Healthy Blue Provider Manual

Medicaid

Provider Services: 844-594-5072
https://provider.healthybluenc.com

BlueCross BlueShield of North Carolina | HealthyBlue®

NCHB-CD-PM-073039-24

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The material in this provider manual is subject to change. Visit **provider.healthybluenc.com** for the most up-to-date information.

Providers can obtain an online copy of the provider manual and view the provider directory at **provider.healthybluenc.com**. To request a hard copy of the provider manual and/or provider directory from the plan at no cost, call Healthy Blue Provider Services at **844-594-5072**.

To view PDF documents, you will need Adobe Acrobat Reader. If you do not have it already, you can access the website for Adobe directly at **get.adobe.com/reader**.

Welcome to the Healthy Blue network!

We combine national expertise with an experienced local staff to operate community-based health care plans. We are here to help you provide quality health care to our members.

Along with hospitals, pharmacies, and other providers, you play the most important role in managing care. Earning your respect and gaining your loyalty are essential to a successful collaboration in the delivery of health care.

We want to hear from you! We invite you to participate in one of our quality improvement committees. Please feel free to call Healthy Blue Provider Services at **844-594-5072** with any suggestions, comments and/or questions.

Together, we can make a real difference in the lives of our members — your patients.

How to apply for participation
If you are interested in participating in the Healthy Blue network and are registered with NC Medicaid via NC Tracks, visit **provider.healthybluenc.com** or call **844-594-5072**.

If you are not registered with NC Medicaid, visit **nctracks.nc.gov** to get started.

How to apply for participation
If you are interested in participating in the Healthy Blue network, visit **https://provider.healthybluenc.com** or call **844-594-5072**.

SUMMARY OF CHANGES

Date	Chapter: Section: Subsection	Page	Change(s)
Throughout: updated websites to remove https://www from websites			
7/1/23	Introduction	1	Wording change, date updated
7/1/23	Multiple	Multiple	Corrected all references to NCDHHS
7/1/23	Multiple	Multiple	Removed all references/language pertaining to NC Health Choice
7/1/23	Multiple	Multiple	Updated Availity Portal references to change the word portal to tool
7/1/23	Multiple	Multiple	Updated references of health care to healthcare
7/1/23	Multiple	Multiple	Removed or replaced references to Interactive Care Reviewer (ICR)
7/1/23	Multiple	Multiple	Corrected acronym of Physician-Administered Drug Program
7/1/23	Multiple	Multiple	Updated references of Provider Experience to Healthcare Networks
7/1/23	Multiple	Multiple	Changed references of him or her to them
9/9/24	Multiple	Multiple	Updated Weston Pkwy (Cary) address to new Durham, NC address throughout
Chapter 1: Introduction			
7/1/23	1.3 Quick Reference Information: Prior Authorization/ Notification – Physical Health	13	Updated language
7/1/23	1.3 Quick Reference Information: Hi-Tech Radiology, Cardiology, Musculoskeletal, and Rehabilitation Precertification Vendor — Carelon Medical Benefits Management, Inc.	14	Added “Rehabilitation”
7/1/23	1.4 Provider Claims Payment: Payment Dispute	16	Updated number of days for submitting disputes
7/1/23	1.4 Provider Claims Payment: Member Grievances	17	Updated mailing address
1/24/25	1.3 Quick Reference Information	13-19	Added Healthy Blue Provider and Facility Digital Guidelines
Chapter 2: Provider Information			
7/1/23	Provider information	17-18	Added language

Date	Chapter: Section: Subsection	Page	Change(s)
9/18/23	Member Grievances	17	Updated member grievance address
7/1/23	2.1 Advanced Medical Homes (AMH): Standard Terms and Conditions for Tier 3 Advanced Medical Home Practices	18-22	Removed language
9/18/23	2.5 PCP Onsite Availability	29-33	Added language
9/18/23	2.6 PCP Adequacy, Access, and Availability	33-35	Updated and removed language
11/10/23	2.6 PCP Adequacy, Access, and Availability	33-35	Added language
7/1/23	2.7 Panel Management	35-36	Added language
9/18/23	2.11 Specialty Care Providers' Access and Availability	38-39	Updated and removed language
9/18/23	2.12 Telehealth	39-41	Removed text box
7/1/23	2.14 Member Enrollment	42-45	Updated website
9/1/23	2.14 Member Enrollment	42-45	Updated hyperlinks
9/1/23	2.14 Member Enrollment	42-45	Added Provider Restriction language
9/1/23	2.15 PCP Auto Assignment Process for Members	45-46	Added and removed language
7/1/23	2.16 Member ID Cards	46	Added "Sample" to member ID cards
9/1/23	2.21 Provider Support	49-51	Added Provider Survey language and Emergency Management subhead
7/1/23	2.22 Care Management Oversight	51-52	Added language
9/18/23	2.23 Reporting Changes in Address and/or Practice Status	52-53	Updated website
9/18/23	2.25 Medically Necessary Services	53-54	Removed text box
9/18/23	2.26 Provider Bill of Rights	54	Removed language
9/18/23	2.28 Benefits	55-72	Updated language in Behavioral health services section
9/18/23	2.31 Well-Child Visits Reminder Program	75-77	Updated hyperlinks
9/18/23	2.32 Immunizations	77-78	Removed text boxes
9/18/23	2.33 Blood Lead Screening	77-78	Removed text boxes
9/9/2024	2.40 State Fair Hearing Process	84	Updated phone numbers
7/1/23	2.41 Provider Post Service Medical Necessity Appeals	85-87	Updated language
7/1/23 9/18/23 12/28/23	2.42 First Line of Defense Against Fraud	87-90	Updated language Added About Prepayment Review language;

Date	Chapter: Section: Subsection	Page	Change(s)
			Updated Acting on Investigative Findings language; Removed language about Provider Post Service Medical Necessity Appeals
Chapter 3: BEHAVIORAL HEALTH SERVICES			
9/18/23	3.15 Access to Care Standards	110-111	Updated language
9/18/23	3.16 Behavioral Health Covered Services	111-112	Updated table
Chapter 4: Member Management Support			
9/18/23	4.4 Continuity of Care	120-121	Added language
7/1/23	4.5 New Baby, New Life℠ Pregnancy Support Program	121-124	Added and removed language
Chapter 5: Precertification/Prior Notification Process			
7/1/23	How to provide notification or request prior authorization	133	Updated language
7/1/23	5.1 Precertification of All Inpatient Elective Admissions	134-135	Updated ICR reference
7/1/23	5.6 Prior authorization/notification Coverage Guidelines: Durable medical equipment (DME)	139-150	Added and removed language
7/1/23	5.6 Prior authorization/notification Coverage Guidelines: Rehabilitation therapy (short term): speech, physical and occupational therapy	139-149	Added language
Chapter 6: Quality Management			
9/18/23	6.1 Quality Management Program	156-160	Added language
9/18/23	6.2 Quality of Care	160-161	Added and removed language
7/1/23	6.6 Clinical Criteria	162-163	Updated department name
9/18/23	6.10 Credentialing and Recredentialing	165	Added language
9/9/24	6.11 Provider Enrollment and Disenrollment	166-169	Added language
Chapter 7: Claim Submission And Adjudication Procedures			

Date	Chapter: Section: Subsection	Page	Change(s)
7/1/23	7.2 Electronic Data Interchange (EDI) – Electronic Submission of Claims	170	Added language
9/9/2024	7.3 Paper Claims Submission	170-172	Added ‘Level 7: Trading partner specific’
9/18/23	7.6 Claims Adjudication	177-178	Updated time limit days
7/1/23	7.8 Claims Status	179	Updated name of Provider Services
7/1/23	7.9 Reimbursement Policies: Outlier Reimbursement — Audit and Review Process	179-192	Updated language
9/9/2024	7.10 Coordination of Benefits and Third-Party Liability	193-194	Updated language
7/1/23 9/18/23	7.11 Billing Members	195-196	Removed language and added/adjusted language to Exceptions to Cost sharing

INTRODUCTION

1.1 Who Is Healthy Blue?

Healthy Blue is the Medicaid plan offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC). Blue Cross NC is dedicated to offering real solutions that improve health care access and quality for our members while proactively working to reduce the overall cost of care to taxpayers. Blue Cross NC does not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, gender, sexual orientation, gender identity or disability.

We help coordinate physical and behavioral health care, and we offer education, access to care and condition care programs. As a result, we lower costs, improve quality and encourage better health status for our members.

We strive to:

- Improve access to preventive primary care services.
- Ensure selection of a primary care provider (PCP) who will serve as a provider, care manager and coordinator for all basic medical services.
- Improve health status outcomes for members.
- Educate members about their benefits, responsibilities and appropriate use of care.
- Utilize community-based enterprises and community outreach.
- Integrate physical and behavioral health care.
- Encourage:
  - Stable relationships between our providers and members.
  - Appropriate use of specialists and emergency rooms.
  - Member and provider satisfaction.

1.2 Whom Do We Serve?

The North Carolina Department of Health and Human Services (NCDHHS) transitioned most Medicaid beneficiaries to Standard Plans on July 1, 2021. Healthy Blue is a statewide Standard Plan. Standard Plans are integrated health plans that provide:

- Physical health, pharmacy, care coordination and basic behavioral health services
- Added services, such as wellness programs

NCDHHS is responsible for managing and maintaining Standard Plan enrollment criteria. The following people qualify for Standard Plans:

- Most families and children
- Pregnant women
- People who are blind or disabled and not receiving Medicare

People with the following managed care statuses in NC FAST qualify for Standard Plans:

- Standard Plan (mandatory)
- Tailored Plan*
- Tribal – Tailored Plan*
- IHS – Tailored Plan*

*These managed care statuses may choose a Standard Plan (voluntary).

1.3 Quick Reference Information and Provider and Facility Digital Guidelines

Please use the Quick Reference table below for important phone numbers, hours of operations, and links to online resources. All of this information is also on our **Healthy Blue Provider Website – provider.healthybluenc.com**

From our public provider website, you can also access our secure provider tool, Availity Essentials (**Availity.com**) which offers a full complement of online capabilities including improved functions such as:

- Enhanced account management transactions
- Detailed eligibility look-up feature with downloadable panel listing
- Comprehensive, downloadable member listings
- Easy authorization submission
- New provider data, termination and roster transactions
- Access to drug coverage information

Blue Cross NC Office Address
Blue Cross NC | Healthy Blue 1965 Ivy Creek Blvd Durham, NC 27707

Phone Numbers	
Provider Services:	**844-594-5072** Monday through Saturday, 7 a.m. to 6 p.m. Eastern time Voice portal accessible 24/7; Interpreter services also available
Prior Authorization/ Notification – Physical Health:	Phone: **844-594-5072, option 2** Online: PA requests can also be submitted digitally. Access the authorization application through Availity Essentials at **Availity.com**. (Select Patient Registration > Authorizations & Referrals) Provide the following: • Member ID number • Legible name of referring provider • Legible name of person referred to provider/pharmacy • Number of visits/services • Date(s) of service • Diagnosis • CPT® code • Clinical information Fax: PA fax forms are available online at **provider.healthybluenc.com/north-carolina-provider/forms**.
Availity Client Services:	Phone: **800-AVAILITY (800-282-4548)**, Monday through Friday 8 a.m. to 8 p.m. Eastern time
Member Services Nonemergency:	**844-594-5070** Monday through Saturday, 7 a.m. to 6 p.m. Eastern time
Behavioral Health Crisis Line:	**844-594-5076** — accessible 24/7
CarelonRx* — Pharmacy Benefits Manager:	Monday through Saturday, 7 a.m. to 6 p.m. Eastern time including state holidays Pharmacy Member Services: **844-594-5084** (24/7) Help for Pharmacists: **833-434-1212** (24/7) Provider Services (with Pharmacy PA Prompts): **844-594-5072** Prior authorization voice portal available 24/7
24/7 Nurse Line (Member Emergent):	**844-545-1427 (Spanish 844-545-1428)** Accessible 24/7; including state holidays
Telecommunication Relay Services:	**711**
Nonemergent Transportation Vendor — ModivCare™:	**855-397-3602** (reservations and ride assistance) Online: https://modivcare.com/

Vision Vendor — EyeMed:	Fax: **513-492-3259** Email: **eyemedqa@eyemed.com** Online: **eyemedinfocus.com/healthybluenc**
Durable Medical Equipment, Home Health and Home Infusion Services:	Phone: **844-594-5072** Online: **provider.healthybluenc.com**
Hi-Tech Radiology, Cardiology, Musculoskeletal, and Rehabilitation Precertification Vendor — Carelon Medical Benefits Management, Inc.:	Phone: **866-745-1788** Monday through Friday, 7 a.m. to 7 p.m. Eastern time Online: **providerportal.com**
North Carolina Department of Health and Human Services (NCDHHS), Division of Health Benefits:	Phone: **800-662-7030** Online: **medicaid.ncdhhs.gov**
Member Medical Appeals:	Member medical necessity appeals must be filed within 60 calendar days of the date of action. Providers may appeal on behalf of the member with the member's written consent. Submit a member medical appeal to: Blue Cross NC | Healthy Blue Central Appeals and Grievance Processing P.O. Box 62429 Virginia Beach, VA 23466-62429 You can also submit via fax at: **844-429-9635** Email: **ncmedicaidgrievances@nchealthyblue.com** To file by phone, call Member Services at **844-594-5070**. You can also file with Availity Essentials: • Log into **Availity.com** • Locate claim using Claim Status • Select dispute button to initiate appeal • Navigate to Claims & Payments and select Appeals • Locate initiated appeal and upload documents For urgent issues at all other times, call **844-594-5072**.

Healthy Blue Provider and Facility Digital Guidelines

Blue Cross NC understands that working together digitally streamlines processes and optimizes efficiency. We developed the Healthy Blue Provider and Facility Digital Guidelines to outline our expectations and to fully inform providers and facilities about our digital platforms.

Notes:

- CarelonRx, Inc. is an independent company providing pharmacy benefit management services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.
- Carelon Medical Benefits Management, Inc. is an independent company providing utilization review services for Healthy Blue providers on behalf of Blue Cross and Blue Shield of North Carolina.

Blue Cross NC expects Healthy Blue providers and facilities will utilize digital tools, unless otherwise prohibited by law or other legal requirements.

Digital guidelines establish the standards for using secure digital provider platforms (websites) and applications when transacting business with Blue Cross NC. These platforms and applications are accessible to both participating and nonparticipating providers and facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Blue Cross NC has available to participating and nonparticipating providers and facilities who serve its members. The expectation of Blue Cross NC is based on our contractual agreement that providers and facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirements.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, claim status
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to providers and facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management, Inc.
- Services through Carelon Behavioral Health, Inc.

Blue Cross NC expects Healthy Blue providers and facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes providers using their practice management software & clearinghouse billing vendors.

Providers and facilities who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital Member ID cards, providers and facilities may need to implement changes in their processes to accept this new format. Blue Cross NC expects that providers and facilities will accept the digital version of the member identification card in lieu of a physical card when presented. If providers and facilities require a copy of a physical ID card, members can email a copy of their digital card from their smartphone application, or providers and facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and facilities should leverage these Availity Clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response
  - Blue Cross NC supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials
  - The Eligibility and Benefits Inquiry verification application allows a provider and facility to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs
  - Blue Cross NC has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and facilities should leverage these channels for prior authorization submission, status inquiries and to submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
  - Blue Cross NC supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
  - Blue Cross NC supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:

    - Authorization applications include the Availity Essentials multi-payer Authorization and Referral application for authorization submissions not accepted through Availity Essentials' multi-payer application.
        - Both applications enable prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.
- Provider desktop integration via B2B APIs:
    - Blue Cross NC has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, claims payment disputes, attachments, and status

Claim submissions status and claims payment disputes

Providers and facilities should leverage these channels for electronic claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – Professional, institutional, and dental claim submission (version 5010):
    - Blue Cross NC supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
    - 837 Claim batch upload through EDI allows a provider to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
    - Blue Cross NC supports the industry standard X12 276/277 transaction set for claim status inquiry and response as mandated by HIPAA.
- Availity Essentials: The Claims & Payments application enables a provider to enter a claim directly into an online claim form and upload supporting documentation for a defined claim.
    - Claim Status application enables a provider to access online claim status. Access the claim payment dispute tool from Claim Status. Claims Status also enables online claim payment disputes in most markets and for most claims. It is the expectation of Blue Cross NC that electronic claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
    - Blue Cross NC has also enabled real-time access to Claim Status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and facilities should leverage these channels for electronic claim attachments from Availity.com:

- EDI transaction: X12 275 – Patient information, including HL7 payload attachment:

  - Blue Cross NC supports the industry standard X12 275 transaction for electronic transmission of supporting claim documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application enables a provider or facility to digitally submit supporting claims documentation, including medical records, directly to the claim.
  - Digital Request for Additional Information (Digital RFAI) – The Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a claim.

Section 5: Electronic remittance advice and electronic claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your claims. Blue Cross NC supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and facilities can register, enroll, and manage ERA preference through **Availity.com**. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for your claims, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic claims payment

Electronic claims payment is a secure and fast way to receive payment, reducing administrative processes. There are several options to receive claims payments electronically.

- Electronic Funds Transfer (EFT)

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a provider's or facility's bank account at no charge for the deposit. Health plans can use a provider's or facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

  To enroll in EFT: Providers and facilities can register, enroll, and manage account changes for EFT through EnrollSafe at **enrollsafe.payeehub.org**. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient **EnrollSafe User Reference Manual**.

To disenroll from EFT: Providers and facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at **enrollsafe.payeehub.org**.

- Virtual Credit Card (VCC)

  For providers and facilities who don't enroll in EFT, and in lieu of paper checks, Blue Cross NC is shifting some reimbursements to virtual credit card (VCC). VCC allow providers and facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

  Note that Blue Cross NC may receive revenue for issuing a VCC.

  Opting out of virtual credit card payment. Providers and facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

  - Enrolling for EFT payments automatically opts you out of virtual credit card payments. To receive EFT payments instead of virtual credit cards payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    OR
  - To opt out of virtual credit card payments, call **800-833-7130** and provide your taxpayer identification number.

- Zelis Payment Network (ZPN) electronic payment and remittance combination

  The Zelis Payment Network (ZPN) is an option for providers and facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Blue Cross NC may receive revenue for issuing ZPN.

  ERA through Availity is not available for providers and facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at **enrollsafe.payeehub.org**.
    OR
  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at **877-828-8770**.

Not being enrolled for EFT, VCC, or ZPN will result in paper checks being mailed to the mailing address Blue Cross NC has on file.

1.4 Provider Claims Payment

We strive to continuously increase service quality to our providers. Our Healthy Blue Provider Blue Line℠ (Blue Line) helps with claims payment and issue resolution.

Call 844-594-5072 and select the claims prompt within our voice portal.

The Blue Line connects provides a dedicated resource team to ensure:

- Availability of helpful, knowledgeable representatives to assist
- Increased first-contact, issue resolution rates
- Significantly improved turnaround time of inquiry resolution
- Increased outreach communication to keep providers informed of inquiry status

For adverse determinations related to claims, a health care provider has the right to an independent review of the adverse action of the prepaid health plan.

Payment Dispute

If, after working through the Blue Line, you remain in disagreement over a zero or partial claim payment, or in lieu of this process, you may file a formal dispute with the Healthy Blue Payment Dispute Unit. We must receive your dispute within 30 calendar days from the date of the *EOP*.

We will send a determination letter within 30 business days of receiving the dispute.

If you are dissatisfied, you may submit a request for a Level II review. We must receive your request within 30 calendar days of receipt of the Level I determination letter. Submit a payment dispute to:

Blue Cross NC | Healthy Blue
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466

Member Grievances

Submit a member grievance to:

Grievance and Appeals Team
Blue Cross NC | Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23366-2429

PROVIDER INFORMATION

Providers must be enrolled with NCDHHS to render services to Healthy Blue patients. Providers must complete and submit a *Provider Enrollment Application* for their specific provider type. The online *Provider Enrollment Application* is available through the NCTracks Provider Portal.

Providers who want to enroll as groups must complete and submit an online *Provider Enrollment Application* via the NCTracks Provider Portal for their specific provider type (organization or individual).

Atypical providers are providers who do not provide health care as defined under *HIPAA* in Federal Regulations at *45 CFR section 160.103*. Examples of atypical providers reimbursed by the Medicaid program are individuals or businesses that bill for services such as taxi services, home and vehicle modifications, and respite services. Atypical providers will use system-generated provider identification numbers to file their claims.

Providers must be licensed, accredited, endorsed and/or certified according to the specific laws and regulations that apply to their service type. Enrollment qualifications vary, but **all** providers must complete an application and an NCDHHS *Provider Administrative Participation Agreement*. All providers are responsible for maintaining the required licensure, endorsement and accreditation specific to their provider type to remain qualified and are required to notify NCDHHS immediately if a change in status occurs.

For detailed information regarding specific requirements for each provider type:

- Refer to the *Provider Qualifications and Requirements Checklist* on the NCTracks website at **nctracks.nc.gov/content/public/providers/provider-enrollment.html.**
- Contact the NCTracks Operation Center at **800-688-6696**.
- Information about enrollment in NCTracks can be found online at: **nctracks.nc.gov/content/public/providers/provider-enrollment/getting-started.html**.

Providers who wish to contract with a Prepaid Health Plan (PHP), including Blue Cross NC, must be enrolled with North Carolina Medicaid via NCTracks prior to being considered a participating provider for a PHP.

All provider enrollment, AMH attestation, data management, recredentialing and verification must be completed by the provider within NCTracks.

Tobacco-free Policy Requirement

Providers, except for residential provider facilities as described below, must develop, and implement a tobacco-free policy covering any portion of the property on which the Provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting the Provider from purchasing, accepting as donations, and/or distributing

tobacco products (combustible and noncombustible products including electronic cigarettes) to the clients the 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. In these settings, the Provider shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

- Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by the Provider
- For outdoor areas of campus, the Provider shall ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and prohibit staff/employees from using tobacco products anywhere on campus

For more information about the North Carolina Standard Plan Tobacco-Free Requirement, please visit the NC Medicaid Blog published on January 25th, 2022 **medicaid.ncdhhs.gov/blog/2022/01/25/north-carolina-standard-tailored-plan-tobaccofree-policy-requirement#:~:text=A%20tobacco%2Dfree%20policy%20includes,medications%2C%20as%20well%20as%2C%20prohibiting**

2.1 Advanced Medical Homes (AMH)

The following are required provisions for Advanced Medical Home providers. These provisions are independent of practices' agreements with the North Carolina Department of Health and Human Services (NCDHHS) and Community Care of North Carolina around Carolina ACCESS and will not affect those agreements.

Services/Obligations for Advanced Medical Home Practices

- Provider will accept members and be listed as a PCP in Healthy Blue member-facing materials for the purpose of providing care to members and managing their health care needs.
- Provider will provide primary care and member care coordination services to each member.
- Provider will provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions 24/7. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- Provider will provide direct patient care a minimum of 30 office hours per week.
- Provider will provide preventive services in accordance with the preventive health requirements set forth in the provider manual and government contract.
- Provider will establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of members.
- Provider will maintain a unified medical record for each member following Healthy Blue medical record documentation guidelines.
- Provider will promptly arrange referrals for medically necessary health services that are not provided directly and document referrals for specialty care in the medical record.

- Provider will transfer the member's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Blue Cross NC (if applicable) and as authorized by the member within 30 days of the date of the request.
- Provider will authorize care for members or provide care for members based on the standards of appointment availability as defined by Healthy Blue network adequacy standards.
- Provider will refer for a second opinion as requested by the member, based on state agency guidelines and Healthy Blue standards.
- Provider will review and use member utilization and cost reports provided by Blue Cross NC for the purpose of Advanced Medical Home level utilization management and advise Blue Cross NC of errors, omissions or discrepancies if they are discovered.
- Provider will review and use the monthly enrollment report provided by Blue Cross NC for the purpose of participating in Healthy Blue or practice-based population health or care management activities.

Standard Terms and Conditions for Tier 3 Advanced Medical Home Practices
The terms and conditions set forth here will apply to the extent the provider is an attested and contracted Tier 3 Advanced Medical Home practice (as defined in the government contract) to which care management has been delegated as part of NC Medicaid Transformation. Unless otherwise specified, any required element can be performed either by the Tier 3 Advanced Medical Home practice itself or by a clinically integrated network with which the practice has a contractual agreement that contains equivalent contract requirements.

AMH Providers must be able to risk stratify all empaneled members:

- Provider must ensure that assignment lists transmitted to the practice by Blue Cross NC are reconciled with the practice’s panel list and are up to date in the clinical system of the record.
- Provider must use a consistent method to assign and adjust risk status for each assigned member.
- Provider must use a consistent method to combine risk scoring information received from Blue Cross NC with clinical information to score and stratify the member panel.
- Provider must (to the greatest extent possible) ensure that the method is consistent with the state agency's program policy of identifying priority populations for care management.
- Provider must ensure that the whole care team understands the basis of the practice’s risk scoring methodology (even if this involves only clinician judgment at the practice level) and that the methodology is applied consistently.
- Provider must define the process and frequency of risk score review and validation.

AMH Provider must be able to provide care management to high-needs members:

- Provider must use its risk stratification method to identify members who may benefit from care management.
- Provider must perform a comprehensive assessment (as described below and in policy) on each member identified as a priority for care management to determine care needs. The comprehensive assessment can be performed as part of a clinician visit or separately by a team led by a clinician with a minimum credential of registered nurse

(RN) or licensed clinical social worker (LCSW). The comprehensive assessment must includeat a minimum:
  - The member's immediate care needs and current services
  - Other state or local services currently used
  - Physical health conditions
  - Current and past behavioral and mental health and substance use status and/or disorders
  - Physical and intellectual developmental disabilities
  - Medications
  - Priority domains of social determinants of health (housing, food, transportation and interpersonal safety)
  - Available informal, caregiver or social supports (including peer supports)
- Provider must have North Carolina licensed, trained staff at the practice level (or at the clinically integrated network level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need members.
- For each high-need member, providers must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

AMH Provider must use a documented care plan for each high-need member receiving care management:

- Provider must develop the care plan within 30 days of comprehensive assessment (or sooner if feasible) while ensuring needed treatment is not delayed by the development of the care plan.
- Provider must develop the care plan so that it is individualized and person-centered, using a collaborative approach including member and family participation where possible.
- Provider must incorporate findings from the prepaid health plan care needs screening/risk scoring, practice-based risk stratification and comprehensive assessment with clinical knowledge of the member into the care plan.
- Provider must include, at a minimum, the following elements in the care plan:
  - Measurable member (or member and caregiver) goals
  - Medical needs including any behavioral health needs
  - Interventions
  - Intended outcomes
  - Social, educational and other services needed by the member
- Provider must have a process to update each care plan as member needs change and/or to address gaps in care, including, at a minimum, review and revision upon reassessment.
- Provider must have a process to document and store each care plan in the clinical system of record.
- Provider must periodically evaluate the care management services provided to high-risk, high-need members by the practice to ensure that services are meeting the needs of empaneled members, and refine the care management services as medically necessary.
- Provider must track empaneled members’ utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency

departments and hospitals, through active access to an admissions, discharge and transfer data feed that correctly identifies when empaneled members are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.

- Provider or clinically integrated network must implement a systematic, clinically appropriate care management process for responding to certain high-risk admissions, discharge and transfer alerts (indicated below):
  - Real-time (minutes/hours) response to outreach from emergency departments relating to member care or admission/discharge decisions (for example, arranging rapid follow-up after an emergency department visit to avoid an admission)
  - Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital
  - Within a several-day period to address outpatient needs or prevent future problems for high-risk members who have been discharged from a hospital or emergency department (for example, to assist with scheduling appropriate follow-up visits or medication reconciliations postdischarge)

Providers must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled members who have an emergency department visit or hospital admission/discharge/transfer and who are at risk of readmissions and other poor outcomes:

- Provider must have a methodology or system for identifying members in transition who are at risk of readmissions and other poor outcomes that consider all of the following:
  - Frequency, duration and acuity of inpatient, skilled nursing facility and long-term services and supports admissions or emergency department visits
  - Discharges from inpatient behavioral health services, facility-based crisis services, nonhospital medical detoxification, medically supervised or alcohol and drug abuse treatment center
  - NICU discharges
  - Clinical complexity, severity of condition, medications or risk score
- For each member in transition identified as high risk for admission or other poor outcomes with transitional care needs, provider must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.
- Provider must include the following elements in transitional care management:
  - Ensuring that a care manager is assigned to manage the transition
  - Facilitating clinical handoffs
  - Obtaining a copy of the discharge plan/summary
  - Conducting medication reconciliation
  - Following up by the assigned care manager rapidly following discharge
  - Ensuring that a follow-up outpatient, home visit or face-to-face encounter occurs
  - Developing a protocol for determining the appropriate timing and format of such outreach

AMH Provider must use electronic data to promote care management:

- Provider must receive claims data feeds (directly or via a clinically integrated network) and meet department-designated security standards for their storage and use.
- Provider must participate in all annual audit activities which was preceded by a successful pre-delegation audit to assess delegated care management readiness.
- Provider (directly or via a clinically integrated network) must participate in joint operations meetings (JOC) or similar committees with the health plan as part of the Tier 3 Advanced Medical Home care management agreement to review performance, data reports, quality issues and address any administration issues at least quarterly.

For more information regarding AMH practice requirements, please see the Advanced Medical Home Manual published by the Department, available online at **medicaid.ncdhhs.gov/advanced-medical-home** or contact your Healthy Blue Provider Collaboration representative.

2.2 Primary Care Providers

As a primary care provider (PCP), you serve as the entry point into the health care system for the member — you are the foundation of the collaborative concept known as a Patient-Centered Medical Home™ (PCMH). The PCMH is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care.
Each patient has a relationship with a PCP who leads a team that takes collective responsibility for patient care, providing for all of the patient's health care needs and appropriately arranging care with other qualified professionals.

A medical home is a collaborative relationship that provides high levels of care, access and communication; care coordination and integration; and care quality and safety, including provision of preventive services and treatment of acute and chronic illness. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

Several organizations have introduced a set of standards and a process through which primary care practices may be recognized as PCMHs. The best reason for pursuing PCMH recognition is that fulfilling the requirements of a recognition process will help your organization make great strides toward transforming into a true medical home — a health center of the 21st century where care is coordinated, accessible and keeps patients at the center. Completing the recognition process will allow your organization to assess its strengths and achievements; recognize areas for improvement; and ultimately develop more efficient, effective and patient-centered care processes.

We offer the following support to practices that are seeking or have achieved PCMH recognition:

- Suite of reports to assist with management of your patient population
- Opportunities for frequent interaction with our medical director
- Dedicated, local medical practice consultants who support practice improvements and facilitate information sharing
- Alignment of care coordination activities, including care managers who work with your practice and may collaborate with you onsite

- Quality coaches who educate and support your practice to build systems for quality improvement
- Innovative models of reimbursement and incentives

You are responsible for the complete care of your patient, including:

- Providing primary care inclusive of basic behavioral health services
- Providing the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring referrals to specialist care
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements
- Referring patients to subspecialists, subspecialty groups, and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available.
- Authorizing hospital services
- Maintaining the continuity of care
- Ensuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally responsive or appropriate manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Maintaining a medical record of all services rendered by you and other referral providers.
- Communicating with members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations
- Providing a minimum of 30 office hours per week of appointment availability as a PCP.
- Arranging for coverage of services to assigned members 24/7 in person or by an on-call physician
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs).
- Answering after-hours phone calls from members immediately or returning calls within 30 minutes from when calls are received
- Continuing care in progress during and after termination of your contract for up to 30 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations

2.3 Responsibilities of the PCP

PCPs have the responsibility to:

- Adhere to all terms and conditions within the prepaid health plan (PHP)/provider contract and this provider manual

Communicate With Members

- Make provisions to communicate in the language or fashion primarily used by the member, including translation or oral interpretation services; contact Healthy Blue Provider Services if you need assistance with translation services for a Healthy Blue member

- Freely communicate with members about their treatment, regardless of benefit coverage limitations
- Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their healthcare
- Advise members about their health status, medical care and treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered
- Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings

Maintain Medical Records

- Treat all members with respect and dignity
- Provide members with appropriate privacy
- Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse the release of records
- Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care
- Share records subject to applicable confidentiality and *HIPAA* requirements
- Upon notification of the member's transfer to another health plan:
  - Blue Cross NC will request copies of the member's medical record unless the member has arranged for the transfer. The provider must transfer a copy of the member's complete medical record and allow the receiving health plan access (immediately upon request) to all medical information necessary for the care of that member
- Transfer of records should not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving health plan are the responsibility of the relinquishing health plan
- A copy of the member's medical record and supporting documentation should be forwarded by the relinquishing health plan's PCP within 10 business days of the receiving health plan's PCP's request
- Obtain and store medical records from any specialty referrals in the member's medical records
- Manage the medical and health care needs of members to ensure all medically necessary services are made available in a timely manner
- Retain the member's medical records in accordance with your *Provider Agreement*

Cooperate and Communicate with Blue Cross NC

- Participate in:
  - Internal and external quality assurance
  - Utilization review

  - Continuing education
  - Other similar programs
  - Complaint and grievance procedures when notified of a member grievance
- Inform Blue Cross NC if a member objects to provision of any counseling, treatments or referral services for religious reasons.
- Identify members who would benefit from our care management or condition care programs.
- Comply with our Quality Improvement Program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Cooperate with the integration of behavioral health into our service delivery model in accordance with state mandates.

Cooperate and Communicate with Other Providers

- PCPs are required to screen their patients for common behavioral health disorders, including screening for developmental, behavioral and social delays, as well as risk factors for child maltreatment, trauma and adverse childhood experiences. Members screening positive for any of these conditions should be referred to a behavioral health specialty provider for further assessment and possible treatment. Screening tools for common disorders typically encountered in primary care are available on the Healthy Blue provider website at **provider.healthybluenc.com**.
- Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service.
- Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid.
- Provide care management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs, and other responsibilities as defined in the state's Medicaid program.
- Coordinate the services we furnish to the member with the services the member receives from any other Healthy Blue network program during member transition.
- Share with other health care providers serving the member the results of your identification and assessment of any member with special health care needs (as defined by the state) so those activities are not duplicated.
- Blue Cross NC will work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral and social delays, as well as child maltreatment risk factors, trauma and adverse childhood experiences. We will work to increase the percentage of children with positive screens who:
  - Receive a warm handoff to and/or are referred for more specialized assessment or treatment.
  - Receive specialized assessment or treatment.

Cooperate and Communicate with Other Agencies

- Maintain communication with the appropriate agencies such as:
  - Local police
  - Social services agencies
  - Poison control centers

    - Women, Infants, and Children (WIC) program
- Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the *Americans with Disabilities Act*.
- Coordinate the services we furnish to the member with the services the member receives from any other managed care plan during ongoing care and transitions of care.

As a PCP, you may practice in a:

- Solo or group setting
- Clinic (for example, a Federally Qualified Health Center [FQHC] or Rural Health Clinics Center [RHC])
- Outpatient clinic

2.4 Who Can Be a PCP?

Physicians with the following specialties can apply for enrollment with Healthy Blue as a PCP, including but not limited to:

- Family practice/family medicine
- Federally Qualified Health Centers (FQHCs)
- General practice
- Internal medicine
- Local health department (LHD)
- Nurse practitioner
- Obstetricians/gynecology
- Pediatricians
- Physician assistant
- Rural Health Clinics Centers (RHC)
- Certified nurse midwife
- Indian Health Care Provider (IHCP) that are able to provide PCP services

In order for a provider to be designated as a PCP/AMH, providers must be contracted with at least one eligible taxonomy code as indicated on the NCTracks Provider Permission Matrix (PPM) which is available on the website at **nctracks.nc.gov/content/public/providers/provider-enrollment.html**. If you are not an AMH and wish to be a PCP, Blue Cross NC must also have a completed *Provider Information Sheet* which will request additional information of non-AMH PCPs. Please contact us via email for more information at NC_Provider@healthybluenc.com.

Vulnerable priority populations (for example, persons with multiple disabilities or acute or chronic conditions, as determined by Blue Cross NC) are allowed to select their attending specialists as their PCP as long as the specialist is willing to perform the responsibilities of a PCP. The specialist will provide and coordinate the member's primary and specialty care. Prior approval is required for the authorization of a specialist as a PCP. Requests will be considered on a case-by-case basis.

2.5 PCP Onsite Availability

You are required to abide by the following standards to ensure access to care for our members – your patients:

- Offer 24/7 phone access for members. A 24-hour phone service may be used. The service may be answered by a designee such as an on-call physician or nurse practitioner with physician backup.
- Use an answering service or pager system. This must be a confidential line for member information and/or questions. If you use an answering service or pager, the member's call must be returned within 30 minutes.
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/precertification guidelines. This is a requirement for covering physicians.

Additionally, we strongly encourage you to offer after-hours office care in the evenings and on weekends. We encourage two hours at least one day per week after 5 p.m. and four hours or longer on Saturdays.

Examples of unacceptable PCP after-hours coverage:

- The PCP's office phone is only answered during office hours.
- The PCP's office phone is answered after hours by a recording that tells patients to leave a message.
- The PCP's office phone is answered after hours by a recording that directs patients to go to an emergency room for any services needed.
- Returning the member's after-hours call outside of 30 minutes.

It is **not** acceptable to automatically direct the member to the emergency room when the PCP is not available unless the clinical decision of the rendering provider is that the care needed is an emergency.

Time and distance standards

To ensure that all Members have ***timely access*** to all covered health care services, our Provider Network Integrity Workgroup will monitor and adjust our provider network according to changing circumstances with the objective of maintaining the stability and capacity of existing delivery systems. Our monitoring tools will include our GeoAccess mapping, periodically reviewing providers for availability and type, and surveying and responding to member needs. Time and distance standards are applied to adult and child members separately. 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 physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children or adolescent) services are those provided to a member who is less than 21 years of age.

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

Urban — defined as nonrural counties or counties with average population densities of 250 or more people per square mile

Rural — defined as a county with average population density of less than 250 people per square mile

Time and distance standards		
Service type	**Urban standard**	**Rural standard**
Primary care (adult and pediatric)	≥ 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 (adult and pediatric)	≥ 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 members
Hospitals*	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital 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 (OB/GYN)** ***Measured on members who are female and age 14 through age 44. Certified Nurse Midwives may be included to satisfy OB access requirements.*	≥ 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 Note: 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 Note: Research-based behavioral health treatment for Autism Spectrum Disorder (ASD): not subject to standard

Time and distance standards		
Service type	**Urban standard**	**Rural 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 specialized services (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
State plan long-term services and supports (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 and available to deliver the 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*	PHPs must have at least 1 nursing facility accepting new patients in every county.	PHPs must have at least 1 nursing facility accepting new patients in every county.

Definition of service category for behavioral health time and distance standards	
Service type	**Definition**
Outpatient behavioral health services	• Outpatient behavioral health services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment
Location-based services (behavioral health)	• Outpatient Opioid treatment (OTP) (adult)
Crisis services (behavioral health)	• Professional treatment services in a facility-based crisis program (adult) • Facility-based crisis services for children and adolescents • Ambulatory detoxification

Definition of service category for behavioral health time and distance standards	
Service type	**Definition**
	• Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) • Detoxification crisis stabilization (adult)
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)
Clinically managed low-intensity residential treatment services (behavioral health)	• Clinically managed low-intensity residential treatment services

2.6 PCP Adequacy, Access, and Availability

Our ability to provide quality access to care depends upon your accessibility. To ensure our members have access to quality care, Healthy Blue conducts access and availability studies of participating providers at regular intervals to determine adequate access to covered benefits.

We assess provider to member ratios by specialty and services including Behavioral Health (BH) and Long-Term Services and Support (LTSS) for members within the specified timeframe and or when signification changes occur. The access and availability studies will be used to determine any deficiencies in the network. The access and appointment wait time standards are listed below and Healthy Blue reports its progress to State Regulators at regular intervals.

You are required to adhere to the following access standards:

Appointment Wait Time Standards		
Visit type	**Description**	**Standard**
Preventive care service — adult, 21 years of age and older[1]	Care provided to prevent illness or injury; examples include but are not limited to routine physical	Within 30 calendar days

Appointment Wait Time Standards		
Visit type	**Description**	**Standard**
	examinations, immunizations, mammograms, and Pap smears	
Preventive care services — child, birth through 20 years of age[1]		Within 14 calendar days for member less than 6 months of age Within 30 calendar days for members 6 months or age and older
Urgent care services care provided for a nonemergent illness	Care services care provided for a nonemergent 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, nonresolving headache	Within 24 hours
Routine/check-up without symptoms[1]	Nonsymptomatic visits for routine health check-up	Within 30 calendar days
After-hours access — emergent and urgent	Care requested after normal business office hours	Immediately available 24 hours a day, 365 days a year
Prenatal Care		
Initial appointment[1, 2] — first or second 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 14 calendar days
Initial appointment[1, 2] — high-risk pregnancy or third trimester		Within five calendar days

Notes:
1 In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.
2 For women who are past their first trimester of pregnancy on the first day they are determined to be eligible for North Carolina Medicaid, first prenatal appointments should be scheduled as outlined in this chart.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

You may not use discriminatory practices such as:
- Showing preference to other insured or private-pay patients.
- Maintaining separate waiting rooms.

- Maintaining appointment days.
- Offering hours of operation that are less than the hours of operation offered to patients with other health insurance coverage, including but not limited to commercial health plans.
- Offering office hours not equal to hours offered to other prepaid health plans participating in the Medicaid program.
- Denying or not providing to a member any covered service or availability of a facility.
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large.

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the *Americans with Disabilities Act*. Health care services provided through Blue Cross NC must be accessible to all members.

2.7 Panel Management

Blue Cross NC would like to remind our Healthy Blue network that providers should update NCTracks with any limitations for age and gender as well as whether they are accepting new patients and/or siblings. PHPs ingest the information from NCTracks when establishing panel limits for Standard Plans.

Panel Limits for Accepting or Not-Accepting New Patients, Age, and Gender

Blue Cross NC will prepopulate its system with the NCTracks panel limits for accepting or not-accepting new patients, ages, and gender provided to prepaid health plans (PHPs). We encourage validating your panel in NCTracks before contacting Blue Cross NC.

To change your accepting or not-accepting new patients (open or close panel) status, age, or gender panel limitations, complete a full Managed Change Request (MCR) then navigate to the Services page to update your panel information. Ensure your practice reviews the limitations for all locations, especially those with AMH Tiers and or PCP-designated locations.

For assistance completing the MCR in NCTracks, see the User Guides and Fact Sheets webpage. Contact NCTracks directly through the following methods:

- Phone: **800-688-6696**
- Email: NCTracksprovider@nctracks.com

Panel Volume

Panel capacity or volume limit(s) noted in NCTracks is not transferred to PHPs. If your practice or location needs to modify the capacity of Healthy Blue members, contact us at NC_Provider@healthyblue.com to request an adjustment to volume limit(s). Note: Changes to panel capacity will not adjust any existing member assignments; it will only prevent new members from being assigned beyond the limit once implemented.

Please review the **DHHS Panel Management Fact Sheet** which provides an overview of how you can manage your panel as well as how to verify member eligibility and enrollment within NCTracks. For additional Managed Care Fact Sheets, please visit the **Fact Sheet webpage**.

As a reminder, members are assigned to providers at the group/AMH level. If your office notices the PCP listed on a member's ID card is no longer with your practice or if the member asks for help changing their PCP to your practice, the member and provider can complete the ***PCP Change Form***. **Member consent and choice is of the utmost importance when it comes to selecting an AMH**. Member consent is needed for a provider to submit this form on their behalf. The member should sign the PCP Change Form prior to it being submitting to the PHP.

Please verify each member receiving treatment in your office appears on your panel reporting.

Panel reports can be accessed via our provider website online application, Provider Online Reporting, accessed through Payer Spaces on Availity Essentials. Access requires an Availity password and user ID. An online training resource is available describing how to pull panel reports using the application at **Availity.com**. Select Payer Spaces > Custom Learning Center > Resources > Provider Online Reporting Overview.

Providers will not have closed panels, unless otherwise requested, and Healthy Blue will encourage provider collaboration should the need arise to limit their member panel. Healthy Blue requires providers to submit written notice at least 90 days prior to the effective date of closing the panel.

2.8 Specialty Care Providers

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

Members and providers can access a searchable online directory through our website at **provider.healthybluenc.com**.

2.9 Role and Responsibilities of Specialty Care Providers

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

Note that PCP referral is not required, but it is encouraged to ensure coordination of care.

You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program.
- Accepting all members referred to you.
- Rendering covered services only to the extent and duration indicated on the referral.
- Submitting required claims information, including source of referral and referral number.
- Arranging for coverage with network providers while off duty or on vacation.
- Verifying member eligibility and precertification of services at each visit.

- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis.
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval.
- Coordinating care with other providers for:
  - Physical and behavioral health comorbidities
  - Co-occurring behavioral health disorders
- Adhering to the same responsibilities as the PCP.

2.10 Role and Responsibilities of LTSS Providers

The very nature of home- and community-based services (HCBS) is that LTSS/HCBS providers support members in their homes and in community settings, which makes them particularly suited to collaborate with care managers and other providers to support members in meeting their goals.

LTSS/HCBS providers will provide services and supports to members who are approved in the person-centered service plan or otherwise authorized by Blue Cross NC. Obligations of the LTSS/HCBS providers include the following:

- Complying with all applicable statutory and regulatory requirements of the state's Medicaid program, including CMS' HCBS Final Settings Rule and program-specific requirements from the NCDHHS
- Meeting eligibility requirements to participate in the Medicaid program, as well as specific requirements applicable to particular services
- Submitting required claims information
- Complying with the state's Electronic Visit Verification (EVV) requirements
- Complying with program-specific documentation and service delivery requirements
- Where applicable, participating with the member's Interdisciplinary Team in developing and implementing the person-centered service plan
- Reviewing and acknowledging the contents of the person-centered service plan to ensure services are provided in accordance with the individual's expectations

2.11 Specialty Care Providers' Access and Availability

You must adhere to the following access standards:

Access standards — specialty care provider		
Visit type	**Description**	**Standard**
Urgent care services	Care provided for a nonemergent 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, nonresolving headache	Within 24 hours
Routine/check-up without symptoms*	Nonsymptomatic visits for health check	Within 30 calendar days

Access standards — specialty care provider		
Visit type	**Description**	**Standard**
After-hours access — emergent and urgent	Care requested after normal business office hours	Immediately available 24 hours a day, 365 days a year

Note: In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 90 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free number at all times.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual phone surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

You may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients
- Maintaining separate waiting rooms
- Maintaining appointment days
- Offering hours of operation that are less than the hours of operation offered to patients with other health insurance coverage, including but not limited to commercial health plans
- Offering office hours not equal to hours offered to other prepaid health plans participating in the Medicaid program
- Denying or not providing to a member any covered service or availability of a facility.
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients, or the public at large

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the *Americans with Disabilities Act*. Health care services provided through Blue Cross NC must be accessible to all members.

2.12 Telehealth

Telemedicine is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. For example, through a telehealth encounter, a patient at a telehealth clinic in a rural area may seek medical treatment from a provider or specialist without incurring the expense of traveling to distant locations.

The advantages of communicating via telehealth are the following:

- Providers can choose from the Healthy Blue network of specialists, no matter where the member lives.
- The member does not have to wait long periods of time to schedule an appointment with a specialist.
- Providers can electronically send the member's medical data to a specialist for review.
- Specialists can use the computers and other equipment to send a recommendation for care back to the providers and members from a distance.

Telehealth does not include services rendered by audio-only telephone, fax or email communication.

North Carolina Medicaid will reimburse for live video medical services and tele-psychiatry services. All of the following conditions must be met:

- The beneficiary must be present at the time of consultation
- The medical examination must be under the control of the consulting provider
- The distant site is the location from which the provider furnishes the telehealth services to the beneficiary.
- The consultation must take place by two-way real-time interactive audio and video telecommunications system

For contracting questions, call Healthy Blue Provider Services at **844-594-5072**.

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other provider training sessions.

Service standards

- **Access** — Blue Cross NC pays for telehealth care services delivered by care providers contracted with the health plan. The telehealth providers must confirm member eligibility every time members access virtual visits, similar to in-person visits.
- **Staffing credentials** — All professional staff are certified or licensed in their specialty or have a level of certification, licensure, education and/or experience in accordance with state and federal laws.
- **Staff orientation and ongoing training** — The telehealth providers must comply with all applicable state, federal and regulatory requirements relating to their obligations under contract with Blue Cross NC. Telehealth providers must participate in initial and ongoing training programs including policies and procedures.
- **Service response time** — The telehealth provider will comply with the response time requirements outlined in their contract.
- **Compliance and security** — The telehealth platform should be *HIPAA* compliant and meet state, federal and 508 compliance requirements. The telehealth providers will conduct all member virtual visits via interactive audio and/or video telecommunications systems using a secure technology platform and will maintain member records in a

secure medium, which meets state and federal law requirements for security and confidentiality of electronic patient information.

- **Certification** — Blue Cross NC strongly encourages providers to obtain one of the following: CIHQ, URAC or ATA accreditation.
- **Continuous quality improvement (CQI)** — The telehealth providers must have a documented CQI program for identifying through data opportunities for real, time measured improvement in areas of core competencies. There must be demonstrated ties between CQI findings and staff orientation, training, and policies and procedures.
- **Member complaints** — The telehealth providers are not delegated for complaint resolution but will log, by category and type, member complaints and should refer member complaints to Member Services.
- **Regulatory assessment results** — Blue Cross NC reserves the right to request access to any applicable regulatory audit results.
- **Utilization** — The telehealth provider will comply with the reporting requirements outlined in their contract.
- **Electronic billing/encounter coding** — The telehealth provider will submit virtual visit encounters or claims with proper coding as part of the existing encounter submission process.
- **Eligibility verification** — The telehealth provider will use existing eligibility validation methods to confirm virtual visit benefits.
- **Case communication** — The telehealth provider will support patient records management for virtual visits using existing electronic medical records (EMR) systems and standard forms. EMRs should contain required medical information including referrals and authorizations.
- **Joint operating committee** — The telehealth provider will participate in joint operations meetings (JOC) or similar committees with the health plan to review data reports, quality issues and address any administration issues at least quarterly.
- **Professional environment** — The telehealth provider will help ensure that, when conducting virtual visits with members, the rendering care provider is in a professional and private location. The telehealth provider (rendering care providers) will not conduct member virtual visits in vehicles or public areas.
- **Medical director** — The telehealth provider will employ or engage a licensed care provider as medical director. The medical director is responsible for clinical direction.

2.13 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. Blue Cross NC recognizes the uniqueness of the EBCI community and will give specific attention to health care and related services available through tribal organizations. Blue Cross NC will refer tribal members to Indian Health Care Providers (IHCPs) and will continually work with the NCDHHS to identify other providers offering culturally competent care. To help ensure cultural sensitivity, Blue Cross NC has established an ongoing partnership with the EBCI and other tribal populations that supports members who are tribal members. Blue Cross NC will also offer training for culturally competent care to its provider network. For information on provider cultural competency

training, please see the Healthy Blue provider website, or contact your Provider Relations representative.

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 provide PCP services at all times.

Blue Cross NC 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
The plan 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 Blue Cross NC cannot provide timely access to necessary services in state and/or in network for Tribal members, the plan will provide access to out-of-state and/or out-of-network IHCPs.

Fees
Blue Cross NC 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.

2.14 Member Enrollment

Nondiscrimination and accessibility requirements update
On May 13, 2016, the NCDHHS Office of Civil Rights (OCR) released the *Nondiscrimination in Health Programs and Activities Final Rule* (*Final Rule*) to improve health equity under the *Affordable Care Act* (*ACA*). Section 1557 of the *ACA* prohibits discrimination on the basis of race, color, national origin, gender, sexual orientation, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government and b) are administered by any entity established under Title I of the *ACA*.

How does the *Final Rule* apply to prepaid health plans?
Blue Cross NC complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities.

Blue Cross NC provides free tools and services to people with disabilities to communicate effectively with us. Language services at no cost to people whose primary language is not English (for example, qualified interpreters and information written in other languages) are also provided.

Whom can I talk to if Blue Cross NC isn't following these guidelines?
If you or your patient believe that Blue Cross NC has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our compliance coordinator via:

- Mail: Blue Cross NC | Healthy Blue1965
  Ivy Creek Blvd
  Durham, NC 27707

- Phone: **844-594-5070**

If you or your patient need help filing a grievance, the compliance coordinator is available to help. You or your patient can also file a civil rights complaint with the OCR:

- Online at the OCR complaint website: **ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **By mail to:** U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201
- By phone at: 877-696-6775 (TTY/TTD: 711)

Complaint forms are available at **hhs.gov/ocr/complaints/index.html**. For additional details about Section 1557 and the *Final Rule*, visit:

- The OCR information page: **hhs.gov/civil-rights/for-individuals/section-1557/index.html**
- Frequently asked questions published by the DHHS: **hhs.gov/answers/index.html**

We notify your Healthy Blue patients these services can be obtained by calling the Member Services phone number on their member ID card.

Member eligibility
Medicaid recipients who meet the state's eligibility requirements for participation in managed care are eligible to join Blue Cross NC. Members are enrolled without regard to their health status. Our members:

- Are enrolled for a period of up to 12 months, contingent upon enrollment date and continued Medicaid eligibility.
- Can choose their PCPs and will be auto-assigned to a PCP if they do not select one.
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment.

Medicaid eligible newborns and their mothers, to the extent that the mother is eligible for Medicaid, should be enrolled in the same Medicaid plan with the exception of newborns placed for adoption or newborns who are born out of state and are not North Carolina residents at the time of birth.

- Coverage is provided for all newborn care rendered within the first month of life, regardless if provided by the designated PCP or another network provider. Providers will be compensated a minimum of 90% of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within 30 days of the member's birth, regardless of whether the provider rendering the services is contracted with Blue Cross NC, but subject to the same requirements as a contracted provider.

- Blue Cross NC covers all newborn care rendered by contracted network providers within the first 30 days of birth, regardless if provided by the designated PCP or another network provider.
- Newborn members must be enrolled in Medicaid with a state-assigned ID prior to submitting claims.
- Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Fax *Newborn Notification of Delivery Form* to **800-964-3627**.
- The clinical information required is outlined as follows:
  - Date of birth
  - Indicate whether it was a live birth
  - Newborn's birth weight
  - Gestational age at birth
  - Apgar scores
  - Disposition at birth
  - Gender
  - Type of delivery: vaginal or Cesarean; if a Cesarean, the reason the Cesarean was required
  - Single/multi birth
  - Gravida/para/ab for mother
  - Estimated date of confinement (EDC) and if neonatal intensive care unit admission was required

Providers may use the standard reporting form specific to their hospital as long as the required information outlined above is included.

Provider Restrictions

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

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

2.15 PCP Auto Assignment Process for Members

During enrollment, a member can choose his or her PCP. When a member does not choose a PCP at the time of enrollment or during auto-assignment, we will auto-assign a PCP within two business days from the date we process the daily eligibility file from the state.

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

1. **Beneficiary history with a PCP**. The algorithm will first attempt to match a beneficiary to their previous PCP. If there is no previous PCP assignment, claims history provided by the state will be used to match a beneficiary to a PCP with whom the beneficiary had a previous relationship where possible.
2. **Family history with a PCP**. If the beneficiary has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the beneficiary's family, such as a sibling, is or has been assigned to.
3. **Geographic proximity of PCP to beneficiary residence**. The auto-assignment logic will ensure beneficiaries' travel time and mileage do not exceed Blue Cross NC access standards.
4. **Appropriate PCP type**. The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

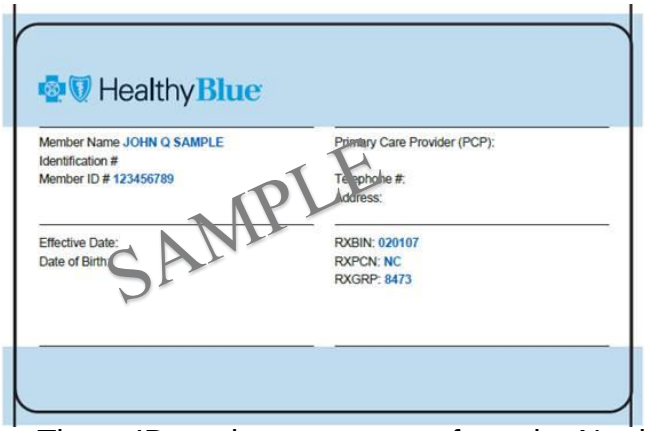
Pregnant members should select a PCP for the child prior to the birth. If we receive notification of birth prior to discharge, we will auto-assign a PCP before discharge from the hospital or birthing center.

Members receive a Healthy Blue ID card that displays their PCP's name and phone number, in addition to other important plan contact information.

Members may elect to change their PCP at any time with cause by calling Healthy Blue Member Services. The requested changes will become effective the first day of the following month, and a new ID card will be issued.

2.16 Member ID Cards

Healthy Blue member ID cards look similar to the following sample.



These ID cards are separate from the North Carolina Department of Health and Human Services (NCDHHS) ID card issued to the member by the state.

2.17 Member Missed Appointments

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not shown up for or canceled an appointment without rescheduling. Contact the member by phone to:

- Educate them about the importance of keeping appointments.
- Encourage them to reschedule the appointment.

For members who frequently cancel or fail to show up for appointments, call Healthy Blue Provider Services at **844-594-5072** to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and adhere to a plan of care recommended by their PCPs.

2.18 Members Exhibiting Potential Noncompliance

Reasonable efforts should always be made to establish a satisfactory Provider and Member relationship in accordance with practice standards. You (the provider) should provide adequate documentation in the Member's medical record to support his/her efforts to develop and maintain a satisfactory Provider and Member relationship. If a satisfactory relationship cannot be established or maintained, you should continue to provide medical care for the Member until such time notification is received from Healthy Blue stating that the Member has been transferred from the Provider's practice, and such transfer has occurred.
Contact Healthy Blue Provider Services if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment
- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

2.19 Members With Special Health Care Needs

Adults and children with special health care needs include those members with mental health disorders, physical disabilities, complex chronic medical conditions, long-term services and support needs, or other circumstances that place their health and ability to fully function at risk, requiring individualized health care requirements.

We have developed systems for:

- Well-child care
- Health promotion and disease prevention
- Specialty care for those who require such care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Long-term services and support needs

- Care management systems for ensuring children or adults with serious, chronic and rare disorders receive appropriate assessment, management and diagnostic workups on a timely basis
- Coordinated care for individuals diagnosed with autism spectrum disorder (ASD), at risk of an ASD diagnosis or in need of applied behavioral analysis services

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member. The plan may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities or acute or chronic conditions, as determined by the plan) to select their attending specialists as their PCP as long as the specialist is willing to perform responsibilities of a PCP.

With the assistance of network providers, we will identify members who are at risk of or have special needs. Screening procedures for new members will include a review of hospital and pharmacy utilization. We will develop care plans with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers, if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member upon enrollment or a member upon diagnosis requires very complex, highly specialized health care services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Training sessions and materials and after-hours protocols for a provider's staff will address members with special needs. Protocols must recognize that a nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.

Care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

2.20 Covering Physicians

During your absence or unavailability, you need to arrange for coverage for your patients assigned to your panel. You will be responsible for making arrangements with:

- One or more network providers to provide care for your patients

- Another similarly licensed and qualified participating provider who has appropriate medical staff privileges at the same network hospital or medical group to provide care to the members in question
- Payments under locum tenens arrangements:
  - Blue Cross NC will recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are Medicaid enrolled providers in accordance with 45 C.F.R. § 455.410(b).
  - Blue Cross NC will establish and maintain a Locum Tenens Policy to comply with the requirements of N.C. Gen. Stat. § 58-3-231(b) and (c) and will submit the policy to DHHS for review 90 days after the contract.

In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing and participation.

You will be solely responsible for:

- A non-network provider's adherence to our network provider agreement
- Any fees or money due and owed to any non-network provider providing substitute coverage to a member on your behalf

2.21 Provider Support

Blue Cross NC supports Healthy Blue providers with meaningful online tools, telephone access to Provider Services, and local Healthy Blue Provider Relationship Account Management and Provider Collaboration representatives.

- Healthy Blue Provider Services supports provider inquiries about a variety of topics including but not limited to member eligibility and benefits, authorizations, and claims issues.
- Local Healthy Blue Provider Relationship Account Management representatives are here to support all participating providers by facilitating provider orientations and educational programs. Provider Relationship Account Management representatives will make provider office visits to share information at a minimum, annually.
- The Healthy Blue Provider Collaboration team partners with AMHs and LHDs to provide VBP strategy support and delegated care management oversight. Provider Collaboration processes are designed to help delegated entities achieve/maintain service levels consistent with our policies, procedures, and applicable regulatory and legal requirements, as well as identify opportunities to enhance clinical quality and utilizations efficiency.

We also communicate with providers and office staff through newsletters, alerts and updates posted to our provider website (**provider.healthybluenc.com**) or via email, fax or mail.

Healthy Blue also posts a weekly Known Issues Bulletin on our provider website to share information related to known issues impacting providers, such as with claims configuration or system defects. All bulletins will be stored on our provider website within the Provider news archives (**provider.healthybluenc.com/north-carolina-provider/archives**).

Training
Blue Cross NC conducts initial training for newly contracted Healthy Blue providers and provider groups within 30 days of joining the network. Additional training will be conducted as determined necessary or as requested by NCDHHS. We provide training through multiple modalities including:

- In person
- Online or through webinars
- Mail, email or fax
- Posting important news and resources to the provider website
- Resources on the provider website

Training events will be announced in advance. Announcements are mailed and posted to the provider website and are offered to all providers and their office staff. Training is offered in large group settings, via webinars or in person as appropriate. We maintain records of providers and staff who attend trainings and assess participant satisfaction.

Provider Surveys
We will conduct an annual survey to assess provider satisfaction with provider enrollment, communications, education, complaints resolution, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward Patient-Centered Medical Home implementation.

To collect your feedback on how well Blue Cross NC meets your needs, we conduct an annual *Provider Satisfaction Survey*. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined, and the participants are kept anonymous, unless you grant the survey vendor permission to disclose your name and comments for follow-up purposes. Blue Cross NC will analyze the findings and assess appropriate course of action to sustain strengths and improve on opportunities. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives.

You will receive this survey via mail or email. If you are selected to participate, we appreciate you taking the time to complete the survey and provide input to improve our service to you. A report summarizing the survey methods, findings and analysis of opportunities for improvement will be provided to the NCDHHS for review within 120 days after the end of the plan year.

Emergency Management
In the event of a disaster or emergency, Blue Cross NC will follow DHHS guidance and issue guidance to providers through various communication methods to ensure providers are aware of process changes. Blue Cross NC completes disaster and emergency relief planning and is prepared to respond in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease.

In the event of a disaster or emergency Blue Cross NC will be in contact with providers for process changes.

2.22 Care Management Oversight

As a primary function of our field-based Provider Collaboration team, Healthy Blue provides oversight of care management services delegated to contracted tier 3 AMHs and Local Health Departments, including primary care management, care management of at-risk children (CMARC), care management of high-risk pregnancies (CMHRP), and services provided through the State's Healthy Opportunities Pilot and Integrated Care for Kids program. The objective of this oversight is to ensure compliance, quality, and effectiveness of delegated care management services rendered to Heathy Blue members by our AMH providers with focus on improved health outcomes of targeted populations.

Following the execution of a CIN/AMH3 Agreement, which includes a Delegated Services Addendum, and the successful completion of a pre-delegation audit, there are activities that will take place prior to the membership attribution and payment for delegated care management aligned with contract requirements. The Provider Collaboration team will begin monitoring key care management activities to ensure compliance with requirements and expectations defined in said Agreement. These activities include:

- Secure and timely transmission of care management-related files
- Risk stratification of empaneled patients
- Provision of care management for high need/high risk patients
- Development of care plans
- Transitional care and medication reconciliation for members following ER visit, discharge from hospital admission, and those at risk for readmission or poor outcomes
- Remediation of any deficiency within a Corrective Action Plan (CAP), if applicable

For more information on care management oversight activities and expectations, delegated entities should refer to the ***Oversight Process Guide for Advanced Medical Homes and Local Health Departments Providing Primary Care Management, Care Management of At-Risk Children, and Care Management for High-Risk Pregnancies*** or reach out to your designated Provider Clinical Liaison.

2.23 Reporting Changes in Address and/or Practice Status

To maintain the quality of provider data, Blue Cross NC asks that changes to practice contact information or the information about participating providers within a practice is submitted via NCTracks as soon as the change is known.

Please report status or address changes through NCTracks: **nctracks.nc.gov**

2.24 Second Opinions

The member, the member's parent or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion should be provided at no cost to the member.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion if the provider is not a network provider. Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When we request a second opinion, we will make the necessary arrangements for the appointment, payment, and reporting. We will inform you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

2.25 Medically Necessary Services

Medically necessary services are those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:

- Deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life; cause suffering or pain; or have resulted or will result in a handicap, physical deformity or malfunction.
- No more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, not approved by the U.S. Food and Drug Administration, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his or her discretion on a case-by-case basis.

We only cover items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part.

Healthy Blue Utilization Management program policies and *Clinical Utilization Management Guidelines* are available **provider.healthybluenc.com**.

2.26 Provider Bill of Rights

Each network provider who contracts with Blue Cross NC to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options whether the benefits for such care or treatment are provided under the contract.
  - The risks, benefits and consequences of treatment or nontreatment.
  - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about future treatment decisions.
- Receive information on the grievance, appeal and state fair hearing procedures.
- Have access to Healthy Blue policies and procedures covering the precertification of services.
- Be notified of any decision by Blue Cross NC to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested.
- Challenge on the member's behalf, at the request of the Medicaid member, the denial of coverage or payment for medical assistance.
- Be free from discrimination where Healthy Blue selection policies and procedures govern particular providers who serve high-risk populations or specialize in conditions that require costly treatment.
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Blue Cross NC complies with the provisions of *42 CFR §438.102(a)(1)(ii)* concerning the integrity of professional advice to members, including interference with a provider's advice to members and information disclosure requirements related to physician incentive plans.

2.27 Prohibited Marketing Activities

Blue Cross NC and our subcontractors, including health care providers, are prohibited from engaging in the following, which are considered to be member marketing activities:

- Claiming that a member must enroll in Healthy Blue to obtain benefits or to not lose benefits

- Claiming that Blue Cross NC is endorsed by CMS, the federal or state government, or a similar entity
- Using the NCDHHS or State of North Carolina logo in marketing materials
- Using the name of NCDHHS in conjunction with any marketing material and/or activities without prior written approval by NCDHHS
- Referencing competing PHPs or other contractors of the NCDHHS list or referencing providers who are not part of the Healthy Blue network, or including negative information about NCDHHS or other PHPs in any marketing materials
- Directly or indirectly engaging in door-to-door, telephone, email, text or other cold-call marketing activities including direct mailings and solicitation
- Falsely describing covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers
- Marketing materials or activities that are discriminatory or that target potential members based on health status, geographic residence, location of the provision of possible services or income
- Offering gifts, coupons for products of material value or incentives to enroll, except as provided in the contract
- Distributing marketing materials or engaging in marketing activities in service areas prohibited by the NCDHHS
- Engaging in activities that seek to target members currently enrolled in other PHPs
- Offering choice counseling or seeking to enroll potential members in Healthy Blue; this is the sole responsibility of NCDHHS and the enrollment broker
- Distributing, displaying or otherwise conducting marketing activities in health care settings, except in common areas; common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms
- Conducting marketing activities in areas where patients primarily intend to receive health care services; these prohibited areas include but are not limited to emergency rooms, patient hospital rooms, exam rooms and pharmacy counter areas

2.28 Benefits

Service	Description
Inpatient hospital services	Services that are: • Ordinarily furnished in a hospital for the care and treatment of inpatients • Furnished under the direction of a physician or dentist • Furnished in an institution that: • Is maintained primarily for the care and treatment of patients with disorders other than mental diseases • Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting • Meets the requirements for participation in Medicare as a hospital • 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:

Service	Description
	Swing bed hospitals: a hospital or critical access hospital (CAH) participating in Medicare that has Centers for Medicare & Medicaid Services (CMS) approval to provide posthospital 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).* 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 three hours of therapy (physical therapy, occupational therapy, speech-language pathology or prosthetics/orthotics therapy) per day at least five 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 consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in *42 C.F.R. § 485.58*. Specialty hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who either: • Have cardiac or orthopedic conditions • Are receiving a surgical procedure • Need any other specialized category of services designated by CMS Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for long-term care hospitals and have an average Medicare length of stay described in *42 C.F.R. § 412.23(e)(2).* Refer to *Clinical Coverage Policy 2A-2, Long Term Care Hospital Services*. Inpatient hospital services do not include skilled nursing facility and intermediate care facility services furnished by a hospital with a swing-bed approval. Inpatient hospital services that include services furnished under the direction of a dentist are carved out of Medicaid managed care and should be billed to the Medicaid fee-for-service program.
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative or palliative services that: • Are furnished to outpatients • Are furnished by or under the direction of a physician or dentist • Are furnished by an institution that:

Service	Description
	• Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting • Meets the requirements for participation in Medicare as a hospital Preventive, diagnostic, therapeutic, rehabilitative, or palliative services may be limited by a Medicaid agency in the following manner: • A Medicaid agency may exclude from the definition of *outpatient hospital services* those types of items and services that are not generally furnished by most hospitals in the state. Outpatient hospital services that include preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished by or under the direction of a dentist are carved out of Medicaid managed care and should be billed to the Medicaid fee-for-service program.
Early and Periodic Screening, Diagnostic and Treatment services (EPSDT)	Any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina state Medicaid plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at *42 U.S.C. § 1396d(a) 1905(a)* of the *Social Security Act.*
Nursing facility services	A nursing facility is a medical health facility or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid 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 that 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 ensure 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*.

Service	Description
Physician services	Physician services are services furnished by a physician in the office, the beneficiary's home, a hospital, a skilled nursing facility or elsewhere: Within the scope of practice of medicine or osteopathy as defined by State law. 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: • Scientifically validated clinical studies. • Medical literature research. • Qualified medical experts. Injections are excluded when oral drugs may be used in lieu of injections. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.
Rural health clinic services	Congress passed *Public Law 95-210*, the *Rural Health Clinic (RHC) Services Act*, in December 1977. The act authorized Medicare and Medicaid payments to certified rural health clinics for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, nurse practitioner or certified nurse midwife. The *RHC Services Act* established a core set of health care services. The specific health care encounters that constitute a core service include the following face-to-face encounters: • 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 • Services provided by physician assistants and incident services supplied • Nurse practitioners and incident services supplied • Nurse midwives and incident services supplied • Clinical psychologists and incident services supplied • Clinical social workers and incident services supplied
Federally Qualified Health Center (FQHC) 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 FQHC services to the Medicaid program.

Service	Description
	Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. The specific health care encounters that constitute a core service include the following face-to-face encounters: • 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 • Services provided by physician assistants and incident services supplied • Nurse practitioners and incident services supplied • Nurse midwives and incident services supplied • Clinical psychologists and incident services supplied • Clinical social workers and incident services supplied
Telemedicine	The use of two-way, real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.
Laboratory and X-ray services	All diagnostic X-ray tests, diagnostic laboratory tests and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.
Family planning 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.

Certified pediatric and family nurse	Requirements for certified pediatric nurse practitioner: The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (a)(1) or (a)(2) of this section.
	• (1) If the State specifies qualifications for pediatric nurse practitioners, the practitioner must:
	  ○ Be currently licensed to practice in the State as a registered professional nurse.
	  ○ Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services.
	• (2) 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:
	  ○ Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State.
	  ○ Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.

Service	Description
	Requirements for certified family nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (b)(1) or (b)(2) of this section. • (1) 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. • (2) 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)	Freestanding 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.
Nonemergent transportation to medical care	Medicaid is required to ensure 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 and enrolled Medicaid provider. Medicaid only pays for the least expensive means suitable to the recipient’s needs.
Ambulance services	Ambulance services provide medically necessary treatment for North Carolina Medicaid 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 nonemergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary..
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.
Clinic services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; the term includes the following services furnished to outpatients: • Services furnished at the clinic by or under the direction of a physician or dentist

Service	Description
	• Services furnished outside the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist. These 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 sensory motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a physical therapist as defined in *42 C.F.R. § 440.110* and be licensed pursuant to North Carolina State law or a licensed physical therapy assistant under the supervision of a licensed physical therapist.
Occupational therapy	Services to address the functional needs of a child related to adaptive development; adaptive behavior and play; and sensory, motor and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices. These services must be provided by an occupational therapist as defined in *42 C.F.R. § 440.110* and be licensed pursuant to North Carolina State law or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist.
Speech, hearing and language disorder services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a speech pathologist as defined *in 42 C.F.R. § 440.110* and be licensed pursuant to North Carolina State law, or a speech/language pathology assistant who works under the supervision of an enrolled licensed speech pathologist. A speech/language pathology assistant (SLPA) must hold an Associate's degree in speech/language pathology or a bachelor's degree from an accredited institution with specialized coursework in speech/language pathology. An SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.

Service	Description
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policy	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. Refer to NC clinical coverage policies and services listed.
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the *Social Security Act* when provided by the respiratory therapist licensed under the provisions of the *North Carolina Respiratory Care Practice Act*.
Other diagnostic, screening, preventive and rehabilitative services	• Any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force; with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and (C) any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level • 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; • Any medical or remedial services (provided in a facility, a home or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
Podiatry services	Podiatry, as defined by *G.S. § 90-202.2*, “is the surgical, medical or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant 2 years of age or less.”
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.

Service	Description
	Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in *42 C.F.R. § 410.21*.
Private duty nursing services	Medically necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with *42 C.F.R. § 440.80* and prior approval by the Division of Medical Assistance or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse, and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for personal care services, skilled nursing visits, or home health aide services provided during the same hours of the day as PDN services. Medicaid payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services 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.
Personal care services (PCS)	PCS offer a range of services in the home for members who are unable to perform activities of daily living due to their disability or chronic condition. 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, include: 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 are provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility or combination home, and who meets the state's qualifications.

Service	Description
	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 by the state and as specified in the beneficiary's approved plan of care.
Hospice services	The North Carolina Medicaid hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG delivers medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers and families necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are *General Statute 131E-200* through *207* and the licensure rules are under *Title 10A* of the *North Carolina Administrative Code* (*10A NCAC 13K*); (*G.S. 131E, Article 9, 175190*) 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 (DME)	Durable medical equipment refers to the following categories of equipment and related supplies for use in a beneficiary's home: • Inexpensive or routinely purchased items • Capped rental/purchased equipment • Equipment requiring frequent and substantial servicing • Oxygen and oxygen equipment • Related medical supplies • Service and repair • Other individually priced items • Enteral nutrition equipment
Prosthetics, orthotics, and supplies	Medically necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be medically necessary, effective, and efficient are covered.

Service	Description
	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 beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: • Total parenteral nutrition (TPN) • Enteral nutrition (EN) • Intravenous chemotherapy • Intravenous antibiotic therapy • Pain management therapy, including subcutaneous, epidural, intrathecal and intravenous pain management therapy
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting 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.
Inpatient psychiatric services for individuals under age 21	Provides hospital treatment in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.
Transplants and related services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.
Ventricular assist device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.
Allergies	Provides testing for allergies. The term *allergy* indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called *allergens*. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (in other words, desensitization, hyposensitization, allergy injection therapy or allergy shots) is an effective treatment for allergic rhinitis, allergic asthma and Hymenoptera sensitivity.

Service	Description
Anesthesia	Refers to practice of medicine dealing with, but not limited to: • The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures • The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations • The clinical management of the patient unconscious from whatever cause • The evaluation and management of acute or chronic pain • The management of problems in cardiac and respiratory resuscitation • The application of specific methods of respiratory therapy • The clinical management of various fluid, electrolyte and metabolic disturbances
Auditory implant external parts	Replacement and repair of external components of a cochlear or auditory brainstem or bone anchored hearing aid implant device that are necessary to maintain the device's ability to analyze and code sound, therefore, providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.
Behavioral health services	Covered services include: • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • Peer Support Service (upon approval of State Plan Amendment 19-006 by CMS) • Partial hospitalization • Mobile crisis management • Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program • Outpatient opioid treatment • Ambulatory detoxification • Research-based behavioral health treatment. • Diagnostic assessment • EPSDT • Non-hospital medical detoxification • Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization (ADATC) •
Burn treatment and skin substitutes	Provides treatment for burns
Cardiac procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives

Service	Description
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.
Hearing aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, repairs, and dispensing fees when there is medical necessity
Maternal support services	Provides childbirth, health and behavioral interventions, and home nursing benefits for mothers and newborns
Obstetrics and Gynecology	Provides for obstetrical and gynecological care
Pharmacy services	Provides a comprehensive prescription drug benefit
Reconstructive surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.
Vision services (includes optometry and ophthalmological services)	Optical vision services include: Medicaid will cover the following optical services when provided by ophthalmologists and optometrists: • Routine eye exams, including the determination of refractive errors • Prescribing corrective lenses (one pair of eyeglasses per year for children ages 0 through 20, one pair of eyeglasses every two years for adults 21 and older and medically necessary contact lenses). • Dispensing approved visual aids Opticians are qualified providers for visuals aids (eyeglasses and contact lenses). Providers who supply eye exams and eyeglasses in their office must also supply Medicaid eye exams and fee-for-service eyeglasses to members. Providers obtain Medicaid fee-for-service eyeglasses through the traditional NCDHHS process and bill Blue Cross NC for the dispensing fees, after the NCDHHS fee-for-service eyeglasses are dispensed to the member. General ophthalmologic services include: • Intermediate ophthalmological services: an evaluation of 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 that is stable.

Service	Description
	• 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 that go beyond the services included under general ophthalmological services or in which special treatment is given.

Additional covered services

- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Ventricular assist device
- Burn treatment and skin substitutes
- Dietary evaluation and counseling and medical lactation services
- Maternal support services
- Targeted care management services

Note: We do not cover experimental procedures or medications.
UM criteria are available upon request. Contact the UM Team by phone at **844-594-5082**.

Changes to covered benefits

Blue Cross NC will cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid state plans, except to the extent the service is carved out of Medicaid managed care or may only be covered by a BH I/DD tailored plan in accordance with North Carolina law.

Covered services for individuals with LTSS

Blue Cross NC covers LTSS under the Healthy Blue program. Our fundamental approach to LTSS is founded on person-centered principles and practices to facilitate member and family driven services and supports that are responsive and meaningful to evolving preferences, support needs and personal goals. We are dedicated to assisting all members in exploring service and support options to maximize community integration in alignment with their personal goals and the Olmstead Decision. Through this commitment, not only do we support members to succeed in communities of their choice, we also partner with providers, stakeholders and associations.

A wide range of services are provided over an extended period, predominantly in the homes and communities. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation.

Blue Cross NC provides the following covered services as part of the overall benefits packages for enrolled Healthy Blue members. Any modification to covered services will be communicated through a provider newsletter, provider manual update and/or contractual amendment. The scope of benefits includes the following:

- Nursing facility services (up to 90 days)

- Home health services
- Personal care services
- Hospice
- Home infusion therapy
- Private duty nursing
- Durable medical equipment

2.29 Pharmacy Services

Our pharmacy benefit provides coverage for medically necessary medications from licensed prescribers for the purpose of saving lives in emergency situations or during short-term illness, sustaining life in chronic or long-term illness, or limiting the need for hospitalization. Members have access to most national pharmacy chains and many independent retail pharmacies.

Monthly limits:

- Most prescriptions are limited to a maximum 34-day supply per fill.
- Members may obtain a 90-day supply of other medications if the claim is for a noncontrolled, maintenance medication. Members may obtain up to a 12-month supply of oral contraceptives.
- Mail order is available as an option for our members with the same day supply limitations.

Covered drugs

The Healthy Blue Pharmacy program uses the NCDHHS *Preferred Drug List* (*PDL*). This is a list of the preferred drugs within the most commonly prescribed therapeutic categories. The *PDL* comprises drug products reviewed and approved by the North Carolina Preferred Drug List Review Panel, a committee overseen by NCDHHS. The *PDL* also includes several over-the-counter (OTC) products that are recommended as first-line treatment where medically appropriate.

Refer to the Healthy Blue *PDL* on our website at **provider.healthybluenc.com**.

Prior authorization drugs

You are strongly encouraged to write prescriptions for preferred products as listed on the *PDL*. If a member cannot use a preferred product as a result of a medical condition, you may be required to contact our Healthy Blue Provider Services Department through phone, fax or electronic portal to obtain prior authorization. You must be prepared to provide relevant clinical information regarding the member's need for a nonpreferred product or a medication requiring prior authorization. Decisions are based on medical necessity and are determined according to certain established medical criteria.

OTC drugs

The Healthy Blue *PDL* includes coverage of several OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes:

- Smoking deterrent agents (nicotine)
- Proton pump inhibitors

- Second generation antihistamines
- Second generation antihistamine-decongestant combination products (quantity limits apply)
- Insulins
- Syringes
- Test strips
- Control solution
- Lancets
- Lancing device
- Pen needles
- Contraceptives (oral)

Excluded drugs

The following drugs are examples of medications that are excluded from the pharmacy benefit:

- Weight control products
- Anti-wrinkle agents (for example, Renova)
- Drugs used for cosmetic reasons or hair growth
- Experimental or investigational drugs
- Drugs used for experimental or investigational indication
- Infertility medications
- Erectile dysfunction drugs to treat impotence
- Drug Efficacy Study Implementation (DESI) drugs
- OTCs (except insulin and selected OTC products per *Clinical Coverage Policy 9A*, *Over-The-Counter Products* at **medicaid.ncdhhs.gov**)
- Devices
- Diaphragms
- DME
- Drugs from manufacturers who have not signed *Drug Rebate Agreements*
- Inpatient hospital prescriptions
- Prescriptions dispensed by providers who are not enrolled with Medicaid
- Drug samples
- Drugs obtained from any patient assistance program
- Drugs used for the symptomatic relief of cough and colds that contain expectorants or cough suppressants
- Legend vitamins and mineral products (except prenatal vitamins, fluoride and calcitriol [vitamin D] when the calcitriol is being used for predialysis beneficiaries, dialysis beneficiaries and hypoparathyroidism beneficiaries)

Specialty drug program

We cover most specialty drugs under the pharmacy benefit. These drugs can be obtained through any pharmacy in our network that dispenses these medications.

We also cover many, but not all, primarily injectable drugs that are purchased and administered by a medical professional in a physician's office or in an outpatient clinic setting under the medical benefit through the NC Physician-Administered Drug Program (PADP).

2.30 Services Covered Under the North Carolina State Plan or Fee-for-Service Medicaid

Some services are covered by the North Carolina State Plan or fee-for-service Medicaid instead of Blue Cross NC. These services are called carved-out services. Even though we do not cover these services, we expect you to:

- Provide all required referrals
- Assist in setting up these services

These services will be paid for by NCDHHS on a fee-for-service basis. Carved-out benefits include the following:

- 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
- Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses and ophthalmic frames
- 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 through the Program for All Inclusive Care for the Elderly (PACE)
- Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan

For details on how and where to access these services, please call NCDHHS at **919-855-4800**.

2.31 Well-Child Visits Reminder Program

EPSDT is Medicaid's federally mandated comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the *Omnibus Budget Reconciliation Act of 1989* and requires states to cover all services within the scope of the federal Medicaid program. The intent of the EPSDT program is to focus attention on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.

Services include:

- Screening
- Diagnosis and treatment
- Transportation and scheduling assistance

Screening must include:

- Comprehensive health and developmental assessment and history, both physical and mental health development
- Immunizations appropriate to age and health history
- Comprehensive, unclothed physical exam
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Health education including anticipatory guidance
- Vision services
- Dental services
- Hearing services
- Use of scientifically validated brief screens to assess health risks, developmental risks, and progress, emotional/behavioral issues and smoking and/or drug and alcohol problems
- Other necessary health care, such as diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services

Schedules used to determine when services are due:

- American Academy of Pediatrics (AAP) Periodicity schedule: **aap.org/en-us/Documents/periodicity_schedule.pdf**

Based on our claims data, we send PCPs a list of members who have not received well-child services according to our schedule. We also mail information to these members, encouraging them to contact their PCP to set up appointments for needed services.

Notes:

- We list the specific service each member needs in the report.
- You must render the services on or after the due date in accordance with federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and NCDHHS guidelines.
- Healthy Blue reviews all EPSDT requests for services covered in 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 utilizing Medical Necessity Criteria. Specific details for providers regarding the prior authorization process can be accessed at **provider.healthybluenc.com/north-carolina-provider/prior-authorization**
- We base our list on claims data we receive before the date on the list. Check to see whether you have provided the services after the report run date. Submit a completed claim form for those dates of services to the Claims Department at:

  Blue Cross NC | Healthy Blue
  Claims Department
  P.O. Box 61010
  Virginia Beach, VA 23466

2.32 Immunizations

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 **immunize.nc.gov/providers/enrollmentrequirements.htm** for more information or contact the NC Immunization Branch at **877-813-6247** to begin the VFC enrollment process.

Assigned primary care providers with the Blue Cross NC network are expected to provide comprehensive EPSDT services to member, including administration of vaccines in accordance with current ACIP guidelines.

You must report all immunizations administered to the North Carolina Immunization Registry (NCIR), **immunize.nc.gov/providers/ncir.htm.** To request access, contact the NC Immunization Branch at **877-873-6247**. If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available free of charge from NCDPH Immunization Branch for NC Registry.

Our members can self-refer to any qualified provider in or out of our network.

We reimburse local health departments for the administration of vaccines regardless of whether they are under contract with us.

Blue Cross NC provides all members with all vaccines and immunizations in accordance with ACIP guidelines.

ACIP guidelines can be found on the Center for Disease Control and Prevention website at **cdc.gov/vaccines/hcp/acip-recs**.

2.33 Blood Lead Screening

You must screen for the presence of lead toxicity during a well-child visit for children between 6 months and 6 years of age. Perform a blood test at 12 months and 24 months to determine lead exposure and toxicity. You should also give blood lead screening tests to children over the age of 24 months up to 72 months if you have no past record of a test.

You can find blood lead risk forms online at **provider.healthybluenc.com**.

***Clinical Laboratory Improvement Amendments* reporting**

We are bound by the *Clinical Laboratory Improvement Amendments (CLIA) of 1988*. The purpose of the *CLIA* program is to ensure laboratories testing specimens in interstate commerce consistently provide accurate procedures and services. As a result of *CLIA*, any laboratory soliciting or accepting specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the *CLIA* requirements.

The *CLIA* number must be included on each *CMS-1500* claim form for laboratory services by any laboratory performing tests covered by *CLIA* or the claim may be denied.

2.34 Member Rights and Responsibilities

Our members have rights and responsibilities. Our Member Services representatives serve as their advocates. Below are the rights and responsibilities of members.

Members have the right to:

- Receive information on their rights and responsibilities
- Make suggestions and recommendations to Blue Cross NC about its rights and responsibilities policy
- Receive information about the organization, its services, its practitioners, and providers and member rights and responsibilities.
- Be cared for with respect and due consideration for their dignity and right to privacy; without regard for health status, sex, race, color, religion, national origin, age, marital status, sexual orientation or gender identity
- Be told where, when and how to get the services they need from Blue Cross NC
- Be told by their PCP what health issues they may have, what can be done for them and what will likely be the result, in language they understand
- Receive a full, clear and understandable explanation of treatment options and alternatives, and the risks of each, so they can make an informed decision, regardless of cost or whether it is part of covered benefits
- Get a second opinion about their care
- Give their approval of any treatment
- Right to participate with practitioners in making decisions about their health care and give their approval of any plan for their care after that plan has been fully explained to them
- Refuse care and be told what they may risk if they do
- Give a copy of their medical record and talk about it with their PCP
- Ask, if needed, that their medical record be amended or corrected
- Be sure that their medical record is private and will not be shared with anyone except as required by law, contract or with approval
- Use the Blue Cross NC complaint process to voice complaints or appeals about the organization or the care it provides
- Request an appeal or a Fair Hearing if they believe the Health Plan was wrong in denying, reducing or stopping a service or item

- Appoint someone they trust (relative, friend or lawyer) to speak for them if they are unable to speak for themself about their care and treatment
- Receive considerate and respectful care in a clean and safe environment, free of unnecessary restraints
- Be free of any form of restraint or seclusion used as coercion, discipline, convenience or retaliation;
- Receive information on how to complete advance directives and choose not to have or continue any life-sustaining treatment
- Receive interpretation and translation services free of charge
- Refuse oral interpretation services
- Understand how to get benefits and how benefits are approved
- Receive timely health care services based on urgency and need regardless of gender, gender identity, race, ethnicity or physical or mental disability
- Know Blue Cross NC will not avoid costs for health services
- Be free to exercise their rights without fear of being treated unfairly by a provider or Blue Cross NC

Members have the responsibility to:

- Work with their PCP to protect and improve your health
- Find out how their health plan coverage works
- To supply information, to the extent possible, that the organization and its providers need in order to provide care
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- Listen to their PCP's advice, follow plans and instructions that were mutually agreed to with their practitioners and ask questions
- Call or go back to their PCP if they do not get better or ask for a second opinion
- Treat health care staff with respect
- Tell Healthy Blue if they have problems with any health care staff by calling Member Services at **844-594-5070** (TTY **711**)
- Keep appointments or timely notify providers if they must cancel.
- Use the emergency department only for real emergencies
- Call their PCP when they need medical care, even if it is after hours
- Receive considerate and respectful care in a clean and safe environment, free of unnecessary restraints

2.35 Member Grievance

Our members have the right to say they are dissatisfied with Blue Cross NC or a provider's operations. A member or member's representative (including a provider on behalf of a member) may file a grievance at any time verbally or in writing. If you as the provider files the grievance, you must obtain the member's authorization, signed by the member, to act as the member's representative.

We will acknowledge the member's grievance in writing within five calendar days of receipt of the grievance.

We will inform the member, investigate the grievance and resolve it within 30 calendar days from the date we received the grievance. If a grievance relates to the denial of an expedited appeal request, Blue Cross NC will resolve the grievance and provide notice to the member and, as applicable, the member's authorized representative within five calendar days from the date the grievance is received.

Blue Cross NC may extend the time frames for resolution of a grievance by up to 14 calendar days if the member requests the extension or if Blue Cross NC determines that there is a need for additional information and the delay is in the member's interest. If the time frame is extended other than at the member's request, Blue Cross NC will make reasonable efforts to give the member verbal notice of the delay and within two calendar days provide written notice informing the member of the right to file a grievance if he or she disagrees with that decision. Blue Cross NC will resolve the grievance as expeditiously as the member's health condition requires and no later than the date the extension expires.

A member can file a grievance verbally by calling Member Services at **844-594-5070**. He or she can also file a grievance in writing. Any supporting documents must be included. Grievances should be sent to:

Blue Cross NC | Healthy Blue
1965 Ivy Creek Blvd
Durham, NC 27707

- Fax: **844-429-9635**
- Email: ncmedicaidgrievances@nchealthyblue.com

Member grievances do not involve:

- Medical management decisions
- Interpretation of medically necessary benefits
- Adverse determinations

These are called appeals and are addressed in the next section.

We will notify the member in writing of:

- The names(s), title(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance
- Our decision
- The reason for the decision
- Policies and procedures regarding the decision
- Information about how members can submit a complaint with NCDHHS if the member is dissatisfied with the resolution of a grievance

2.36 Avoiding an Administrative Adverse Decision

Adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Being familiar with Healthy Blue's notification and precertification policies and acting to meet those policies can eliminate the majority of adverse decisions. Other administrative adverse decisions can result from misinformation about the member's Medicaid status or benefits.

2.37 Member Medical Necessity Appeals

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are:

- Standard resolution of appeal: 30 calendar days from the date of receipt of the appeal.
- Expedited resolution of appeal: 72 hours from receipt of the appeal; we make every reasonable effort to give the member or their representative oral notification and then follow it up with a written notification.

The member, or the member's representative, has the right to file an appeal within 60 calendar days of an adverse benefit determination. An appeal can be filed either orally or in writing, or the member may choose to present evidence in person. A provider may file an appeal on behalf of the member if the provider has the member's written consent to do so.

Blue Cross NC may extend the time frames for resolution of an appeal by up to 14 calendar days if the requestor asks for an extension or if we determine that there is a need for additional information and the delay is in the member's interest. If the time frame is extended by Blue Cross NC, we will make reasonable efforts to give the requestor verbal notice of the delay, and within two calendar days, provide written notice informing the member of their right to file a grievance if they disagree with that decision. Blue Cross NC will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

We will inform the requestor of the limited time they have to present evidence and allegations of fact or law to support the appeal. We will ensure no punitive action will be taken against a provider who supports an appeal.

We will send our members the results of the resolution in a written notice within 30 calendar days of receipt of the appeal. If an appeal is not wholly resolved in favor of the member, the notice will include:

- Our decision
- The reason for the decision
- Medical necessity criteria used to make the decision
- The name(s), title(s), and qualifying credentials of the person or persons completing the review of the appeal
- The right for our member to request a state fair hearing and how to do it
- The right to receive benefits while this hearing is pending and how to request it
- Notice that the member may have to pay the cost of these benefits if the state fair hearing officer upholds the Healthy Blue action

2.38 Expedited Appeal

Our expedited appeal process is available upon the member's request or when the provider indicates that a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.

An expedited appeal can be filed either orally or in writing, or the member may present evidence in person. A provider may file an appeal on behalf of the member if the provider has the member's written consent to do so.

Expedited appeals are resolved within 72 hours of receipt of the request. Blue Cross NC may extend the time frames for resolution of an appeal by up to 14 calendar days if the requestor asks for an extension or if we determine that there is a need for additional information and the delay is in the member's interest. If the time frame is extended by Blue Cross NC, we will make reasonable efforts to give the requestor verbal notice of the delay, and within two calendar days, provide written notice informing the member of their right to file a grievance if they disagree with that decision. Blue Cross NC will resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

If your request is deemed to be a non-expedited issue, our standard 30-day timeline for appeal resolution will apply.

2.39 Continuation of Benefits During Appeals or State Fair Hearings

Blue Cross NC is required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following occur:

- The member, or the member's authorized representative, files the request for an appeal timely.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The period covered by the original authorization has not expired.
- The member files for continuation of benefits within 10 calendar days of Blue Cross NC sending the notice of the adverse benefit determination (or before) or on the intended effective date of the proposed adverse benefit determination, whichever comes later. *42 C.F.R. § 438.420(b).*

If Blue Cross NC continues the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal or state fair hearing request in writing.
- The member does not request a state fair hearing and continuation of benefits within 10 calendar days from when Blue Cross NC mails an adverse decision regarding the member's PHP.
- A state fair hearing decision adverse to the member is made. *42 C.F.R. § 438.420(c).*

Blue Cross NC will not allow a provider to request continuation of benefits on behalf of a member. *42 C.F.R. § 438.402(c)(ii)*

Blue Cross NC will be permitted to recover the cost of services furnished to the member during the pendency of the plan appeal and the contested case hearing if:

- Blue Cross NC notified the member of the potential for recovery.
- Blue Cross NC furnished benefits to the member solely because of the requirement for continuation of benefits.

- The final resolution of the plan appeal or the contested case hearing is adverse to the member (in other words, upholds Blue Cross NC adverse benefit determination). *42 C.F.R. § 438.420(d)*

If Blue Cross NC chooses to seek to recover the cost of services provided to members during the pendency of the plan appeal or the fair hearing, Blue Cross NC may do the following:

- Develop a member hardship exemption process.
- Obtain prior approval from NCDHHS for each instance in which Blue Cross NC seeks to recover the costs of benefits provided to members under this section, which includes an explanation of the services provided to the member, the amount Blue Cross NC is seeking to recover and a detailed explanation for why Blue Cross NC is seeking recovery.

2.40 State Fair Hearing Process

The member or his or her representative (with written consent signed by the member) should submit a request for a state fair hearing to the Office of Administrative Hearings (OAH) within 120 calendar days from the date of the notice of resolution regarding the member's standard appeal. The request will be submitted within 10 calendar days of the date of the notice of resolution if the member wishes to have continuation of benefits during the state fair hearing. The state fair hearing is afforded only to members who exhaust the internal plan appeal level.

A provider may file a request for state fair hearing only as a representative of a member, with written consent signed by the member, for those members who have exhausted the internal plan appeal process.

A State Fair Hearing (SFH) can be requested:

- **Verbally:** calling The Office of Administrative Hearings at **984-236-1860**
- **Written:** Send to North Carolina Office of Administrative Hearings, Hearings Division and Clerks' office:

Office of Administrative Hearings
1711 New Hope Church Road
Raleigh, NC 27609

- Phone: **984-236-1860**
- Fax: **984-236-1871**

For Medicaid-specific inquiries, contact the Office of Administrative Hearings Medicaid Hotline at **984-236-1850.**

If a decision to deny, limit or delay services is reversed, we will authorize and/or provide the disputed services promptly and as expeditiously as the member's health condition requires, and no later than 72 hours from the date we receive the notice to reverse the determination.

2.41 Provider Appeals, Grievances and Payment Disputes

Blue Cross NC has a provider appeals and grievance system, distinct from that offered to members, that includes a grievance process for providers to bring issues to Healthy Blue and an appeals process for providers to challenge certain decisions.

Provider grievance: Any verbal or written complaint or dispute by a provider, where remedial action is requested, over any aspects of the operations, activities, or behavior of Blue Cross NC except for any dispute about which the Healthy Blue provider has appeal rights. Provider grievances will be resolved within 30 calendar days.

There are several options to file a grievance:

- **Verbally:** Call Healthy Blue Provider Services at **844-594-5072**.
- **Online:** Use Availity secure provider Appeals and Grievance feature at **Availity.com**. Through Availity, providers can upload supporting documentation and will receive immediate acknowledgement of their submission.
- **Written:** Mail all required documentation (see below for more details), including the *Provider Appeals and Grievance Form* to:

  Blue Cross NC | Healthy Blue
  Provider Grievance and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Provider appeal: a review of an adverse determination. The following are the reasons a network provider may appeal an adverse decision:

- Program Integrity related findings or activities.
- Finding of fraud, waste or abuse.
- Finding of or recovery of an overpayment.
- Withholding or suspension of a payment related to fraud, waste or abuse concerns
- Termination of or determination not to renew an existing contract for Local Health Department (LHD) care management services.
- Determination to lower an AMH provider's tier status.
- Violation of terms between Blue Cross NC and the Healthy Blue provider.

The following are the reasons an out-of-network provider may appeal an adverse decision:

- An out-of-network payment arrangement.
- Finding of waste or abuse by Blue Cross NC.
- Finding of or recovery of an overpayment by Blue Cross NC.

Resolution of provider appeal:

- Blue Cross NC Provider Appeals Committee will review and make decisions on provider appeals. The committee will consist of at least three qualified individuals who were not involved in the original decision, action or inaction giving rise to the right to appeal. The committee will include an external peer reviewer when the issue on appeal involves whether the provider met objective quality standards.
- Blue Cross NC will provide written notice of decision of the appeal within 30 calendar days of receiving a complete appeal request or, if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to Healthy

Blue. Blue Cross NC will provide written notice of a provider's right to appeal with the *Notice of the Decision*.
- Blue Cross NC will allow Healthy Blue providers to be represented by an attorney during the appeal process.
- Providers must exhaust the internal appeal process before seeking recourse under any other process permitted by contract or law.

2.42 Provider Post Service Medical Necessity Appeals

Blue Cross NC offers Healthy Blue providers the right to file an appeal related to an unfavorable medical necessity decision after a *Notice of Adverse Benefit* determination has been issued. Providers may submit an appeal via the provider website using Availity secure provider Appeals and Grievance feature at **Availity.com**. Through Availity, providers can upload supporting documentation and will receive immediate acknowledgement of their submission as well as obtain that status of their appeals.

Providers can also file in writing utilizing:
- Fax: **844-429-9635**
- Email: ncmedicaidgrievances@nchealthyblue.com
- Mail:

Blue Cross NC | Healthy Blue
Appeals
Healthy Blue
P.O. Box 62429
Virginia Beach, VA 23466-2429

Requests for appeal must be submitted within 90 calendar days of receiving the *Notice of Adverse Benefit* determination. Blue Cross NC will send the provider a written acknowledgment letter within 5 calendar days of receipt of the appeal request. A provider must exhaust the internal appeals process before seeking recourse under any other process permitted by contract or law. Blue Cross NC will resolve appeals and provide a written resolution letter within 30 calendar days of receiving the appeal request.

If a provider is not satisfied with the first-level decision, they may submit a second-level appeal within 30 calendar days of receiving the *Appeal Resolution* letter. Blue Cross NC will also resolve second-level appeals and provide a written resolution letter within 30 calendar days of receiving the second-level appeal request.

Office of the Ombudsman:
Providers may contact the NCDHHS Ombudsman Program established to assist providers with submitting a complaint about Blue Cross NC.

Providers may call the Medicaid Managed Care Provider Ombudsman Program at **866-304-7062.** Providers can receive information about the Medicaid Managed Care Provider Ombudsman Program and how to submit a complaint via email at: Medicaid.ProviderOmbudsman@dhhs.nc.gov

Payment Disputes:
Blue Cross NC has a specific provider claim payment dispute process. Provider claim payment disputes are considered a grievance.

If a provider disagrees with the outcome of a claim, you may begin the claim payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized, but you disagree with the outcome.

Note there are three common, claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, they are defined briefly here:

- **Claim inquiry:** a question about a claim but not a request to change a claim payment.
- **Claims correspondence**: when Blue Cross NC requests further information to finalize a claim; typically includes medical records, itemized bills or information about other insurance a member may have.
- **Clinical/medical necessity appeals**: an appeal for a denied service; for these, a claim has not yet been submitted (see **Section 2.41 Provider Post Service Medical Necessity Appeals**).

The claim payment dispute process consists of two steps. Providers will not be penalized for filing a claim payment dispute, and no action is required by the member.

- **Claim payment reconsideration**: This is the first step in the claim payment dispute process. The reconsideration represents the initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
- **Claim payment appeal**: This is the second step in the claim payment dispute process. If a provider disagrees with the outcome of the reconsideration, the provider may request an additional review as a claim payment appeal.

A claim payment dispute may be submitted for one or multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid claims
- Claim coding edit issues
- Duplicate claim issues
- Retro-eligibility issues
- Claim data issues
- Timely filing issues
- We will consider reimbursement of a claim that has been denied due to failure to meet timely filing if the provider can do one of the following:
  1. Provide documentation the claim was submitted within the timely filing requirements
  2. Demonstrate that good cause exists

How to submit a provider claim(s) payment dispute
There are several options for filing a provider dispute:

- **Online:** Use Availity Essentials, our secure provider portal, to select the **Claims & Payments** menu at **Availity.com**.

- Select **Claim Status**
- Select the organization and payer
- Complete the required fields for provider, patient and claim information.
- Select submit
- Locate the claim you want to dispute using **Claim Status** from the **Claims & Payments** menu
- If available, select **Dispute Claim** to initiate the dispute
- Go to **Request** to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit
- **Written:** Mail all required documentation (see below for more details), including the *Claim Payment Appeal Form* or the *Reconsideration Form* to:

  Blue Cross NC | Healthy Blue
  Provider Grievance and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Claim inquiries
A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but the outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Healthcare Networks program helps you with claim inquiries. Just call **844-594-5072** and select the **Claims** prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence
Claim correspondence is different from a payment dispute. Correspondence is when Blue Cross NC requires more information to finalize a claim. Typically, Blue Cross NC makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Blue Cross NC will use it to finalize the claim.

2.42 First Line of Defense Against Fraud

We are committed to protecting the integrity of our health care program and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse. Combating fraud, waste and abuse begins with knowledge and awareness.

- **Fraud** — Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. This includes any act that constitutes fraud under applicable Federal or State law.
- **Waste** — Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions but, rather, occurs when resources are misused.
- **Abuse** — behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care.

To help prevent fraud, waste and abuse, providers can assist by educating members. For example, spending time with members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent member fraud is as simple as reviewing the member identification card. It is the first line of defense against possible fraud. Blue Cross NC may not accept responsibility for the costs incurred by providers supplying services to a person who is not a member, even if that person presents a member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status and identity.

Providers should encourage members to protect their ID cards as they would a credit card, to carry their health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud and working with members to protect their health benefit ID card can help prevent fraudulent activities. If you believe an individual has presented a stolen member ID and/or one that does not belong to the patient, contact Healthy Blue Member Services at **844-594-5070**. If you have a patient who has lost their ID card or suspects it was stolen, have the member call the Healthy Blue Member Services at **844-594-5070**.

Reporting fraud, waste, and abuse
If you suspect a provider (for example , provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person and their information, if supplied, who reports the incident is kept in strict confidence by the Special Investigations Unit (SIU).

To report concerns:
- Anyone can visit our **fighthealthcarefraud.com** education site; at the top of the page, select *Report it* and complete the ***Report Waste, Fraud and Abuse*** form
- Participating Providers can call your Provider Relationship Account Consultant
- Call Member Services
- Call the SIU fraud hotline: **866-847-8247**

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.
Examples of provider fraud, waste, and abuse:

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling –when multiple procedure codes are billed individually for a group of procedures that should be covered by a single comprehensive procedure code
- Upcoding –when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.), include the following information:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of member fraud, waste, and abuse:

- Forging, altering or selling prescriptions
- Letting someone else use the member's ID card
- Relocating to out-of-service plan area and not letting us know
- Using someone else's ID card

When reporting concerns involving a member, include the following information:

- The member's name
- The member's date of birth, and member ID if you have it
- The city where the member resides
- Specific details describing the fraud, waste or abuse

If a member appears to have committed fraud, waste or abuse or has failed to correct issues, the member may be involuntarily disenrolled from our health care plan, with state approval.

Investigation Process
Blue Cross NC investigates all reports of fraud, waste and abuse for all services provided to members. If appropriate, allegations and the investigative findings are reported to all

appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, Blue Cross NC may take corrective action with provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the Provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries***:** Blue Cross NC recovers overpayments directly from the Healthy Blue provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU, all checks and correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Paper medical records and claims are sent to a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY** (**282-4548**) for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Standard Evaluation for Prepayment Review
Unless the North Carolina Medicaid Division of Health Benefits (NCHB) or law enforcement directs otherwise, per North Carolina state statute § 108C-7, prepayment claims review shall not continue longer than 24 consecutive months. Failure of a Provider to meet the seventy percent (70%) for three consecutive months clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the Provider to meet the seventy percent (70%) clean claims rate minimum requirement and shall result in exclusion of the Provider from future participation in the Medicaid program. If a Provider fails to meet the seventy percent (70%) clean claims rate minimum requirement and subsequently requests a voluntary termination, the termination shall reflect the Provider's failure to successfully complete prepayment claims review and shall result in exclusion of the Provider from future participation in the Medicaid program.

A Provider shall not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the Provider has been taken off of prepayment review for any reason, including attaining a minimum of seventy percent (70%) clean claims rate for three consecutive months, the expiration of the 24-month time limit, or the termination of the Provider.

In addition, correspondence from the SIU regarding prepayment review contains information on:

1. The SIU's decision to place the provider on prepayment review.
2. A description of the review process and claims processing times.
3. A description of the claims subject to the SIU prepayment review program
4. A specific list of all supporting documentation the provider will need to submit to the SIU prepayment review team for all claims that are subject to the prepayment claims review.

5. The process for submitting claims and supporting documentation.

Acting on Investigative Findings
If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse the Provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a Member or Provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a Member appears to have committed fraud, waste or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our health care plan, with state approval.

Offsets
Blue Cross NC be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by [health plan brand] to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Blue Cross NC that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, Blue Cross NC shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by [health plan brand] to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Healthy Blue procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend Blue Cross NC's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Blue Cross NC reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant Legislation

False Claims Act
Blue Cross NC are committed to complying with all applicable federal and state laws, including the federal *False Claims Act* (*FCA*). The *FCA* is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the *FCA*, anyone who

knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The *FCA* also contains Qui Tam or *whistleblower* provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government, or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the *FCA* and may be entitled to a percentage of the funds recovered by the government.

HIPAA

The *Health Insurance Portability and Accountability Act* (*HIPAA*) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Blue Cross NC strives to ensure both Healthy Blue and contracted participating providers conduct business in a manner that safeguards member information in accordance with the privacy regulations enacted pursuant to *HIPAA*. Contracted providers will have the following procedures implemented to demonstrate compliance with the *HIPAA* privacy regulations:

- Blue Cross NC recognizes its responsibility under *HIPAA* privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose; conversely, network providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting us; however, privacy regulations allow the transfer or sharing of member information. Blue Cross NC may request information to conduct business and make decisions about care, such as a member's medical record, authorization determinations or payment appeal resolutions. Such requests are considered part of the *HIPAA* definition of treatment, payment or health care operations.
- Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to us, verify the receiving fax number is correct, notify the appropriate staff at Blue Cross NC and verify the fax was received.
- Internet email (unless encrypted and/or transferred by another secure service) should not be used to transfer files containing member information (for example, Excel spreadsheets with claim information); such information should be mailed or faxed.
- Use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked *confidential* and addressed to a specific individual, P.O. Box or department.
- The Healthy Blue voicemail system is secure and password-protected. When leaving messages for any of our associates, leave only the minimum amount of member information required to accomplish the intended purpose.
- When contacting us, be prepared to verify the provider's name, address and tax identification number (TIN) or member's provider number.

Employee education about the *False Claims Act*

As a requirement of the *Deficit Reduction Act of 2005*, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources) must comply with the following:

- Establish written policies for all employees, managers, officers, contractors, subcontractors and agents of the network provider. The policies must provide detailed information about the *False Claims Act*, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).
- Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

2.43 *HIPAA*

The *Health Insurance Portability and Accountability Act* (*HIPAA*):

- Improves the portability and continuity of health benefits
- Provides greater patient rights to access and privacy
- Ensures greater accountability in health care fraud
- Simplifies the administration of health insurance

We are committed to safeguarding patient/member information. As a contracted provider, you must have procedures in place to demonstrate compliance with *HIPAA* privacy regulations. You must also have safeguards in place to protect patient/member information such as locked cabinets clearly marked and containing only protected health information, unique employee passwords for accessing computers and active screen savers.

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information to:

- Conduct business and make decisions about care
- Make an authorization determination
- Resolve a payment appeal

Requests for such information fit the *HIPAA* definition of treatment, payment or health care operations.

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us:

- Verify the receiving fax number
- Notify us you are faxing information
- Verify that we received your fax

Do not use internet email (unless encrypted) to transfer files containing member information to us. You should mail or fax this information. Mail medical records in a sealed envelope marked *confidential* and addressed to a specific individual or department at Blue Cross NC.

Our voicemail system is secure and password-protected. You should only leave messages with the minimum amount of member information necessary. When contacting us, be prepared to verify your name, address, NPI, TIN and Healthy Blue provider number.

2.44 Steerage of Membership

Per our contract with NCDHHS, we cannot have contractual arrangements in which a provider represents that he or she will not contract with another health plan or in which we represent that we will not contract with another provider. Contractual arrangements between us and each provider must be nonexclusive.

Steerage of membership by us and/or our network providers is prohibited. If NCDHHS determines steerage has occurred, the Department has wide discretion in assessing both financial penalties and nonfinancial penalties such as member disenrollment.

BEHAVIORAL HEALTH SERVICES

3.1 Overview

Blue Cross NC facilitates integrated physical and behavioral health services, and this integration is a part of our health care delivery system. Our mission is to comprehensively address the physical and behavioral health care of the members by offering a wide range of targeted interventions, education, and enhanced access to care, to ensure improved outcomes and quality of life for members. Healthy Blue care management works collaboratively with hospitals, group practices, independent behavioral health care providers, community and government agencies, human service districts, Federally Qualified Health Centers (FQHC), Rural Health Clinics Center (RHC), community behavioral health centers, and other resources to successfully meet the needs of members with behavioral health, substance use, and intellectual and developmental disabilities.

3.2 Target Audience

The Healthy Blue provider network is inclusive of specialized behavioral health care providers, as well as a comprehensive array of supports and services, designed to serve the needs of individuals who comprise one of the following target populations:

- Medicaid eligible adults, adolescents and children with behavioral health (behavioral health and substance abuse) needs that are not best managed by basic behavioral health services in the primary care setting by a primary care provider
- Adults, adolescents and children who have mild to moderate mental illness and/or substance use disorders

3.3 Goals

The goals of the behavioral health program are to:

- Provide whole-person management of all medical and behavioral health benefits including pharmacy through a team approach.
- Integrate the management and delivery of physical and behavioral health services in the members' communities through collaboration with providers and community stakeholders.
- Drive improvements in health outcomes and quality of care to achieve quality initiatives including those related to HEDIS®, National Committee for Quality Assurance (NCQA), North Carolina Department of Health and Human Services (NCDHHS), and other governmental entities' performance requirements.
- Work with members, providers, Advanced Medical Homes (AMH), Clinically Integrated Networks (CIN) and community supports to provide community-based integrated recovery and resilience tools to create an environment that supports members' progress toward their identified goals.
- Work with members to connect with necessary providers, social supports and assist with navigation of the systems of care.
- Encourage and facilitate collaboration between providers and community organizations.
- Support cost-effective utilization of the most appropriate and least restrictive medical and behavioral health care while uniting communities and health care systems.

3.4 Objectives

The objectives of the behavioral health program are to:

- Support continuity and coordination of care between physical and behavioral health care practitioners.
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow members to achieve their recovery and resilience goals.
- Leverage individualized, person-centered planning approaches to assist members in life planning to increase their personal self-determination and optimize their own independence.
- Provide member education on treatment options and pathways toward recovery and resilience.
- Provide high-quality care management and care coordination services that identify member needs and address them in a personal and holistic manner.
- Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings, waiver services and outpatient care at the least restrictive level.
- Enhance provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives.
- Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals.
- Use evidence-based practices, guidelines and clinical criteria and promote their use in the provider community.
- Maintain compliance with accreditation standards and with local, state and federal requirements.
- Deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the state of North Carolina.
- Reduce repeat emergency room visits, unnecessary hospitalizations, out-of-home placements and institutionalizations.
- Improve member clinical outcomes through continuous quality monitoring of the health delivery service system.

3.5 Guiding Principles of the Behavioral Health Program

Recovery is a member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on behavioral health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency.

The ten fundamental components of recovery identified by SAMHSA are:

1. **Self-direction**: Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
2. **Individualized care**: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences and experiences including past trauma and cultural background.
3. **Empowerment**: Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, that will affect their lives, and are educated and supported in doing so.
4. **Holistic**: Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (for example, recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person.
5. **Nonlinear**: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the member to move on to fully engage in the work of recovery.
6. **Strengths-based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.
7. **Peer support**: Mutual support including the sharing of experiential knowledge, skills and social learning plays an invaluable role in recovery.
8. **Respect**: Community, systems and societal acceptance, and appreciation of members, including protecting their rights and eliminating discrimination and stigma, are crucial to achieve recovery.
9. **Responsibility**: Members have a personal responsibility for their own self-care and journeys of recovery.
10. **Hope**: Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is the ability of an individual or family to cope and adapt to the challenges due to changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one's life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

3.6 Systems of Care

Services provided to people with serious emotional disturbances, and their families, are best delivered based on the System of Care Values and Principles that are endorsed by Substance Abuse and Mental Health Services Administration and the Center for Mental Health Services. Services should:

- Be person-centered and family-focused with the needs of the person and their family dictating the types and mix of services provided.
- Be community-based with the focus of services, as well as management and decision making responsibility, resting at the community level.
- Be culturally competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- Be comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.
- Be personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.
- Be delivered in the least restrictive, most normative environment that is clinically appropriate.
- Be integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services; inclusive of care management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner; and adapted in accordance with the changing needs of the person and their family.
- Be delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.
- Be oriented to recovery and providing services that are flexible and evolve over time.
- Include the use of telemedicine as an alternative service delivery model to support members' access to care by meeting the members where they are (home, school, primary care clinic, behavioral health [BH] or substance use disorder [SUD] provider) and includes member access to specialty care and BH/SUD treatment through FastMed's (Bright Heart Health and FasPsych) service model to offer virtual visits seven days a week.
- Increase access to specialists by enabling PCPs to use telemedicine technology, distance learning through Project ECHO (Extension for Community Healthcare Outcomes) and e-consults.
- Offer virtual visits through FastMed.
- Provide member access to Direct to Consumer telemedicine visits via smartphone, tablet or computer.

3.7 Coordination of Behavioral Health and Physical Health Treatment

The integration of behavioral health and physical health treatment is the cornerstone of the Healthy Blue philosophy of treating the needs of the whole person. Principles that guide this integration of care include the following:

- Behavioral health is essential to overall health and not separate from physical health.
- Mental illness, substance use disorders and other health care conditions must be integrated into a comprehensive system of care that meets the needs of individuals in the setting where they feel most comfortable. This includes primary care settings and/or behavioral health care settings.
- Many people suffer from mental illness, substance use disorders and other health care conditions concurrently; as care is provided, the dynamic of having co-occurring illnesses must be understood, identified and treated as primary conditions.

- The system of care must be accessible and comprehensive and fully integrate an array of prevention and treatment services for all age groups. It is designed to be evidence informed, responsive to changing needs and built on a foundation of continuous quality improvement.

It is our goal to make relevant clinical information accessible to all health providers on a member's treatment team consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.

Key elements of our model for coordinated and integrated health services include but are not limited to:

- Ongoing communication, coordination and collaboration between primary care providers and specialty providers, including behavioral health (behavioral health and substance use) providers, with appropriate documented consent.
- The expectation that primary care providers will regularly screen members for behavioral health, substance use (including tobacco), co-occurring disorders and problem gaming, and refer members to behavioral health specialty providers as necessary.
- The expectation that behavioral health providers will screen members for common medical conditions including tobacco use and refer members to the primary care provider for follow-up diagnosis and treatment.
- Collaboration between all health care providers with support from Blue Cross NC in managing health care conditions of members.
- Referrals to primary care providers or specialty providers, including behavioral health providers, for assessment and/or treatment for members with co-occurring disorders and/or any known or suspected and untreated health disorders.
- Development of patient-centered treatment plans involving members, as well as caregivers and family members, and other community supports and systems when appropriate.
- Care management, condition care management programs to support the coordination and integration of care between providers.
- The requirement of all providers to complete an annual integrated care self-assessment using the Substance Abuse and Mental Health Services Administration (SAMHSA) Integrated Practice Assessment Tool and report their results to Blue Cross NC upon request.

Fostering a culture of collaboration and cooperation helps Blue Cross NC sustain a seamless continuum of care that positively impacts our member outcomes. To maintain continuity of care, patient safety and member well-being, communication between integrated health care providers is critical, especially for members with comorbidities receiving pharmacological therapy.

To achieve our fully integrated health care system for Healthy Blue members, Blue Cross NC will:

- Provide to NCDHHS on an annual basis a self-assessment to be inclusive of, but not limited to, such factors as provider locations, integrated or collocated provider numbers, programs focusing on members with both behavioral health and primary care needs, use

of multiple treatment plans, and unified systems across behavioral and physical health management.

- Work with NCDHHS to develop a plan to conduct annual assessments of practice integration using the Integrated Practice Assessment Tool on a statistically valid sampling of providers to include but not limited to behavioral health providers, primary care providers, internists, family practitioners, pediatrics, OB/GYNs and any other providers who are likely to interface with behavioral health populations.
- Provide trainings on integrated care including but not limited to the appropriate utilization of basic behavioral health screenings in the primary care setting, as well as basic physical health screenings in the behavioral health setting.
- Identify available opportunities to provide incentives to clinics to employ licensed behavioral health professionals in primary care settings and to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner) part or full-time in a psychiatric specialty setting to monitor the physical health of patients.
- Encourage and endorse real-time consultation of primary care providers with behavioral health professionals or psychiatrists for behavioral health issues or consultations on medications.
- Have integrated data, quality and claims systems.
- Have a single or integrated clinical documentation system in order to see the whole health of the member.
- Identify *hot spot* sources of high emergency department referrals and/or inpatient psychiatric hospitalization and provide pre-emptive care coordination.

3.8 Behavioral Health Provider Roles and Responsibilities

The behavioral health care benefit is fully integrated with the rest of the health care programs and inclusive of our fee-for-service Medicaid members requiring behavioral health services only. This coordination of health care resources requires certain roles and responsibilities for behavioral health providers, including the following:

- Adhere to all terms and conditions within Blue Cross NC Healthy Blue provider contract.
- Participate in the care management and coordination process for each Healthy Blue member under your care.
- Seek prior authorization for all services that require it.
- Attempt to obtain appropriate consent for the disclosure of substance use treatment information to the member's primary care provider for all members treated for behavioral health conditions, document attempts and report information to Blue Cross NC upon request.
- Provide Blue Cross NC and the member's primary care provider with a summary of the member's initial assessment, primary and secondary diagnosis and prescribed medications if the member is at risk for hospitalization; this information must be provided within 24 hours after the initial treatment session.
- Provide initial and summary reports to the primary care provider, or to Blue Cross NC, upon request. This must be provided within five calendar days of the visit for members not at risk for hospitalization. The minimum elements to include are:
  - Patient demographics
  - Date of initial or most recent behavioral health evaluation

  - Recommendation to see primary care provider, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (for example, Early and Periodic Screening, Diagnostic and Treatment [EPSDT] screen, complaint of physical ailments)
  - Diagnosis and/or presenting behavioral health problem(s)
  - Prescribed medication(s)
  - Behavioral health clinician's name and contact information
- Notify Blue Cross NC and the member's primary care provider of any significant changes in the member's status and/or change in the level of care.
- Ensure that members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge with a qualified mental health professional — this treatment must be provided within seven calendar days from the date of the member's discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial members.
- Encourage members to consent to the sharing of substance abuse treatment information.
- Comply with mainstreaming requirements.
- Refrain from excluding treatment or placement of members for authorized behavioral health services solely on the basis of state agency involvement or referral.
- Providers have an obligation to monitor and report on preventable conditions.

3.9 Clinical Staff

All clinical staff members are licensed and have prior health care experience. Our medical director is board certified in adult, adolescence and child psychiatry and licensed in the state of North Carolina. Our highly trained and experienced team of utilization managers, care managers and support staff provide high-quality utilization management, care management, and care coordination services to our members and strive to work collaboratively with all providers.

Care Management services are available to all Healthy Blue members by contacting us via phone at **844-594-5072**, or fax at **844-451-2792**.

3.10 Member Records and Treatment Planning: Comprehensive Assessment

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews.

Information related to the provision of appropriate services to members must be included in the records with documentation in a prominent place whether there is an executed declaration for behavioral health treatment.

Providers must complete a comprehensive assessment that provides a description of the member's physical and behavioral health status at the time of admission to services. It should include:

- Psychiatric and psychosocial assessment including:

  - Description of the presenting problem
  - Psychiatric history and history of the member's response to crisis situations
  - Psychiatric symptoms
  - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Mental status exam
- Medical assessment including:
  - Screening for medical problems
  - Medical history
  - Present medications
  - Medication history
- Substance use assessment that includes:
  - Frequently used over-the-counter medications
  - Current and historical usage of alcohol and other drugs reflecting impact of substance use in the domains of the community functioning assessment.
  - History of prior alcohol and drug treatment episodes and their effectiveness.
  - History of alcohol and drug use
- Community functioning assessment or an assessment of the member's functioning in the following domains:
  - Living arrangements, daily activities (vocational/educational)
  - Social support
  - Financial
  - Leisure/recreational
  - Physical health
  - Emotional/behavioral health
  - An assessment of the member's strengths, current life status, personal goals and needs

3.11 Member Records and Treatment Planning: Personalized Support and Care Plan

When individualized treatment plans are required, they must be:

- Completed and submitted within the first 24 hours or next business day for members admitted to an acute behavioral health or acute care inpatient setting
- Completed and submitted within the first 14 days of admission to outpatient behavioral health services

Treatment plans must be updated no less than every 180 days or more frequently as necessary based on the member's progress toward goals, a significant change in psychiatric symptoms, medical condition and/or community functioning, as well as the level of care where the member is receiving treatment. Additionally, the development of a crisis prevention plan is required for those members with multiple hospitalizations or more than three visits to the emergency room for urgent or nonemergent care.

There must be a signed release of information to provide information to the member's primary care provider, including disclosure of substance use information or evidence that the member refused to provide a signature. Such information must be reported to Blue Cross NC upon

request. Disclosures of substance use information must include a prohibition against re-disclosure. There must be documentation that referral to appropriate medical or social support professionals have been made.

A provider who discovers a gap in care is responsible to help the member get that gap in care fulfilled, and documentation should reflect the action taken in this regard.

For providers of multiple services, one comprehensive treatment/care/support plan is acceptable, as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.

The individualized treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the member is seeking treatment
- Member goals related to each problem(s) identified, written in member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent de-escalation or defuse crisis situations; names and phone numbers of contacts who can assist the member in resolving crises; and the member's preferred treatment options, to include psychopharmacology, in the event of a behavioral health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the member and provider
- Signatures of the member as well as family members, caregivers or legal guardian as appropriate

3.12 Member Records and Treatment Planning: Progress Notes

Progress notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the member's treatment, including signed and dated notations of phone calls concerning the member's treatment
- Indication of active follow-up actions for referrals given to the member and actions to fill gaps in care
- A brief discharge summary completed within 15 calendar days following discharge from services or death
- Discharge summaries for psychiatric hospital SUD and residential treatment facility admissions that occur while the member is receiving behavioral health services

3.13 Psychotropic Medications

Prescribing providers must inform all members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the member or, if appropriate, a

referral to a nutritionist or obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about their condition, and their treating provider should be identified in the documentation and coordination efforts with that provider should be indicated as well. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the member's primary care provider.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that providers are knowledgeable about side effects and risks of medications and regularly inquire about and look out for any side-effects from medications. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth, especially for those on antipsychotics or mood stabilizers
- Glucose tolerance test or hemoglobin A1C tests, especially for those members on antipsychotics or mood stabilizers
- Triglyceride and cholesterol checks, especially for those members on antipsychotics and mood stabilizers
- Electrocardiogram checks for members placed on medications with risk for significant QT prolongation
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders. Guidelines for such testing and follow-up are provided by the American Psychiatric Association, among others. Summary guidelines are referenced in our *Clinical Practice Guidelines* located on our website at **provider.healthybluenc.com**. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the member's medical record.

3.14 Behavioral Health Utilization Management

As a corporation, and as individuals, utilization management (UM) decisions are governed by the following statements:

- UM decision making is based only on appropriateness of care, service and existence of coverage
- Practitioners or other individuals are not specifically rewarded for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denial of benefits
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service
- Behavioral health UM guidelines and the UM policy description can be accessed at **provider.healthybluenc.com**

Timeliness of decisions on requests for authorization — behavioral health:

- If referral is made from an emergency room or a facility that does not have a psychiatric unit, the decision will be made and communicated to the provider within one hour of request.
- If in an inpatient facility where they will be hospitalized, the decision will be made and communicated to the provider as expeditiously as possible but no later than 72 hours of request.
- **Routine, nonurgent requests (initial request):** within two business days of receipt of all necessary information but no later than 14 days from the request for services.
- **Routine, nonurgent requests (concurrent review):** within one business day of obtaining all necessary information but no later than 14 days from the request for services.
- Retrospective review requests: within 30 days of request.

3.15 Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care.

Appointment Wait Time Standards — behavioral health

- **Mobile crisis management services:** within 2 hours
- **Urgent care for mental health:** within 24 hours
- **Urgent care for SUDs:** within 24 hours
- **Routine services for mental health:** within 14 calendar days
- **Routine services for SUDs:** within 48 hours
- **Emergency services for mental health:** immediately available 24 hours a day, 365 days a year
- **Emergency services for SUDs:** immediately available 24 hours a day, 365 days a year

Definitions

- **Emergent:** Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.
- **Urgent:** A service need that is not emergent and can be met by providing an assessment and services within 24 hours of the initial contact. If the member is pregnant and has substance use problems, she is to be placed in the urgent category.
- **Mobile crisis management services**: Mobile crisis services for adults and children that are direct and periodic services available at all times, 24/7 , 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.
- **Routine:** A service need that is not urgent and can be met by receiving treatment within 14 calendar days.
- **Follow-up routine care appointments:** Visits at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit.

- **Outpatient following discharge from an inpatient hospital:** Services within seven days to include psychotherapy and, if needed, medication management

3.16 Behavioral Health Covered Services

Standard Plan: Healthy Blue covered services and PA limits	
BH state plan services	**BH visit limits/PA requirement**
Inpatient behavioral health services	PA requirements apply
Outpatient behavioral health emergency room services	No PA requirements apply
Behavioral Health Urgent Care	BH limits apply/No PA requirements apply
Outpatient behavioral health services provided by direct-enrolled providers	BH visit limits/ PA requirements apply
Peer support services	No PA requirements apply
Partial hospitalization	PA requirements apply
Mobile crisis management	PA requirements apply
Facility-based crisis services for children and adolescents	PA requirements apply
Professional treatment services in facility-based crisis program	PA requirements apply
Outpatient opioid treatment	PA requirements apply
Ambulatory detoxification	PA requirements apply
Research-based intensive behavioral health treatment	BH visit limits/PA requirements apply
Diagnostic assessment	BH visit limits/PA requirements apply
Non-hospital medical detoxification	PA requirements apply
EPSDT	PA requirements apply in some circumstances
Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization (ADATC)	PA requirements apply

Services covered by the LME-MCO

- Residential treatment facility services for children and adolescents
- Child and adolescent day treatment services
- Intensive in-home services
- Multisystemic therapy services
- Psychiatric residential treatment facilities (PRTFs)
- Assertive community treatment (ACT)
- Community support team (CST)
- Psychosocial rehabilitation
- Substance abuse intensive outpatient program (SAIOP)
- Substance abuse comprehensive outpatient treatment program (SACOT)
- Substance abuse non-medical community residential treatment
- Substance abuse medically monitored residential treatment
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Waiver services:
  - Innovations waiver services
  - Traumatic brain injury (TBI) waiver services
  - 1915(b)(3) services
- State-funded BH and I/DD services
- State-funded TBI services

BH visit limits and prior authorization requirements are subject to change. Blue Cross NC will implement changes to covered or carved-out services within 30 calendar days after notification by NCDHHS unless otherwise indicated.

For code-specific BH visit limits and authorization rules, visit the provider website at **provider.healthybluenc.com** or call **844-594-5072**.

3.17 Behavioral Health In Lieu of Services (ILOS)

In Lieu of Services (ILOS) are services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service. Blue Cross NC must submit an ILOS request form prior to implementation to NCDHHS for approval. Blue Cross NC in no instance can reduce or remove an ILOS service without approval by NCDHHS concurrent within a contract year. If changes, reduction or removal of ILOS services is approved, Blue Cross NC must notify all members of the change by mail and update all marketing and educational materials to reflect the change within 30 days of approval. Blue Cross NC will notify NCDHHS of the transition plan for current members receiving the terminated ILOS, and care managers or other Healthy Blue staff will notify all members of other approved service options. Members are not required to use ILOS services and all ILOS services are placed on the Healthy Blue website. Blue Cross NC will monitor the cost-effectiveness of each approved ILOS by tracking utilization and expenditures. Blue Cross NC offers the following ILOS to Healthy Blue members:

- **Behavioral health urgent care**: services include assessment and diagnosis for mental illness, substance use, and intellectual and developmental disability issues; planning and

referral for future treatment; medication management; outpatient treatment; and short-term follow-up care. This service intends to divert members from inpatient hospitalizations and long wait times/observation in emergency rooms for placement for stabilization of condition and ability to return to the community (no authorization required).

- **Institute for mental disease (IMD):** a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. The treatment of alcoholism, substance abuse or other chemical dependency syndromes are included in this definition. This service potentially expands access to inpatient psychiatric care for the adult population (*NCDHHS Family and Children's Manual*, 2013) (authorization requirements apply).

3.18 *Clinical Practice Guidelines*

All providers have access to and are strongly encouraged to make use of evidence-based *Clinical Practice Guidelines* for a variety of behavioral health disorders commonly seen in primary care, including attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, schizophrenia, and substance use disorders.

Clinical Practice Guidelines are located online at **provider.healthybluenc.com**.

3.19 Medical Policy

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over clinical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts will supersede MCG Guidelines and our *Medical Policies* and *Clinical UM Guidelines*. Medical technology is constantly evolving, and the Healthy Blue Utilization Management Department reserves the right to review and periodically update medical policy and utilization management criteria. The Healthy Blue Utilization Management Department reviews the medical necessity of medical services using:

- State guidelines
- Federal EPSDT guidelines for members under the age of 21 years
- Our *Medical Policies* and *Clinical UM Guidelines*
- MCG Guidelines criteria

Medical Policies and *CUMGs* are available on the provider website:
provider.healthybluenc.com/north-carolina-provider/home-main
In addition, Blue Cross NC will use the following level of care tools for medical necessity reviews:

- American Society for Addiction Medicine (ASAM) for substance abuse services for all populations except children ages 0 to 6; EPSDT criteria will be used for the evaluation for service for children
- Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for infants, toddlers and preschoolers for children ages 0 to 5 or another validated assessment tool with prior approval by NCDHHS

3.20 Emergency Behavioral Health Services

Primary care providers should immediately refer any member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

3.21 Behavioral Health Self-Referrals

Blue Cross NC does not require members to obtain a referral or prior authorization for the first mental health or substance dependence assessment completed in a 12-month period. Members may self-refer to any behavioral health care provider in the Healthy Blue network. Providers and members have access to a complete listing of mental health and substance use disorder providers that specifies provider groups and practitioners that specialize in children's mental health services. If the member is unable or unwilling to access timely services through community providers, call Healthy Blue Provider Services for assistance.

Primary care providers may treat members with situational behavioral health disorders, the most common of which are depression and anxiety. For members whose behavioral health does not respond to treatment in a primary care setting, contact us for referral and authorization information regarding assessment and ongoing services at **844-594-5072**.

Primary care providers are required to refer members who are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms or are in a crisis state. Refer to the benefits matrix for the range of services covered.

Primary care providers are also required to make referrals for members whose symptoms of anxiety and mild depression persist or become worse. Any member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications.

Primary care providers should refer any member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health specialist (this list is not all-inclusive):

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Multiple diagnosis
- Psychoses
- Schizophrenia
- Depressive disorders
- Problem gaming

3.22 Requesting Behavioral Health Services

To request prior authorization, providers can visit **Availity.com** (Select **Patient Registration > Authorizations & Referrals**). Providers may also request authorization for inpatient mental health and substance use disorder services by calling **844-594-5072** 24/7, 365 days a year. Be prepared to provide clinical information in support of the request at the time of the call.

The fax form is on our website at **provider.healthybluenc.com**.

For assistance with behavioral health services:

- Providers can call Healthy Blue Provider Services at **844-594-5072**.
- Members can call:
  - Member Services at **844-594-5070** (TTY **711**), Monday to Friday from 7 a.m. to 7 p.m., except for holidays; or
  - Behavioral Health Crisis Line at **844-594-5076**.

3.23 Links to Forms, Guidelines and Screening Tools

On our Healthy Blue website at **provider.healthybluenc.com** you will find links to forms, guidelines and screening tools for the following:

- Behavioral health and substance use covered services
- Services requiring precertification
- Noncovered diagnoses Screening tools for primary care providers and behavioral health providers

MEMBER MANAGEMENT SUPPORT

4.1 Welcome Call

We give new members a welcome call to:

- Educate them about our services.
- Help them schedule initial checkups.
- Identify any health issues (for example, pregnancy or previously diagnosed diseases).

4.2 24/7 NurseLine

Our 24/7 NurseLine is a 24-hour triage phone service your Healthy Blue patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after hours or on weekends.
- Schedule appointments with you or other network doctors.
- Get to urgent care centers or walk-in clinics.
- Obtain a virtual physician visit directly with a North Carolina-licensed online physician.

Members will also have access via a secure website that enables with a video-enabled computer, tablet or smartphone to receive a live audio/video consultation with a North Carolina-licensed, board-certified physician who can diagnose, make medical recommendations and prescribe medications when necessary for clinically appropriate conditions such as upper respiratory or urinary tract infections, cough, cold, fever, or flu. This innovative service will provide your patients needing after-hours and/or nonemergent urgent care with a unique and convenient alternative to the emergency room when they are unable to see a physician in person.

We encourage you to tell your Healthy Blue patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Members can reach the 24/7 NurseLine at **844-545-1427** (Spanish: **844-545-1428**) TTY services are available for the hearing impaired, and language translation services are also available.

4.3 Care Management

We have a voluntary, comprehensive program to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment. Members may be referred to care management through medical management programs, provider referrals, discharge planners, caregivers or self-referrals. Once we have identified a member's need, our clinicians will work with that member and the member's PCP to identify the:

- Level of care management needed
- Appropriate alternate settings to deliver care
- Healthcare services
- Equipment and/or supplies
- Community-based services
- Communication between the member and his or her PCP

For members who are hospitalized, our clinicians will also work with the member, Utilization Review Team, and PCP or hospital to develop a discharge plan of care and link the member to:

- Community resources
- Our outpatient programs
- Our Condition Care program (CNDC)

The care manager will partner with providers to facilitate comprehensive care delivery for the member and coordinate related services and supports to prevent duplication of services, ensure timely access and identify any service gaps for the member.

Member assessment

Our care manager conducts a comprehensive assessment to determine a member's needs, including but not limited to evaluating that person's:

- Medical condition and immediate care needs
- Previous pregnancy history (when applicable)
- Current pregnancy status (when applicable)
- Functional status
- Physical, intellectual or developmental disabilities
- Goals
- Life environment or unmet health-related resources
- Support systems
- Emotional status
- Ability for self-care
- Current treatment plan

Through communication with members or members' representatives and information from PCPs and specialists, our care manager will coordinate current medical and nonmedical needs.

Person-Centered Care Management Model

Our approach uses regional care management teams with multifunctional expertise to assist care managers, members, families, representatives and members' interdisciplinary teams in the development of person-centered service plans and serve as an ongoing resource to meet the varying needs of members to support health, well-being, independence and community living in the most integrated setting, such as employment and participation in community activities. Our care management model involves a continuous process of communicating, coordinating, delivering, monitoring and assessing services and supports and progress toward achieving member goals to optimize person-centered service delivery.

The core components of the care management model will include:

- Providing interface to ensure providers have timely access to an individual's person-centered care plan.
- Matching our members to the right care manager by carefully considering member diagnoses, complexity of medical and/or behavioral health conditions, and intensity of

service and support needs, and identifying a care manager on our team with appropriate experience, knowledge and skills.

- Person-centered planning through partnership and collaboration with members, their natural supports and member-identified interdisciplinary teams who will consider members holistically using discovery and assessment results to make sure that medical, behavioral, social and educational needs are addressed to maximize health, well-being and independence in the development of a comprehensive, person-centered service plan.
- Coordination and collaboration across member systems of care to align resources based on need, integrate services, reduce duplication of efforts, improve continuity of care and services, and increase cost efficiencies.
- The continuous process of delivering, monitoring and assessing interventions designed to meet the members' goals defined in person-centered service plans, as well as other care/treatment plans as part of their system of care to maximize individual health, well-being and quality of life.
- Technology and innovations to improve member and natural support experiences expand the tools to enable collaboration among multiple stakeholders, enhance our members' ability to self-direct services and supports, provide real-time member information, and improve provider and system performance.
- Ongoing stakeholder engagement at the member and system levels to build consensus, innovative solutions related to issues and concerns, and facilitate continuous program improvements to better serve members.

Supporting member education and informed choices

A core responsibility within our model is embracing person-centered service planning. We communicate an array of options available to our members, supporting and promoting their informed decision-making and their well-being. Our approach promotes member engagement in all aspects of care and services, including interdisciplinary team development, use of supports and choice of specific providers. From our experience, we know fully informed members make effective decisions that promote health and safety and are suited to their preferences. This is a cornerstone to improving the member experience, adherence to the service plans and overall outcomes.

If you have questions about or need a copy of an individual's care plan or have a referral for an individual who can benefit from complex care management, contact our Care Management Department through Healthy Blue Provider Services at **844-594-5072**.

4.4 Continuity of Care

To assist in the transition of Healthy Blue members from one level of care to another, Blue Cross NC recommends that transition meetings or appointments be held prior to the member moving from higher to lower restrictive levels of care to ensure continuity of treatment. Blue Cross NC encourages providers to include Healthy Blue care managers in these meetings and appointments. Blue Cross NC collaborates with providers who are actively caring for members to ensure continuity of care and will share information around assessed or

identified member needs. Members are provided care management support for up to 90 days post discharge. Blue Cross NC will closely collaborate and work directly with community and provider-based care managers to ensure seamless transition back to the community.

High Level Clinical Setting
Pursuant to the State Contract, as applicable, Providers shall notify Healthy Blue when a member in a high-level clinical setting is being discharged. High level clinical settings include, but are not limited to: (i) Hospital/Inpatient acute care and long-term acute care; (ii) Nursing Facility; (iii) Adult Care Home; (iv) Inpatient behavioral health services; (v) Facility-based crisis services for children; (vi) Facility-based crisis services for adults: and (vii) ADATC.

Transition of Care
During the first 90 days of enrollment, authorization is not required for certain members with previously approved services by the state or another managed care plan. Healthy Blue will continue to be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside of Healthy Blue's network until such time as Healthy Blue can reasonably transfer the Member to a service and/or network Provider without impeding service delivery that might be harmful to the Member's health. However, notification to Healthy Blue is necessary to properly document these services and determine any necessary follow-up care.

Healthy Blue will cooperate with the receiving health plan regarding the course of ongoing care with a specialist or other Provider when Members move to a new health plan for transition of care needs. When Healthy Blue becomes aware that a covered Medicaid Member will be disenrolled from Healthy Blue and will transition to an NC Medicaid Fee for Service (FFS) program or another managed care plan, a Healthy Blue review nurse / case manager who is familiar with that Member will provide a transition of care (TOC) summary to the receiving plan or appropriate contact person for the designated FFS program.

If a Provider receives an adverse claim determination which they believe was a transition of care issue, the Provider should fax the adverse claim determination to the Appeals department with documentation of approval from agency or previous managed care organization for reconsideration.

4.5 New Baby, New Life℠ Pregnancy Support Program
New Baby, New Life℠ is the Healthy Blue Pregnancy Management Program, a proactive care management program for mothers and their newborns that includes care management for high-risk pregnancies in collaboration with the Care Management for High-Risk Pregnancy (CMHRP) program*. We use extensive methods to identify pregnant women as early in their pregnancy as possible through review of state enrollment, claims data, hospital census reports, Availity and notification of pregnancy forms, and the State's *Pregnancy Risk Screening Form* as well as provider and member self-referrals. Once identified, we act quickly to further assess the member's obstetrical risk and ensure she has the appropriate level of care and care management services to mitigate those risks.

* Members will be referred to their local health departments to participate in the Care Management for High-Risk Pregnancy (CMHRP) program.

Experienced care managers work with members and providers to establish a care plan for our highest-risk pregnant members. Care managers collaborate with community agencies to ensure mothers have access to necessary services.

When it comes to our pregnant members, we are committed to keeping both mom and baby healthy. That is why we encourage all of our moms-to-be to take part in our New Baby, New Life program — a comprehensive care management and care coordination program offering:

- A referral to the member's local health departments to participate in the CMHRP program.
- Individualized, one-on-one care management support for women at the highest risk via the state's CMHRP program.
- Care coordination for moms who may need a little extra support.
- Educational materials and information on community resources.
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born.

As part of the New Baby, New Life program, members are offered the My Advocate®* program. This program provides pregnant women proactive, culturally appropriate outreach and education through Interactive Voice Response (IVR). Eligible members receive regular phone calls with tailored content from a voice personality (Mary Beth), or they may choose to access the program via a smartphone application or website. This program does not replace the high-touch care management approach for high-risk pregnant women. However, it does serve as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify pregnant women who have become high-risk, to facilitate connections between them and our care managers, and improve member and baby outcomes.

For more information on My Advocate, visit **myadvocatehelps.com**.

Blue Cross NC encourages notification of pregnancy at the first prenatal visit and notification of delivery following birth. You may complete the notification of pregnancy and delivery forms and fax them to **800-964-3627**.

We also encourage providers to complete the *Maternity Form* accessed through Availity Essentials:

- Perform an Eligibility and Benefits (E&B) request on the desired member.
- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- Before the benefit results screen, you will be asked if the member is pregnant. Choose "Yes", if applicable. If you indicate "Yes" you may provide the estimated due date, if it is known, or leave it blank if the due date is unknown.

- After submitting your answer, the E&B will display. If the member was identified as pregnant, a Maternity form will be generated. Once generated, you may access the form in the Maternity work queue on Availity.

NICU Case Management

For parents with infants admitted to the neonatal intensive care unit (NICU), in addition to making referrals to the Care Management for At Risk Children (CMARC) program*, we offer the NICU Case Management program. This program provides education and support designed to help parents cope with the day-to-day stress of having a baby in the NICU, encourages parent/caregiver involvement, and helps them to prepare themselves and their homes for discharge. Parents are provided with education and resources that outline successful strategies they may use to collaborate with the baby's NICU care team while inpatient and manage their baby's health after discharge. Once discharged, highly skilled and specialized NICU case managers continue to provide education and support to foster improved outcomes, prevent unnecessary hospital readmissions and promote efficient community resource consumption.

* Members will be referred to their local health departments to participate in the Care Management for At Risk Children (CMARC) program.

The stress of having an infant in the NICU may result in post-traumatic stress disorder (PTSD) symptoms for parents and loved ones. To reduce the impact of PTSD among our members, we assist by:

- Guiding parent(s) into hospital-based support programs, if available.
- Screening parent(s) for PTSD approximately one month after their baby's date of birth.
- Referring parent(s) to behavioral health program resources, if indicated.
- Reconnecting with a one-month follow-up call to assess if the parent(s) received benefit from initial contact and PTSD awareness.

Our NICU case managers are here to help you. If you have a patient in your care that would benefit from participating in the NICU Case Management program, please call Healthy Blue Provider Services at **844-594-5072.**

Within 24 hours of the birth of a newborn (or within one business day of delivery), clinical birth information is required to be submitted to Blue Cross NC by the hospital. Fax *Newborn Notification of Delivery Forms* to **800-964-3627**.

The clinical information required is outlined as follows:

- Indicate whether a live birth
- Newborn's birth weight
- Gestational age at birth
- Apgar scores
- Disposition at birth
- Type of delivery: vaginal or Cesarean
  - If a Cesarean: the reason the Cesarean was required
- Date of birth
- Gender

- Single/multi birth
- Gravida/para/ab for mother
- Estimated date of confinement (EDC) and if NICU admission was required

Providers may use their standard reporting form specific to their hospital as long as the required information outlined above is included.

After delivery, members may be contacted by a representative of the Maternal Postpartum Outreach program to remind them to schedule their postpartum appointment between 7 to 84 days. If the member has not scheduled an appointment, the representative will assist them with scheduling an appointment and will work closely with the provider offices to ensure the member has an appointment scheduled. The member will be mailed a reminder appointment card and receive a reminder call prior to the appointment. After the appointment has occurred, the representative will contact the provider's office to verify the member's attendance at the appointment and will contact the member to reschedule if the appointment was missed. If a member cannot physically go for a postpartum visit due to access to care issues, transportation, childcare or not being able to get an appointment during the 7- to 84-day time frame, the member will be eligible to receive a provider home visit through a contracted agency to receive her postpartum visit during the designated time frame. The contracted agency will share visit information with the managing OB/GYN after the visit.

Members may also receive calls from care managers to provide interconceptional care management, with education and support in obtaining information to develop an interconceptional family life plan.

4.6 Condition Care

Our Condition Care (CNDC) approach is based on a system of coordinated care management interventions and communications designed to assist physicians and other health care professionals in managing members with chronic conditions. Condition Care include a holistic, focusing on the needs of the member through telephonic and community-based resources. Motivational interviewing techniques used in conjunction with member self-empowerment. The ability to manage more than one condition to meet the changing health care needs of our member population. Our condition care programs include the following:

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder — adult and child/adolescent
- Substance use disorder
- Schizophrenia

In addition to our condition-specific condition care programs, our member-centric, holistic approach also allows us to assist members with smoking cessation and weight management education.

Program features:

- Proactive population identification process
- Program content is based on evidence-based *Clinical Practice Guidelines*
- Collaborative practice models, which include the physician and support providers in treatment planning
- Continuous self-management education
- Ongoing communication with primary and ancillary providers regarding patient status

Nine of our Condition Care programs are NCQA-accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Condition care *Clinical Practice Guidelines* are located at **provider.healthybluenc.com**.

A copy of the guidelines can be printed from the website, or you can call Healthy Blue Provider Services at **844-594-5072** to receive a printed copy.

Who is eligible?

Members diagnosed with one or more of conditions listed above are eligible for condition care services.

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their condition. They are provided with continuous education on self management concepts, which include primary prevention, coaching related to healthy behaviors and compliance/ monitoring, as well as care/case management for high-risk members. Providers are given phone and/or written updates regarding patient status and progress.

Condition care provider rights and responsibilities

Providers have additional rights and responsibilities, such as the right to:

- Obtain information about the organization’s services, staff qualifications and any contractual relations.
- Decline to participate in or work with the organization’s programs and services on behalf of their patients.
- Be informed how the organization coordinates interventions with care plans for individual members.

- Know how to contact the care manager responsible for managing and communicating with their patients.
- Be supported by the organization when interacting with members to make decisions about their health care.
- Receive courteous and respectful treatment from the organization's staff.
- Communicate complaints to the organization.

Hours of operation
Our CNDC care managers are registered nurses. They are available 8:30 a.m. to 5:30 p.m. local time. Confidential voicemail is available 24 hours a day. The 24/7 Nurse Line is also available for our members 24 hours a day, 7 days a week.

Contact
You can call a CNDC Team member at **888-830-4300**. CNDC program content is located at **provider.healthybluenc.com/docs/inline/NCNC_CAID_Forms_Other_DiseaseManagementReferral.pdf?v=202104212223**. Providers can go to the provider website and download the CNDC referral form.

4.7 Provider Directories

We make provider directories available to members in online searchable and hard copy formats. Because members use these directories to identify health care providers near them, it is important that your practice address(es), doctors' names and contact information are promptly updated when changes occur. Providers should ensure demographics are updated in NCTracks to be reflected in the Healthy Blue Provider Directories and *Find Care* tool on our website.

You can view your practice information by:

- Visiting **provider.healthybluenc.com**.
- Calling Healthy Blue Provider Services.
- Contacting Healthy Blue Provider Relationship Account Managers

The provider directory is available on the member website at **healthybluenc.com**.

4.8 Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Healthy Blue wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that

healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described.
- Expectations of care and treatment options.
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine. Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Healthy Blue ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. We encourage providers to access and utilize the following resources.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- **Caring for Children with ADHD:** Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- **My Inclusive Practice — Improving Care for LGBTQIA+ Patients:** Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.
- **Improving the Patient Experience:** Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- **Medication Adherence:** Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.

- **Moving Toward Equity in Asthma Care:** Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Health Care Stereotype Threat (HCST):** Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training: A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Blue Cross NC requires and provides training on cultural competence to network providers, including cultural awareness working with Native American Indian/Alaska Native populations. The Cultural Competency Training is available on **Healthy Blue Training Academy (healthybluenc.com).**

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients. To access the toolkit, go to **Healthy Blue Training Academy (healthybluenc.com)** > Caring for Diverse Populations Toolkit.

Providers should attempt to collect member demographic data, including but not limited to ethnicity, race, gender, gender identity, sexual orientation, religion and social class. This will allow the provider to respond appropriately to the cultural needs of the community being served. Members must be given the opportunity to voluntarily disclose this information; it cannot be required.

Interpreter/Translation Services
It is important to use an interpreter, when necessary, to ensure your patient understands all of his or her options and is able to make informed decisions. Interpreter services are available to Healthy Blue members 24/7 in over 170 languages by calling the Healthy Blue Provider Services line at **844-594-5072**, and are available for provider visits via in-person (with 72-hour notice), virtual, and telephonic. Interpreter services can also be set up for consecutive appointments.

Healthy Blue's in-person interpreter services are typically for hearing or vision impaired members, however additional languages can be supported. The interpreter service is available when a translator is physically required to join the member's appointment and should be arranged prior to the member's appointment:

- A 72-hour prior notice is required for an in-person translator prior to the appointment date unless it is an urgent visit (sick). Call Healthy Blue Provider Services at 844-594-5072.
- When the interpreter request is received, Healthy Blue reaches out to the member via the phone to schedule the interpreter services for their scheduled appointment.

The service is of no cost to the member and offered as part of their benefits.

Blue Cross NC appreciates the shared commitment to ensuring members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

4.9 Member Records

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

A member's previous provider must forward a copy of all medical records to you within 10 business days from receipt of your request at no charge. Members are entitled to one copy of their medical record per year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Member records must be retained for at least six years after the last good, service or supply has been provided to a member or an authorized agent unless those records are subject to review, audit or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Blue Cross NC requires access to member records for the purpose of conducting medical record reviews.

Our medical records standards include the following:

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work phone numbers, and marital status; primary languages spoken and translation needs must be included
- Date and corroboration — dated and identified by the author
- Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
- Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No Known Allergies
- Past medical history — for patients seen three or more times; include serious accidents, operations, illnesses, and prenatal care of mother and birth for children
- Immunizations — a complete immunization record for pediatric members 20 years of age and younger with vaccines and dates of administration; evidence of lead screening for ages 6 months to 6 years
- Diagnostic information including growth charts, head circumference and developmental milestones, if applicable
- Medical information, including medication and instruction to patient; current list of medications
- Identification of current problems
- Serious illnesses
- Medical and behavioral conditions

- Health maintenance concerns
- Instructions, including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
- Smoking/alcohol/substance abuse — notation required for patients ages 12 and older and seen three or more times
- Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
- Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
- Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
- Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

4.10 Patient Visit Data

You must provide the following:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
- Admission or initial assessment must include:
  - Current support systems
  - Lack of support systems
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating either:
  - Decreased
  - Increased
  - Unchanged
- A plan of treatment including:
  - Activities
  - Therapies
  - Goals to be carried out
- Diagnostic tests
- Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment or documentation as to why no family involvement is present
- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
- Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

4.11 Advance Directives

We adhere to the *Patient Self-Determination Act* and recognize and support the following advance directives:

- Durable power of attorney
- Living will

A durable power of attorney lets a member name a patient advocate to act on his or her behalf. A living will let a member state his or her wishes on medical treatment in writing. We encourage members ages 18 and older to ask you for an advance directive form and education at their first appointment. Document their forms in your medical records. We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care. Note, a Healthy Blue associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

PRECERTIFICATION/PRIOR NOTIFICATION PROCESS

Referrals to in-network specialists are not required. However, some specialty services require precertification as specified below. We encourage members to consult with their PCPs prior to accessing nonemergency specialty services. The two processes are defined below.

Precertification is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. *Prospective* means the coverage request occurred prior to the service being provided.

Elective services require precertification, meaning the provider should notify Blue Cross NC by phone, fax or the provider website before providing the service. Member eligibility and provider status (network and non-network) and medical necessity will be verified.

Blue Cross NC may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] services), provided the services furnished can reasonably be expected to achieve their purpose.

Please note: Emergency room visits do not require precertification or notification. If an emergency room visit results in an in-patient admission, you should notify us within 24 hours of the visit or the next business day. No precertification is required for EPSDT services for in-network and out-of-area network providers.

How to provide notification or request prior authorization

To request digital prior authorizations, providers can visit Availity Essentials at **Availity.com**. Through this secure provider website, you can access the authorization application, which offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical and behavioral health services for Healthy Blue members. Providers can also use this application to inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool). Access the authorization application by selecting Patient Registration from Availity's homepage, then choose Authorizations and Referrals.

- Initiate preauthorization requests online, eliminating the need to fax. The application allows detailed text, photo images and attachments to be submitted along with your request.
- Review requests previously submitted via phone, fax, or other online tool.
- Gain instant accessibility from almost anywhere, including after business hours.
- Utilize the dashboard to provide a complete view of all utilization management requests with real-time status updates.
- Get real-time results for some common procedures.
- Access the authorization application by selecting Patient Registration from Availity's homepage, then choose Authorizations and Referrals.

To access ICR, you will need to have your own Availity unique ID and password and have the appropriate Availity role assignment. Your Availity administrator should assign you the Authorization and Referral Request role or the Authorization and Referral Inquiry role.

To learn more about ICR navigation and features, register for one of our ICR provider webinars.

For an optimal experience with the ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer 11, Chrome, Firefox or Safari.

The website will be updated as additional functionality and lines of business are added throughout the year.

5.1 Precertification of All Inpatient Elective Admissions

We require precertification of all inpatient elective admissions. The referring PCP or specialist is responsible for precertification. The requesting physician identifies the need to schedule a hospital admission; to do so, you can either:

- Submit your request online through Availity Essentials at **Availity.com**. (Select Patient Registration > Authorizations & Referrals)
- Fax the physical health request to **855-817-5788**
- Call Healthy Blue Provider Services at **844-594-5072**
- The fax forms are conveniently located on our website at **provider.healthybluenc.com**.

Submit requests for precertification with all supporting documentation immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a precertification is on file by:

- Visiting **provider.healthybluenc.com/north-carolina-provider/patient360**
- Calling Healthy Blue Provider Services at **844-594-5072**

If coverage of an admission has not been approved, the facility should call Healthy Blue Provider Services. We will contact the referring physician directly to resolve the issue.

We are available 24/7 to accept precertification requests. When a request is received from the physician online, via phone or by fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Our precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue a Healthy Blue reference number to the requesting physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider will be able to discuss the case with the Healthy Blue medical director prior to the determination.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the requesting provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter (including the member's appeal and fair hearing appeal rights) will be mailed to the requesting provider, member's PCP and member.

5.2 Emergent Admission Notification Requirements

Network hospitals must notify us within 24 hours or the next business day of an emergent admission. Network hospitals can notify us by calling Healthy Blue Provider Services 24/7 at **844-594-5072**, by fax at **855-817-5788** or online at **provider.healthybluenc.com**.

Our Medical Management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions based on medical necessity.

All clinical documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary.

If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider actually treating the member is responsible until, and will determine when, the member is stabilized. We will mail a denial letter to the provider and the member and include the member's appeal and fair hearing rights and process.

5.3 Nonemergent Outpatient and Ancillary Services — Precertification and Notification Requirements

We require precertification for coverage of certain nonemergent outpatient and ancillary services (see the Precertification/Notification Coverage Guidelines section). To ensure timeliness, you must include the following:

- Member name and ID
- Name, phone number and fax number of the physician providing the service
- Name of the facility and phone number where the service will be performed
- Name of servicing provider and phone number
- Date of service

- Diagnosis using ICD-10-CM
- Name of elective procedure with HCPCS or CPT-4 code
- Medical information to support the request:
  - Signs and symptoms
  - Past and current treatment plans, along with the provider who provided the surgery
  - Response to treatment plans
  - Medications, along with frequency and dosage

For the most up-to-date precertification/notification requirements and prior authorization form, visit **provider.healthybluenc.com** and select **Precertification Lookup** or ***Prior Authorization Form*** from the *Quick Tools* list.

5.4 Medical Necessity Determination and Peer Review

When a provider requests initial or continued precertification for a covered service, our utilization managers obtain necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.

If the information submitted does not appear to meet such criteria, the utilization manager submits the information for review by the medical director or other appropriate practitioner as part of the peer review process.

The reviewer, or the requesting provider, may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.

If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request such a conversation. In this case, we will make a medical director, or other appropriate practitioner, available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.

Members requesting providers and applicable facilities are notified of any adverse decision within notification time frames that are based on the type of care requested and in conformance with regulatory and accreditation requirements.

5.5 Prenatal Ultrasound Coverage Guidelines

The following are frequently asked questions and answers about our prenatal ultrasound policies.

Question	Answer
What are the requirements for precertification for total obstetric care?	For obstetric care, we do not require precertification; we only require notification to our Healthy Blue Provider Services Team.

Question	Answer
In which trimester of a woman's pregnancy is she determined to be an obstetric patient?	A member is considered to be an obstetric patient once pregnancy is verified.
Are there precertification requirements for prenatal ultrasound?	There are no precertification requirements for prenatal ultrasound studies. Payment is administered by matching the procedure with the appropriate diagnosis code submitted on the claim.
Is there a medical policy covering prenatal ultrasound procedures?	Yes, there is a detailed policy covering certain prenatal ultrasound procedures. To review the complete policy: • Go to **provider.healthybluenc.com** The policy describes coverage of ultrasound studies for maternal and fetal evaluation as well as for evaluation and follow-up of actual or suspected maternal or fetal complications of pregnancy.
Why was the policy created?	The policy was created to ensure members receive the most appropriate ultrasound for the diagnosis or condition(s) being evaluated.
Does the policy describe limits on the number of prenatal ultrasound procedures a woman may have during her pregnancy?	The policy covers two routine ultrasounds per pregnancy (CPT code 76801 or 76805). Additional prenatal ultrasounds for fetal and maternal evaluations or for follow-up of suspected abnormalities are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study performed. Not all diagnosis codes are acceptable and appropriate for all ultrasounds. When submitted incorrectly, a claim will be denied.
Which ultrasound procedures are covered under this policy?	The policy does not apply to ultrasound studies with CPT codes not specifically listed in the policy such as nuchal translucency screening, biophysical profile and fetal echocardiography. For CPT codes 76801 (+76802) and 76805 (+76810), two routine ultrasound studies are covered per pregnancy. For CPT codes 76811 (+76812), 76815, 76816 and 76817, additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT code 76811 (and +76812) is only reimbursable to maternal fetal medicine specialists.
Are there exceptions to this policy?	The policy does not apply to the following specialists: Maternal fetal medicine specialists (S142, S083, S055 and S088) Radiology specialists (S164 and S232)

Question	Answer
	The policy also does not apply to ultrasounds performed in place of service code 23 — emergency department.

5.6 Prior authorization/Notification Coverage Guidelines

For code-specific prior authorization requirements, visit the provider website.	
Air ambulance services	Prior authorization is required for nonemergent air ambulance services.
Auditory implant external parts	Prior authorization is required for auditory implant external parts. Device manufacturers are the only qualified providers for these services.
Behavioral health/ substance abuse services	To obtain information about prior authorization requirements for behavioral health services, visit **provider.healthybluenc.com**. For information or to make referrals, call **844-594-5072**. Visit **provider.healthybluenc.com/north-carolina-provider/prior-authorization-lookup** to provide notification or request prior authorization for behavioral health services. PA can also be requested through our online precertification application which you can access through Availity Essentials at **Availity.com**. (Select Patient Registration > Authorizations & Referrals).
Chemotherapy	Prior authorization is required for inpatient chemotherapy as part of the inpatient admission and for oncology drugs and adjunctive agents. However, precertification is not required for procedures performed in the following outpatient settings: • Office • Outpatient hospital • Ambulatory surgery center
Circumcision	Routine circumcisions are covered within the first 30 days of life and medically necessary circumcisions are covered with no age limit.
Dermatology	No prior authorization is required for a network provider for the following: • Evaluation and management • Testing • Procedures Cosmetic services or services related to previous cosmetic procedures are not covered.
Diagnostic testing	No prior authorization is required for the following: • Routine diagnostic testing Prior authorization is required for the following: • MRA • MRI

For code-specific prior authorization requirements, visit the provider website.	
	• CAT scans • Nuclear cardiac • Video EEG • PET imaging
Durable medical equipment (DME)	To obtain information about prior authorization requirements for Durable medical equipment (DME), visit **provider.healthybluenc.com**. Prior authorization requirements are based on the code being requested. According to clinical policies 5A-1, 5A-2, 5A-3, and 5B, there may be appropriate limits placed, based on medical necessity criteria, on DME and medical supplies. When the prescribing Healthy Blue physician, physician assistant, or nurse practitioner orders equipment or supplies beyond these limits, the provider should request DME prior authorization (PA) for these items through Blue Cross NC. A PA request for an override of a quantity limit or lifetime expectancy must include the usual PA documentation (Subsections 5.2 and 5.3 of all clinical policies above) along with the following additional information: • The item being requested for an override clearly marked on the PA form. • The type of override (quantity limit or lifetime expectancy) clearly stated. • An explanation of the medical necessity for the override from the physician, physician assistant, nurse practitioner, or therapist. Override PA requests are reviewed for medical necessity as per normal PA review timelines. Override PA review outcomes are communicated to providers and beneficiaries in the same manner as a typical PA request. It should be clearly stated that a PA exception is being requested. Visit **provider.healthybluenc.com/North-carolina-provider/prior-authorization-lookup** to provide notification or request prior authorization for DME. Healthy Blue PA requests can be submitted via: • Phone: **844-594-5072**, option 2 • Fax: **855-817-5788** • Availity at **Availity.com** Proper HCPCS and/or other codes for billing are required in addition to the use of appropriate modifiers (NU for new equipment, RR for rental equipment). For details regarding our policy on rent-to-purchase DME, please see the DME Reimbursement Policy posted on our website at **provider.healthybluenc.com**.

For code-specific prior authorization requirements, visit the provider website.	
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit	Self-referral; use the EPSDT schedule and document visits. Note: Vaccine serum is received under the Vaccines for Children Program.
Educational consultation	No prior authorization is required.
Emergency room	No prior authorization is required. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room.
ENT services (otolaryngology)	No prior authorization is required for a network provider for the following: • Evaluation and management • Testing • Certain procedures Prior authorization is required for the following: • Nasal/sinus surgery • Cochlear implant surgery and services
Family planning/ sexually transmitted infection care	Self-referral; members may self-refer to any in-network or out-of-network provider. Encourage your patients to receive family planning services in network to ensure continuity of service.
Gastroenterology services	No prior authorization is required for a network provider for the following: • Evaluation and management • Testing • Certain procedures Prior authorization is required for the following: • Bariatric surgery • Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components • Upper endoscopy
Gynecology	No prior authorization is required for a network provider for the following: • Evaluation and management • Testing • Certain procedures
Hearing aids	Prior authorization is required for digital hearing aids.
Hearing screening	No prior authorization is required for the following: • Diagnostic and screening tests • Hearing aid evaluations

For code-specific prior authorization requirements, visit the provider website.	
	• Counseling
Home health care and home IV infusion	Prior authorization is required for the following: • Skilled nursing • Extended home health services • IV infusion services • Home health aide • Physical, occupational and speech therapy services • Physician-ordered supplies • IV medications for in-home therapy Note: DME may require separate precertification. Drugs also may require precertification through the pharmacy benefit if the site of care is the home and if the drug is not listed in the home infusion policy.
Hospice	Prior authorization is not required.
Hospital admission	Prior authorization is required for the following: • Elective admissions • Some same day/ambulatory surgeries We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room. Preadmission testing must be performed by a Healthy Blue preferred lab vendor or network facility outpatient department. See our provider directory for a complete listing. We do not cover the following: • Rest cures • Personal comfort and convenience items • Services and supplies not directly related to patient care (phone charges, take-home supplies, etc.) We request notification of inpatient emergency admissions within one business day of admission. Failure of admission notification after one business day may result in claim denial. Non-business days, in addition to the weekend, include New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, day after Thanksgiving Day and Christmas Day.
Laboratory services (outpatient)	Prior authorization is required for the following: • Genetic testing • All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition
Long-term care	Prior authorization and plan of care are required. We will cover the first 45 days of long-term care (or until the member's eligibility with us terminates).
Medical injectables	We cover most specialty drugs under the pharmacy benefit. These drugs can be obtained through any pharmacy in our network that dispenses these medications. We also cover many, but not all, primarily injectable drugs that are purchased and administered by a medical professional in a physician's office or in an

For code-specific prior authorization requirements, visit the provider website.	
	outpatient clinic setting under the medical benefit through the NC Physician-Administered Drug Program (PADP). For a complete list of drugs covered under the PADP as well as reimbursement rates, visit our provider website. Injectables under the medical benefit will not require prior authorization if being used for FDA-approved or medically appropriate indications (benefit exclusions may apply).
Neurology	Prior authorization is not required for a network provider for the following: • Evaluation and management • Testing • Certain other procedures Prior authorization is required for: • Neurosurgery • Spinal fusion • Artificial intervertebral disc surgery
Observation	No prior authorization is required for in-network observation from a minimum of 8 hours to 30 hours. If observation results in admission, notification is required within 24 hours or the next business day. If your observation results in an admission, you must notify us within 24 hours or on the next business day.
Obstetrical (OB) care	OB care management programs are available for high-risk women. No prior authorization is required for the following: • Obstetrical services and diagnostic testing • Obstetrical visits • Certain diagnostic tests and lab services by a participating provider • Prenatal ultrasounds • Normal vaginal and Cesarean deliveries Actions to consider: • Blue Cross NC does not require prior authorization for obstetric care. • Notification to Healthy Blue Provider Services at **844-594-5072** for the first prenatal visit is required. • All inpatient admissions require providers to provide notification to Healthy Blue including admission for normal vaginal and Cesarean deliveries. • Prior authorization n is not required for normal vaginal and Cesarean deliveries. Blue Cross NC will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal Cesarean delivery. The hospital is required to notify Blue Cross NC of the discharge date of the mother. Fax *Maternal Discharge Notifications* to **844-451-2694** (within one business day of discharge).

For code-specific prior authorization requirements, visit the provider website.	
	• For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for Cesarean delivery, the hospital is required to provide notification to Healthy Blue Provider Services (phone **844-594-5072** or fax **800-964-3627** and initial clinical and updates directly to Healthy Blue via fax **844-451-2694**). • Blue Cross NC is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an obstetrical admission exceeding 48 hours after a vaginal delivery and 96 hours after a Cesarean section. In these cases, Blue Cross NC is allowed to deny only the portion of the claim related to the inpatient. • If a member is admitted for an induction or labor and fails to deliver by day two of the admission, the hospital is required to submit clinical via fax (**844-451-2694**) for the first two days of admission for medical necessity review. • Within 24 hours of the birth of a newborn (or within one business day of delivery), clinical birth information is required to be submitted to Healthy Blue by the hospital. Fax *Newborn Notification of Delivery Forms* to (**844-451-2694**)**.** • The clinical information required is outlined as follows: ○ Indicate whether a live birth ○ Newborn's birth weight ○ Gestational age at birth ○ Apgar scores ○ Disposition at birth ○ Type of delivery: vaginal or Cesarean ○ If a Cesarean: the reason the Cesarean was required ○ Date of birth ○ Gender ○ Single/multi birth ○ Gravida/para/ab for mother ○ EDC and if neonatal intensive care unit (NICU) admission was required Providers may use the standard reporting form specific to their hospital, as long as the required information outlined above is included. If a newborn requires admission to the NICU, the hospital must provide notification to Healthy Blue Provider Services (phone **844-594-5072** or fax **800-964-3627** and initial clinical and updates directly to Healthy Blue via fax **844-451-2694**). Well babies are covered under the mother's hospitalization authorization. If a newborn requires hospitalization as a border baby beyond the mother's discharge date, the hospital must provide notification as directed for NICU admissions. OB care management programs are available for all high-risk women through the Local Health Department
Ophthalmology	No prior authorization is required for the following: • Evaluation and management • Testing Prior authorization is required for repair of eyelid defects.

For code-specific prior authorization requirements, visit the provider website.	
	We do not cover services that are considered cosmetic.
Oral maxillofacial	See Plastic/cosmetic/reconstructive surgery section.
Out-of-area/ out-of-network care	Prior authorization is required for all out-of-network services except for emergency care; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening; family planning; and OB care. Note: prior authorization is not required for EPSDT screening for both in-network and out-of-area network providers.
Outpatient/ ambulatory surgery	Our prior authorization requirement is based on the procedure performed; visit our provider website for more details.
Pain management/ physiatry/ physical medicine and rehabilitation	Prior authorization is required for non-evaluation and management-level services. Pain management services require precertification.
Pediatric day health care (PDHC)	Prior authorization is required for the following services and codes: • T2002
Personal care services	Requires prior authorization.
Pharmacy services	The pharmacy benefit covers medically necessary prescription and over-the-counter drugs prescribed by a licensed provider. Refer to the *PDL* for the preferred products within therapeutic categories as well as requirements around generics, prior authorization, step therapy, quantity edits and the prior authorization process. Quantity and day supply limits may apply. The PDL includes medications in commonly prescribed categories, but does not represent all covered medications.
Plastic/cosmetic /reconstructive surgery (including oral maxillofacial services)	No prior authorization is required for the following: • Evaluation and management services • Oral maxillofacial evaluation and management services Prior authorization is required for the following: • All other services • Trauma to the teeth • Oral maxillofacial medical and surgical conditions • TMJ We do not cover the following: • Services considered cosmetic in nature • Services related to previous cosmetic procedures Reduction mammoplasty requires our medical director’s review.

For code-specific prior authorization requirements, visit the provider website.	
Podiatry	No prior authorization is required for evaluation and management, testing, and most procedures.
Radiology	See Diagnostic Testing section.
Rehabilitation therapy (short term): speech, physical and occupational therapy	Effective May 1, 2023, Carelon Medical Benefits Management will manage Medicaid rehabilitation services reviews for certain places of service* for Healthy Blue members in North Carolina through the Rehabilitation Program. * Carelon Medical Benefits Management will manage reviews for specific places of service including: • Outpatient Office - place of service designation 11 • Outpatient Independent Clinic - place of service designation 49 • Telehealth - place of service designation 02 • Outpatient Hospital - place of service designation 22/19 Other place of service such as 03 (school), 99 (other), and 12 (home) will be the responsibility of the Health Plan to review. To request prior authorization from Carelon Medical Benefits Management, the most efficient way to submit a therapy service request is to use the Carelon Medical Benefits Management provider portal. The provider portal allows providers to open a new order, update an existing order, and retrieve their order summary. As an online application, the provider portal is available 24/7. The first step is to register in provider portal if the provider is not already registered. Go to www.providerportal.com to register. Providers should select an out place of service designation on portal that coincides with the place of service designation they will send on their claim for a Healthy Blue member. If the outpatient place of service designation that your facility bills with is not shown, your facility will be referred to the health plan for prior authorization. Requests submitted with incomplete clinical information may result in a denial. Initial outpatient therapy evaluations and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be completed and submitted with prior authorization requests.
Spinal surgery	Prior authorization is required.
Nursing facility	Prior authorization is required.
Sterilization	No prior authorization is required for the following: • Sterilization • Tubal ligation • Vasectomy We require a sterilization consent form for claims submissions. We do not cover reversal of sterilization.
Nonemergent transportation	No prior authorization is required.

For code-specific prior authorization requirements, visit the provider website.	
Urgent care center	No prior authorization is required for a participating facility.
Well-woman exam	No prior authorization is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network GYN. The visit includes the following: • Examination • Routine lab work • Sexually transmitted infection screening • Mammograms for members 35 and older • Pap smears Members can receive family planning services without precertification at any qualified provider. Encourage your patients to receive family planning services from an in-network provider to ensure continuity of service.
Revenue (REV) codes	Prior authorization is required for services billed by facilities with REV codes for the following: • Inpatient • OB • Home health care • Hospice • CT, PET and nuclear cardiology • Chemotherapeutic agents • Pain management • Rehabilitation (physical/occupational/respiratory therapy) • Rehabilitation short-term (speech therapy) • Specialty pharmacy agents Refer to the provider website for code-specific precertification requirements. For a complete list of specific RV codes, visit **provider.healthybluenc.com**.

Blue Cross NC has staff available 7 days a week to accept prior authorization requests. When a medical request is faxed, Blue Cross NC will:

- Verify our member's eligibility and benefits.
- Determine the appropriateness of the request.
- Issue you a reference number.

For urgent or stat requests, if documentation is not complete, we will ask for additional necessary documentation. For cases in which a provider indicates, or Blue Cross NC determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, Blue Cross NC must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service."

In compliance with our Medicaid Managed Care contract, and in compliance with 42 CFR

438.210, it is required that we render decisions on expedited authorization requests within 72 hours after the receipt of the request for authorization.

Blue Cross NC receives a significant volume of Healthy Blue requests for expedited authorizations which do not meet the statutory requirements for an expedited review. Effective April 1, 2022, Blue Cross NC will downgrade requests for authorizations received as expedited to a standard authorization request, when the expedited request does not meet the definition and requirements of 42 CFR438.210 (d)(2)(i)). This will allow us to prioritize urgent service authorization requests appropriately and improve turnaround time on non-urgent, standard service requests.

Some expedited requests that will be impacted by this change includes but is not limited to the following services:

- Therapy services (occupational, speech therapy, physical therapy, and home therapy)
- Cranial remolding helmet
- Sleep studies
- Genetic testing
- Chronic pain management for spinal/facet injections
- Vein ablation
- Foot orthotics
- Knee braces
- Plastic or reconstructive procedures
- Cochlear implants
- Screening colonoscopy

If your request is denied by our medical director, you will have the opportunity to discuss your case with him or her. We will mail a denial letter to the hospital, the member's PCP and the member, and we will include the member's appeal and fair hearing rights and process.

5.7 Hospital Admission Reviews

Observation

Outpatient observation does not require prior authorization for in-network providers. We allow observation from a minimum of 8 hours to 30 hours. During an initial observation stay, if the attending physician determines that the patient requires inpatient admission, the hospital is required within 24 hours or the next business day to notify Blue Cross NC.

We do not auto-convert patients to an inpatient status at the end of 30 hours. There should be a physician's order for admission, and the admission must meet medical necessity guidelines before it will be approved.

Inpatient admission review

Notification of admission to Blue Cross NC is your essential first step in the precertification process.

We review all inpatient hospital admissions and urgent and emergent admissions. We determine the member's medical status through:

- Phone or onsite review
- Communication with the hospital's Utilization Review Department

We then document the appropriateness of stay and refer specific diagnoses to our Care Management staff for care coordination or care management based on our integrated rounds.

Inpatient concurrent review

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record.

It is the hospital's responsibility to submit clinical information for review by the specified next review date and time determined by Blue Cross NC at the time of admission and for continued length of stay.

The clinical submission deadline for Blue Cross NC is 3 p.m. Eastern time. We will implement a 10-minute grace period to alleviate time discrepancies on fax machines. Submissions of clinical information beyond 3:10 p.m. Eastern time may result in a denial of authorization. A fax confirmation for the transmittal of documentation prior to a specified time will be accepted by the plan as meeting the deadline.

We will communicate approved days and bed-level coverage to the hospital for any continued stay.

Your Utilization Management resources	
Hospital Prior Authorization Admission Notification:	Precertification request and notification of intent to render covered medical services **Phone**: **844-594-5082** **Online: provider.healthybluenc.com**
Inpatient Utilization Management:	Emergent inpatient admission required review for medical necessity and clinical information submitted
Outpatient Utilization Management:	**Phone: 844-594-5082**
Inpatient Behavioral Health Utilization Management:	Emergent inpatient admission requires review for medical necessity and clinical information submitted **Phone: 844-594-5082** **Online: provider.healthybluenc.com**
Outpatient Behavioral Health Utilization Management:	**Phone: 844-594-5082** **Online: provider.healthybluenc.com**

Utilization Management staff will identify themselves by name, title and as a Healthy Blue employee when initiating and returning calls regarding UM issues.

5.8 Discharge Planning

Our Utilization Management (UM) clinician coordinates our members' discharge planning needs with:

- The hospital's utilization review and/or care management staff.
- The attending physician.

We review discharge plans daily. As part of our UM program, the clinician will try to meet with the member and family when necessary to:

- Discuss any discharge planning needs
- Verify they know the member's PCP's name, address and phone number

The attending physician is responsible for coordinating follow-up care with the member's PCP, and the PCP contacts the member to schedule the care. This includes members who are administratively discharged by the facility.

For ongoing care, we work with the provider to plan discharge to an appropriate setting such as a(n):

- Hospice facility
- Convalescent facility
- Home health care program (for example, home intravenous antibiotics)
- Adult care home/assisted living facility
- Long-term acute care
- Skilled nursing facility

Precertifications include but are not limited to:

- Home health
- DME
- Follow-up visits to certain practitioners
- Outpatient procedures
- Outpatient rehabilitation

For postdischarge support, we provide a Post-Discharge Care Management Program to help the members identified as high risk prevent a readmission to the hospital by providing:

- Short term care management when discharging from the hospital to home by engaging directly with the member.
- Review of precipitating factors (for example, situations or conditions that led to an admission).
- Medication management: new prescriptions ordered postdischarge and medication reconciliation.
- Follow-up care and establishing a medical home; ensuring appointments are made and having discussions regarding the importance of coordination through the member's primary care physician.
- Red flag management — factors that trigger the member to contact their physician or modify behavior related to their condition or chronic disease.
- Encouragement to the member to manage their patient-centered record.
- Disease-specific education.
- The 24/7 NurseLine phone number, as well as other resources for condition changes.

For members transitioning to the fee-for-service program, we will continue to bear financial responsibility of an enrolled member who is currently admitted to an inpatient facility while covered by Healthy Blue plan through the date of discharge from such facility. Postdischarge care may be coordinated prior to discharge.

5.9 Confidentiality of Information

The following ensure that members' protected health information (PHI) is kept confidential:

- Utilization Management
- Care Management
- Condition Care (CNDC)
- Discharge Planning
- Quality Management
- Claims Payment
- Pharmacy

PHI is shared only with those individuals who need access to it to conduct utilization management.

5.10 Misrouted Protected Health Information

Providers and facilities are required to review all member information received to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Healthy Blue Provider Services Team at **844-594-5072** for assistance.

5.11 Emergency Services

Emergency services, including those for specialized behavioral health, do not require precertification. Blue Cross NC covers and pays for emergency services, regardless of whether the provider that furnishes the emergency services is contracted with us. Blue Cross NC will not deny payment for treatment obtained when a member had an emergency medical condition as defined in *42 CFR §438.114(a)*, nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms. We do not deny or discourage our members from using 911 or accessing emergency services. As a matter of course, we grant authorizations for these services immediately.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

The attending emergency physician or the provider treating the member will determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on Blue Cross NC for coverage and payment. If there is a disagreement between a hospital or other treating facility and Blue Cross NC concerning whether the member is stable enough for

discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on Blue Cross NC. This subsection does not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized. If the emergency department cannot stabilize and release our member, we will help coordinate the inpatient admission.

Any transfer from an out of network hospital to an in-network hospital can only take place after the member is medically stable.

5.12 Urgent Care/After-Hours Care

We strongly encourage our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer him or her to one of our participating urgent care centers or another provider who offers after-hours care. Precertification is not required.

We strongly encourage PCPs to provide evening and weekend appointment access to members. We encourage two hours at least one day per week after 5 p.m. and four hours or longer on Saturday. To learn more about participating in the after-hours care program, call your local Provider Relationship Management representative.

QUALITY MANAGEMENT

6.1 Quality Management Program

We have a comprehensive Quality Management (QM) program to monitor the demographic and epidemiologic needs of the population served. We evaluate the needs of the Healthy Blue population annually, including age/sex distribution and inpatient, emergent/urgent care and office visits by type, cost, and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

QM Program activities include but are not limited to:

- Ensuring appropriate access to care by monitoring practitioner and provider access and availability reports and member grievance reports to address any network gaps identified.
- Ensuring quality of care and service provided to the members including the integration of physical health services, behavioral health services, substance use services, and services to address unmet health-related resource needs (social determinants of health/healthy opportunities).
- Monitoring clinical outcomes and appropriateness of care through quality indicators, performance improvement projects and Healthcare Effectiveness Data and Information Set (HEDIS®) measures.
- Implementing interventions and corrective actions plans when results indicate improvement is needed.
- Monitoring and improving provider satisfaction and member satisfaction through analysis of annual provider satisfaction survey, member CAHPS® satisfaction survey and complaint/grievance reports.
- Monitoring and maintaining full compliance with the applicable state, federal and accreditation requirements.
- Monitoring and maintaining patient safety including promotion of safe clinical practices
- Implementing value-based payment/alternative payment models to reward providers meeting performance goals.
- Implementing a member incentive program designed to engage members to seek preventive and wellness services, and to better manage chronic conditions.
- Aligning incentives and program interventions to address public health priorities.
- Advancing health equity to improve lives and communities.
- Promoting wellness/prevention and improving chronic condition management.

Performance Improvement Projects

- Are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Include measurement of performance using objective quality indicators;
- Include implementation of interventions to achieve improvement in access to and quality of care;
- Include evaluation of the effectiveness of the interventions; and
- Include planning and initiation of activities for increasing or sustaining improvement.

Healthy Blue current performance improvement projects are:

- Diabetes HbA1c Control
- Prenatal/Postpartum Care

- Childhood Immunizations
- Tobacco Cessation

NCDHHS Quality Measures for Standard Plans

NQF#	Measure	Steward
Pediatric Measures[24]		
1800	Asthma Medication Ratio (AMR) – Ages 5 to 18 Years	NCQA
0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Ages 3 Months to 17 Years	NCQA
1516	*Child and Adolescent Well-Care Visits (WCV)*	NCQA
0038	*Childhood Immunization Status (Combination 10) (CIS)[25]*	NCQA
0033	*Chlamydia Screening in Women (CHL) – Ages 16 to 20*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH) – Ages 6 to 17	NCQA
0108	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	NCQA
1407	*Immunization for Adolescents (Combination 2) (IMA)*	NCQA
0418/0418e	*Screening for Depression and Follow-up Plan (CDF) – Ages 12 to 17*	CMS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
1392	*Well-Child Visits in the First 30 Months of Life (W30)*	NCQA
Adult Measures (Age 18 or Older Unless Otherwise Noted)		
1800	Asthma Medication Ratio (AMR)	NCQA
0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA
0032	*Cervical Cancer Screening (CCS) – Ages 21-64*	NCQA
0033	*Chlamydia Screening in Women (CHL) – Ages 21-24*	NCQA
0034	Colorectal Cancer Screening (COL) – Ages 45-75	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA

0018	*Controlling High Blood Pressure (CBP)*	NCQA
0039	Flu Vaccinations for Adults (FVA)*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0059/0575	*Hemoglobin A1c Control for Patients with Diabetes (HBD)*	NCQA
N/A	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU)	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*[26]	NCQA
1768	*Plan All-cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA
N/A	Rate of Screening for Unmet Resource Needs[27]	DHHS
0418 / 0418e[28]	*Screening for Depression and Follow-up Plan (CDF)*	CMS
N/A	*Total Cost of Care**	Health Partners
Maternal Measures		
N/A	Low Birth Weight[29]	DHHS
1517	*Prenatal and Postpartum Care (PPC)[30]* • Timeliness of Prenatal Care • Postpartum Care	NCQA
N/A	Rate of Screening for Pregnancy Risk	DHHS

NCDHHS Quality Measures for Advanced Medical Homes

NQF#	Measure Name	Steward	Frequency
Pediatric Measures			
1516	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL) – Ages 16 to 20	NCQA	Annually
1407	Immunizations for Adolescents (Combination 2) (IMA)	NCQA	Annually
0418/0418 e	Screening for Depression and Follow-up Plan (CDF) – Ages 12 to 17	CMS	Annually
1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures (Age 18 and Older Unless Otherwise Noted)			

0032	Cervical Cancer Screening (CCS) – Ages 21 to 64	NCQA	Annually
0033	Chlamydia Screening in Women (CHL) – Ages 21 to 24	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059/0575	Hemoglobin A1c Control for Patients With Diabetes (HBD)	NCQA	Annually
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	CMS	Annually
N/A	Total Cost of Care	Health Partners	Annually
1517	**NEW:** Prenatal and Postpartum Care (PPC)[21]	NCQA	Annually

Providers must comply with all quality improvement activities including:

- Providing timely response to medical record requests
- Cooperating with quality-of-care investigations
- Participating in quality audits
- Participating in HEDIS® medical record review

Resources

At Healthcare Effectiveness Data and Information Set (HEDIS) (**healthybluenc.com**), you will find the following resources:

- HEDIS® Prenatal and Postpartum Care ECDS Coding Bulletin 2023
- HEDIS® Coding Booklet 2023
- HEDIS® Desktop Reference Guide 2023
- HEDIS® Category II Coding Bulletin 2023
- HEDIS® Well Child and Immunizations Coding Bulletin 2023
- Electronic Clinical Data Systems Coding Booklet

You have opportunities to make recommendations for areas of improvement. To contact the QM Department about quality concerns or to make recommendations, call Healthy Blue Provider Services at **844-594-5072**.

6.2 Quality of Care

Potential QOC issues may be identified by internal Healthy Blue departments or external sources including but not limited to:

- Department of Insurance
- Department of Health and Human Services
- State Department of Health
- State Medicaid Agency
- Centers for Medicare and Medicaid Services (CMS)
- Members

- Members' Authorized Representatives
- Providers
- Complaints/Grievances

Situations to be reported include, but are not limited to:

- Adverse Events, Sentinel Events, Never Events (which include Hospital-Acquired Conditions), Critical Incidents
- A pattern of substandard care that is likely to result in future dangers to members.
- Failure to comply with accepted ethical and professional standards of behavior.
- An action that represents a clear and serious breach of accepted professional standards of care, such that continued care of members by the provider could endanger their safety or health.
- Instances of an individual receiving, or not receiving, health care services that are inappropriate for their medical condition according to current clinical practice guidelines.

Healthy Blue of North Carolina assures mandated behavioral health providers, defined by the North Carolina General Statute 122C, Article 2 of the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and the North Carolina *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services (10A North Carolina Administrative Code 27G),* consistently report critical incidents in the Incident Response Improvement System (IRIS) which is maintained by the North Carolina Department of Health and Human Services. Mandated providers required to report are defined as follows:

- Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals. These include 24-hour residential facilities, day treatment, PRTFs and outpatient services
- Category B – G.S. 122C, Article 2, community-based providers not requiring State licensure

A critical incident is defined as any event that results in death or serious physical harm, abuse, neglect, or exploitation of the individuals diagnosed receiving care from a North Carolina facility, Category A or B, providing services to the individuals diagnosed with a mental health condition, developmental disability or substance abuse disorder.
All identified or potential quality concerns are forwarded to the QM Department for investigation. Cases are assigned severity levels 0-5.

- Cases with severity level 2 are reviewed by the Medical Director.
- Cases with severity level 3 or greater are reviewed by the Peer Review Committee.
- If the committee decides to pursue remedial action, the health plan medical director will attempt to reach an agreement with the provider on a remedial action plan.
- QOC issues are entered into the corporate QOC database for tracking and trending.
- The Peer Review Committee and Quality Management Committee review reports to identify opportunities to improve care and make recommendations for quality improvement actions.

6.3 Quality Management Committee

The Quality Management (QM) Committee's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program

- Establish processes and structure that ensure National Committee for Quality Assurance (NCQA) compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of QM activities
- Review HEDIS data and action plans for improvement
- Review and approve the annual QM program description
- Review and approve the annual work plans for each service delivery area
- Review and approve the annual QM program evaluation
- Provide oversight and review of delegated services
- Provide oversight and review of subordinate committees
- Receive and review reports of utilization review decisions and take action when appropriate
- Analyze member and provider satisfaction survey responses
- Monitor Healthy Blue operational indicators through the plan's senior staff

6.4 Use of Performance Data

Practitioners and providers must allow Blue Cross NC to use performance data in cooperation with our quality improvement program and activities.

6.5 Medical Review Criteria

Healthy Blue *Medical Policies* and *Clinical UM Guidelines*, which are publicly accessible from the Healthy Blue website, became the primary plan policies for determining whether services are considered to be:

- Investigational/experimental
- Medically necessary
- Cosmetic or reconstructive. MCG Care Guidelines criteria will be used when no specific Healthy Blue *Medical Policies* or *Clinical UM Guidelines* exist. A list of the specific Healthy Blue *Clinical UM Guidelines* used will be posted and maintained on the Healthy Blue website and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or Centers for Medicare & Medicaid requirements will supersede both MCG Care Guidelines and Healthy Blue *Medical Policy* criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

6.6 Clinical Criteria

Healthy Blue utilization reviewers currently use MCG Care Guidelines criteria for inpatient concurrent clinical decision support for medical management coverage decisions and for discharge planning. The criteria provide a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based on clinical appropriateness. Criteria include the following:

- Acute care

- Long-term acute care
- Rehabilitation
- Subacute and skilled nursing facility

You can obtain copies of the criteria used in a case to make a clinical determination by calling Provider Services. You may also submit your request in writing to:

Blue Cross NC | Healthy Blue
Medical Management
1965 Ivy Creek Blvd
Durham, NC 27707

Informal reconsideration/peer-to-peer (P2P) discussion

If our medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or servicing physician, and the member. You have the right to discuss this decision with our medical director by calling Healthy Blue Provider Services.

As a provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Care Management Services Department.

Additional guidelines regarding inpatient P2P discussions are below:

- Urgent requests for P2Ps will be handled within the same business day.
- We will allow P2Ps to be scheduled within five business days from the issuance of the faxed denial notification for inpatient concurrent stays.
  - We will not complete P2P discussions on retrospective eligible, postdischarge hospitalizations. For retrospective eligible postdischarge adverse determinations, follow the Healthy Blue formal medical necessity appeals process.
  - If the request for the P2P is outside of the established time frame, you'll need to follow the formal appeal process.
- The provider will be outreached by a Healthy Blue associate to schedule the P2P within one business day.
  - If you're unable to accept or schedule a P2P discussion within the specified time frame, you'll need to follow the formal appeal process.

The medical director will make two attempts to connect with the provider at the provider's specified contact number. If the provider fails to return the contact to the Healthy Blue medical director, the request for a P2P will be closed and the provider's next course of action will be to follow the formal medical necessity appeal process.

6.7 Medical Advisory Committee

We have established a medical advisory committee to:

- Utilize ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk-prevention activities

- Review and provide input based on the characteristics of the local delivery system and approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study design and results
- Develop and approve action plans/recommendations regarding clinical quality improvement studies
- Consider/recommend actions with regard to physician quality of care issues
- Review and provide input to clinically oriented quality management policies and procedures, UM policies and procedures, and disease/care management policies and procedures
- Review and provide feedback regarding new technologies
- Oversee compliance of delegated services

6.8 Utilization Management Decision Making

Utilization Management (UM) decisions are governed by the following statements:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- Blue Cross NC does not specifically reward practitioners or other individuals for issuing denial of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

6.9 Utilization Management Committee

We have established a Utilization Management (UM) committee to provide relevant UM information to the Quality Management program for quality improvement activities. This includes identifying quality of care concerns, disproportionate utilization trends, duplicative services, adverse access patterns, and lack of continuity and coordination of care processes.

The UM committee achieves its goals and objectives by working collaboratively with a variety of other departments external to our Care Management Services Department such as our Regulatory, Compliance, Provider Contracting/Provider Relationship Management, Clinical Informatics, Quality, Pharmacy, Medical Finance and the National Customer Care Departments, including Member Services.

The UM committee is responsible for providing oversight of UM activities at the plan, provider and membership levels. The UM committee convenes no less than quarterly but will meet on an ad hoc basis as needed. Meeting minutes will be taken at each UM committee meeting, and those minutes will be submitted to the North Carolina Department of Health and Human Services.

The committee responsibilities include but are not limited to the following:

- Monitoring providers' requests for rendering health care services to its members through the medical necessity and authorization process

- Monitoring the medical appropriateness and necessity of health care services provided to its members utilizing providers' quality and utilization profiling
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task
- Monitoring consistent application of medical necessity criteria
- Application of *Clinical Practice Guidelines*
- Monitoring over-/under- and duplicative utilization as well as outlier trends

6.10 Credentialing and Recredentialing

Blue Cross NC, at the department's direction, will not make a quality determination or use independent credentialing quality standards to evaluate providers. Blue Cross NC will consider any provider included by DHHS in the Provider Enrollment File (PEF) submission with an active enrollment date, as being acceptable for network inclusion subject to completion of Healthy Blue provider contracting process. Blue Cross NC will not make independent screening, enrollment, or credentialing determinations and will not request the submission of additional documentation from any provider. However, as part of the contracting process, Blue Cross NC may collect roster information including additional data elements required for claims payment and directory purposes. Most data will be provided to Healthy Blue via the Provider Enrollment File, though we may ask for additional points of contact, claims submission types, LME affiliation (if a BH provider), and provider type to ensure proper set up in our system.

During the provider credentialing transition period, as a provider is recredentialed through the Provider Enrollment process, Blue Cross NC will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily PEF. Blue Cross NC's process will occur no less frequently than every five years consistent with the Department policy and procedure.

After the Provider Credentialing Transition Period, Blue Cross NC will evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily PEF. Blue Cross NC's process will occur every three years consistent with department policy and procedure, unless otherwise notified by the department.

6.11 Provider Enrollment and Disenrollment

Through the uniform credentialing process, the Department will screen and enroll and periodically revalidate all PHP network providers as Medicaid providers.

Nondiscrimination Statement

Blue Cross NC will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran or marital status, or any unlawful basis not specifically mentioned herein. Additionally, Blue Cross NC will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to members to meet their needs and preferences, this information is not required in

the contracting process. Decisions are based on issues of professional conduct and competence as reported and verified through the contracting process.
Blue Cross NC policies and processes will not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

Disclosure Requirement
Blue Cross NC is prohibited from using, disclosing, or sharing provider enrollment/credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the department.

Enrollment
Each provider must first enroll with the Department's Medicaid program. The Department will ensure that the applicants meet all program requirements and qualifications.

- Based on state and federal requirements:
- Federal and state application fee
- Training
- Fingerprinting
- Site visits
- Criminal background checks
- Federal database checks
- Verification of provider certification, license and accreditation

Blue Cross NC's role and responsibilities:

- Blue Cross NC will accept provider screening, enrollment, credentialing and verified information from the Department on the PEF.
- Blue Cross NC may collect or request information from providers for contracting purposes only.
- Blue Cross NC will not request any additional credentialing information from a provider without the department's written prior approval.
- Blue Cross NC will not delegate any part of the centralized approach to a provider entity during the credentialing transition period.
- Blue Cross NC will not solicit or accept any provider credentialing or verified information from any other source except as permitted by the Department.
- Blue Cross NC may execute a network provider contract, pending the outcome of department screening, enrollment and revalidation, of up to 120 days, but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of 120-day period without enrollment of the provider, and notify affected members.

Ongoing sanction monitoring
Blue Cross NC will not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; Title XI §1128, §1156 and §1892. Any such payments actually claimed for Federal Financial Participation (FFP) constitute an overpayment under section 1903(d) (2) (A) of the Act and are unallowable for FFP. The one exception of the provision 42 CFR 1001.1901(c) law - payment

may be made under Medicare, Medicaid, or other Federal Health Care programs for certain emergency items or services furnished by an excluded individual or entity, or at the medical direction or from the receipt on the prescription of an excluded physician or other authorized individual during the period of exclusion.

To be payable, a claim for such emergency items or services must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an individual or entity eligible to furnish or order such items or services. This applies to all of Blue Cross NC's Federal Health Care program offerings including Medicaid, Medicare and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).

Blue Cross NC performs ongoing monitoring to help ensure continued compliance and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, Blue Cross NC will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources, including but not limited to the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid reports
3. State licensing boards/agencies
4. Any other information received from sources deemed reliable by Blue Cross NC

Provider disenrollment and termination

Payment suspension at recredentialing:

- Blue Cross NC will suspend claims payment to any provider for dates of services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit recredentialing documentation to the Department or otherwise failing to meet Department requirements.
- Blue Cross NC will reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with 50 days of suspension, the Department will terminate the provider from Medicaid.
- Blue Cross NC is not liable for interest or penalties for payment suspension at recredentialing.

Termination as a Medicaid provider by the Department:

- Blue Cross NC will remove any provider from the network and claims payment system, and terminate its contract consistent with the effective date provided by the Department with the provider within one business day of receipt of a notice from the Department that the provider is terminated as a Medicaid provider. This applies to all providers, regardless of the provider's network status.
- If Blue Cross NC suspended the provider payment, then upon notice by the Department that the provider is terminated from Medicaid, Blue Cross NC will release applicable claims and deny payment.

Blue Cross NC provider termination:

- Blue Cross NC may terminate a provider from its network with cause. Any decision to terminate will comply with the requirements of the state contract.
- Blue Cross NC will provide written notice to the provider of the decision to terminate the provider. At a minimum, the notice will include:
  - The reason for Blue Cross NC's decision;
  - The effective date of termination;
  - The Provider's right to appeal the decision; and
  - How to request an appeal

Blue Cross NC will report data to the Department on the number of providers terminated by provider type.

The information below may be collected for contracting purposes to support claim payment, directories and data management.

Additional contracting data	
Office:	**Practitioner:**
• Provider's website	• PCP or specialist status • Practitioner's hospital affiliations and/or admitting privileges • Languages spoken by the provider and office staff other than English • Has practitioner completed cultural competency training?
Financial:	
• Tax (*W9*) name • Tax (*W9*) address • Remittance address	

6.12 Peer Review

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:

- Participate in the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director.

The medical director:

- Assigns a level of severity to the grievance.
- Invites the cooperation of the physician.

- Consults with and informs the Medical Advisory Committee (MAC) and peer review committee.
- Informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken.

Note: The MAC is a recommending body to the regional Credentials Committee if the step involves a review of a provider's participation.

We report outcomes to the appropriate internal and external entities, including the quality management committee.

The peer review process is a major component of the MAC's monthly agenda.

CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

7.1 Claims Submission

You have the option of submitting claims electronically or by mail. We encourage you to submit claims electronically either through an EDI clearinghouse or directly to the claims department of Healthy Blue through Availity.

7.2 Electronic Data Interchange (EDI) – Electronic Submission of Claims

Blue Cross NC uses Availity as its exclusive partner for managing all Electronic Data Interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient, and cost-effective way for providers and employers to do business.

Use Availity for the following EDI transactions

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **availity.com** > Provider Solutions > EDI Clearinghouse.
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports

Claims submitted electronically will return reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please ensure you are receiving all reports. It's important to review rejections on the EDI reports as they will not continue for claims processing. For

questions on electronic rejections contact your Clearinghouse or Billing Vendor or Availity if you submit directly at **800- AVAILITY (800-282-4548)**.

Payer ID
Your Payer Name is Healthy Blue North Carolina, and the Payer ID is 00602.

Availity's Payer ID's
apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:
1. Log in to **Availity** at **Availity.com**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

Note: *If you use a clearinghouse, billing service or vendor, please work with them on ERA registration.*

Contact Availity
Please contact Availity Client Services with any questions at **800-AVAILITY** (**282-4548**)

Electronic Funds Transfer (EFT)
Electronic claims payment through electronic funds transfer (EFT) is the fastest and secure way to receive payment, reducing administrative processes. An EFT deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

Use EnrollSafe (**enrollsafe.payeehub.org**) to register and manage EFT account changes.

EDI Submission for Corrected Claims

For corrected electronic claims the following frequency code:
- 7 – Replacement of Prior Claim

EDI segments required:
- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

Useful EDI Documentation

Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity **EDI Companion Guide** - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
Availity Registration Page - Availity register page for users new to Availity.
X12 EDI Codes — X12 code descriptions used on EDI transactions.

7.3 Paper Claims Submission

You must submit a properly completed *UB-04* or *CMS-1500 (08-05)* claim form:

- Within 180 calendar days from the date of discharge for inpatient services or from the date of service for outpatient services; Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening claims should be filed as soon as possible within the timely filing period.
- On the original claim form with *drop-out* red ink.
- Computer-printed or typed.
- In a large, dark font.

Submit paper claims to:

Blue Cross NC | Healthy Blue
Claims Department
P.O. Box 61010
Virginia Beach, VA 23466

There are exceptions to the timely filing requirements. They include the following:
For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date of the primary carrier's *Explanation of Benefits* or 365 days from the date of discharge for inpatient services.

As a reminder, the following information applies to administrative retroactive correction claims:

- Claims must be submitted via paper/hard copy.
- A copy of the voided *Explanation of Payment* is required for documentation purposes.
- Claims received more than six months after the date the claim is voided will be denied for untimely filing.
- *CMS-1500* and *CMS-1450* forms are available from the Centers for Medicare & Medicaid Services at **cms.gov/medicare/cms-forms/cms-forms/cms-forms-list.html**.

Claims submission quality expectations

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for Compliance SNIP levels 1 to 4:

- Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims
- Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims

Claim submissions, whether electronic or paper, must include the following information:

- Member's ID number including alpha prefix
- Member's name
- Member's date of birth
- ICD-10-CM diagnosis code
- Date of service
- Place of service
- Procedures, services or supplies rendered with CPT-4 codes/HCPCS codes/ disease-related groups
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Billing provider information, and rendering provider information when different than billing or when billing a group taxonomy
- NPI of billing and rendering provider when applicable, or API when NPI isn't appropriate
- Taxonomy of billing provider, attending and rendering provider when submitted
- Coordination of benefits/other insurance information
- Precertification number or copy of precertification
- NDC, unit of measure and quantity for medical injectables
- Any other state-required data (see *Appendix A*)

Provider and member data will be verified against state reference data for accuracy and active status. Be sure to validate this data in advance of claims submission. This validation will apply to all provider data submitted and applies to atypical and out-of-state providers.

NDC data will be validated for appropriate use for service rendered as well as confirming the NDC is effective on the date of service.

The *Patient Protection and Affordable Care Act* ([H.R. 3590] Section 65607 [Mandatory State Use of National Correct Coding Initiative (NCCI)]) requires state Medicaid programs to incorporate NCCI methodologies into their claims processing systems. The purpose of the NCCI edits is to prevent improper payments when incorrect code combinations are reported.

The two components of NCCI are procedure-to-procedure edits (CCI) and medically unlikely edits (MUE):

- CCI procedure-to-procedure edits are for practitioners, ambulatory surgical centers and outpatient hospital services (only for drugs, high-tech images, ultrasounds and labs as they are billed at a CPT/HCPCS code level) that define pairs of HCPCS/CPT codes that should not be reported together.

- MUE are units of service edits for practitioners, ambulatory surgical centers, outpatient hospital services (only for drugs, high-tech images, ultrasounds and labs as they are billed at a CPT/HCPCS code level) and DME. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct (for example, claims for excision of more than one appendix or more than one hysterectomy).

Providers are reminded that:

- Services must be reported correctly.
- Multiple HCPCS/CPT codes should not be reported when there is a single comprehensive HCPCS/CPT code.
- The code describes these services.
- A procedure should not be fragmented into component parts.
- A bilateral procedure code should not be unbundled into two unilateral procedure codes.
- Down-coding and upcoding should be avoided.
- The appropriate procedure codes should be used based on age and gender of the patient.
- If a procedure code is submitted that requires a primary procedure code, verify that the primary procedure code has been submitted.
- Procedure codes are billed in the appropriate place of service as defined by AMA and/or CMS (for example, certain procedure codes are not permitted to be performed outside of an inpatient setting).
- Obstetric services including antepartum care, delivery and postpartum care are billed appropriately.
- The appropriate evaluation and management (E&M) codes are used for new patients and established patients.
- Certain services related to a surgical procedure are included in the payment of the global surgery package. These services would include E&M and related surgical procedures performed by the same physician for the same patient.
- Duplicate services are not submitted for the same provider, same patient for the same date of service.
- Consent forms are required for the following services: abortion, hysterectomy and sterilization.
- Providers must submit both the National DME Miscellaneous and corresponding Local W codes on claims. Local codes should be noted in the service description, as they will fail National Uniform Billing Committee service validations if used as the principal service. If the specified local W codes are not on the claim, the claim(s) will be denied. To view the current list of codes, visit **nubc.org**.
- Newborns must have their assigned Medicaid ID before the provider can bill for services. Newborn claims cannot be billed under the mother following the delivery.
- Hospitals are required to follow the requirements for reporting and reimbursing for hospital acquired conditions.

Healthy Blue uses **SNIP Level Validation *(SNIP = Strategic National Implementation Process)***

- **Level 1:** Standard Integrity Testing — This level of compliance will check the formatting of the transaction:
  Example: Non numeric values found in numeric fields.

- **Level 2:** Implementation Guide Requirement Testing — Specific to HIPAA-implementation guides - This level will validate the required and situational loops and segments for the transaction:
  - Example: Provider sends a file with no billing provider information. The claim would reject for a level 2 error because the provider information is required on every claim.

- **Level 3:** Balancing — Balanced field totals, record or segment counts — This level will validate all of the values submitted within the transaction balance:
  - Example: If the total service line charges do not match the total charge reported by the submitter it would reject at this level.

- **Level 4:** EDI Situational Testing — This level will validate the situational rules for the various loops and segments:
  - Example: If the provider submits a claim with a value of zero in the patient paid amount segment the compliance checker would reject the claim because the Patient Amount Paid of '0' is not an acceptable value.

- **Level 5:** Code Sets — Implementation-guide specific code values. This level validates against all HIPAA code sets and verifies appropriateness of usage:
  - Example: Provider submits a claim with a place of service code of "O" for office. This value would not be a valid Place of service code therefore it would be rejected.

- **Level 6:** Product Type or Type of Service — Required by healthcare specialties, such as ambulance, chiropractic, (DME):
  - Example: Claim is received for an Ambulance service and the transport information is missing the claim can be rejected due to missing information as a result of this level of editing.

- **Level 7:** Trading partner specific — The implementation guides contain some *HIPAA* requirements that are specific to Medicare, Medicaid, Indian Health, and are unique to each payer. Compliance or testing with these payer specific requirements is not required from all trading partners.

7.4 International Classification of Diseases, 10th Revision (ICD-10)

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

What is ICD-10?
International Classification of Diseases, 10th Revision (ICD-10) is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although, we often use the term ICD-10 alone, there are two parts to ICD-10:
ICD-10-CM (clinical modification) used for diagnosis coding and ICD-10-PCS (procedure coding system) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets ICD-9-CM Volumes 1 and 2 for diagnosis coding; ICD-10-PCS replaced ICD-9-CM Volume 3 for inpatient hospital procedure coding.

7.5 Encounter Claim Data

If you are reimbursed by capitation or have a delegated arrangement, you must send us encounter data for each member encounter.

You must submit encounter data no later than 30 calendar days from the date of adjudication through:

- EDI submission methods
- A *CMS-1500* (*08-05*) claim form
- Other arrangements that are approved by Blue Cross NC

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening claims as well as physician-administered drugs should be filed as soon as possible within the timely filing period.

Encounter data will be reviewed using the same claims submission quality expectations as defined in **Section 7.4**.

Required data and data editing is consistent to that of an inbound claim submission plus any corresponding adjudication results.

7.6 Claims Adjudication

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

You must use *HIPAA*-compliant billing codes when billing Blue Cross NC electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

Whether you submit claims through electronic data interchange or on paper, use our claims guide charts in Appendix A to ensure you submit clean and complete claims.

For your claims payment to be considered, you must adhere to the following time limits:

- Submit claims within 365 calendar days from the date of service **or** from the date of discharge for inpatient claims filed by a hospital
- Submit claims for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as soon as possible within the timely filing period
- In the case of other insurance, submit the claim within 365 calendar days from the third-party payer
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within six months from the date that the claim is voided by Medicaid

We will deny claims submitted after the filing deadline. Our claims payment system requires you to split-bill claims that span more than one calendar year.

7.7 Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted on time
- Is accurate
- Is submitted on a standard claim form (*CMS-1500* or *UB-04*)
- Requires no further information, adjustment or alteration to be processed and paid
- Is not from a provider who is under investigation for fraud or abuse
- Is not a claim under review for medical necessity

We will adjudicate clean medical claims to a paid or denied status at lesser of 30 calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication. If we do not pay the claim within 30 calendar days, we will pay all applicable interest as required by law.

We produce an *Explanation of Payment* (*EOP*) and it shows the status of each claim that has been adjudicated during the previous claim cycle.

If we do not receive all of the required information, we will deny the claim either in part or in whole within 30 calendar days of receipt of the claim. A request for the missing information will appear on your *EOP* or *835 Electronic Remittance Advice* (if registered to receive *835's*). You may use Availity to register for ERA and manage account changes. Providers can also view, save and print copies of their paper *EOP* using Availity Remittance Inquiry tool under payer spaces for Healthy Blue.

Once we have received the requested information, we will be paid or denied at lesser of 30 calendar days of receipt of the requested additional information or the first scheduled provider reimbursement cycle following adjudication receipt.

We will return paper claims that are determined to be unclean along with a letter stating the reason for the rejection. We will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.

Interest and penalty provisions apply for late payment or underpayment by Blue Cross NC:

- We will pay interest on late payments to the provider at the annual percentage rate of 18% beginning on the first day following the date that the claim should have been paid as specified in the contract.
- In addition to the interest on late payments required by this section, we will pay the provider a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid as specified in the contract.
- We will not be subject to interest or penalty payments under circumstances specified in *N.C. Gen. Stat. § 58-3-225(k)*.

7.8 Claims Status

You can check claims status on our website or by calling Healthy Blue Provider Services at **844-594-5072.** You can also submit a Claim Status batch transaction through EDI.

If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the response reports for acceptance of the claim that you receive from your Clearinghouse or practice management vendor.

7.9 Reimbursement Policies

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if services are covered by the member's Healthy Blue benefit plan. These policies can be accessed on the provider site. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Healthy Blue reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the

loading of policies into the claims platforms in the same manner as described; however, Blue Cross NC strives to minimize these variations.

Reimbursement hierarchy
Claims submitted for payments must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Review schedules and updates to reimbursement policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Healthy Blue business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Medical coding
The Medical Coding Department ensures that correct coding guidelines have been applied consistently through Blue Cross NC. Those guidelines include but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD-10 diagnosis/procedures, revenue codes, etc.)
- Code editing rules, appropriately applied and within regulatory requirements.
- Analysis of codes, code definitions and appropriate use

Reimbursement by code definition
Blue Cross NC allows reimbursement for covered services based on their procedure code definitions or descriptors, unless otherwise noted by state or provider contracts or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluation and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

Outlier Reimbursement — Audit And Review Process

Requirements and Policies
This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or where the entire claim is paid at percent of billed charge.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/Records Requests

At any time, a request may be made for on-site, electronic, or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood and Blood Products
Administration of Blood or Blood Products are not separately reimbursable on inpatient claims. Administration charges on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage and processing, thawing fees charges, irradiation, and other processing charges, are also not separately reimbursable.

Emergency Room Supplies and Services Charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

Facility Personnel Charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Charges for Outpatient Services for facility personnel are also not separately reimbursable. The reimbursement is included in the payment for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV Sedation and Local Anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the Operating Room (“OR”) time/procedure reimbursement. Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab Charges
The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor Care Charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing Procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit will not be reimbursed separately. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, IV or PICC line insertion at bedside, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Operating Room Time and Procedure Charges
The operating room ("OR") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse’s notes. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel

Personal Care Items and Services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-

medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

Pharmacy Charges
Reimbursement will be made for the cost of drugs prescribed by the attending physician. Additional separate charges for the administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel will not be reimbursed separately. All other services are included in the drug reimbursement rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable Charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-Operative Care or Holding Room Charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately.

Preparation (Set-Up) Charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery Room Charges
Reimbursement for recovery room services (time or flat fee) includes the use of all and/or available services, equipment, monitoring, and nursing care that is necessary for the patient’s welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room Services Related to IV Sedation and/or Local Anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) Examples of procedures include arteriograms and cardiac catheterization.

Supplies and Services
Items used for the patient which are needed as a direct result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable.

Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments.

Special Procedure Room Charge
Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges
Standby equipment and consumable items which are on standby, are not reimbursable. Standby charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat Charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and Equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, Oxygen, and isolation carts and supplies are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time Calculation:
- Operating Room (OR) – Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- **Hospital/ Technical Anesthesia** - Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time.
- **Recovery Room** – The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.
- **Post Recovery Room** – Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Video or Digital Equipment Used in Operating Room
Charges for video or digital equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	**Supplies and Equipment:** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes; • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls; Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin, and saline flushes, etc.)
0220 – 0222, 0229, 0250	• Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges • IV Solutions 250 cc or less, except for pediatric claims • Miscellaneous Descriptions • Non-FDA Approved Medications
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	• Specimen collection • Draw fees • Venipuncture • Phlebotomy • Heel stick • Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) • Thawing/Pooling Fees
0270, 0272, 0300 – 0309	• Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment:** • Oxygen • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heal/Elbow Protector • Burrs • Cardiac Monitor

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia if provided by RN • Intubation/Extubation • CPR
0410	Respiratory Functions: • Oximetry reading by nurse or respiratory • Respiratory assessment/vent management • Medication Administration via Nebs, Metered dose (MDI), etc. • Charges Postural Drainage • Suctioning Procedure • Respiratory care performed by RN
0940 – 0945	Education/Training

7.10 Coordination of Benefits and Third-Party Liability

Other health insurance (OHI) means a member is covered under one or more private health insurance programs. For example, if a Healthy Blue member is covered under another insurance carrier, they have OHI.

We follow state-specific guidelines when coordination of benefits procedures are necessary. We use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

When third-party resources and third-party liability (TPL) resources (also referred to as other health insurance) are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, we will reject the claim and redirect you to bill the appropriate insurance carrier (unless certain pay-and-chase circumstances apply — see below). Or if we do not become aware of the resource until after payment for the service was rendered, we will pursue post-payment recovery of the expenditure.

As a Medicaid prepaid health plan (PHP), we process claims after OHI. When a member has more than two insurers, Medicaid acts as the payer of last resort for most services. When a Healthy Blue member has OHI, the provider needs to submit the claim to the primary health insurance company first. If there are any remaining charges, the claim would then be submitted to Blue Cross and Blue Shield of North Carolina (Blue Cross NC) to be processed accordingly. You must not seek recovery in excess of the Medicaid -payable amount. The Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members.

Blue Cross NC does not require prior authorization (PA) when the member has OHI. However, a PA will be required if Healthy Blue becomes the primary payer for the service(s) rendered.

To validate OHI for Healthy Blue members, providers should navigate to Availity Essentials and use the *Eligibility and Benefits Inquiry* option located under the *Patient Registration* drop-down menu instead of NCTracks.
Blue Cross NC may pay-and-chase the full amount allowed under the payment schedule for the claim and then seek reimbursement from the TPL insurer within 30 days after the end of the month in which the payment was made, for any liable TPL of legal liability if:

- The claim is for prenatal care for pregnant women.
- The claim is for preventive pediatric services (including Early and Periodic Screening, Diagnosis and Treatment [EPSDT] and well-baby screenings).
- The claim is for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

Blue Cross NC will cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed, except for the pay-and-chase circumstances as outlined above.

Claims for labor and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees.

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

Coordination of benefits claim examples:

- Scenario one — professional claim: Medicaid pays the allowable amount minus TPL payment or total patient responsibility amount (copay, co-insurance and/or deductible). The Medicaid allowed amount minus the TPL paid amount is less than the patient responsibility; thus, the Medicaid allowed amount is the payment. Blue Cross NC is responsible up to the Medicaid allowable amount or the patient's responsibility, whichever is the lesser amount.
- Scenario two — outpatient claim: Medicaid zero pays the claim; when cost-compared, the private insurance paid more than the Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment and the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.
- Scenario three — inpatient claim: The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.

Billing for specialized behavioral health services for dual-eligibles: For dual-eligible members (Medicare and Medicaid), Blue Cross NC will be the secondary payer on hospital and professional claims for specialized behavioral health and substance use services. Providers should submit claims for dual-eligible enrollees to Medicare as the primary payer for hospital and professional claims. Claims for services delivered by unlicensed staff should be submitted directly to Blue Cross NC.

If you have any questions regarding paid, denied or pended claims, call Healthy Blue Provider Services at **844-594-5072**. Healthy Blue posts weekly Known Issues Bulletins on our provider website to share information related to known claims issues. All bulletins will be stored on our provider website within the Provider news archives (**provider.healthybluenc.com/north-carolina-provider/archives**).

7.11 Billing Members

Before rendering a service that is not covered by Blue Cross NC, inform our member that we do not cover the cost of the service; he or she will have to pay for the service.

If you choose to provide services that we do not cover:

- Understand that we only reimburse for services that are medically necessary, including hospital admissions and other services.
- Obtain the member's signature on the *Client Acknowledgment Statement* specifying that the member will be held responsible for payment of services.
- Understand that you may not bill for or take recourse against a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program.

You cannot balance-bill for the amount above that which we pay for covered services.

In addition, you may not bill a member if any of the following occurs:

- Failure to submit a claim on time, including claims not received by Blue Cross NC
- Failure to submit a claim to Blue Cross NC for initial processing within the timely filing deadline for providers
- Failure to dispute a corrected claim within the clean-claim submission period
- Failure to appeal a claim within the 60-day payment dispute period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made by the provider in claims preparation, claims submission or the appeal/dispute process

Exceptions to Cost sharing

For NC Medicaid, member cost sharing does not apply to subset of the following population:

- Children under age of 21
- Pregnant women
- Federally-recognized American Indians/Alaska Natives
- BCCCP beneficiaries
- Foster children and disabled children under Family Opportunity Act
- Individuals whose medical assistance services are furnished in an institution is reduced and is based off the members' available income and not based off personal needs
- Family planning
- Hospice Care
- NC Blue Cross will not impose cost sharing on behavioral health services, as defined by NCDHHS

Please see the table below for an additional summary of member cost sharing.

Income level	Annual enrollment fee	Service	Copay
Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and brand prescriptions Chiropractic Optical services/supplies Optometrists Nonemergency visit in hospital ER	$4 per visit $4 per visit $4 per visit $4 per script $4 per visit $4 per visit $4 per visit $4 per visit

7.12 Client Acknowledgment Statement

Private Pay for Noncovered Services

A provider may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are true:

- The provider informs the member that the service is a non-covered benefit under Medicaid

- The provider informs the member that that service is a non-covered benefit under Healthy Blue
- The member is notified of the financial liability in advance of the service being provided including the cost
- The member requests the specific service or item
- A written acknowledgment signed by the provider and the member prior to the service(s) being obtained by the member

7.13 Overpayment Process

Refund notifications may be identified by two entities: Blue Cross NC and its contracted vendors or the providers. Blue Cross NC researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check or authorize setup of a claims adjustment to reconcile the overpayment amount.

Once an overpayment has been identified by Blue Cross NC, Blue Cross NC will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment, it can be reconciled by either of the two methods listed below:

- ***Refund Notification Form*:** To submit a refund, a completed *Refund Notification Form* specifying the reason for the return must be included. This form can be found on the provider website at **provider.healthybluenc.com** > Forms. The submission of the *Refund Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, call Healthy Blue Provider Services at **844-594-5072** and select the appropriate prompt.
- ***Recoup Notification Form*:** To refund an overpayment via a claims adjustment, a completed *Recoup Notification Form* specifying the reason for the adjustment must be included. The *Recoup Notification Form* allows a provider to grant authorization to adjust claims and create claim offsets, which allows setup of claim adjustments that will result in overpayments being withheld from future claims payments. This form can be found on the provider website at **provider.healthybluenc.com.** The submission of the *Recoup Notification Form* will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the recoup notification procedure, call Healthy Blue Provider Services at **844-594-5072** and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement. Changes addressing the topic of overpayments have taken place with the passage

of the *Patient Protection and Affordable Care Act* (*PPACA*), commonly known as the *Healthcare Reform Act*.

The provision directly links the retention of overpayments to false claim liability. The language of *42 U.S.C.A. § 1320a-7k* makes explicit that overpayments must now be reported and returned to states or respective PHPs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the *False Claims Act*, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the *PPACA*.

The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," codified at *42 U.S.C.A. § 1320a-7k*, clarifies the uncertainty left by the *2009 Fraud Enforcement and Recovery Act*. This provision of the *Healthcare Reform Act* applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

Additionally, Healthy Blue will conduct facility claim reviews, in conjunction with our designee, CERiS. CERiS' professional review process identifies errors, unrelated charges, and non-separately billable charges on facility claims for inpatient services, on a prepayment basis.

In accordance with NCDHHS guidance, hospital inpatient claims received on or after August 25th, 2022, with a header or total billed amount greater than $250,000 will be eligible for review. Healthy Blue or CERiS may request documentation, such as an itemized bill, to conduct the review. Once contacted, please submit the requested information within seven calendar days. Healthy Blue may accept additional documentation from the provider such as other documents substantiating the treatment or health service or delivery of supplies; provider's established internal policies; or business practices justifying the health care service or supply.

Claims should be billed and appropriately coded according to Blue Cross NC policies along with industry standard coding guidelines for the applicable bill type, (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). In accordance with NCDHHS guidance, Healthy Blue will not modify any line items allowed or paid amounts. It will either pay or deny each line on the claim.

Providers should follow the process outlined in **Section 2.40** for an appeal. There is no special process for an appeal related to CERiS audits.

7.14 NCDHHS Encounter Data Submissions

NCDHHS collects and uses medical, behavioral health, transportation, vision and pharmacy service encounter data for many purposes including but not limited to:

- Federal reporting
- Drug rebates
- Budgeting
- Rate setting
- Capitation payments
- Risk adjustment
- Qualified directed payments
- Services verification
- Medicaid managed care quality improvement activity
- Fraud/waste/abuse monitoring
- Measurement of utilization patterns
- Access to care
- Hospital assessment updates
- Research studies

Encounter data is created from the claim data submission from our providers. We are obligated to submit encounter data to NCDHHS, so accurate claims data will translate to complete, accurate and timely encounter data to NCDHHS.

NCDHHS billing policy is the basis of encounter data quality validations, which Blue Cross NC will also use to monitor the quality of the inbound Healthy Blue claims data.

Provider Services: 844-594-5072
https://provider.healthybluenc.com

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