Standard Appeal

A standard appeal asks AmeriHealth Caritas North Carolina to review a decision about the member's care. The member must file an appeal either orally or in writing within sixty (60) calendar days from the Notice of Adverse Benefit Determination.

An Appeal Request Form will be sent to the member with the Adverse Benefit Determination, or the member may access the form at www.amerihealthcaritasnc.com.

1. To pursue a standard appeal, the member or the member's authorized representative can file through one of the following methods: **To file a written appeal,** the member or authorized representative should complete the Appeal Request Form and send the appeal to:

   AmeriHealth Caritas North Carolina
   Attn: Member Appeals Coordinator
   Member Appeals Department
   PO Box 7378
   London, KY 40742-7378

2. Or submit by fax: **1-833-883-2262**
3. Appeals can also be submitted over the telephone (orally) by calling AmeriHealth Caritas Member Services: **1-855-375-8811**; TTY: **1-866-209-6421**
   Member Services Hours of Operation: 24 hours per day, 7 days per week.
4. Provider Appeals (on behalf of a member and with written consent): call **1-855-375-8811** and follow the prompts.
5. The member has the right to present their appeal information in person at the ACNC office in Raleigh, NC.

AmeriHealth Caritas North Carolina
8041 Arco Corporate Drive
Raleigh, NC 27617

If the member or the authorized representative chooses to file an appeal by telephone, the Appeal Request Form should be used as a reference for the information that will be needed to initiate the appeal.

The review begins the day ACNC receives the oral or written request. ACNC will send a written acknowledgement to the member within five (5) business days of receipt of the appeal. ACNC will provide a written notice of resolution of the appeal as expeditiously as the member's health condition requires and no later than thirty (30) calendar days after receiving the appeal, whether oral or written, to make a decision regarding the matter.

Before ACNC makes a decision, the member and/or the person helping the member with the appeal may give information in writing or in person to AmeriHealth Caritas North Carolina.

In some cases, ACNC, or the member may need more time to request additional information. The members or ACNC may request up to fourteen (14) more days to provide additional information when the delay is in the member's best interest. If ACNC needs more time, the member will be informed in writing of the reason for the extension.

The member may review his/her file any time while AmeriHealth Caritas North Carolina is reviewing the appeal. In the case of member's death, his/her authorized estate representative may request the case file The file may include medical records and/or additional documents.

AmeriHealth Caritas North Carolina will send the member or his/her authorized representative a letter with the decision, explaining how AmeriHealth Caritas North Carolina made its decision and the date the decision was made.

Expedited Appeal

If the time for a standard resolution could jeopardize the member's life, health; or ability to attain, maintain or regain function; a member, or his/her authorized representative may request an expedited appeal orally or in writing. **Note:** Expedited appeals are for health care services only – not denied claims.

For expedited appeal requests made by providers on behalf of Members, the AmeriHealth Caritas North Carolina will presume an expedited appeal resolution is necessary and grant the request for expedited resolution. AmeriHealth Caritas North Carolina will ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a member's appeal. 42 C.F.R. § 438.410(a)-(b).

To request an expedited appeal, the member or his/her authorized representative may call Member Services within 60 calendar days of the date on the notice of adverse benefit determination. ACNC will not take punitive action against a provider who either requests an expedited resolution or supports a member's appeal. If the request to expedite the appeal process is denied, the appeal will immediately be moved into the standard appeal timeframe of no longer than 30 calendar days and the member will be notified in writing within two business days of the denial for an expedited appeal request.

The member may file a grievance if they do not agree with the decision to change the appeal timeframe to a standard appeal. For expedited resolution of appeals, ACNC will make a determination as expeditiously as the Member's health condition requires but will provide written notice, and make reasonable effort to provide oral notice, of resolution no later than seventy-two (72) hours of receipt of the expedited appeal request.

ACNC may extend the timeframes for expedited resolution of an appeal request by up to fourteen (14) calendar days if The Member requests the extension, or ACNC determines that there is a need for additional information and the delay is in the Member's interest. If ACNC needs more time, the member will be informed of the reason for the extension in writing.

For appeals not resolved wholly in favor of the member, the written notice will include the right to request a State Fair Hearing, including the procedures to do so and the right to request to receive benefits while the hearing is pending, including instructions on how to make the request. The written notice will also include notice that the member may be held liable for the cost of those benefits if the hearing upholds ACNC's action.

State Fair Hearing

The member or his/her authorized representative may seek a Fair Hearing after the appeals process has been exhausted, but the Fair Hearing must be requested within 120 calendar days from the date of AmeriHealth Caritas's Notice of Decision letter. A provider may also request a Fair Hearing on behalf of a member with the member's consent by written notice. A representative (family member, friend, or physician) with a signed consent may request a state Fair Hearing on your behalf when the appeal process has been exhausted.

Members have the right to self-representation or to be represented by a family caregiver, legal counsel, or other representative during a Fair Hearing. Parties to the Fair Hearing are ACNC and the member or his/her authorized representative.

A State Fair Hearing can be requested by calling The Office of Administrative Hearings at **1-984-236-1860** or by writing to the North Carolina Office of Administrative Hearings, Hearings Division and Clerk's office:

Office of Administrative Hearings
1711 New Hope Church Road

Raleigh NC 27609
Phone: **1-984-236-1850**
Fax: **1-984-236-1871**

For Medicaid-Specific inquiries:
Office of Administrative Hearings Medicaid Hotline
Phone: **1-984-236-1850**

Office hours are 8:00 a.m. – 5:00 p.m. Monday-Friday. The office is closed all State holidays.

Continuation of Benefits

A member may continue to receive services while waiting for the AmeriHealth Caritas North Carolina appeal or the State Fair Hearing decision if **all** the following apply:

- The appeal is filed timely as described above.
- The request for continuation of benefits is filed for within ten (10) calendar days of the date on AmeriHealth Caritas North Carolina's adverse benefit decision, or before the intended effective date of the proposed action, whichever is later.
- The appeal is related to reduction, suspension, or termination of previously authorized services.
- The services were ordered by an authorized provider.
- The authorization period has not ended.
- The member requested the services to continue.

The member's services continue to be covered until one of the following occurs:

- The member decides not to continue the appeal or request for State Fair Hearing.
- Ten (10) calendar days have passed from the date of the notice of resolution of the appeal unless the member has requested a Fair Hearing within that timeframe.
- The time covered by the authorization is ended or the limitations on the services are met
- The Fair Hearing office issues a hearing decision adverse to the member.

The member may have to pay for the continued services if the final decision from the Fair Hearing is averse to them. If the Fair Hearing officer agrees with the member, AmeriHealth Caritas North Carolina will pay for the covered services that were rendered to the member while waiting for the decision. If the Fair Hearing officer agrees with the member and the member did not continue to receive covered services while waiting for the decision, AmeriHealth Caritas North Carolina will issue an authorization for the covered services to restart as soon as possible and ACNC will pay for the covered services.

Peer-to-Peer Telephone Line

Providers may reach the Peer-to-Peer telephone line by following the prompts at **1-833-900-2262** to discuss a medical determination with a physician in the AmeriHealth Caritas North Carolina Medical Management department. Providers must call within five (5) business days of the verbal/ faxed notification of the determination.

As a reminder, a provider may also file an appeal on a member's behalf, with the member's written consent. To file an appeal as an authorized representative on behalf of a member, a provider may call the Provider Appeals telephone line by following the prompts at **1-855-375-8811**

Note: The purpose of the Peer-to-Peer process is to address ***medical determinations*** regarding health care services. This process is not intended to address denied claims or other issues. For information on filing a grievance, please refer to the "Provider Grievances and Appeals" section of this *Provider Manual*. For information on disputing a claim, please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual.*

SECTION VII
Provider Grievances and Appeals

VII: Provider Grievances and Appeals

Providers can make inquiries, register complaints, and settle grievances with AmeriHealth Caritas North Carolina. This section sets forth the procedures by which Providers may register grievances about contracting differences, ACNC's policies, procedures, or any aspects of ACNC's administrative functions, or claim denials.

What is a Provider Grievance?

A Provider Grievance is a verbal or written complaint or dispute by a Provider over any aspect of the operations, activities, or behavior of AmeriHealth Caritas North Carolina, except for any dispute over which the Provider has appeal rights. It is an opportunity for the Provider to bring issues to ACNC.

Examples of Provider grievances include, but are not limited to:

- Service issues regarding engagement with ACNC including failure by ACNC to return a Provider's calls, frequency of site visits by Provider Account Executives and lack of Provider Network orientation/education by ACNC.

- Process issues with ACNC including failure to notify Providers of policy changes, dissatisfaction with ACNC's Prior Authorization process, dissatisfaction with ACNC's referral process and dissatisfaction with ACNC's Formal Provider Appeals Process

- Contracting and date dispute issues including dissatisfaction with ACNC's reimbursement rate, and incorrect information regarding the Provider in ACNC database.

Grievance Process

Providers can file an electronic grievance using the following electronic resource:

Electronic Submission:

1. Provider should register for NaviNet and submit a grievance, using the Forms and Dashboards workflow on the left side. Select grievance, fill out the form and submit. The provider will be given a document ID number for reference. To follow up on your grievance submission, submit a provider inquiry and include your document ID.

2. Via the phone contact Provider Services at **1-888-738-0004.** The representative will try to resolve the issue(s) in real time. If the issue(s) is not resolved, a grievance can be created on your behalf by Provider Contact Service Department and forwarded to Provider Network Operations for investigation and resolution. The provider will be given a service form ID number for reference.

Written Submission:

Visit our website and complete the grievance submittal form, include any applicable supporting documentation and mail the grievance form and documentation to the address below:

Provider Network Management Department
Provider Grievances
AmeriHealth Caritas North Carolina
PO Box 7379
London, KY 40742-7379

At a minimum, ACNC will take the following actions in response to a grievance:

- Notify providers of receipt of grievance; include anticipated resolution date.
- Thoroughly investigate each provider grievance using applicable statutory, regulatory, contractual and provider contract provisions. All pertinent facts will be investigated and considered. AmeriHealth Caritas North Carolina's policies and procedures will also be considered.

Time Frame for Resolution
AmeriHealth Caritas North Carolina will investigate, conduct an on-site meeting with the Provider (if one was requested), and issue written resolution of a formal grievance within thirty (30) calendar days of receipt of the grievance from the Provider.

On-Site Meeting
Providers may request an on-site meeting with a Provider Account Executive, either at the Provider's office or at AmeriHealth Caritas North Carolina to discuss the Grievance. Depending on the nature of the Grievance, the Provider Account Executive may also request an on-site meeting with the Provider. The Provider or Provider Account Executive must request the on-site meeting within seven (7) calendar days of the filing of the Grievance with AmeriHealth Caritas North Carolina. The Provider Account Executive assigned to the Provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Provider Appeals

AmeriHealth Caritas North Carolina maintains a formal provider Appeals process by which Providers may challenge decisions of ACNC. Providers may appeal for the following reasons:

Network Providers	Out-of-Network Providers
• Program Integrity related findings or activities • Finding of fraud, waste, or abuse by ACNC • Finding of or recovery of an overpayment by ACNC	• A determination to not contract with a provider based on objective quality reasons outlined in ACNC's Objective Quality Standards

• Withhold or suspension of a payment related to fraud, waste, or abuse concerns • Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in ACNC's Objective Quality Standards* • Termination of, or determination not to renew, an existing contract for local health department care/case management services • Determination to lower an AMH provider's Tier Status • Violation of terms of the provider contract between the Provider and AmeriHealth Caritas North Carolina	• An out-of-network payment arrangement • Finding of waste or abuse by ACNC • Finding of or recovery of an overpayment by ACNC

**** Provider terminations based on quality-of-care reasons may be appealed in accordance with the AmeriHealth Caritas North Carolina Provider Sanctioning Policy outlined in Section VIII.***

Additional Grounds for an Appeal
In addition to the reasons outlined above, Providers may appeal most grievances not resolved through the Provider Grievance process to the Provider's satisfaction, following the below guidelines.

General Appeal Timeframes and Formal Provider Appeal Process
The Provider's right to appeal will generally follow a decision by ACNC that is adverse to the Provider. At the time ACNC sends the notice of decision, written notice of a Provider's right to appeal will be included.

Providers wishing to file an appeal must do so using electronic or written means within thirty (30) calendar days from the date on which: (a) the Provider received written notice from ACNC of the decision giving rise to the right to the appeal; or (b) ACNC should have taken a required action but failed to take such action.

If the provider does not provide supporting documentation with the appeal form, it is possible ACNC will extend the timeframe by thirty (30) calendar days for Providers to request an appeal for "good cause" shown as determined by ACNC. "Good cause" reasons include, but are not necessarily limited to, the requirement to provide voluminous required evidence/supporting documentation and appeals arising from adverse quality decisions by ACNC.

When requested by NCDHHS, ACNC will share information regarding provider appeals.

A provider must exhaust the internal appeals process before seeking recourse under any other process permitted by contract or law.

Provider Portal Electronic Submission:
Register for NaviNet via our website and submit using the Forms and Dashboards workflow on the left side. Fill out the Appeals form and submit. The provider will be given a document ID number for reference.

Written Submission:
A written appeal can be submitted to the address below.

Provider Appeals Department
AmeriHealth Caritas North Carolina
P.O. Box 7379
London, KY 40742-7379

ACNC will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request.

Appeals Panel Review

The Appeals Panel is comprised of at least three individuals who have the authority, training, and expertise to address and resolve Provider Appeals issues. The Panel will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal. The provider may exercise the option to be represented by an attorney during the appeals process.

The Appeals Panel will issue a determination to uphold, modify, or overturn the original determination based upon:

- Clinical judgment, if applicable;
- Established standards of medical practice;
- Review of available information including but not limited to:

    - AmeriHealth Caritas North Carolina medical and administrative policies;
    - Information submitted by the Provider or obtained by ACNC
    - North Carolina through investigation;
    - The Provider's contract with AmeriHealth Caritas North Carolina;
    - AmeriHealth Caritas North Carolina's contract with NCDHHS and relevant Medicaid laws, regulations and rules.

Appeals on Behalf of a Member

Any benefit determination, denial, or reduction of services-by ACNC, may be appealed by the Member, or the Health Care Provider, **with written consent of the Member**, through AmeriHealth Caritas North Carolina's Member Grievance Process outlined in the Section VI of this *provider manual*.

In addition to the Provider Grievance and Appeals Process, Providers may, in certain instances, pursue a Member Complaint or Grievance appeal on behalf of a member. Such actions are ***not*** Provider Grievances or Provider Appeals; rather, they are handled by AmeriHealth Caritas North Carolina as a Member Complaint or Grievance. A comprehensive description of AmeriHealth Caritas North Carolina's Member Complaint, Grievance and Fair Hearings Process is located in Section VI of the Manual.

Appeals Panel Review

The Appeals Panel is comprised of at least three individuals who have the authority, training, and expertise to address and resolve Provider Appeals issues. The Panel will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal. The provider may exercise the option to be represented by an attorney during the appeals process.

The Appeals Panel will issue a determination to uphold, modify, or overturn the original determination based upon:

- Clinical judgment, if applicable;
- Established standards of medical practice;
- Review of available information including but not limited to:

    - AmeriHealth Caritas North Carolina medical and administrative policies;
    - Information submitted by the Provider or obtained by ACNC
    - North Carolina through investigation;
    - The Provider's contract with AmeriHealth Caritas North Carolina;
    - AmeriHealth Caritas North Carolina's contract with NCDHHS and relevant Medicaid laws, regulations and rules.

Time Frame for Resolution

AmeriHealth Caritas North Carolina will provide written notice of the decision of the appeal within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the Provider to submit additional evidence, within thirty (30) calendar days of the date on which all the evidence is submitted to ACNC.

Appeals of Suspension or Withhold of Provider Payment

AmeriHealth Caritas North Carolina will limit the issue on appeal in cases of suspension or withholding of Provider payment to whether AmeriHealth Caritas North Carolina had good cause to commence the withhold or suspension of payment. AmeriHealth Caritas North

Carolina will not address whether the Provider has or has not committed fraud or abuse. AmeriHealth Caritas North Carolina will notify the NCDHHS within ten (10) business days of a suspension or withhold of Provider payment.

AmeriHealth Caritas North Carolina will offer the Provider an in-person or telephone hearing when the Provider is appealing whether AmeriHealth Caritas North Carolina has good cause to withhold or suspend payment to the Provider.

AmeriHealth Caritas North Carolina will schedule the hearing and issue a written decision regarding whether there was good cause to suspend or withhold payment within fifteen (15) business days of receiving the Provider's appeal. Upon a finding that AmeriHealth Caritas North Carolina did not have good cause to suspend or withhold payment, AmeriHealth Caritas North Carolina will reinstate any payments that were withheld or suspended within five (5) business days.

AmeriHealth Caritas North Carolina will pay interest and penalties for overturned denials, underpayment, or findings it did not have good cause to suspend or withhold payment, calculated from the original date of payment, suspension, withhold or denial.

Provider Contract Terminations

NCDHHS initiated Medicaid Provider Terminations

AmeriHealth Caritas North Carolina will remove any provider from the AmeriHealth Caritas North Carolina network, claims payment system, and terminate its contract consistent with the effective date provided by NCDHHS with the provider within one (1) business day of receipt a notice from NCDHHS that the Provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.

If AmeriHealth Caritas North Carolina suspended provider payment, then upon notice by NCDHHS that the provider is terminated from Medicaid, AmeriHealth Caritas North Carolina will release applicable claims and deny payment.

AmeriHealth Caritas Provider Terminations

AmeriHealth Caritas North Carolina may terminate a provider from its network with cause. Any decision to terminate must comply with the requirements of the Contract.

AmeriHealth Caritas North Carolina will comply with the Program Integrity Provider Termination Requirements.

AmeriHealth Caritas North Carolina will provide written notice to the provider of the decision to terminate to the provider. The notice, at a minimum, must include:

A. The reason for AmeriHealth Caritas North Carolina's decision;

B. The effective date of termination;
C. The Provider's right to appeal the decision; and;
D. How to request and appeal.

AmeriHealth Caritas North Carolina will report data to NCDHHS

AmeriHealth Caritas North Carolina Provider Agreements specify termination provisions that comply with the NCDHHS requirements. Provider terminations are categorized as follows:

- Plan Initiated "For Cause"
- Plan Initiated "Without Cause"
- Provider Initiated
- Mutual.

In addition to those requirements identified in the Provider Agreement, AmeriHealth Caritas North Carolina will comply with the following guidelines, based on category of termination.

Plan Initiated "For Cause"
AmeriHealth Caritas North Carolina may initiate termination of a Provider Agreement if the provider breaches ACNC Provider Agreement. A "for cause" termination may be implemented when there is a need to terminate a provider's contract. Depending upon the nature of the breach, the provider may be given an opportunity to "cure" the breach and, if successful, the termination will be rescinded. However, there are instances where the breach is incapable of being cured and the termination will become effective immediately. The provider should review his or her participation agreement for the circumstances that justify an immediate for cause termination. If terminating a Provider Agreement for cause, ACNC will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.
- Notify the provider, the NCDHHS, and the member immediately in cases where an AmeriHealth Caritas North Carolina member's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the North Carolina Board of Medicine or other governmental agency.
- Provide the NCDHHS with reason(s) for termination for cause.
- Offer appeal rights for physicians, as applicable.

Plan Initiated "Without Cause"
AmeriHealth Caritas North Carolina may terminate a Provider Agreement "without cause" for various reasons (e.g., provider relocation or dissolution of a medical practice). If this occurs, ACNC will:

- Send applicable termination letters in accordance with the notification provisions of the Provider Agreement.

- Notify ACNC network provider, the NCDHHS, and members in active care at least 30 calendar days before the effective date of the termination.
- Fax all AmeriHealth Caritas North Carolina termination letters to the NCDHHS.
- Offer appeal rights to physicians, as applicable.

Provider Initiated

- The provider must provide ninety (90) days prior written notice to ACNC if intending to terminate from ACNC network for cause. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.
- The provider must provide ninety (90) days prior written notice to ACNC if intending to terminate from ACNC network without cause.
- Under either circumstance, written notice must be delivered in accordance with the method(s) specified in your Provider Agreement and the termination letter must reflect the signature of an individual authorized to make the decision to terminate the agreement.
- If the provider is a PCP, ACNC will send a written notification to the members who have chosen the provider as their PCP no less than 15 calendar days after receipt of the termination notice or at least 30 days prior to the termination date, whichever is sooner.
- If an ACNC member has special health care needs and his or her treating provider gives notice of termination with ACNC, Member Services and/or Case Management staff will personally contact the member by telephone and in writing to provide assistance in securing a new provider.

Mutual Terminations

A mutual termination is a termination of a Provider Agreement(s) in which the effective date is agreed upon by both parties. The termination date may be other than the required days' notice specific to ACNC's Provider Agreement language.

- All mutual termination letters require signatures by both parties.
- Regarding mutual terminations of any AmeriHealth Caritas North Carolina Provider Agreement, the termination date should provide a minimum number of required days in order to provide notice to members. A mutual agreement termination date should not be a retroactive date.
- AmeriHealth Caritas North Carolina will notify the NCDHHS and members in active care at least 30 calendar days before the effective date of the termination.

Member Notification of Provider Termination

AmeriHealth Caritas North Carolina shall notify each Member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the network. ACNC will make a good faith effort to provide written notice within fifteen (15) calendar days after receipt of a notice of termination by NCDHHS or issuance of termination notice to the provider by ACNC. 42 C.F.R. § 438.10(f)(1).

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

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

If a terminated provider is an AMH/PCP for a Member, AmeriHealth Caritas North Carolina shall validate that the Member selects or is assigned to a new AMH/PCP within thirty (30) calendar days of the date of notice to the Member and notifies the Member of the procedure for continuing to receive care from the terminated provider and the limitations of the extension. ACNC will support transition of care for the Member to the new provider.

AmeriHealth Caritas North Carolina shall use a Member notice consistent with the Department-developed model Member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).

Continuity of Care

Plan members who are in active treatment at the time a Provider Agreement terminates will be allowed to continue care with a terminated treating provider, pursuant to the terms of the Provider Agreement, but no less than through the earlier of:

- Completion of treatment for a condition for which the member was receiving care at the time of the termination; or,
- Until the member changes to a new provider.
- ACNC will support transition of care for the Member to the new provider.

AmeriHealth Caritas North Carolina will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider through the completion of postpartum care.

Notwithstanding the provisions in this section, a terminated provider may refuse to continue to provide care to a member who is abusive or noncompliant.

For continued care, AmeriHealth Caritas North Carolina and the terminated provider will continue to abide by the same terms and conditions as outlined in the Provider Agreement and in the "Quality Assurance and Performance Improvement Program" section VIII of this *Provider Manual.* These provisions for continuity of care set forth above will not apply to providers who have been terminated from AmeriHealth Caritas North Carolina for cause.

Provider Ombudsman Program

Office of the Ombudsman
Providers may contact the NCDHHS Ombudsman Program established to assist Providers with submitting a complaint about AmeriHealth Caritas North Carolina or any PHP.

Providers may call the Medicaid Managed Care Provider Ombudsman Program at **1-866-304-7062**. Providers can also find more information about the Medicaid Managed Care Provider Ombudsman Program and how to submit a complaint via:

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

Section VIII
Quality Assessment and Performance Improvement Program

VIII. Quality Assessment and Performance Improvement Program

AmeriHealth Caritas North Carolina's Quality Assessment and Performance Improvement (QAPI) program provides a framework for evaluating the delivery of health care and services provided to members. AmeriHealth Caritas North Carolina's leadership provides strategic direction for the QAPI program and retains ultimate responsibility for ensuring that the QAPI program is incorporated into ACNC's operations. Operational responsibility for the development, implementation, monitoring and evaluation of the QAPI program is delegated by AmeriHealth Caritas North Carolina's leadership through the regional president, to the AmeriHealth Caritas North Carolina Market Chief Medical Officer (CMO). The CMO is Chairman of the Quality Assessment Performance Improvement Committee (QAPIC) and is licensed in the state of North Carolina.

The purpose of the QAPI program is to provide a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Caritas North Carolina members by providers.

The QAPI program also provides oversight and guidance for the following:

- Determining practice guidelines and standards by which the program's success will be measured.
- Complying with all applicable laws and regulatory requirements, including but not limited to applicable state and federal regulations and NCQA accreditation standards.
- Providing oversight of all delegated services.
- Help ensure that AmeriHealth Caritas North Carolina's Credentialing/Re-credentialing policies and procedures are consistently followed and aligned with state policies and procedures.
- Monitor the credentialing processes to help ensure implementation is in accordance with applicable federal, state and NCQA standards.
- Compare provider performance against quality data, including quality of care and quality of service concerns, and review provider performance at least as often as the NCDHHS re-credentialing cycle. Any severity levels reached as outlined in the Review of Potential Quality of Care Cases policy will be presented to the QAPIC for review, discussion, and determination.
- Helping to ensure that a qualified network of providers and practitioners, present on the PEF extended file, is available to provide care and service to members.
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement.

- Reducing health care disparities by measuring, analyzing, and re-designing services and programs to meet the health care needs of our diverse membership.

AmeriHealth Caritas North Carolina develops goals and strategies considering applicable state and federal laws and regulations and other regulatory requirements, including North Carolina's Quality Management Strategy (QMS), NCQA accreditation standards, evidence-based guidelines established by medical specialty boards and societies, public health goals and national medical criteria. ACNC also uses performance measures such as HEDIS®, CAHPS®, consumer and Provider surveys, and available results of the External Quality Review Organization (EQRO), as part of the activities of the QAPI program.

Providers have a key role in helping AmeriHealth Caritas North Carolina measure and report the quality of care delivered to our members:

- Every provider in the AmeriHealth Caritas North Carolina provider network is required by contract to cooperate with and participate in AmeriHealth Caritas North Carolina's quality management/quality assessment & performance improvement (QM/QAPI) program. We rely on your cooperation and participation to meet our own state and federal obligations as a Prepaid Health Plan.

- AmeriHealth Caritas North Carolina's access to the medical records maintained by our providers is a critical component of our data collection as we seek to ensure appropriate and continued access to care for our member population. AmeriHealth Caritas North Carolina or its designee must receive medical records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program. AmeriHealth Caritas North Carolina will reach out from time to time to request records for these purposes; it is essential that you provide requested records within the timeframes set forth in those notices.

- As our technological capabilities continue to advance, AmeriHealth Caritas North Carolina will seek to enhance the efficiency of our data collection activities in support of our QAPI and population health programs, including through the use of bi-directional automated data exchange with our providers These exchange opportunities, as available, are intended to capture data related to gaps in care, and to identify social determinants of health that may also be targets for intervention. AmeriHealth Caritas North Carolina will work with our providers to identify and implement the most appropriate format and cadence for data exchange.

- AmeriHealth Caritas North Carolina clinical reviewers fully investigate potential quality of care (QOC) concerns, in accordance with AmeriHealth Caritas North Carolina policy. Providers are expected to comply with QOC review processes,

beginning with the timely submission of records in response to requests from AmeriHealth Caritas North Carolina. Your support of and participation in this critical review process helps to ensure the provision of high-quality care and service to the AmeriHealth Caritas North Carolina member population.

Quality Assessment Performance Improvement Committee (QAPIC)
The QAPIC oversees AmeriHealth Caritas North Carolina's efforts to measure, manage and improve quality of care and services delivered to ACNC members, and evaluates the effectiveness of the QAPI program. Additional committees and councils support the QAPI program and report into the QAPIC:

Member Advisory Committee
Provides a forum for member participation and input on Plan programs and policies to promote collaboration, maintain a member focus and enhance the delivery of services to AmeriHealth Caritas North Carolina communities.

The North Carolina Medicaid Pharmacy and Therapeutics Committee
The primary responsibility of the North Carolina Medicaid Pharmacy and Therapeutics (P&T) Committee is to review and approve and recommend pharmacy policies and criteria to the NC Physician's Advisory Group (PAG). The committee also develop policies for drug formulary management, pharmacy benefits management, and pharmacy prior authorization criteria, To maximize patient health outcomes for NC Medicaid beneficiaries, we help ensure members have access to cost efficient prescriptions, and that medically appropriate drug therapies are available.

Quality of Service Committee (QSC)
Monitors performance and quality improvement activities related to ACNC services; reviews, approves, and monitors action plans created in response to identified variances. Also tracks and reviews operational service performance levels for multiple departments and ensure compliance with state contractual requirements.

Health Equity and Culturally and Linguistically Appropriate Service (HECLAS) Committee
Provides direction for Plan activities that are relevant to the 15 national CLAS standards and to NCQA's Health Equity Accreditation Standards to ensure that AmeriHealth Caritas North Carolina members are served in a way that is responsive to their cultural and linguistic needs.

Practitioner Involvement

We encourage provider participation in our quality-related programs. Providers who are interested in participating in one of our Quality Committees may contact Provider Services at **1-888-738-0004** or their Provider Network Account Executive.

QAPIC Activities

The QAPI program is designed to monitor and evaluate the quality of care and service. provided to members. Practitioners and providers agree to allow AmeriHealth Caritas North Carolina to use their performance data as needed for the organization's QI activities to improve the quality of care and services, and the overall member experience.

Performance Improvement Projects

ACNC develops and implements Performance Improvement Projects (PIPs) focusing on areas of concern or low performance, both clinical and service-related, identified through internal analysis and external recommendations. ACNC will engage providers in performance improvement activities that support attainment of optimal clinical and service outcomes.

Ensuring Appropriate Utilization of Resources

ACNC will perform baseline utilization measurements to calculate inpatient admission rates and length of stay, emergency room utilization rates and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected range to assess for over- or under-utilization.

Disease Management Programs

ACNC's Disease Management Programs were selected to address the expected high-incidence conditions for which there are evidence-based protocols that have been shown to improve health outcomes.

Measuring Member and Practitioner Satisfaction

ACNC uses the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess member satisfaction. The CAHPS survey is fielded by an External Quality Review Organization contracted by NCDHHS. ACNC will conduct Practitioner Satisfaction studies quarterly and will utilize Provider Satisfaction survey data provided by NCDHHS to assess provider satisfaction. Survey results are reported to the QAPIC for review and identification/prioritization of opportunities for improvement.

Member and Practitioner Dissatisfaction

Dissatisfactions or complaints/grievances from members and providers are investigated, responded to, and trended. Trends and the results of investigations are reported to the QAPIC, which coordinates initiatives to address identified opportunities for improvement.

Member Safety Programs

The QAPI department is responsible for coordinating activities to promote member safety. Initiatives focus on promoting member knowledge about medications, home safety and hospital safety. Members are screened for potential safety issues during the initial assessment.

Preventive Health and Clinical Practice Guidelines

The QAPIC is responsible for approving all preventive health and clinical practice guidelines. Guidelines are developed using criteria established by nationally recognized professional organizations and with input from the QAPIC. Guidelines are distributed via ACNC's website, with hard copies available upon request. As mandated by the State, participating providers will utilize clinical practice guidelines, including but not limited to those addressing:

- Adult and child preventive care, including Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- Chronic conditions (i.e., diabetes and asthma)
- Behavioral health services
- Obstetrical care
- AIDS/HIV
- Palliative care

Availability and Accessibility Audits

Compliance with ACNC's availability standards is monitored at least quarterly to ensure sufficient numbers of network providers are available to meet member needs. An assessment is conducted to compare the type, number and location of network practitioners and providers to approved standards. The Quality Assessment Performance Improvement Committee (QAPIC) reviews and evaluates the report. ACNC also conducts routine assessments of network providers' compliance with appointment standards for routine, urgent and sick office visits. The QAPIC Committee receives, reviews, and approves the results of the survey annually.

Medical Record Requirements

Medical records of network providers are to be maintained in a manner that is current, detailed, organized, and permits for effective and confidential patient care and quality review. Provider offices are to have an organized medical record filing system that facilitates access, availability, confidentiality, and organization of records at all times.

Provider agrees to retain all medical records, whether electronic or paper, for a period of no less than ten (10) years after the last payment was made for the services of the member.

Providers are required by contract to make medical records accessible to all appropriate government agencies, including but not limited to the NCDHHS, the North Carolina Division of Health Benefits (DHB), the United States Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and/or the Office of the Inspector General (OIG), and their respective designee's in order to conduct fraud, abuse, waste and/or quality improvement activities.

Providers must follow the medical record standards outlined below, for each member's medical record, as appropriate:

- Each provider furnishing services to members is required to maintain and share with other PCPs, Specialists, and Behavioral Health providers as appropriate, a member health record in accordance with professional standards and state and federal law.
- Elements in the medical record are organized in a consistent manner and the records must be kept secure.
- Patient's first and last name and identification number is on each page of record.
- All entries specify location, date, times of service provision and are legible.
- Identification of the type of service being provided.
- All entries are initialed or signed by the author including professional credentials, if any.
- Personal and biographical data are included in the record.
- Current and past medical history and age-appropriate physical exam are documented and include serious accidents, operations, and illnesses.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking, and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- There is documentation of discussions of a living will or advance directives for each member.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded.
- Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded, as appropriate.
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated, as needed.
- Specific interventions, including name, dosage, and route of medications administered.
- Any supplies dispensed as part of the service.
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated, as appropriate.
- Screening and preventive care practices are in accordance with ACNC's Preventive Health Guidelines.
- Member's response to staff interventions.
- An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).

- Requests for consultations are documented in writing and are consistent with clinical assessment/physical findings.
- Laboratory and other studies ordered, as appropriate, are documented in writing.
- Laboratory and diagnostic reports reflect practitioner review, documented in writing.
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented in writing.
- There is written evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.
- Identification of the timeframe for documentation completion.
- Process to ensure units of service billed for payment are based on services provided with substantiating documentation.
- A provider may correct a medical record before submitting a claim for reimbursement; however, the correction must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

Medical Record Audits and Requests

AmeriHealth Caritas North Carolina conducts medical record reviews to capture HEDIS® data not obtained through claims submission. Medical records may be audited year-round. This effort is part of health plan operations and within plan expectations for participating providers. A written notification request may be submitted to a provider office requesting specific medical records be sent to ACNC. At least five (5) business days' notice will be provided for a scheduled onsite audit. If requested, a member list will be provided with Medicaid ID, date of birth, and HEDIS® measure prior to the audit. The names of the reviewers performing the audits will also be provided, if requested.

The Quality Management Department may conduct random quality reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality reviews will be forwarded to the certifying or accrediting entity.

A quality review could include, but is not limited to, interviews with the consumer and the consumer's parents or legal guardian, designated case manager, and/or provider staff. A review of case files, staff personnel records, compliance with provider standards with state and federal code, and organizational policies and procedures and documentation may be conducted.

Adverse Events include Sentinel and Never events as defined below:

Sentinel Event – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have

caused a death and all attempted suicides. These events are referred to as "sentinel" because they signal the need for immediate investigation and response.

- Please note, the terms "sentinel event" and "medical error" as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. Examples of a sentinel event include:
    - Maternal death after delivery.
    - Suicide while inpatient.

Never Event – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above. Examples of Never Events include:

- Surgery performed on the wrong patient.
- Surgery on the wrong body part.
- Unintended retention of a foreign object after surgery.

See www.CMS.gov for a complete list.

Provider Preventable Conditions

AmeriHealth Caritas North Carolina will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions. Providers must also report Critical Incidents to ACNC.

Health Care Acquired Conditions

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, ACNC does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity

- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric populations

Reporting of critical incidents is required for all health plan members.

AmeriHealth Caritas North Carolina monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of ACNC.

AmeriHealth Caritas North Carolina's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences;
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes, and strategies for prevention.

Reporting Provider Preventable Conditions

Please contact AmeriHealth Caritas North Carolina UM Department at **1-833-900-2262** to report a provider preventable condition. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information regarding AmeriHealth Caritas North Carolina's policy on provider preventable conditions and how to report such conditions via the claims process.

Adverse Event Reporting

In accordance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, with governing regulations codified at 45 CFR Parts 60 and 61, AmeriHealth Caritas North Carolina sends information on reportable events, (as outlined in the NPDB Reporting Manual instructions) to the respective entity and to the State Board of Medicine, as appropriate, in North Carolina.

Mandatory Reporting Requirements

AmeriHealth Caritas North Carolina providers are required to comply with the reporting of specific conditions, diseases, and major incidents in accordance with state regulations and guidelines. Participating providers are also required to report suspected abuse, neglect and financial exploitation of adults and suspected abuse or neglect of children in accordance with State law.

Potential Quality of Care Concerns

Potential quality of care concerns are fully investigated by AmeriHealth Caritas North Carolina. Quality of care (QOC) concerns will be thoroughly investigated by clinical reviewers in accordance with company policy. Providers are required to comply with AmeriHealth Caritas North Carolina QOC review process to include submitting records timely in accordance with our policy and procedures.

Activity summaries are presented to the QAPIC on a quarterly basis at minimum. Serious QOC concerns may result in a referral to the Peer Review Committee and Quality Assessment Performance Improvement Committee (QAPIC) for further review. The QAPIC may recommend action including, but not limited to, panel restriction or termination from ACNC's network, sanctions, or corrective action. Referral to the Peer Review Committee and QAPIC is at the discretion of ACNC Medical or Quality Management (QM) Director.

If the QAPIC investigation involves an action reportable to a national or state entity or database, the appropriate practitioner/provider's case information will be reported to the National Practitioner Data Bank (NPDB) and state regulatory agencies.

The Quality Management Department reserves the right to impose any of the following actions, based on its discretion:

- Submission of medical records.
- Requiring the practitioner/provider to submit of a written description and explanation of the quality-of-care event or issue as well as the controls and/or changes that have been made to processes to prevent similar quality issues from occurring in the future. If the practitioner/provider does not provide this explanation, the QAPIC may impose further actions.
- Conducting a medical record review audit.
- Requiring that the practitioner/provider conform to a corrective action plan which may include continued monitoring by AmeriHealth Caritas North Carolina to ensure that adverse events do not continue.

This requirement will be documented in writing. A corrective action plan may also include provisions that the practitioner/provider maintain an acceptable pass/fail score with regard to a particular performance metric.

In addition, QAPIC may recommend the following:

- Implementing formal sanctions, including termination from AmeriHealth Caritas North Carolina network if the offense is deemed an immediate threat to the well-being of Plan members.

AmeriHealth Caritas North Carolina reserves the right to impose formal sanctions if the practitioner/provider does not agree to abide by any of the corrective actions listed above.

At the conclusion of the investigation, the practitioner/provider will be notified by letter of the concern of the actions recommended by the QAPIC, including an appropriate time period within which the practitioner/provider must conform to the recommended action.

Provider Sanctioning Policy

It is the goal of AmeriHealth Caritas North Carolina to assure members receive quality health care services. In the event that medical, behavioral health, or LTSS care services rendered to a member by a network provider represent a serious deviation from, or repeated non- compliance with, ACNC's quality standards, recognized treatment patterns of the organized medical community, and/or standards established by the State, the network provider may be subject to AmeriHealth Caritas North Carolina's formal sanctioning process.

Except for any applicable state licensure board reporting requirements, all sanctioning activity is strictly confidential.

Formal Sanctioning Process

Following a determination to initiate the formal sanctioning process, AmeriHealth Caritas North Carolina will send the practitioner/provider written notification of the following by certified mail or via another means providing for evidence of receipt. The notice will include:

- The reason(s) for proposed action and information on the practitioner/provider's right to request a hearing with AmeriHealth Caritas North Carolina on the proposed action.
- Reminder that the practitioner/provider has 30 days following receipt of notification within which to submit a written request for a hearing. Otherwise, the right to a hearing will be forfeited. The practitioner/provider must submit the hearing request by certified mail and must state what section(s) of the proposed action he/she wishes to contest.
- Notification that the practitioner/provider may waive his/her right to a hearing and that the right will be considered waived if no written request for a hearing is submitted.

Notice of Hearing
If the provider requests a hearing in a timely manner the provider will be notified of the following in writing:

- The place, date, and time of the hearing, which will not be less than 30 days after the date of the notice.
- That the provider has the right to request postponement of the hearing, which may be granted for good cause as determined by AmeriHealth Caritas North

Carolina Market Chief Medical Officer and/or upon advice of the AmeriHealth Caritas Legal Affairs department.

- A list of witnesses (if any) expected to testify at the hearing on behalf of AmeriHealth Caritas North Carolina.

Conduct of the Hearing and Notice

The hearing will be held before a panel of individuals appointed by AmeriHealth Caritas North Carolina (the Hearing Panel), as follows:

- Individuals on the Hearing Panel will not be in direct economic competition with the practitioner/provider involved, nor will they have participated in the initial decision to propose sanctions.
- The Hearing Panel will be composed of physician members of AmeriHealth Caritas North Carolina's quality-related committees, AmeriHealth Caritas North Carolina's Market Chief Medical Officer and/or designee, and other physicians and administrative persons affiliated with AmeriHealth Caritas North Carolina as deemed appropriate by ACNC's Market Chief Medical Officer, such as legal counsel.
- AmeriHealth Caritas North Carolina's Market Chief Medical Officer or his/her designee serves as the Hearing Officer.
- The right to the hearing will be forfeited if the practitioner/provider fails, without good cause, to appear.

Provider Hearing Rights

The provider has the right to:

- Representation by an attorney or other person of the provider's choice;
- Have a record made of the proceedings (copies of which may be obtained by the provider upon payment of reasonable charges associated with the preparation);
- Call, examine and cross-examine witnesses;
- Present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law;
- Submit a written statement at the close of the hearing;
- Receive the written recommendation(s) of the Hearing Panel within 15 working days of completion of the hearing, including statement of the basis for the Hearing Panel's recommendation(s), which will be provided by certified mail or via another means providing for evidence of receipt; and,
- Receive AmeriHealth Caritas North Carolina's written decision within 60 days of completion of the hearing, including the basis for AmeriHealth Caritas North Carolina's decision(s), which will be provided by certified mail or via another means providing for evidence of receipt.

Appeal of AmeriHealth Caritas North Carolina Decision

The provider may request an appeal after the final decision of AmeriHealth Caritas North Carolina. The practitioner/provider must submit a written appeal by certified mail or via

another means providing evidence of receipt, within 30 days of the receipt of ACNC's decision; otherwise, the right to appeal is forfeited. Written appeal will be reviewed and a decision rendered by ACNC's QAPIC within 45 days of receipt of the notice of the appeal.

Summary Actions Permitted
The following summary actions can be taken, without the need to conduct a hearing, by the Regional President or Market President of AmeriHealth Caritas North Carolina or by ACNC's Market Chief Medical Officer:

- Suspension or restriction of the practitioner or provider's participation status for up to 14 days, pending an investigation to determine the need for formal sanctioning process; or,
- Immediate suspension or revocation, in whole or in part, of panel membership or participating practitioner/provider status, subject to subsequent notice and hearing, when it is determined that failure to take such action may result in immediate danger to the health and/or safety of any individual. A hearing will be held within 30 days of the summary action to review the basis for continuation or termination of this action.

Critical Incidents

All critical incidents require verbal notification to the Plan immediately (for level III incidents) and must be submitted within 72 hours of discovery of the incident via the North Carolina Incident Response Improvement System (IRIS) in accordance with the North Carolina Division of MH/DD/SAS IRIS Manual.

The IRIS platform utilizes an algorithm to determine level status based on information contained in the incident report. A critical incident includes but is not limited to the following incidents:

• Death of a member;
• Incidents of concern for community;
• Suspected physical, mental or sexual mistreatment, abuse and/or neglect of a member;
• Suspected theft or financial exploitation of a member;
• Restrictive Interventions;
• Injury sustained by a member;
• Consumer Behavior, i.e., suicidal ideations or attempts, aggressive or destructive behavior, and/or consumer absence
• Suspension and/or expulsion from treatment;
• Medication error involving a member;
• Inappropriate/unprofessional conduct by a provider involving a member;
• Fire; or
• Other incidents such as search and seizure or confidentiality breaches

Reporting Critical Incidents

Behavioral Health Providers are expected to report critical incidents to ACNC in real- time. ACNC recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All critical incidents must be reported to ACNC within 72 hours of discovery through the identified critical incident reporting process noted below.

Behavioral Health providers should report critical incidents through the North Carolina Incident Response Improvement System (IRIS). LTSS critical incidents should be reported to ACNC's Quality Management Department by email to ACNCCriticalincident@amerihealthcaritasnc.com. Questions related to Critical Incidents should be sent to this email.

AmeriHealth Caritas North Carolina will not take punitive action or retaliate against any person for reporting occurrence critical incident. The practitioners involved will be offered the opportunity to present factors leading to the event and to respond to any questions arising from the review of the critical incident.

Once an AmeriHealth Caritas North Carolina staff member identifies or is notified of a critical incident, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Quality Management department is notified of the event via an incident report, telephone, or email as soon as reasonably possible after identification of the occurrence.
2. The Quality Management department leads the investigation; analysis and reporting of all identified unusual occurrences.
3. All critical incidents require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance.
4. As appropriate, issues are identified for correction and corrective action plans are developed by the provider to prevent reoccurrence of the event. The corrective action plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The corrective action plan by the provider will address responsibility for implementation, oversight, timelines, and strategies for measuring the effectiveness of the actions.
5. Critical incidents will be reported to the North Carolina Medicaid Division of Health Benefits (DHB) and other appropriate investigative agencies by ACNC within contractual reporting requirements.
6. As appropriate, other state and federal agencies will also be notified of critical incidents
7. As appropriate, information from the investigation of critical incidents will be provided to NCDHHS to support the re-credentialing process.

Section IX
Cultural Competency Program and Requirements

IX. Cultural Competency Program and Requirements

Introduction

Embedded in all AmeriHealth Caritas North Carolina's efforts is a culturally and linguistically appropriate approach to the delivery of health care services. We foster cultural awareness both in our staff and in our provider community, by leveraging race, ethnicity, and language data (REL) to ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network.

AmeriHealth Caritas North Carolina routinely examines the access to care standards for both the general population and the population who speaks a threshold language. A threshold language is a language spoken by at least five percent or 1,000 members of AmeriHealth Caritas North Carolina's member population, whichever is less.

In addition, every edition of the provider newsletter includes a pertinent article on addressing cultural or language issues.

Our Cultural Competency Program, led by a cross-departmental workgroup, has been built upon the following 15 National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication of Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS- related measures into assessment measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance-resolution process that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Providers may request more information on the Cultural Competency Program by contacting Provider Services **1-888-738-0004**.

Cultural and Linguistic Requirements

Section 601 of Title VI of the Civil Rights Act of 1964 states that:
No person in the United States will, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Section 4302 of the Affordable Care Act supports the self-reported collection of race, ethnicity, sex, primary language, and disability status according to the Office of Management and Budget (OMB categories). This provision allows ACNC to comply with federal and national provisions established to reduce health disparities and deliver culturally competent care.

As a provider of health care services who receives federal financial payment through the Medicaid program, you are responsible for making arrangements for language services for members, upon request, who are either Limited English Proficient (LEP), that is they do not speak English as their primary language and have a limited ability to read, write, speak, or understand English, sensory impaired or experience other interpretation needs, and facilitate the provision of health care services to such members.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/health care provider relationship. The key to ensuring equal access to benefits and services for LEP, sensory impaired, or members that experience other interpretation needs is to ensure that you, our Network Provider, can effectively communicate with these members**.** Plan providers are required to offer translation services to LEP member's needs upon request and to accommodate members with other sensory impairments.

Providers are required to:

- Offer written and verbal language access at no cost to Plan members with limited- English proficiency or other special communication needs, at all points of contact and during all hours of operation. Language access includes the provision of qualified interpreters, as necessary.
- Offer members verbal or written notice (in their preferred language or format) about their right to receive free language services assistance.
- Post and offer easy-to-understand member signage and materials in the languages of the 15 most frequently used non-English languages spoken in the

state. Vital documents, such as patient information forms and treatment consent forms, must be made available in other languages and formats.

- Discourage members from using family or friends as oral translators.*
- Advise members that language services are available through AmeriHealth Caritas North Carolina if the Provider is not able to obtain necessary language services for a member.

Note: The assistance of friends, family, and bilingual staff is not considered qualified, quality interpretation. These persons should not be used for interpretation services except in ad hoc interpreter situations involving an imminent threat to the safety or welfare of a patient with LEP when no qualified interpreter is immediately available or where a member has been made aware of his/her right to receive free interpretation services and continues to insist on using a friend, family member, or bilingual staff for assistance in his/her preferred language.

AmeriHealth Caritas North Carolina contracts with a competent telephonic interpreter service provider. We have an arrangement to make our corporate rate available to participating plan providers. If you need more information on using this telephonic interpreter service, please contact Provider Services at **1-888-738-0004.**

Health care providers who are unable to arrange for interpretation services for an LEP, LLP or sensory impaired member should contact Member Services at **1-855-375-8811, TTY**: **1-866-209-6421**, and a representative will help locate a professional interpreter to communicate in the member's primary language.

When a member uses ACNC's interpretation services, the provider must sign, date and complete documentation in the medical record in a timely manner to reflect the use of services.

In addition to the requirements listed above, under The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) as set forth by the U.S. Department of Health and Human Services, Plan providers are strongly encouraged to:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

Additional tips to support members with LEP and other interpretation needs include:

- Establishing written policies to provide interpretive services for plan members upon request.
- Routinely document preferred language or format, such as Braille, audio, or large type, in all member medical records.

Enhancing Cultural Competency in Health Care Settings

AmeriHealth Caritas North Carolina encourages providers and their staff to report their race and ethnicity, the languages they speak and language services available through the practice. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or CAQH.

Provider and member information is analyzed to identify opportunities for improvement so ACNC can provide the best possible service to its providers and members.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

Additional Resources

The following additional resources are available upon request:

- HHS Health Resources and Services Administration: Culture, Language Health Literacy
- The Health Literacy & Plain Language Resource Guide
- National Institutes of Health: Clear Communication / Cultural Competency Health Literacy Innovations™

Cultural Sensitivity Training

To deliver culturally sensitive and appropriate care to members who have limited English proficiency, represent diverse multicultural and ethnic backgrounds, have special health needs, are impacted by Opportunities for Health, or are from a historically marginalized population group, AmeriHealth Caritas North Carolina offers providers an annual cultural competency training that will address:

- Delivering services and care that honors members' beliefs and cultural practices
- Understanding and providing services in a manner that is sensitive to cultural diversity

- Fostering attitudes and interpersonal communication styles that respect diverse cultural backgrounds
- Addressing health disparities, social determinants of health, and health literacy

Providers are also encouraged to complete the free e-learning cultural competency training offered by HHS Office of Minority Health titled, "A Physician's Practical Guide to Culturally Competent Care." This training offers up to 6 CEU's can be accessed at: https://cccm.thinkculturalhealth.hhs.gov/.

Cultural Competency Terms and Definitions

Providers should be aware of the following terms and their definitions:

Cultural Competency or Cultural Competence
The ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of the individuals are met. The ability to interact effectively with people of different cultures, helps to ensure the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural competency means to be respectful and responsive to the health beliefs and practices and cultural and linguistic needs of diverse populations.

"Culture" as defined by the CDC refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

"Competence," as defined by the U.S. Department of Health and Human Services implies having the capacity to function effectively as a participant and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities.

"Cultural Responsiveness" requires a set of knowledge and skills to provide services unique to everyone, designed to effectively meet the needs of individuals from diverse cultural backgrounds and experiences.

Cultural affiliations may include, but are not limited to race, preferred language, gender, disability, age, religion, deaf and hard of hearing, sexual orientation, homelessness, and geographic location.

Individuals with Limited English Proficiency (LEP)
Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand the English language.

Low Literacy Proficiency
In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.

Sensory Impaired
A person who is deaf or visually impaired.

SECTION X: TRIBAL ENGAGEMENT

X. Tribal Engagement

Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI) are exempt from managed care but have the option of participating in the North Carolina Medicaid transformation.

AmeriHealth Caritas North Carolina recognizes the uniqueness of the EBCI community and will give specific attention to health care and related services available through tribal organizations. AmeriHealth Caritas North Carolina will refer tribal members to Indian Health Care Providers (IHCPs) and will continually work with the North Carolina Department of Health and Human Services to identify other providers offering culturally competent care.

To help ensure cultural sensitivity, AmeriHealth Caritas North Carolina has established an ongoing partnership with the EBCI and other tribal populations that supports Members who are tribal members. AmeriHealth Caritas North Carolina will also offer training for culturally competent care to its provider network. For information on provider culturally competent training, please see the AmeriHealth Caritas North Carolina provider website, or contact your Provider Account Executive.

If providers have questions regarding participating in the AmeriHealth Caritas North Carolina programs, please call the local Tribal Liaison office at: **1-336-341-9563**

Indian Health Care Providers (IHCP)

Tribal members are eligible to receive services from an IHCP and to choose the IHCP as the Tribal member's PCP, if the IHCP has the capacity to always provide PCP services.

IHCP Claims and Billing

IHCPs who have questions regarding claims, should contact the Tribal Liaison office at**: 1-336-341-9563**

Transition of Care

AmeriHealth Caritas of North Carolina will provide coordination of Members transitioning from AmeriHealth Caritas North Carolina to another plan, or other types of pre-paid health plans.

Referral Requirement

AmeriHealth Caritas North Carolina will consider any referral from such IHCP acting as the Member's PCP to a network provider as satisfying any coordination of care or referral requirement.

Out of network IHCPs can make referrals to contracted providers for any Tribal members without prior authorization or a referral from a participating provider.

Access to Care

ACNC will provide Tribal members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP. If AmeriHealth Caritas North Carolina cannot provide timely access to necessary services in state and/or in network for Tribal members, ACNC will provide access to out-of-state and/or out-of-network IHCPs.

Fees

AmeriHealth Caritas North Carolina will not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any Tribal member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

Section XI
Claims Submission Protocols And Standards

XI. Claims Submission Protocols and Standards

Claims Submission

All claims for services rendered by in-network providers must be submitted to AmeriHealth Caritas North Carolina within 365 days from the date of service (or the date of discharge for inpatient admissions). Claims submitted by practitioners must be billed on the CMS-1500 or UB-04 or via the electronic equivalent (EDI) of these standard forms. The following mandatory information is required on all claims:

- Member's (patient's) name
- Member's Plan ID number
- Member's date of birth and address
- Other insurance information: company name, address, policy and/or group number
- Amounts paid by other insurance (with copies of matching EOBs)
- Information advising if member's condition is related to employment, auto accident or liability suit
- Date(s) of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits.
- Name of referring physician, if appropriate
- HCPCS procedures, services or supplies codes
- CPT procedure codes with appropriate modifiers
- CMS place of service code
- Charges (per line and total)
- Days and units
- Physician/supplier Federal Tax Identification Number or Social Security Number
- National Practitioner Identifier (NPI) and Taxonomy
- Physician/supplier billing name, address, zip code, and telephone number
- Name and address of the facility where services were rendered
- NDC's required for physician administered injectables that are eligible for rebate
- Invoice date
- Provider Signature

Note: AmeriHealth Caritas North Carolina also encourages providers to submit claims using:

- Plan-assigned individual practitioner ID numbers
- Plan-assigned member ID numbers

Out-of-network providers are required to submit claims within 365 days from the date of service.

General Procedures for Claim Submission

AmeriHealth Caritas North Carolina is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

When required data elements are missing or invalid, claims will be **rejected** by ACNC for correction and re-submission. Claims for billable services provided to AmeriHealth Caritas North Carolina members must be submitted by the provider who performed the services.

Important: A ***Clean Claim*** is a claim for services submitted to a health plan by a Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

Claims filed with AmeriHealth Caritas North Carolina are subject to the following procedures:

- Verification that all required fields are completed and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that an
- Out-of-network provider has received authorization to provide services to the eligible member.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas North Carolina.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that ACNC is the "payer of last resort" on all claims submitted to AmeriHealth Caritas North Carolina.
- All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN and Location Numbers). When required data elements are missing or are invalid, claims will be rejected by the Plan for correction and re-submission.

For more detailed billing information and line-by-line instructions, please refer to the *Claims Filing Instructions*, available in the provider area of our website at: www.amerihealthcaritasnc.com.

Electronic Claims Submission (EDI)

AmeriHealth Caritas North Carolina encourages all providers to submit claims electronically. For those interested in electronic claim filing, please contact your EDI software vendor or visit the ACNC Claims and Billing webpage for additional information.

Paper Claim Mailing Instructions

Please submit paper claims to the address below:

AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P.O. Box P.O. Box 7380
London, KY 40742-7380

Claim Filing Deadlines

All original paper and electronic claims must be submitted to AmeriHealth Caritas North Carolina within 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to capitated and fee-for-service claims. Please allow for normal processing time before re- submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. to be transmitted to ACNC the next business day.

Unless otherwise agreed to by AmeriHealth Caritas North Carolina and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within 365 calendar days from the date the services were rendered (or the date of discharge for inpatient admissions), provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

Rejected claims are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 365 calendar days from the date services were rendered.

Rejected claims

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is **not** an AmeriHealth Caritas North Carolina claim number. Rebilling of a rejected claim should be done as an original claim.
- Since rejected claims are considered original claims the timely filing limits should be followed.

Denied claims are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Corrected claims are those that ACNC paid based on the initial submission, but were later resubmitted by the provider with corrected data. A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet®.
- **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number.**

Corrected/replacement and voided claims may be sent electronically or on paper.

- If sent electronically, the ***claim frequency code*** (found in the 2300Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement(correction) of a prior claim and '**8**' for the void of a prior claim. The Value '**6**' should not be sent.

- In addition, the submitter must also provide the original claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted within one hundred eighty (180) Calendar Days of the date on the primary insurer's EOB.

Payment of Claims

AmeriHealth Caritas North Carolina will pay claims according to the following timeframes for both in- network and out-of-network providers.

AmeriHealth Caritas North Carolina will promptly pay Clean Claims, regardless of provider contracting status. ACNC will reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received

Medical Claims

a). ACNC will, within eighteen (18) calendar days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.

b.) ACNC will pay or deny a Clean Medical Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

c.) A Medical Pended Claim will be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

Pharmacy Claims

ACNC will within fourteen (14) calendar days of receiving a Pharmacy Claim, pay or deny a Clean Pharmacy Claim.

Interest for Late Payments of Clean Claims

AmeriHealth Caritas North Carolina will pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.

AmeriHealth Caritas North Carolina will not be subject to interest payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).

Retrospective Reviews of Claims

AmeriHealth Caritas North Carolina may conduct retrospective reviews of claims for services that did not receive prior authorization to ensure medical necessity. If a retrospective review is to be conducted, ACNC will complete the review within 90 days of the date the claim is paid.

Payment Recovery

AmeriHealth Caritas North Carolina may recover payments from providers for reimbursed services determined not to be medically necessary.

Important Billing Reminders

Visit Reporting

CMS defines an encounter as "an interaction between an individual and the health care system." Encounters occur whenever an AmeriHealth Caritas North Carolina member is seen in a provider's office or facility, whether the visit is for preventive health care services or for treatment due to illness or injury. An encounter is any health care service provided to an

ACNC member. Encounters must result in the creation and submission of an encounter record or claim (CMS-1500 or UB-04; paper form or electronic submission) to AmeriHealth Caritas North Carolina. The information provided on these claims represents the encounter data ACNC reports to the state, according to mandatory reporting requirements.

Completion of Encounter (Claims) Data

PCPs must complete and submit a CMS-1500 or UB-04 paper form or file an electronic claim every time an AmeriHealth Caritas North Carolina member receives services from the provider. Completion of the CMS-1500 or UB-04 form or electronic claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services.
- It allows ACNC to gather statistical information regarding the medical services provided to members, which better support our statutory reporting requirements.
- It allows ACNC to identify the severity of illnesses of our members.

AmeriHealth Caritas North Carolina accepts claim submissions via paper or electronically (EDI). For more information on electronic claim submission and how to become an electronic biller, please contact the EDI Technical Support at **1-833-885-2262** or refer to the billing information available on our Plan website at www.amerihealthcaritasnc.com.

To support timely statutory reporting requirements, PCPs must submit encounters (claims) within 365 days of the visit.

AmeriHealth Caritas North Carolina monitors claim data submissions for accuracy, timeliness, and completeness through claims processing edits and through network provider profiling activities. Claims can be rejected or denied for inaccurate, untimely, and incomplete information. Network providers will be notified of the denial via a remittance advice and are expected to re-submit corrected information to ACNC. Network providers may also be subject to sanctioning by ACNC for failure to submit accurate claim data in a timely manner.

Known System Issues Tracker

AmeriHealth Caritas North Carolina publishes a weekly Known System Issues Tracker on our provider website. The tracker includes the following information:

a) Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);
b) Number of Impacted Providers: number of known providers impacted by the system issue;
c) Category: type of system issue (e.g., claims, eligibility, provider, prior approval);
d) Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;
e) Date Issue Found: month, day, and year the PHP identified the system issue;
f) Number of Days Outstanding: number of days this issue has been open;

g) Estimated Fix Date: month, day, and year the PHP plans to have this system issue resolved;
h) Status: status of the issue (open, ongoing, or closed);
i) Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;
j) Interest Owed: whether interest will be applied (Yes or No); and
k) Date Resolved: month, day, and year ACNC resolved this system issue.

Provider Claim Inquiries

Claims Inquiry

Providers may file an inquiry about claims no later than 365 days from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is latest. Inquiries are questions from providers regarding how a claim was processed. Inquiries can be submitted via phone, online or written correspondence. An inquiry may or may not result in a change in the payment.

If a provider does not receive payment for a claim within 45 days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the NaviNet provider website, our secure provider portal to log on for web-based solutions for electronic transactions and information.
- You may open a claims investigation via NaviNet with the claims adjustment inquiry function.
- Provider can request inquiry on grievance or appeals status via NaviNet by providing the document or service form ID.
- Calling Provider Services at **1-888-738-0004** and following the prompts.
- Calling your Account Executive for assistance.

Requests for Adjustments

You may open a claims investigation via NaviNet with the claim's adjustment inquiry function.

By telephone: Provider Services: **1-888-738-0004** (Select the prompts for the correct department and then select the prompt for claim issues.)

By mail:
AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P.O. Box 7380
London, KY 40742-7380

Balance Billing Members

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas North Carolina to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balanced billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims provider complaint processes to resolve any outstanding claims payment issues.

Emergency Department Claim Issues

To simplify resolution of Emergency Department level issues, which often arise because a claim was submitted without an Emergency Department summary and/or requires a review of medical records, participating hospital Providers are encouraged to address such payment issues through AmeriHealth Caritas North Carolina's informal Emergency Department Payment Level Reconsideration process before attempting to resolve issues through the Formal Provider Appeals Process. For complete details see the Claims Grievance section of the manual.

Refunds for Improper Payment or Overpayment of Claims

If an ACNC provider identifies improper payment or overpayment of claims from AmeriHealth Caritas North Carolina the improperly paid or overpaid funds must be returned to ACNC within 60 days of identification. Providers are required to return the identified funds to ACNC by submitting a refund check directly to the claims processing team:

AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P. O. Box 7380
London, KY 40742-7380

Note: Please include the member's name and ID, date of service and claim ID.

Third Party Liability/Subrogation

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas North Carolina. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas North Carolina are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the health care provider's charges before a claim is submitted to AmeriHealth Caritas North Carolina.

Therefore, before billing AmeriHealth Caritas North Carolina when there is a Primary Insurer, health care providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) or Claim Adjustment Reason Codes (CARC) or Remittance Advice Remark Code (RARC) statement from the Primary Insurer. Providers may then bill AmeriHealth Caritas North Carolina for the remaining balance on a claim by submitting the claim along with a copy of the Primary Insurer's EOB. For instructions on how to report other insurance information on a claim, refer to the ACNC Provider Claims and Billing Manual on our website. The claim form field requirements are located under the Claim Filing section.

Explanation of Benefits (EOBs)

Claims with Explanation of Benefits (EOBs) **or Claim Adjustment Reason Codes (CARC) or Remittance Advice Remark Code (RARC)** from primary insurers, including Medicare, must be submitted within 180 days of the date on the primary insurer's EOB.

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under AmeriHealth Caritas North Carolina contract, ACNC will be entitled to recover any funds up to the amount owed by the third-party payer.

Pay and Chase
ACNC will pay and then chase for the following services per the federal mandate:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Diagnostic and Treatment (Medical Necessity) after Early and Periodic Screening
- Child support enforcement

Program and Service Exceptions for TPL

ACNC is required to process claims as the primary payer for several state and federal programs. Claims for the state and federal programs are exempt from normal coordination of benefits (see list below).

Providers should identify these programs and members during the initial patient intake. The providers should inquire if the member is enrolled into one of the state or federal programs. ACNC is not able to identify these populations on the 834.

Program and Service Exceptions for TPL and Coordination of Benefits		
Program or Service	**Federal**	**State**
Crime Victims Compensation Fund	X	
Part B and C of the Individuals with Disabilities Education Act (IDEA)	X	
Ryan White Program	X	
Indian Health Services	X	

Veteran's Benefits for state nursing home per diem payments	X	
Veteran's Benefits, for emergency treatment provided to certain veterans in a non-Veteran's Affairs (VA) facility	X	
Older American Act Programs	X	
World Trade Center Health Program	X	
Grantees under Title V of the Social Security Act (Maternal and Child Block Grant)	X	
Division of Service for the Blind		X
Division of Public Health "Purchase of Care" Program		X
Vocational Rehabilitation Services		X
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

Additional Information for Electronic Billing

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to ACNC must first pass the EDI vendor's HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at ACNC. In these cases, the claim must be corrected and re-submitted with all necessary and valid data elements within the required filing deadline of 365 days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the software vendor in order to identify and re-submit these claims accurately.

Monitoring Reports for Electronic Claims

ACNC's vendor will produce an Acceptance Report* and a R059
Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments. To verify satisfactory receipt and acceptance of submitted records, please review the R059 Plan Claim Status Report.

Plan Specific Electronic Edit Requirements

AmeriHealth Caritas North Carolina currently has two specific edits for professional and institutional claims sent electronically:

- **837P –005010X222A1–** Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

- **837I – 005010X223A2 –** Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Please note: statement date must not be earlier than the date of service and Plan-assigned individual practitioner ID number is strongly encouraged.

Electronic Billing Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient, and outpatient claim types.

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
Claim records for medical, administrative, or claim appeals.

Re-submitted Corrected Claims

Providers using electronic data interchange (EDI) can submit "institutional" and "professional" corrected claims* electronically or via paper claim to AmeriHealth Caritas North Carolina. This *Provider Manual* offers basic instructions for the submission of corrected claims via EDI or paper. For more detailed guidance, please refer to the ACNC Claims and Billing webpage for additional information.
*A "corrected claim" is defined as a re-submission of a claim with a specific change you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

Your EDI clearinghouse or vendor needs to remember the following:

- **Do** use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03, (837P). Use "8" to void a prior claim
- **Do** include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number, no dashes or spaces.
- **Do** include ACNC's claim number to submit your claim with the 7 or 8.
- Corrected claims for which the original claim number cannot be validated will be rejected.
- **Do** use the indicator for claims that were previously processed (approved or denied).
- **Do Not** use the indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.

- **Do not** use the indicator for claims that contained errors and were not previously processed (those that were rejected upfront).
- **Do not** submit corrected claims electronically and via paper at the same time.

For more information, please contact EDI Technical Support at **1-833-885-2262** or by email to edi.acnc@amerihealthcaritasnc.com.

Providers can also open a claims investigation via NaviNet with the claim's adjustment inquiry function.

Electronic Billing Inquiries

AmeriHealth Caritas North Carolina contracts with multiple electronic data interchange (EDI) clearinghouses and other electronic billing services. Use of EDI can boost claims submission efficiency and timeliness of reimbursement to enhance your revenue cycle.

You can select the payment method that best suits your accounts receivable workflow. Please visit the ACNC Claims and Billing webpage for additional information.

Provider Preventable Conditions (PPC)

AmeriHealth Caritas North Carolina will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions.

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, ACNC does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
- Except for Pediatric and Obstetric Populations

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, ACNC will not reimburse providers for any of the following never events in any inpatient or outpatient setting:

- Surgery Performed on the Wrong Body Part
- Surgery Performed on the Wrong Patient
- Wrong Surgical Procedure Performed on a Patient

Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make pre- payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; ACNC will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and "E" diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Inpatient Claims

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital- acquired**.**

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member's medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC from the DRG. Facilities do not need to submit copies of medical records for PPCs associated with this payment type.

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator should be reported in the shaded portion of field 67 A – Q. DRG-based facilities may submit POA via 837I in loop 2300; segment NTE, data element NTE02.

Valid POA Indicators Include:

- "Y" = Yes = present at the time of inpatient admission.
- "N" = No = not present at the time of inpatient admission.
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission.
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not "null" = Exempt from POA reporting.

Reimbursement Policy

Prospective Claims Editing Policy

AmeriHealth Caritas North Carolina's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, ACNC also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Section XII
Behavioral Health Care

XII. Behavioral Health Care

Introduction

Behavioral Health Services are a critical part of the overall package of care provided to members of AmeriHealth Caritas North Carolina. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including behavioral health providers, unless otherwise indicated in this section or specified via subsequent communications.

Behavioral Health Provider Application and Credentialing Process

Please refer to Section II, "Provider and Network Information", North Carolina *Centralized Application and Credentialing Process* in section II, "*Provider Network Information* "of this *Provider Manual* for information regarding the required process for behavioral Health practitioners and facilities to join our network.

Contracting and Rate Notices

Contracts

AmeriHealth Caritas North Carolina uses an Ancillary Provider Agreement that has been approved by all the appropriate local authorities. Provider Agreements automatically renew each year. An amendment to the agreement is generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

Rate Notices and Fee Schedules

AmeriHealth Caritas North Carolina fee schedule is reviewed regularly, and rates are adjusted as necessary. As a network provider, you will occasionally receive a "Rate Notice" which is an official amendment to your Provider Agreement. Providers will receive 30 days' notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate their Provider Agreement with 30 days' written notice.

Please review EOB's closely to assure that you begin receiving the new rates for services delivered on or after the date indicated in the Rate Notice. You are responsible to monitor payment received from ACNC. In the event of a discrepancy, please contact your Account Executive immediately. AmeriHealth Caritas North Carolina strongly suggests provider's bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice helps you avoid the need to resubmit corrected claims when the issue is resolved.

Behavioral Health Covered Services

Behavioral Health Services are included in Section III, *Provision of Services",* under *Basic Covered Services* of this *Provider Manual.*

Access to Behavioral Health Care

AmeriHealth Caritas North Carolina providers must meet access standard guidelines as outlined in this publication to help ensure that Plan members have timely access to behavioral health care.

ACNC endorses and promotes comprehensive and consistent access standards for members to assure member accessibility to health care services. AmeriHealth Caritas North Carolina has mechanisms for measuring compliance with existing standards and identifying opportunities for the implementation of interventions for improving accessibility to health care services for members.

Providers are required to offer hours of operation that are no less than the hours of operation offered to patients with commercial insurance. Access to care and office wait times for members should comply with the access standards that apply to behavioral health providers included in Section II, "Provider Network Information".

Behavioral Health Services Requiring Prior Authorization

For a list of services requiring prior authorization or notification, please refer to Section V, "Utilization Management" under "Required Prior Authorization "of this *Provider Manual*.

ACNC's Utilization Management (UM) department hours of operation are 8:00 a.m. to 5:00 p.m. EST, Monday through Friday except for State of North Carolina holidays. For prior authorization requests for behavioral health inpatient admissions, the UM department is available 24/7/365. The UM department can be reached at:

- BH UM Telephone: **1-833-900-2262**
- BH UM Fax: **1-833-893-2262**

For additional information on how to submit requests for prior authorization, please refer to the provider area of our website at www.amerihealthcaritasnc.com

Billing for Behavioral Health Care Services

Behavioral health providers follow the same billing procedures as medical health care providers with some exceptions. Please refer to the "Claims Submission Protocols and Standards" section of this *Provider Manual* for more information on how to submit claims for services covered by ACNC.

For more detailed billing information and line-by-line instructions, please refer to the *Claims Filing Instructions*, available in the provider area of our website at: www.amerihealthcaritasnc.com.

Section XIII
Long Term Services and Support (LTSS)

XIII. Long Term Services and Support

Introduction

The information contained in this section of the *Provider Manual* applies to providers who are contracted with AmeriHealth Caritas North Carolina to provide long term services and support (LTSS) to enrollees of the North Carolina Medicaid Managed Care Program. Please note that, in general, the responsibilities, expectations and processes outlined in this *Provider Manual* pertain to all providers, including LTSS providers, unless otherwise indicated in this section or specified via subsequent communications. For more information, please contact Provider Services at **1-888-738-0004.**

AmeriHealth Caritas North Carolina in providing LTSS for AmeriHealth Caritas North Carolina enrollees, strives to offer quality, cost-effective, and coordinated care for those with chronic, complex, and complicated health care, social, and support services needs in a Nursing Facility or Home and Community-Based setting. Case management for program enrollees includes assessment, planning, coordinating, implementation and evaluating care through a fully integrated physical health, behavioral health, and LTSS program.

ACNC provides all services in a manner that facilitates maximum community integration and participation for members that require LTSS. The North Carolina Department of Health and Human Services (NCDHHS) and ACNC are dedicated to serving individuals in the communities of their choice with the resources available and to implementing the United States Supreme Court's mandate in Olmsted v. L.C. Our mutual goal is to educate members about the LTSS community options available to them and support them in the choices they make.

AmeriHealth Caritas North Carolina supports and enhances member-centered care, regardless of the setting in which our members receive services. When members with long-term care needs live in their own homes or other community-based residential settings, ACNC and our delegates (see the table under Care Management Responsibility for the definition of a delegate) develop care plans to address member care and treatment needs, to provide assurances for health and safety, and to proactively address the risks that may face a member desiring to live as independently as possible.

LTSS Continuity of Care

Transition of New Members

- All new members are assessed to identify needed services and are provided Medically Necessary Covered Services in a timely manner.
- If a member is transferring from AmeriHealth Caritas North Carolina to another health plan, AmeriHealth Caritas North Carolina will coordinate with the receiving health plan to ensure a seamless transition. If the member is hospitalized at the time of enrollment with AmeriHealth Caritas North Carolina, ACNC will be responsible for inpatient facility payment until discharge.
- If a new member transferring from another health plan is hospitalized at the time of enrollment, the originating health plan will be responsible for inpatient facility payment until discharge, but AmeriHealth Caritas North Carolina will be responsible for payments for professional services as of the member's enrollment date, and will participate in discharge planning, and will be responsible for all services upon discharge.
- AmeriHealth Caritas North Carolina will implement a continuity of care transition plan to provide continuity of care for new members.
- For members transferring from another health plan, ACNC will immediately contact the transferring health plan and request the completed member transfer coordination of care form (specified by the State) and transfer of relevant information and data to facilitate continuity of care (e.g., the member's treatment plan or plan of care and identification of the member's providers).
- For members transferring from another health plan, ACNC will contact NCDHHS, in accordance with NCDHHS's processes, within two business days to provide the name and contact information of ACNC's point of contact to facilitate seamless transition, care coordination, integrated physical and behavioral health care, and continuity of care.
- For treatment (other than prenatal services to a pregnant member in the second or third trimester and the provision of services in the NCDHHS benefit package) of a medical or behavioral health condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, ACNC will cover the service from the
  treating provider if located within the distance standards for a lesser of:
  - a period of 90 calendar days or until the treating provider releases the patient from care. If the member is a pregnant woman in her second or third trimester, ACNC will cover prenatal services from the treating provider if located within the distance standard through 60 calendar days post-partum.
  - If the treating provider is not located within the distance standards, ACNC will cover the service but after a period of 30 calendar days may require the member to transfer to a qualified provider that is located within the distance standards.

Member Enrollment in the LTSS Program

AmeriHealth Caritas North Carolina will authorize LTSS based upon a Member's current needs assessment. Treatment will be consistent with their person-centered service care plan.

LTSS will include:

a. Care provided in the home, in community-based settings, or in facilities, such as nursing homes;
b. Care for older adults and people with disabilities who need support because of age, physical cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; and
c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as:

    i. Eating;
    ii. Taking baths;
    iii. Managing Medications;
    iv. Grooming;
    v. Walking;
    vi. Getting up and down from a seated position;
    vii. Using the toilet;
    viii. Cooking;
    ix. Driving;
    x. Getting dressed; or
    xi. Managing money; and/or

d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.

LTSS Covered Services

The following services are covered through AmeriHealth Caritas North Carolina LTSS program:

LTSS Covered Services	
Service	Definition/Limitation
Personal Care services	Personal Care Services (PCS) provide personal care services in the Medicaid beneficiary's private living arrangement or residential facility by paraprofessional aides employed by licensed home care agencies, licensed adult care homes or home staff in licensed supervised living

LTSS Covered Services	
	homes. PCS benefit individuals who require assistance with activities of daily living (ADL), including: • eating • dressing • bathing • toileting • mobility An individual must be enrolled in NC Medicaid.
Skilled nursing facility services (Up to ninety (90) days	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
Hospice	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

LTSS Covered Services	
	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
Home Infusion Therapy (HIT)	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 HIT services are not covered when: • The service duplicates another provider's service. • The service is experimental, investigational, or part of a clinical trial. • The drug therapy is provided for services other than chemotherapy, antibiotic therapy, or pain management. • The beneficiary is receiving Medicare-covered home health nursing services. HIT drug therapy is not allowed for Medicaid beneficiaries receiving private duty nursing
Private Duty Nursing (PDN)	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

LTSS Covered Services	
	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 will 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

LTSS Member Services

A dedicated, 24/7/365 Member Services line is available to help LTSS members with any questions about their coverage and services at: **1-855-375-8811**; TTY **-1-866-208-6421**.

Requesting Long Term Services and Supports (LTSS) Services

All LTSS services should be requested through Utilization Management.

- All unlisted and miscellaneous codes
- All HCBS Habilitation program services
- All services not listed on AmeriHealth Caritas North Carolina Fee Schedule

ACNC's Utilization Management Department hours of operation are 8:00 to 5:00 p.m. ET, Monday through Friday. The team can be reached at:

- Phone: **1-833-900-2262**
- Fax: **1-833-893-2262**

For prior authorizations after hours, weekends and holidays, call Member Services at **1-855-375-8811**.

Reporting Abuse and Critical Incidents

AmeriHealth Caritas North Carolina monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of ACNC. This includes critical incidents, sentinel events and never events, as well as abuse, neglect, and exploitation, which are considered critical incidents.

For more information on AmeriHealth Caritas North Carolina policies and procedures around these incidents, please refer to the "Quality" section of this *Provider Manual*.

For all LTSS Plan members, Case Managers will review abuse, neglect, and exploitation identification materials upon intake and at each face-to-face interaction. Components of member education include descriptions of abuse, neglect, and exploitation, such as:

- **Abuse** includes inflicting pain, injury, mental anguish, unreasonable confinement, or other cruel treatment. Abuse can be:
    - Physical abuse;
    - Emotional abuse or,
    - Sexual abuse.
- **Neglect** can occur:
    - When an adult is unable to care for him/herself or to obtain needed care, placing their health or life at risk;

  - The neglect may be unintended, resulting from the caregiver's lack of ability to provide or arrange the care the person requires;
  - Neglect may be due to the intentional failure of the caregiver to meet the person's needs.

- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of an adult. These funds are paid to the adult or caregiver by a government agency. **Exploitation** can include:

  - Fraud or coercion;
  - Forgery; or,
  - Unauthorized use of banking accounts, cash or government cards.

As part of its Critical Incident reporting protocols, ACNC shares reportable information with the following investigative agencies, as appropriate:

1. Adult Protective Service (APS) for suspected abuse, neglect, disruptive behavior, and exploitation.
2. The Department of Social Services is the designated agency to receive, investigate, and respond to Critical Incidents of abuse or neglect of children living in the community.

ACNC also cooperates fully with NCDHHS and any investigative agency in documenting, investigating, and addressing actual and suspected Critical Incidents. This includes collecting and analyzing data regarding Critical Incidents, tracking, and identifying trends, identifying root causes, and making necessary changes in order to prevent reoccurrence.

LTSS Case Management

ACNC LTSS members are supported through intake and ongoing case management by an ACNC Case Manager or our ACNC delegates who engage the member, caregiver, and family in the planning and decision-making process. Case Managers and our delegates are the primary point of contact with the member. All Case Managers and delegates are Licensed Clinical Social Workers (LCSW) or licensed Registered Nurses (RNs) and/or Social Workers with bachelor's or master's degrees with active licensure and appropriate credentials. (See the table under Care Management Responsibility for the definition of a delegate.)

Case Managers support the member through initial assessment, plan of care development, care coordination, plan of care implementation, and ongoing evaluation.

The LTSS case managers and our provider delegates are responsible to:

- Give the member information about AmeriHealth Caritas North Carolina and answer questions.
- Work with the member to make sure they have all the information needed to make informed choices about their health care.
- Coordinate the person-centered planning process to help the member get appropriate long-term services and supports in the right setting.
- Coordinate the member's physical, mental, and long-term services and supports needs
- Help resolve issues the member is having about the care they are receiving.
- Make sure that the member's care plan is carried out and is working for them.
- Be aware of the member's needs as they change and update their care plan to make sure the services, they are receiving are appropriate for their changing needs.
- Talk with the member's providers to make sure they are informed about the member's health care and to coordinate the member's services.

If the member receives short term nursing facility care, the case manager will:

- Be part of the person-centered planning process with the nursing facility where the member is living.
- Perform any additional needs assessment that may be helpful in managing the member's health.
- Update the nursing facility's care plan when AmeriHealth Caritas North Carolina manages or coordinates physical and mental health care the member needs.
- Coordinate with the nursing facility when the member needs services the nursing facility isn't responsible for providing.
- Assist nursing facility with state disenrollment of long-term care members back to Medicaid Direct after 90 continuous days of a short-term nursing facility stay.

LTSS Application and Credentialing Process

Please refer to Section II, "Provider and Network Information", North Carolina *Centralized Application and Credentialing Process* of this *Provider Manual* for information regarding the required process for LTSS providers and facilities to join our network.

Address Changes

As a reminder, providers are contractually bound to report changes that affect referrals, such as the relocation of an office site. If your office is considered high volume, relocation of your office site will require a site visit from AmeriHealth Caritas North Carolina.

Contracting and Rate Notices

Contracts

AmeriHealth Caritas North Carolina uses a Provider Agreement that has been approved by all the appropriate local authorities. Provider Agreements automatically renew each year. An amendment to the agreement is generated only if new services are added due to a change in the state Medicaid program. Rate Notices are used to document rate or per diem changes to existing services.

Rate Notices and Fee Schedules

AmeriHealth Caritas North Carolina fee schedule is reviewed regularly, and rates are adjusted as necessary. As a network provider, you will occasionally receive a "Rate Notice" which is an official amendment to your Provider Agreement. Providers will receive 30 days' notice of rate changes. Providers who do not accept the terms of the Rate Notice may terminate their Provider Agreement with 90 days' written notice.

Please review EOB's closely to assure that you begin receiving the new rates for services delivered on or after the date indicated in the Rate Notice. You are responsible to monitor payment received from ACNC. In the event of a discrepancy, please contact your Account Executive immediately. AmeriHealth Caritas North Carolina strongly suggests provider's bill the usual and customary charges rather than the rate indicated on the Rate Notice. In the event of a system or data entry error, this practice helps you avoid the need to resubmit corrected claims when the issue is resolved.

Billing for LTSS Providers

AmeriHealth Caritas North Carolina will accept the universal CMS-1500 paper claim form or electronic claims submission. For complete instructions, please refer to AmeriHealth Caritas North Carolina LTSS Provider Claims Filing Instructions at www.amerihealth caritasnc.com.

LTSS Provider Standards

AmeriHealth Caritas North Carolina's LTSS providers are held to the same as all other AmeriHealth Caritas North Carolina providers. All LTSS providers should review all sections of this *Provider Manual* verify that they are compliant with quality standards, cultural competency requirements and more. This LTSS section of the *Provider Manual* covers items that are specific to the LTSS providers but does not preclude LTSS providers from the standards and requirements described throughout this document.

Appendix

Appendix

Attachment A: Prepayment Review Policy No. 106.100.010
Attachment B: AmeriHealth Caritas North Carolina Provider Manual Revision Log

Attachment A

AMERIHEALTH CARITAS FAMILY OF COMPANIES POLICY AND PROCEDURE

Supersedes: N/A

Policy No.: 106.100.010
Page: 1 of 5

Subject: Prepayment Review

Department: Program Integrity

Current Effective Date: 4/15/2024
Last Review Date: 4/1/2024
Original Effective Date: 9/16/2014
Next Review Date: 4/15/2025

Unit: Special Investigations Unit (SIU)

Review Cycle: Annual

Stakeholder(s): Compliance, Facets Configuration, Provider Maintenance

Applicable Party(s): All Associates, Contractors, Consultants, Subcontractors, Vendors, and Delegates

Line(s) of Business: All business entities of AmeriHealth Caritas Family of Companies, including, but not limited to: Medicaid Managed Care Health Plans, Medicare-Medicaid Health Plans, Medicare SNPs, Behavioral Health Managed Care Plans, Federally Qualified Health Plans and Pharmacy Benefits Managers. The LOBs may change periodically but currently include: AmeriHealth Caritas District of Columbia, AmeriHealth Caritas North Carolina, AmeriHealth Caritas New Hampshire, AmeriHealth Caritas Louisiana, AmeriHealth Caritas Pennsylvania, Keystone First, Select Health of South Carolina, Blue Cross Complete of Michigan, AmeriHealth VIP Care, Keystone VIP Choice, AmeriHealth Caritas VIP Care Plus, Keystone First VIP Care Plus, First Choice VIP Care Plus, PerformCare PA, PerformCare New Jersey, PerformRx, Perform Specialty, AmeriHealth Caritas Florida, AmeriHealth Pennsylvania Community Health Choices, AmeriHealth Caritas Delaware, Keystone First Community Health Choices, AmeriHealth Caritas Next Lines of Business, AmeriHealth Caritas Ohio, and First Choice VIP Care.

POLICY

The Program Integrity department is charged with preventing, detecting, investigating, and reporting fraud, waste, or abuse (FWA) for the AmeriHealth Caritas Family of Companies (ACFC). The department has cross-functional teams that support its program to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with relevant State and/or Federal requirements. The program includes the Special Investigations Unit (SIU) prepayment pending of claims (i.e., as a provider corrective action tool) for a provider suspected of fraud or abuse, including providers offering telemedicine. The process pends the provider's claims so that a medical record review occurs prior to payment. The review ensures that the provider's documentation supports the claim's billed services.

Documentation created or maintained in this policy will be recorded in the appropriate information systems and maintained as confidential with restricted access.

PURPOSE

To define the process for flagging a provider's file within the claims processing system to validate services and billing accuracy through medical record review prior to payment.

DEFINITIONS

Abuse: Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid/Medicare/Exchange program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid/Medicare/Exchange program.

Fraud: As defined within 42 C.F.R. § 455.2, fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

FWA: The acronym used for Fraud, Waste, or Abuse.

HIPAA: The acronym used for Federal Health Insurance Portability and Accountability Act of 1996.

HIPAA Definitions: HIPAA Privacy Definitions.

Plan*:* Also known as Line of Business (LOB).

SIU: Special Investigations Unit.

SIU Associates: Investigators, Intake Specialists, Screening Investigator, Research and Reporting Analyst, Data Analysts, and Medical Coding Auditors.

SIU Management: Director and Manager(s) of the SIU.

Telemedicine: Seeks to improve a patient's health by permitting two-way, real-time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio, and video equipment.

Waste: The thoughtless, careless, or otherwise improper use of services by members, provision of and billing for such services by providers, or payment for the services by payers. Waste includes erroneous claims adjudication by the company. Waste, as defined by CMS means

overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

PROCEDURE

Initiation of Prepayment Review

1. SIU may initiate prepayment review, as permissible under applicable contract or governing authority, or at the direction of a regulatory agency. See Attachment A.

2. As to Prepayment Review initiated by SIU, at any time during an SIU investigation, an Investigator may determine that it would be beneficial or necessary to place a provider on Prepayment Review for additional FWA monitoring. Factors considered include, but are not limited to, particularly egregious post-pay review results and/or billings that are inconsistent with Federal law, State law or Plan policies; and billings that are unnecessary; inappropriate to members' health needs; or contrary to customary standards of practice.

3. If an Investigator concludes that Prepayment Review is warranted, he/she will seek approval from SIU Management, and as may be required under applicable contract or governing law, provide notice to and/or request prior approval from a regulatory agency. See Attachment A.

4. SIU will notify the following departments and/or individuals of prepayment review activities:
    a. State and/or Federal Agency as may be necessary or required.
    b. Plan Leadership, including but not limited to, Plan President and Plan Compliance Officer.
    c. Provider Network Management, as may be deemed appropriate or necessary.
    d. Claims Operations.
    e. Others within the Plan or Program Integrity who may need to be notified.

5. Upon being placed on Prepayment Review, the SIU Investigator will send a Prepayment Notification Letter to the affected provider. If the provider has been placed on Prepayment Review at the request of a regulatory agency, a copy of the agency's letter to the provider will be sent along with it.

6. SIU will then request that Claims Operations pend a provider's future claims for medical record review to ensure payment accuracy.

Prepayment Review and Monitoring

1. Upon receipt of the provider's claim, ACFC will pend the claim for review of the accompanying medical records.

    - Claims received without proper medical records will be denied and the provider

will be instructed to resubmit the claim with records.

2. Upon validation that the medical records support the claim's billed services, the claim is processed accordingly.

3. The SIU Investigator will send monthly prepayment claim pend review status letter(s) to the provider and will include a description of the findings of completed reviews.

4. The SIU Investigator and Reviewers will be available to answer any questions and calls from an affected provider regarding the Prepayment Review process or the provider's status.

Removal of Prepayment Review

1. The SIU Investigator will monitor the provider's billing accuracy while the provider is on Prepayment Review. When a provider's billing accuracy has reached 80% accuracy for a period of three (3) consecutive months or as otherwise required/directed by applicable contract or governing authority, the SIU Investigator will notify the provider they are being removed from Prepayment Review.

2. SIU will also notify the following Departments and individuals of the provider's removal from Prepayment Review:
    a. State and/or Federal Agency as may be necessary or required.
    b. Plan Leadership, including but not limited to, Plan President and Plan Compliance Officer.
    c. Provider Network Management, as may be deemed necessary or appropriate.
    d. Claims Operations.
    e. Others within the Plan or Program Integrity who may need to be notified.

3. Upon removal, the provider's billing patterns may continue to be monitored by SIU to ensure continued compliance.

4. The recommended maximum period for a provider to be placed on Prepayment Review should not exceed one (1) year. For providers that fail to meet the threshold set forth in paragraph one (1) within one (1) year, or as otherwise required/directed by applicable contract or governing authority, further actions including, but not limited to, termination of the provider contract may be recommended. In instances, providers may remain on Prepayment Review if a determination is made that this is warranted.

Record Retention

- Fraud and abuse work product created or maintained due to this policy will be recorded in the appropriate information system. ACFC shall retain documents relating to PHI/PII for 10 years in accordance with ACFC policy, unless otherwise required to retain such documentation for a differing period under applicable law or regulation.

Auditing and Monitoring

- SIU Management shall conduct monitoring activities to ensure requirements of this policy and associated contractual, State and Federal regulatory requirements are met by the SIU Associates.

HIPAA Compliance

- SIU Management ensures compliance with applicable corporate HIPAA policies concerning the use and disclosure of Protected Health Information (PHI)/Personal Identifying Information (PII) refer to HIPAA-related policies below.

RELATED POLICIES & PROCEDURES

[Redacted]

SUPERSEDED POLICIES AND PROCEDURES

- N/A

SOURCE DOCUMENTS AND REFERENCES

- None

ATTACHMENTS

[Redacted]

APPROVED BY

[Redacted]

Attachment B

ACNC Provider Manual Version 16 Revision Log as of 9/18/2025

	Topic	Description
Cover	Provider Manual Cover	Updated date to indicate recent publication
7	Member ID Card Title	Edited for consistency with website.
9	Member Right	Added for consistency with Member Handbook
15-16	Amendment 21	Updated Credentialing and Re-credentialing content
35	Prospective (Pre-Claims payment.	Medical Record/Itemized Bill review - updated for clarity
39	Program Integrity	Updated language from recoupment and reporting to Inventory and Recovery
40	Claim Refund form	Added hyperlink to form on website
52	Tobacco Free Policy content	Date updated to support state guidelines. Content moved from page 46 to page 51 for readability.
79	Orthotics, Prosthetics and Supplies	Definitions added
88	Program name updated	Pediatric Preventive Health Care Program is now called Pediatric Wellness
90	Pharmacy Prior Authorization	Submission options updated
92	Pharmacy Lock-in program	Updated from 6 to 10 filled prescriptions. Updated from 3 to 4 providers.
97	Member Benefits Removed from handbook	Sending providers to website for single source of truth.
99	Prenatal rewards	Loaded to CARE Card addition

	Topic	Description
100-108	Population Health Management	Program language updated to match Population Health Program Description.
120	Retrospective/ post-service UM Review	Content moved from website to provider manual
120	Electronic Prior Authorizations	ACNC no longer accepts inpatient concurrent reviews via HIE
121-123	Prior Authorization Content	Updated to drive providers to website for single source of truth. Updated phone and fax number for consistency.
136-138	Provider Appeals	Updated language for consistency with contract.
147	QAPI program and HECLAS	Updated to current business practice and proper names
149	NC Medicaid Pharmacy and Therapeutics Committee	Responsibilities updated
173-188	Claims and Billing	All references to vendors have been removed to drive providers to single source of truth, the ACNC Claims and Billing webpage.