FirstMedicareDirect

FIRSTCAROLINACARE INSURANCE COMPANY

PARTICIPATING PROVIDER MANUAL

Effective 10/1/2016

TABLE OF CONTENTS

Important Phone and Fax Numbers

FCC Main Office	(910) 715-8100
FirstMedicare Direct Customer Service	(844) 201-4957
Eligibility and Claims Inquiries	(844) 201-4957
Credentialing Coordinator	(910) 715-8116
Provider Relations and Contracting Barbara Adcock, Director	(910) 715-8115
Medical Director Jenifir Bruno, MD	(910) 715-5048
Prior Authorizations Fax	(816) 313-3060
Member Appeals/Grievances Fax	(816) 313-3061
Main Fax	(910) 715-8101

Mailing and Physical Address:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28370

Other Resources

Our website, www.FirstMedicare.com, has links to:

- Credentialing application
- Access to provider portal ePower to:
    - Verify member eligibility;
    - Search or submit requests for prior authorization; and
    - Search claims
- Medical management forms
- Provider look-up
- Comprehensive Drug Formulary
- Pharmacy Directory
- Compliance program information

1. INTRODUCTION AND OVERVIEW

FirstCarolinaCare Insurance Company ("FCC") welcomes your participation as a valued provider. FCC is a non-profit health insurance company formed in 1999 by FirstHealth of the Carolinas, a 501(c)(3) community-based hospital system based in Pinehurst, North Carolina.

FCC originally was licensed in North Carolina to operate exclusively as a health maintenance organization authorized to market group HMO and point of service (POS) plans. It sought and received licensure in 2007 to operate as a health insurer in order to have the ability to sell a PPO product line outside of its primary service area. FCC currently serves approximately 18,000 employees and dependents in large and small businesses throughout central and eastern North Carolina. In addition to insured HMO, POS and PPO group plan offerings, FCC has nearly 6,000 members in self-funded plans for which it acts as third party administrator.

In 2013, FCC was approved by the Centers for Medicare and Medicaid Services to offer Medicare Advantage Prescription Drug plans marketed under the name FirstMedicare Direct in a five-county service area (Hoke, Lee, Montgomery, Moore, Richmond, Scotland). Chatham County was added in 2015. As of June, 2016, FirstMedicare Direct had approximately 6500 members. In 2017, FCC will expand its FirstMedicare Direct service area into six western NC counties (Buncombe, Henderson, Madison, McDowell, Transylvania, Yancey) in partnership with Mission Health System. In partnership with Alignment Health and the UNC Health System, FCC is expanding into Wake County.

The purpose of this document is to be a reference and source document for various FCC Medicare Advantage Prescription Drug (MAPD) plan requirements, which include relevant policies and procedures applicable to all providers who contract with FCC. In accordance with the Participating Provider Agreement, MAPD providers must abide by all applicable provisions of this Manual, as may be modified from time to time upon notice. None of the policies or procedures contained in this manual, however, shall override the professional or ethical responsibilities of the providers or interfere with the providers' ability to provide information or assistance to their patients.

FCC may amend this Participating Provider Manual from time-to-time.

Product Offerings

FirstMedicare Direct HMO Plus is marketed in the following counties:
Chatham, Hoke, Lee, Montgomery, Moore, Richmond, Scotland

FirstMedicare Direct Healthy State HMO Plus is marketed in the following counties:
Buncombe, Henderson, Madison, McDowell, Transylvania, Yancey

FirstMedicare Direct PPO Plus is marketed in the following counties:
Chatham, Hoke, Lee, Montgomery, Moore, Richmond, Scotland,

FirstMedicare Direct smartHMO and FirstMedicare Direct preferredPlus are marketed in the following county: Wake

All products include all of the benefits traditionally covered by Medicare plus prescription drug coverage. Supplemental benefits may be identified in the FirstMedicare Direct coverage documents.

To verify plan benefits, copayments, coinsurances and maximum out-of-pocket amounts, providers may contact Customer Services at (844)201-4957.

2. PROVIDER ADMINISTRATIVE STANDARDS

In accordance with generally accepted professional standards and the applicable Participating Provider Agreement, participating MAPD providers shall:

- Cooperate with FCC in its efforts to monitor compliance with its MA contract(s) and/or MA rules and regulations, and assist FCC in complying with corrective action plans necessary to comply with such rules and regulations;
- Cooperate with FCC in its clinical programs, such as case/disease management, quality improvement and utilization management;
- Administer treatment for any member in need of health care services they provide;
- Respond within the identified timeframe to requests for medical records in order to comply with regulatory requirements;
- Allow FCC to use provider performance data;
- Cooperate with quality improvement activities, including HEDIS, CAHPS and the Health Outcomes Survey;
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene;
- Communicate timely clinical information between providers.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen
- Not discriminate in any manner between FirstMedicare Direct members and non-FirstMedicare Direct members;
- Not deny, limit or condition the furnishing of treatment to any member on the basis of any factor that is related to health status, including, but not limited to the following: Medical condition, including behavioral as well as physical illness; claims experience; receipt of health care; medical history; genetic information; or evidence of insurability; including conditions arising out of acts of domestic violence;
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on the member's behalf for the member's health status, medical care, and available treatment or non-treatment options including any alternative treatments that might be self-administered regardless of whether any treatments are Covered Services;
- Identify members who are in need of supportive services related to domestic violence/elder abuse, behavioral health, smoking cessation or substance abuse. If indicated, providers must refer members to FCC-sponsored or community-based programs.

Credentialing and Participation Requirements

FCC's Credentialing/Recredentialing Plan complies with North Carolina statutes, rules and regulations, in addition to Medicare contracting and credentialing requirements. Participating providers are required to provide recredentialing information every three years from the initial

credentialing or last recredentialing date. Please see Appendix C for the most recent version of the Credentialing/Recredentialing Plan. The plan may be amended from time-to-time.

Credentialing/Recredentialing procedures apply to all licensed professionals who contract with FCC to provide covered services. This review includes (as applicable to practitioner type):

- Background;
- Education;
- Postgraduate training;
- Certification(s);
- Experience;
- Malpractice history
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide health care; and
- Accreditation status, as applicable to non-individuals.

Physician applicants who are not accepted as FCC Providers and FCC Providers whose participation status is terminated or suspended by FCC may have the right to appeal FCC's decision. Please refer to the applicable details in the FCC Credentialing/Recredentialing Plan.

Provider Information Changes

Providers are required to give prior notice to FCC for any of the following changes:

- Practitioners who are added or terminated;
- Changes in licensure or Medicare participation;
- Practice 1099 mailing address;
- Tax Identification Number (TIN) or entity affiliation (W-9 required);
- Practice name or affiliation;
- Physical or billing address;
- Telephone and fax number; and
- Closing of practice or practitioner panel to new patients (see below).

A change notification form may be found at www.FirstMedicare.com on the Provider Forms page. Failure to notify FCC of these changes will result in a delay in claims processing and payment.

To comply with CMS provider directory requirements, on a quarterly basis, FCC also will send each practice a query regarding any practice or practitioner changes. Providers are expected to respond to such queries promptly and accurately.

Availability/Accessibility and Patient Satisfaction

Providers are expected to arrange for or provide services to FCC members 24 hours a day, 7 days a week through acceptable on call arrangements. Simply having a phone recording that directs members to the nearest emergency department is insufficient. FCC maintains quantitative

appointment wait time standards with which providers must comply. Please refer to Appendix B for the standards.

FCC conducts an annual survey of member opinion related to availability and accessibility. An annual CAHPS survey also is conducted that includes member feedback on health care quality and accessibility.

Release of Members from a Provider's Practice

Infrequently, a provider may feel it inappropriate to continue to seeing a member. Common reasons may include non-compliance on the part of the patient or failure to pay bills. The basis for release of a patient from a provider's practice is not limited to these--in fact, FCC will not infringe on a provider's right to make such a determination. If a provider does release a member from the practice a notice must be sent to the member with a copy to FCC explaining that services should no longer be sought from the provider and/or practice except in case of an emergency, not in excess of 30 days from the date of the notice.

Closing/Opening Practice to New Patients

A PCP may close his/her practice to all new patients including FirstMedicare Direct members by giving 30 days prior written notice to FCC. This means that a PCP may not close his or her practice to members unless he/she closes his/her practice for all new patients. If a PCP with a closed practice wishes to open his/her practice, written notice must be sent to FCC.

Collection of Copayments, Coinsurance and Deductibles

The provider is responsible for collecting member expenses. Providers are not to bill members for missed appointments, administrative fees or other similar type fees. If a provider collects member expenses determined to exceed the member's responsibility, the provider must reimburse the member the excess amount. The member's responsibility will be clearly stated on the Explanation of Payment (EOP) received by the provider. The provider is required to collect these from the member. The provider also is required to write off the Provider Discount amount shown on the EOP.

Member Billing

No provider may bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against members for covered services. In order to bill a member for services that are not covered services, providers must notify the member in advance of providing the services that they are not covered and obtain written verification that the member chooses to receive and agrees to pay for such services. Balance billing of members is prohibited under Medicare's Terms of Participation.

3. MEMBER ADMINISTRATION

In the Evidence of Coverage and in other materials provided by FCC, members receive information on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation, how to file a grievance or appeal, as well as their rights and responsibilities.

Eligibility Verification

Each FirstMedicare Direct member will be issued an identification card after enrollment. The identification card may be requested prior to rendering services. Emergency services must not be delayed in order to verify coverage. If the provider is unable to verify eligibility at the time of service, the provider should render immediate, necessary care and then further verify eligibility at the first opportunity by calling FCC's Customer Services at either the number shown in Section I of this document or on the back of the member's ID Card. If the patient is not a member, the provider may collect all amounts due from the patient, subject to Medicare billing requirements.

ID cards will include at least the following:

- Member name
- Member ID number
- Health plan issuer number
- Network copayment amounts for PCP and Specialist office visits, if applicable
- Address for filing paper claims and EDI Payer Number
- Customer Service telephone number

To verify eligibility providers may contact Customer Service at (844) 201-4957.

4. CLAIMS

Claims Submission

Unless otherwise stated in the Agreement, providers must submit clean claims (initial, corrected and voided) to FCC within 180 calendar days from the date of discharge for inpatient services or the date of service for all other services. Unless prohibited by federal law or CMS, FCC may deny payment of any claim that fails to meet submission requirements for clean claims or failure to timely submit a clean claim to FCC. FCC will pay clean claims in accordance with the terms of the applicable agreement.

Providers using electronic submission shall submit clean claims through Electronic Data Interchange (EDI) to FCC or its designee, as applicable, using the HIPAA-compliant electronic format.

Providers who do not submit claims electronically are required to submit to FCC a completed CMS 1500 (08-05) claim form or successor claim form in order to receive payment for covered services. Standard CMS 1500 guidelines should be used in completing all applicable fields. Participating hospitals or ancillary providers are required to submit to FCC a completed UB04 CMS1450 or successor claim form.

Paper claims should be mailed to:

FirstCarolinaCare Insurance Company
P.O. Box 830589
Birmingham, Alabama 35283-0589

For electronic claims submission use Payer ID number 56196

To request Electronic Remittance Advice (ERA) and/or Electronic Funds Transfers (EFT), please visit our website at: www.FirstMedicare.com to access the required forms (click on "I am a Provider").

Coordination of Benefits

FCC will coordinate benefits with other health insurance in accordance with Medicare secondary payer rules. When FCC is the primary payer, FCC will reimburse for covered services up to the maximum allowable as stated in Attachment B of the Physician Agreement or Attachment A of the Hospital and Ancillary Agreements (less any copayment, coinsurance or deductible due from member), without considering the other plan's benefits. When FCC is secondary, FCC will coordinate reimbursement with the other plan. In no case will FCC pay more than the maximum allowable established by FCC for such services.

Refunds and Recovery of Overpayments

If a provider believes a claim has been underpaid by FCC, the provider should call Customer Services at (844) 201-4957. FCC will research the payment history, and if indicated, an adjustment will be made. The provider should allow two weeks for FCC to research.

If an overpayment or incorrect payment has been made by FCC, FCC will notify the provider of the overpayment or incorrect payment and request reimbursement. If payment has not been received within the time indicated on the notice then the overpayment or incorrect payment would be deducted from the Provider's next payment. The adjustment will be noted as a negative amount on the EOP and include a Remark Code indicating why the adjustment was made.

Questions concerning claims or denials of claims should be directed to Customer Service at (844) 201-4957.

5. FCC Clinical Programs

Overview:

FCC recognizes the importance of the Primary Care Provider (PCP) in coordinating the care of FirstMedicare Direct members. PCPs include providers whose practices are primarily family medicine, general practice, general internal medicine, general pediatrics, obstetrics and gynecology, or gynecology only. FCC seeks to foster a strong, stable relationship between Members and the PCP of their choice. FirstMedicare Direct plans do not require a PCP referral for a member to see a specialist.

FCC promotes the importance of preventive care and screenings to its members. PCPs play an important role in the overall coordination of all care, including recommendations on appropriate preventive and other care and services.

All FirstMedicare Direct plans cover the mandated Medicare preventive services, many of which have no member cost-sharing. In addition, FirstMedicare Direct covers the Medicare annual preventive exam with no member cost-sharing.

FCC clinical practice guidelines are in accordance with 42 CFR §422.112(a)(6)(ii)), including:

- FCC employs a medical director who is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity. The medical director is a physician with a current and unrestricted license to practice medicine in North Carolina in accordance with (42 CFR §422.562(a)(4));
- Any partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request is reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before FCC issues the organization determination decision. The physician or other health care professional must have a current and unrestricted license to practice within the state of North Carolina.
- Determinations are based on: (1) the medical necessity of plan-covered services - including emergency, urgent care and post-stabilization - based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director; (2) where appropriate, involvement of the organization's medical director per 42 CFR §422.562(a)(4); and (3) the enrollee's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if FCC approves the furnishing of a service through an advance determination of coverage, we may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, CH 6, Section 6.1.3(A)); and
- FCC accepts and processes appeals consistent with the rules set forth at 42 CFR Part 422, Subpart M, and CH 13 of the Medicare Managed Care Manual (MMCM).

FCC's specific clinical programs include the member health risk assessment initiative, utilization management for medical services and prescription drugs, medication therapy management, quality management and disease/case management. These programs are carried out under the

leadership of the FCC Medical Director. Oversight of the clinical programs is the responsibility of the FCC quality management committee, FirstQIC.

Health Risk Assessment Program

FCC's goal is that all of its FirstMedicare Direct members get an annual Health Risk Assessment (HRA) and wellness exam. FCC and/or its designated vendors do outreach to PCPs and to members to make sure most members are seen in the office for either a wellness exam or a full preventive exam.

FCC also may offer PCPs lists of patients who need to schedule appointments and have an HRA completed. FCC also can provide patient-specific forms that include the member's diagnosis history that will suggest diagnoses of conditions that may be ongoing but have not been documented in the current year. Documenting and coding all actual diagnoses and chronic conditions from year-to-year is important for FCC to ensure it receives accurate risk-based reimbursement.

The HRA form may be accessed at www.FirstMedicare.com on the Provider Forms page. Providers may complete and submit to FCC the HRA form, or they may provide the full office visit note provided it contains all of the information contained in the HRA form, including:

- Self-assessment of health status and ADLs
- Psychosocial status
- Behavioral risks
- Current and past medical diagnoses and surgical procedures
- History (personal and family)
- Vital signs
- Physical examination/ Review of systems
- Assessment and management plan for all chronic conditions

PCPs will be compensated by FCC $250.00 for each HRA completed and sent to FCC, as well as reimbursement for an annual wellness visit (G0438-G0439) or annual preventive exam/physical (99396-99497), if applicable. FCC also will reimburse providers for HRAs completed in connection with services reported under other Evaluation and Management codes if the HRA is fully documented.

For detailed information on Medicare coverage of the annual wellness visit and administration of a health risk assessment, please go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Utilization Management

Utilization management (UM) is designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Considerations include:

- Individual member clinical needs;
- Availability of qualified providers;
- Application of clinically sound, evidence-based medical necessity decision-making tools; and
- Available and applicable plan benefits.

Copies of utilization criteria and guidelines will be provided upon request.

The UM Program includes components of prior authorization as well as prospective, concurrent and retrospective review activities, each of which are designed to provide for an evaluation of health care and services based on the member's coverage, the appropriateness of such care and services and, to determine the extent of coverage and payment to providers of care.

FCC's UM Program complies with all applicable state and federal requirements. FCC does not reward its associates or providers, physicians or other individuals or entities performing UM activities for denying coverage, services or care, and financial incentives, if any, do not encourage or promote under-utilization.

The list of services that require a prior authorization is included as Appendix A. Providers may request a prior authorization by faxing a Prior Authorization form (found at www.FirstMedicare.com on the Provider Forms page) to (816) 313-3060.

Providers also may call (844) 201-4957.

Quality Management

FCC collects and reports HEDIS measure data annually for all MAPD plans with 30 or more members. Data is primarily extracted from documentation FCC's claims system and from provider medical records. FCC gathers the information, documents and reports for submission. Other sources for which information is collected include, but are not limited to member and provider brochures, policies and procedures. Providers must cooperate with, and are encouraged to fully participate in, all FCC initiatives to improve compliance with HEDIS standards.

FCC participates in the CAHPS and HOS as required by CMS on an annual basis. FCC contracts with an NCQA-certified survey vendor to conduct the HOS survey on all plans required to collect and report CAHPS and Health Outcomes Survey (HOS) data. The survey vendor utilizes the NCQA-required survey techniques and follows the specifications as required by NCQA. FCC

works with the survey vendor to ensure the data is collected timely and appropriately. The results are then sent to CMS via the survey vendor who in turn reports the information to FCC.

CAHPS and HOS data is evaluated to determine areas of needed improvement and the needs of the population served under the MAPD program. The HOS is used to assess the member's physical and mental well-being at the beginning and end of a two year cycle.

The CAHPS and HOS results are presented to FirstQIC to obtain input from participating providers regarding the needs of the population served based on deficiencies and areas of opportunity identified. Action plans are developed to address the deficiencies and identify areas of needed improvement. The data and action plans are evaluated by FirstQIC for approval.

Case Management/ Disease Management

Case Management's goal is to coordinate timely, cost effective, integrated services for the individual health needs of members to promote positive clinical outcomes.

The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a care management plan.

FCC's Disease Management program attempts to identify members with selected chronic diseases and provide education and health coaching to these members and/or their caregivers to empower them to make behavior changes, self-manage their condition(s) and ensure the choices they make will improve their health and quality of life, as well as reduce the complications of their disease and medical costs. The services are offered through a team of registered nurses, certified health coaches and other professionals with clinical experience in specific diseases.

Prescription Drug Clinical Programs

FCC's prescription drug program employs various tools to ensure that prescription drugs are prescribed and used safely and effectively, including:

- Closed formulary
- Generic substitution
- Quantity limits
- Prior authorization
- Step therapy

Detailed information regarding prescription drug utilization management, the FCC drug formulary and other prescription drug programs is available at www.FirstMedicare.com at the Pharmacy Corner pages.

Members and their providers can ask FCC to make an exception to prescription drug coverage rules. There are several types of exceptions:

- Formulary exceptions. If approved, the drug will be covered at a pre-determined cost-sharing level.
- Tier exception. For Part D plans with tiers, if approved, this would lower the amount a member must pay for a covered non-preferred medication.
- Utilization restriction exception.

FCC will generally only approve tiering exception for higher cost-sharing tier formulary drugs when alternative drug(s) are included in the lower cost-sharing formulary tier but they would not be as effective or would have adverse effects compared to the higher cost share drug. Exceptions for non-formulary drugs or utilization restriction exceptions (such as quantity, step therapy and dose restrictions) are generally considered when treatment using the additional restriction or alternative drugs has been ineffective, is likely to be ineffective or cause adverse effects based on medical evidence.

FCC has a process in place to allow a transition supply of Part D drugs otherwise subject to our utilization management restrictions or not covered on the FCC Part D formulary. The transition process allows for a temporary supply of drugs and sufficient time for members to work with their health care providers to select a therapeutically appropriate formulary alternative, or to request a formulary exception based on medical necessity. Details of the policy are on the prescription drug section of the website above.

Other Part D programs in which FCC participates include:

- The Drug Utilization Review (DUR) program, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the age or gender of a member; or other pharmacy problems at the time a prescription is filled.
- The medication therapy management program is offered to specific members based on CMS approved criteria to assist them with making sure their medications are working, being taken safely and to reduce drug-related problems.
- As a Medicare Part D plan sponsor, FCC must manage drug overutilization within its prescription drug plans. CMS has a robust opioid utilization safety program in which FCC participates. The FCC Medical Director works closely with network providers to ensure that member utilization and dosages of such drugs are medically appropriate.

Methods for Requesting a Coverage Decision

Medical Services - A coverage decision request for medical services may be made via mail at FCC's main address, by phone (844) 201-4957 option 3 or by fax (816) 313-3060.

Prescription Drug Services – A coverage determination request for prescription drugs may be made using the web form located at www.FirstMedicare.com on the Pharmacy Corner page/Coverage Determinations, Appeals and Grievances link.

Methods for Requesting Appeals

Medical Services - Appeal requests for medical services may be made via mail at FCC's main address, by phone (844) 201-4957 option 3 or by fax (816) 313-3061.

Prescription Drug Services – A coverage determination request for prescription drugs may be made using the Reconsideration/Appeal web form located at www.FirstMedicare.com on the Pharmacy Corner page/Coverage Determinations, Appeals and Grievances link.

6. COMPLIANCE

FCC has established a Code of Ethical Conduct that outlines ethical principles to ensure that all business is conducted in a manner that reflects an unwavering allegiance to ethics and compliance. Additionally, FCC's compliance expectations are clearly illustrated in the Code of Ethical Conduct, compliance Policies and Procedures, and Policies on Monitoring and Auditing of First Tier, Downstream, and Related Entities (FDRs). The Code of Ethical Conduct can be found at www.FirstMedicare.com on the Compliance page, along with FCC's Compliance Plan and compliance policies and procedures.

All providers, including provider employees and provider sub-contractors and their employees, are required to comply with FCC compliance program requirements. FCC's compliance-related training requirements include the following:

Required Annual Training

In June of 2015, CMS issued guidance about the requirement to accept completion of CMS' compliance training module on the Medicare Learning Network (MLN) as meeting the Compliance Program Effectiveness (CPE) training requirement effective January 1, 2016. The CMS compliance program training was designed to ensure: (1) providers have at least a basic knowledge and understanding of compliance program requirements; and, (2) providers are knowledgeable about compliance and FWA issues and how to appropriately address them. The general compliance and FWA training courses now offer the ability to provide separate content for compliance and FWA, and provide web-based and downloadable versions. A certificate of completion is generated upon passing a short test with a score of 70% or higher at the end of the training module. Training courses are available on the CMS MLN: https://learner.mlnlms.com/Default.aspx

Who Must Complete The Training?

FCC contracted providers and their employees who have involvement in the administration or delivery of Parts C and D benefits must receive Medicare General Compliance and FWA training within 90 days of initial hiring (or contracting in the case of providers), and annually thereafter. Additional, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function training may be provided:

- upon appointment to a new job function;
- when requirements change;
- when employees are found to be noncompliant;

- as a corrective action to address a noncompliance issue; and
- when an employee works in an area implicated in past FWA.

While providers are required to comply with CMS requirements, including the compliance program training requirements, CMS does not expect a provider's entire staff would necessarily be subject to the requirement. In order to prevent unnecessary burden on providers, FCC notes the examples below of the critical roles within a Provider's organization that should clearly be required to fulfill the training requirements:

Positions/Roles requiring training:

- Senior administrators or managers directly responsible for the contract with FCC (e.g. Senior Vice President, Departmental Managers, Chief Medical or Pharmacy Officer);

- Individuals directly involved with establishing and administering FCC's formulary and/or medical benefits coverage policies and procedures;

- Individuals involved with decision-making authority on behalf of FCC (e.g. clinical decisions, coverage determinations, appeals and grievances, enrollment/disenrollment functions, processing of pharmacy or medical claims);

- Reviewers of beneficiary claims and services submitted for payment; or,

- Individuals with job functions that place the provider in a position to commit significant noncompliance with CMS program requirements or health care FWA.

General Compliance Training

FCC must be able to demonstrate that all Providers and their employees have fulfilled the CMS MLN General Medicare Compliance training requirements. Examples of proof of training may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training.

Please note, Providers deemed to have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are NOT exempt from the general compliance training requirement.

Fraud, Waste and Abuse Training

Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that a Provider or employee of a Provider is deemed. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed.

Methods for Completing the Training

FCC offers three (3) options for ensuring providers and their employees have satisfied the general compliance training requirement:

- Providers can complete the general compliance and/or FWA training modules located on the CMS MLN. Once an individual completes the training, the system will generate a certificate of completion. FCC will accept this MLN certificate of completion as evidence of satisfying the training.

- Providers can incorporate the content of the CMS standardized training modules from the CMS website into their organizations' existing compliance training materials/systems. It cannot be modified, or abbreviated (see below for guidance on enhancements to training).

- Providers can incorporate the content of the CMS training modules into written documents for providers and employees (e.g. Provider Guides, Participation Manuals, Business Associate Agreements, training manuals, etc.). Proof of completion of this training, such as an attestation, would be required.

Although the training content cannot be modified, CMS will allow modifications to the appearance of the content (i.e. font, color, background, format, etc.). Additionally, organizations may enhance or wrap around the CMS training content by adding topics specific to their organization or the employee's job function. At FCC's request, Providers must submit an attestation confirming that the organization has completed the appropriate general compliance and FWA training.

Attestations must include language specifying the entity complies with CMS compliance and FWA training requirements and the training provided includes CMS content. All training, policies, and attestation information can be found on FCC's website at www.FirstMedicare.com on the Compliance page, along with FCC's Compliance Plan and compliance policies and procedures.

FCC is required to maintain records for a period of 10 years of the time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered to their employees, and must require providers to maintain records of the training of the providers' employees.

Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are deemed to have met the FWA training and education requirements. No additional documentation beyond the documentation necessary for proper credentialing is required to establish that an employee or FDR or employee of an FDR is deemed. In the case of chains, such as chain pharmacies, each individual location must be enrolled into Medicare Part A or B to be deemed. See examples of such entities in Pub. 100-16, Medicare Managed Care Manual, chapter 6 §70.

Reporting of Fraud Waste and/or Abuse

FCC is committed to the prevention, detection and reporting of health care fraud and abuse according to applicable federal and state statutory, regulatory and contractual requirements. FCC

investigates all reports and incidents of suspected fraud and abuse. Providers, including provider employees and/or provider sub-contractors, must report to FCC any suspected fraud, waste or abuse, misconduct or criminal acts by FCC, or any provider, including provider employees and/or provider sub-contractors, or by members. Reports may be made anonymously through the FCC compliance hotline, 855-367-8184. Allegations of health care fraud, waste and abuse involving providers would be reviewed by FirstQIC.

Monitoring:

FCC has developed policies that address the ongoing monitoring of sanctions and grievances filed against health care professionals. FCC regularly obtains and reviews reports and other documentation, and provides evidence that its policies have been implemented.

CMS requires ongoing monitoring of lists of practitioners who have been sanctioned and of practitioners who opt-out of accepting Federal reimbursement from Medicare (see above for details), as well as ongoing monitoring and resolution of beneficiary grievances. In addition to these standing requirements, FCC is also required to monitor sanctions and limitations on licensure on a regular basis between re-credentialing cycles.

In the event that FCC finds an incidence of poor quality or any type of sanction activity against a health care professional, FCC is required to intervene and correct the situation appropriately.

If FCC becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, FCC is expected to perform a site visit as soon as possible to assess the facility and identify corrective actions.

Marketing Restrictions

MAPD plan marketing is regulated by the Centers for Medicare and Medicaid Services (CMS). There are specific restrictions on marketing activities in which MAPD network providers may engage. Providers should familiarize themselves with CMS marketing guidelines regulations and the CMS Medicare Managed Care Manual. Generally, providers must remain neutral when asked about MAPD plans. Providers may not:

- Offer scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of plans
- Offer anything of value to induce enrollees to select them as their provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Providers may make available plan marketing materials in common areas, and direct beneficiaries to resources such as the N.C. Senior Health Insurance Information Program or to the CMS website www.Medicare.gov.

Medical Prior Authorization List
Effective January 1, 2016

For Members: The services, items and drugs listed below require a prior authorization in order to be covered. In-network providers must obtain authorization 48 hours to rendering service for the services listed below. Members utilizing out-of-network providers are responsible for obtaining any required prior authorization.

For Providers: Prior authorization requests may be made by faxing the Prior Authorization Fax form to 1-816-313-3030. Forms may be obtained by calling Customer Services or online at www.firstmedicare.com. Urgent requests for care occurring within 48 hours may be made by calling Customer Services at 1-844-201-4957.

Inpatient Services
- Inpatient Admissions
- Acute Inpatient Rehabilitation
- Skilled Nursing Facility, Transitional and Sub-Acute Care
- Transplants-Human Organ, Bone Marrow and Stem Cell
- Mental Health, Substance Abuse, Partial

DME/Prosthetics/Orthotics
- Apnea Monitor
- Bone Stimulator
- CPAP/BIPAP Machines
- CPM Machines
- Customized Equipment
- Hospital Beds and Equipment
- Hoyer Lifts/Seat Lifts
- Electric Wheelchair/Scooter or POV
- DME items > $1000.00 line item cost

Ambulance Services
- Ambulance Services (Non-Emergency)

Laboratory
- Genetic Testing

Services Requiring Determination of Benefit Coverage
- Potentially Cosmetic, Experimental or Investigational Procedures
- Genetic Testing
- Sclerotherapy and Endovenous Laser Ablation
- Select drugs administered by a provider in an office, home or outpatient setting (see list below)
- Temporomandibular Joint Testing

<ACTEMRA® (tocilizumab)
ADAGEN® (pegademase)
ALDURAZYME® (laronidase)
AMEVIVE® (alefacept)
ARALAST® (alpha proteinase inhibitor)
ARCALYST® (rilonacept)
AVONEX® (interferon beta-1a)
BENLYSTA® (belimumab)
BONIVA®IV (ibandronate)
BOTOX® (onabotulinumtoxin A)
CAYSTON® (aztreonam for inhalation)
CEREDASE® (alglucerase)
CEREZYME® (imiglucerase)
CIMZIA® (certolizumab pegol)
CINRYZE® (C1 inhibitor, human)
DYSPORT® (abobotulinumtoxin A)
ELAPRASE® (idursulfase)
FABRAZYME® (agalsidase)
FACTOR PRODUCTS
FLOLAN® (epoprostenol)
HALAVEN® (eribulin mesylate)
HIZENTRA® (immune globulin, sq)
ILARIS® (canakinumab)
IVIG (immune globulin)
KRYSTEXXA® (pegloticase)
KYPROLIS® (carfilzomib)
LUMIZYME® (alglucosidase)
LEUKINE® (sargramostim)
LUPRON DEPOT® (leuprolide acetate) - No PA needed for oncology diagnoses
MAKENA® (hydroxyprogesterone caproate)
MOZOBIL® (plerixafor)
MYOBLOC® (rimabotulinumtoxin B)
NAGLAZYME® (galsulfase)
NULOJIX ® (belatacept)
OFIRMEV® (acetaminophen) injection
OFORTA™ (fludarabine)
ORENCIA® (abatacept)
PERJETA® (pertuzumab)
PROLASTIN® (alpha proteinase inhibitor)
PROLIA® (denosumab)
PROVENGE® (sipuleucel-T)
QUTENZA® (capsaicin 8% patch)
RECLAST® (zoledronic acid) - No PA needed for bone metastasis diagnoses
REMICADE® (infliximab)
RITUXAN® (rituximab) - No prior authorization needed for oncology diagnoses
SOLIRIS® (eculizumab)
STELARA® (ustekinumab)
SUPPRELIN®LA (histrelin) implant
SYNAGIS® (palivizumab)
TEMODAR® oral (temozolomide)
TESTOPEL® (testosterone pellets) implant
TYSABRI® (natalizumab)
TYVASO® (treprostinil)
XEOMIN® (incobotulinumtoxin A)
XGEVA™ (denosumab)- No PA needed for bone metastasis diagnoses
XIAFLEX® (collagenase, *Clostridium histiolyticum*)
VENTAVIS® (iloprost)
VPRIV® (velaglucerase)
VIVAGLOBIN® (immune globulin, SQ)
VORAXAZE® (glucarpidase)
XOLAIR® (omalizumab)
YERVOY® (ipilimumab)

ZEMAIRA® (alpha proteinase inhibitor) >

Coverage decisions are based on plan benefits and appropriateness of care. This list is updated periodically. For the most current list, visit www.FirstMedicare.com.

APPENDIX B

Appointment Wait Times- 90% of members should have waiting times to schedule an appointment as follows:

a. Routine office visits (PCP and specialist): 45 calendar days.

b. Urgent office visits: 48 hours.

c. Emergency: Same day in a hospital emergency department or physician office, as medically appropriate

APPENDIX C

CREDENTIALING/RECREDENTIALING PLAN

FIRSTCAROLINACARE INSURANCE COMPANY

CREDENTIALING PLAN

I. OVERVIEW

A. Purpose. The purpose of the FirstCarolinaCare Insurance Company (FCC) Credentialing Plan (the "Plan") is to establish requirements and standards for obtaining, reviewing, verifying and approving the professional qualifications of physicians and other licensed health care practitioners and providers that desire to participate in FCC's provider network. The credentialing requirements and standards set forth in this Plan fulfill FCC's obligation to FCC members to restrict participation to qualified health care practitioners and providers that meet the requirements and standards set forth below, in accordance with Title 11, Section 20.0401 et seq. of the North Carolina Administrative Code.

B. Scope of Credentialing Program. This Plan applies to all providers that contract with FCC either directly or through an intermediary to provide services covered under FCC health plans, and are listed in FCC's provider directory, including but not limited to:

1. Medical Doctors (MD);
2. Doctors of Osteopathy (DO);
3. Doctors of Podiatric Medicine (DPM);
4. Doctors of Dental Surgery (DDS);
5. Doctors of Optometry (OD);
6. Doctors of Chiropractic (DC); and
7. Advanced practice providers including and not limited to, physician assistants, nurse practitioners, physical therapists, occupational therapists, speech therapists, audiologists, licensed clinical social workers, clinical psychologists, and other mental health practitioners, all of whom are referred to collectively herein as physicians and other practitioners.

All of whom are referred to collectively herein as physicians and other practitioners

This Plan has standards that apply to all health facilities and ancillary services that contract with FCC to provide services covered under FCC plans, including but not limited to:

1. Hospitals;
2. Home health agencies;
3. Ambulatory surgical centers; and
4. Skilled nursing facilities.

C. General Practitioner Selection Criteria. FCC will consider offering participation status in FCC's network to physicians, physician groups, and other licensed health practitioners who:

1. Represent medical or other health specialties and sub-specialties required to provide those healthcare services covered by FCC benefit plan(s);

2. Provide medical or other health services in geographic locations accessible to FCC members within or contiguous to FCC's approved service area;

3. Are professionally qualified, as measured by appropriate provider specialty board certification or eligibility or participation in continuing medical education;

4. Will accept FCC members as new patients as well as existing patients who become members of FCC's benefit plan(s);

5. Agree to participate in, cooperate fully, and comply with FCC's Utilization Management and Credentialing programs;

6. Meet all credentialing requirements, as specified in this Plan.

D. Non-Discrimination. No applicant will be deemed ineligible for participation in FCC's managed care network or be unlawfully discriminated against by FCC in any way solely on the basis of sex, race, color, age, marital status, national origin, or physical disability.

E. Amendment. These credentialing requirements and standards may be amended at any time, in whole or in part, by FCC. Such changes will be submitted to the FirstQIC for approval. Upon approval by FirstQIC a new effective date will be determined for the implementation of the revised policies and procedures.

II. AUTHORITY AND RESPONSIBILITIES

A. Board of Trustees. The FCC Board of Trustees has the ultimate responsibility for oversight of FCC's credentialing program. It has delegated responsibility for approving or disapproving individual practitioners for participation in the FCC network to the FirstQIC.

B. FirstQIC. FirstQIC reports to the Board of Trustees, in accordance with the FirstHealth of the Carolinas and FCC bylaws. FirstQIC has: the medical director to:

1. Designated the Medical Director to:

   a. Review and discuss whether credentialed providers and applicants are meeting reasonable standards of care;

   b. Access appropriate clinical peer input when discussing standards of care for a particular type of provider;

   c. Conduct additional review and investigation of applications when the credentialing process reveals issues that may impact quality of care or services delivered to members;

d. to approve clean and complete applications, provided that such authority is documented and is subject to reasonable guidelines as referenced in FirstQIC minutes of 10/22/13;

3. Through an administrative coordinator, maintain minutes of all committee meetings and documents all actions;

4. Provide guidance to FCC on the overall direction of the credentialing program;

5. Evaluate and report to FirstQIC on the effectiveness of the credentialing program on an annual basis;

6. Review and approve credentialing policies and procedures; and

7. Meet as often as necessary to fulfill its responsibilities, but no less than quarterly.

8. Has final authority to approve or disapprove credentialing/re-credentialing applications;

C. Medical Director. FCC's Medical Director is the senior clinical staff person responsible for oversight of the clinical aspects of the credentialing program. The duties of the Medical Director include:

1. Periodic assessment of adequacy of network, particularly focusing on adequacy and distribution of primary care and specialist physicians, acute care hospitals and behavioral health services;

2. Make recommendations regarding changes to network based on network assessment;

3. Initial review of quality of care complaints made concerning network providers and determination whether issue requires FirstQIC review;

4. Act as advisor to credentialing staff on interpreting any clinical issues that arise from credentialing application review, including but not limited to review of quality of care, utilization and professional malpractice claims and settlements;

5. Additional review and investigation of applications when the credentialing process reveals issues that may impact quality of care or services delivered to members.

D. Director of Provider Relations. The day-to-day operations of the credentialing program are the responsibility of the Director of Provider Relations, who will supervise the following activities conducted by the Provider Relations Coordinators (s):

1. Ensuring compliance with all federal and state law and regulations and accreditation standards applicable to provider credentialing;

2. Recommending and developing policies and procedures for credentialing;

3. Ensuring the confidentiality and security of all documents and materials related to credentialing and limiting access to such materials to authorized staff;

4. Ensuring the timely review of all applications and timely notification of status of applications;

5. Verifying all credentials using the procedures outlined in Section III of this Plan and related policies and procedures;

6. Communicating with applicants as necessary to complete the credentialing process and to provide written notification to applicants of committee determinations in a timely manner;

7. Submitting requests as needed for applicant profiles to the various national and state monitoring agencies;

8. Maintaining a complete and accurate credentialing record for each applicant and/or provider;

9. Conducting re-credentialing, as described in this Plan; and

10. Providing credentialing staff support to the Medical Director.

III. PRACTITIONER CREDENTIALING AND RE-CREDENTIALING STANDARDS AND REQUIREMENTS

A. Credentialing Healthcare Practitioners. All physicians and certain other licensed independent practitioners who wish to be listed in FCC's Provider Directory must meet all of FCC's credentialing criteria and successfully undergo FirstQIC review or its designee as a condition of initial or continued appointment.

B. Practitioner Credentialing Standards and Requirements. Each applicant and re-credentialed FCC Participating Provider has the burden of proving he/she meets all then-current FCC credentialing standards. FCC's Provider Relations Coordinator, with the support of the Medical Director will determine whether an applicant meets the standards described below. FCC's Provider Relations Coordinator will advise the Medical Director whether any of the administrative requirements are not met with respect to any applicable provider. The credentialing standards are as follows:

1. Application: Applicants must submit a complete, signed and dated application on the form approved by the North Carolina Department of Insurance entitled "Uniform Application To Participate as a Health Care Practitioner". The application shall be dated and signed not be more than 180 days prior to the date

of review. The applicant shall attest that the application is complete and accurate to the applicant's knowledge and shall authorize FCC to collect any information necessary to verify the information in the application. The primary and secondary source verification shall be collected not more than six (6) months prior to review.

2. License: *APPLIES TO ALL PRACTITIONERS*. FCC must verify from a primary source that the applicant possesses current licensure without material restrictions, conditions or other disciplinary action taken against applicant's license to practice in the state of North Carolina and any other state in which applicant has an active license. New applicants whose license is suspended or on probationary status will not be considered eligible for credentialing. New applicants whose licensure has been suspended, terminated, surrendered or otherwise limited or restricted will not be considered eligible for credentialing until at least twelve (12) months after the restriction is removed. The Provider Relations Coordinator will verify licensure with the applicable state licensing agency by querying the applicable licensing agency's license verification website. A hard copy of the verification will be maintained in the applicant's file.

3. DEA: *APPLIES TO ALL MDs, DOs, PAs, NPs, ODs.* The applicant must have a current and valid Drug Enforcement Administration (DEA) Registration Certificate, unless the applicant's practice does not require it. (For example, this requirement is not applicable to physicians who do not provide direct patient care). A copy of the DEA certificate used for verification purposes and must be included with the application. New applicants whose DEA certificate has been suspended, terminated, surrendered or otherwise limited or restricted will not be considered eligible for credentialing until at least twelve (12) months after the restriction is removed.

4. Board Certification: *APPLIES TO MDs, DOs.* Unless an exception is made as set forth below, applicant should be board certified in his or her field of practice, as listed with the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) in the specialty(ies) for which the applicant requests to be listed in the FCC Provider Directory. This information should be indicated on the application and a copy of a current board certificate or notification letter with an expiration date (if applicable) or the AMA Master Profile should be submitted with the application. Board Certification must be primary source verified through the ABMS verification service if current information as stated previously is not provided.

   Exceptions to the board certification requirement may be made at FirstQIC's discretion. Such exceptions may include:

   a. Physicians practicing in a rural area that is underserved in the applicant's specialty;

   b. Newly trained physicians with appropriate plans for board certification within seven (7) years;

c. Physicians with an established clinical practice and with at least five (5) years of experience in primary or specialty care.

Applicants who are not board certified in their field of practice must provide the following:

a. Documentation of completing an accredited residency training program indicated on the application. Credentialing staff will primary source verify the information through AMA Master Profile and/or other primary sources if information of completion is not provided

b. Documentation of continuing medical education (CME) hours totaling 60 Category 1 hours for the last three consecutive years. The CME hours must be consistent with the AMA's Physician Recognition Award.

5. Hospital Privileges: *APPLIES TO MDs, DOs.* Applicants who practice in geographic areas in which there is a FCC participating hospital must have current and unrestricted admitting privileges at one or more FCC participating hospitals. Physician applicants who practice in a geographic area in which there is not an FCC participating hospital must have current and unrestricted admitting privileges at a licensed acute care facility serving his/her geographic area. For physicians voluntarily without hospital privileges, an explanation of a process for providing hospital care for FCC members must be provided. Applicant must specify the practitioner(s) of like specialty who will be admitting and attending to his or her patients. Certain specialists who elect not to seek hospital privileges are exempted from this requirement, such as pathologists and other hospital-based providers, psychiatrists where there is no mental health services at the hospital, and dermatologists. Credentialing staff will verify privileges with the primary hospital listed on the application by phone, fax, or letter. In additional, new applicants with a history of a denial, suspension, restriction, surrender or termination of privileges will not be considered eligible for credentialing until at least twelve (12) months after unrestricted privileges are granted or restored.

6. Malpractice Insurance: *APPLIES TO ALL PRACTITIONERS.* Applicants must have current medical malpractice insurance. A copy of the malpractice insurance face sheet that indicates coverage amounts, the effective and lists the applicant as a named insured or as covered under a clinic policy or federally sponsored program is required with the application. All applicants are required to have minimum coverage of $1 million per claim or per occurrence/$3 million aggregate. A history of denial or cancellation of professional liability insurance may warrant denial of participation status.

7. Malpractice History: *APPLIES TO ALL PRACTITIONERS.* Applicants must provide a history of professional liability claims that have resulted in settlements or judgments paid by or on behalf of the applicant. The Provider Relations Coordinator will query the National Practitioner Databank and the Healthcare Integrity and Protection Data Bank (collectively referred to as the Data Bank) for

the applicant's report history. A history of significant malpractice claims, as determined in the discretion of FirstQIC, may warrant denial of participation status.

8. State and Federal Sanctions: *APPLIES TO ALL PRACTITIONERS*. FCC will review reports for any reported state sanctions, revocation of license, and/or imposed penalties or limitations. FCC will request information about Medicare/Medicaid sanctions for each applicant through queries to the Data Bank or by reviewing reports from the Office of the Inspector General (OIG). Applicants who have been sanctioned by any regulatory agency will not be considered eligible for credentialing until at least twelve (12) months after any sanction(s), limitations(s), or restriction(s) have been removed.

9. Education: *APPLIES TO MDs, DOs* Applicants must have graduated from an acceptable school of medicine or osteopathy, defined as a school listed in the then-current Directory of American Medical Education, published by the American Association of Medical Colleges, or in the then-current World Directory of Medical Schools, published by the World Health Organization. Specialty board certification shall be sufficient evidence of graduation from an acceptable school of medicine or osteopathy and completion of an accredited residency program. Graduates of foreign medical schools must have an Educational Commission of Foreign Medical Graduate (ECFMG) Certificate.

10. Professional Competence**:** The applicant for initial or re-credentialing must also meet all professional competence criteria, including, but not limited to, the following:

    i. The absence of conduct that: (a) violates state or federal law or (b) standards of professional conduct governing the applicant's profession;

    ii. An appropriate work history with no significant unexplained gaps (more than 6 months);

    iii. The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the denial of participation status as determined by FirstQIC;

    iv. The absence of ~~a~~ NPDB Adverse Action Reports or HIPDB reports that indicates unsuitability for participation as determined by FirstQIC;

    v. The absence of misrepresentation, misstatement or omission of a relevant fact within the past five (5) years on the Uniform Credentialing Application;

    vi. The absence of evidence that the practitioner improperly and wastefully uses medical resources or otherwise subjects patients to unnecessary tests, procedures or treatments;

vii. The ability to practice to the full extent of the practitioner's professional license and qualifications without a risk to patient safety or health;

viii. Freedom from physical and mental conditions, or problems that currently and adversely affect applicant's ability to practice within the scope of his or her license or, if any such problems exist, evidence that the practitioner can be reasonably accommodated to the extent as to not affect his/her ability to practice within the scope of his or her license;

ix. Freedom from current abuse of controlled substances;

x. Absence of history of a felony conviction or other acts involving dishonesty, fraud, deceit or misrepresentation; or, if such history exists, evidence that this history does not currently affect applicant's ability to perform professional duties for which applicant is contracted, and does not demonstrate the possibility of future substandard clinical performance;

xi. The absence of a history of malpractice lawsuits, judgments, settlements or other incidents that indicates a competency or quality of care problem.

11. Network Requirements. FCC may, in its sole discretion, limit participation in its network to achieve service and efficiency goals and meet business needs and strategies.

C. Re-credentialing Practitioners. FCC participating practitioners are required to provide re-credentialing information every three years from the initial credentialing or last re-credentialing date, to the month. For example, whether the initial credentialing was completed on 7/1, 7/15 or 7/31 of 2009, the organization must re-credential no later than the end of July, 2012. The application shall be dated and signed not be more than 180 days prior to the date of review. The primary and secondary source verification shall be collected not more than six (6) months prior to review. The standards and requirements for re-credentialing are the same as those for initial credentialing, as set forth in Section C. above, with the exception that credentials not subject to expiration (e.g. education, lifetime board certification) do not require re-verification. FCC also considers any collected information regarding the participating provider's compliance with the terms of FCC's provider agreement, including any quality and effectiveness of care information collected through FCC's quality management program. If a re-credentialing application meets all applicable standards and requirements and contains no adverse information including but not limited to, service or quality of care, questionable utilization patterns, licensure or insurance issues or professional malpractice claims, the application may be deemed approved with no further action needed except approval of the applicant by the Executive Committee of the Board of Trustees..

D. Committee Action. FirstQIC or the Credentialing Sub-Committee or their designee may take any of the following actions on an application presented to it:

1. Full Approval. All requirements must be met for an applicant or existing practitioner to receive full approval.

2. Approval with Monitoring. Practitioners may be approved with monitoring on a case-by-case basis if the applicant otherwise meets credentialing standards but may have a particular issue that appears to warrant periodic or early review of adverse trends in utilization, member satisfaction, malpractice events or other circumstances that may compromise care of FCC members. Monitoring may be conducted as determined by the committee or until a full approval is issued and may be part of a corrective action plan.

3. Not Approved. If the adverse decision is based on professional competence or conduct, which could adversely affect patient care, the applicant shall be offered the right to appeal the decision pursuant to the appeals process set forth in Section IX. There is no reconsideration process available to initial applicants denied participation status for reasons unrelated to professional conduct or competence.

IV. CREDENTIALING AND RE-CREDENTIALING OF FACILITIES AND ANCILLARY PROVIDERS

A. Credentialing Standards and Requirements. All health facilities and ancillary providers that wish to be listed in FCC's Provider Directory must meet all of FCC's credentialing criteria. Each facility or ancillary provider must provide the following (as applicable) prior to the credentialing review by the Provider Relations Coordinator, and every three years thereafter:

1. State licensure information (if that type of facility is eligible for a state license);
2. Medicare or Medicaid certification status via Office of the Inspector General (if such certification is available for that type of facility) or proof of Medicare or Medicaid certification;
3. A copy of the facility's liability insurance policy declaration sheet meeting requirements stated in Section III (6);
4. Accreditation status (e.g., TJC, CARF, AAAHC, etc.) if applicable
5. Any other information necessary to determine if the facility meets FCC's participation criteria established for that type of facility including a signed and dated statement from an authorized representative of the facility or ancillary provider attesting that the information submitted with the application is complete and accurate to the facilities' knowledge and authorizing FCC to collect any information necessary to verify the information in the credentialing application (see Attachment A);

The Provider Relations Coordinator will be responsible for assuring that all information collected at the time of initial credentialing and re-credentialing are current and that each provider is in compliance with any of the above requirements that are applicable. Any facility that does not adhere to these requirements will not be eligible for participation in the FCC network. If a re-credentialing application meets all applicable standards and requirements and contains no adverse information, including but not limited to, service or quality of care issues, questionable

utilization patterns, licensure and insurance issues or professional malpractice claims, the application may be deemed approved with no further action needed.

For credentialing and re-credentialing timeframes, see Policy CR-003.

V. CONTINUOUS MONITORING. FCC will establish a process to monitor credentialed practitioners' continuing compliance with FCC credentialing standards and a process to respond to instances in which a provider no longer complies with such standards, e.g. monthly review of OIG sanctions and licensure boards.

VI. DISCIPLINARY ACTION

A. Imposition of Disciplinary Action. The FirstQIC, on its own initiative or following a recommendation from the Medical Director or the Director of Health Services, may take any disciplinary action it deems appropriate due to substandard professional performance or failure to comply with FCC credentialing standards set forth in Section III. Examples of such disciplinary action include but are not limited to:

1. Monitoring the practitioner for a specified period of time, followed by a determination as to whether noncompliance with requirements is continuing;

2. Warning the practitioner that disciplinary action will be taken in the future if noncompliance with FCC requirements continues or reoccurs;

3. Requiring the practitioner to submit and adhere to a corrective action plan;

4. Administrative suspension or termination of the practitioner's participation status for noncompliance with the participation criteria set forth in Section III;

5. Terminating the practitioner's participation status as described in Section VII.

The practitioner shall be informed in writing of the imposition of any disciplinary action. FCC shall determine if any adverse decision is based on professional conduct or competence. The applicant shall be offered the right to appeal the decision pursuant to the appeals process set forth in Section IX. There is no reconsideration process available to initial applicants denied participation status for reasons unrelated to professional conduct or competence.

B. Summary Suspension or Restriction. The Medical Director may summarily suspend a practitioner if he/she determines that the health of any FCC member is in imminent danger, upon notice that the practitioner's license has been revoked or suspended, that the practitioner has been excluded from any federal, state or local government program, or that the practitioner fails to meet FCC's minimum malpractice insurance requirements. All summary suspensions or restrictions shall be reviewed and final decisions made by FirstQIC. A practitioner who is summarily suspended for reasons related to professional

conduct or competence affecting patient care shall be offered an appeal pursuant to Section IX. A practitioner who is summarily suspended for reasons unrelated to professional conduct or competence may request an administrative reconsideration of such suspension under certain circumstances, as set forth in Section X. Any such appeal or administrative reconsideration may be held post-suspension or restriction.

VII. TERMINATION OF PRACTITIONERS

A. Termination by FCC Credentialing Staff. Notwithstanding any provision in this Credentialing Plan, FCC credentialing staff may administratively terminate the participation status of any practitioner in accordance with the FCC participating provider agreement. FCC credentialing staff may also administratively terminate a practitioner if he/she retires, dies, relocates, takes a leave of absence, or fails to complete the re-credentialing process prior to their termination date.

FCC credentialing staff shall provide FirstQIC with a summary report of all terminations and suspensions for cause Medical Director shall provide a practitioner who is terminated or suspended for cause pursuant to this Section VII(A) with written notice of such termination or suspension and the reasons for such action.. Administrative terminations may be subject to administrative reconsideration under the terms and conditions set forth in Section X.

B. Termination by FirstQIC. The Credentialing Subcommittee may decide to terminate the participation status of any practitioner. Consideration of termination may be initiated by any information FirstQIC deems relevant and appropriate.

C. Criteria for Termination. The FirstQIC may consider any of the following criteria as a basis for termination:

1. The practitioner has failed to continuously meet one or more of the participation criteria set forth in Section III(B); or

2. The practitioner engages in uncooperative, unprofessional or abusive behavior towards FCC members, FCC employees, or a member of FirstQIC or Board of Directors.

VIII. PROCEDURES FOR DISCIPLINE AND TERMINATION

A. First QIC Review. When FCC receives information suggesting that discipline or termination of a practitioner may be warranted, FCC credentialing staff shall compile all relevant information and refer the matter to the Medical Director, or if information otherwise comes to the Medical Director's or FirstQIC's attention which it believes suggests that discipline or termination may be appropriate, the Medical Director or FirstQIC may direct credentialing staff to investigate the matter and forward the information obtained to the Medical Director or FirstQIC.

The FirstQIC may elect to request or permit the practitioner to appear before FirstQIC to discuss any issue relevant to the investigation. FirstQIC shall consider the information received and determine whether disciplinary action or termination is appropriate. FirstQIC has complete discretion in determining actions regarding disciplinary or termination matters and may base its decisions on any factors it deems appropriate, whether or not those factors are mentioned in this Credentialing Plan. The practitioner shall be notified in writing by the Medical Director of any decision by FirstQIC to discipline or terminate. FirstQIC's decision shall be forwarded to the Executive Committee for review, subject to any appeal rights provided herein.

B. Notice and Effective Date of Discipline or Termination. In the event FirstQIC decides to discipline or terminate the participation
status of a practitioner, the practitioner shall be provided with written notice of such decision. The notice shall set forth FirstQIC's decision, the proposed effective date of the disciplinary action or termination, a summary of the basis of the decision, the time limit within which to request an administrative reconsideration or appeal, if applicable, and a general description of the review process.

IX. APPEALS COMMITTEE PROCEDURE

A. Appeals Committee Composition. FCC credentialing staff shall convene an Appeals Committee made up of at least three (3) qualified practitioners, who otherwise meet the criteria set forth in this provision. Where possible, FCC will seek to include on the Appeals Committee practitioners who practice in the same area or specialty as the practitioner who is the subject of the hearing. Members of the Appeals Committee may be network practitioners. Members of the Appeals Committee will be individuals who are not, in the judgment of FCC, in direct economic competition with the practitioner who is the subject of the hearing. FCC employees, FirstQIC members and members of the FCC Board of Trustees shall not serve on the Appeals Committee. The Appeals Committee shall elect a chairperson from among its members.

B. Request to Appeals Committee. Requests for appeal must be received by FCC within thirty (30) calendar days of the date of written notice sent to the practitioner. Upon receipt of a practitioner's written appeal request, FCC shall notify the practitioner that an appeal hearing will be scheduled in the near future, and that further information on the hearing date will be provided. The hearing date will be not less than thirty (30) days from the date the practitioner receives the hearing notice, unless a shorter period is mutually agreed to by the parties. Postponements and extensions may be granted by the Medical Director or his/her designee on a showing of good cause. Requests for a postponement or extension must be received within ten (10) days prior to the scheduled hearing date to be considered.

When a hearing is scheduled, FCC will provide written notice stating the date, time, and place of the hearing, and a list of the witnesses (if any) expected to be called by FCC at the hearing, and the composition of the Appeals Committee.

C. Pre-Hearing Matters. FCC will send each Appeals Committee member and the practitioner a packet of the documents relevant to the appeal prior to the hearing. The failure to distribute a document shall not render it inadmissible at the hearing.

D. The Hearing.

1. Representation by Counsel. The practitioner and FCC may be represented by counsel.

2. Record of Proceeding. FCC shall keep a full and accurate record of the hearing. In addition to maintaining the documentary records, FCC shall arrange for an audio record to be made of the hearing. Copies of this record shall be made available to the practitioner upon payment of a reasonable charge.

3. Chairperson's Statement of the Procedure. Prior to the presentation of evidence or testimony by either party, the Chairperson of the Appeals Committee shall announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.

4. Presentation of Evidence by FCC. FCC may present any relevant oral testimony or written evidence to the Appeals Committee for consideration. The practitioner or the practitioner's counsel shall have the opportunity to question any witness testifying on behalf of FCC. The practitioner may be called and questioned by FCC whether he/she testifies or not.

5. Presentation of Evidence by Practitioner. After the completion of FCC’s submission of evidence, the practitioner shall present any relevant oral or written evidence to rebut or explain the situation. FCC shall have the opportunity to question any witness testifying on behalf of the practitioner.

6. Plan Rebuttal. FCC may present any additional witnesses or submit additional documents to rebut the practitioner's evidence. The practitioner shall have the opportunity to question any additional witnesses testifying on behalf of FCC on rebuttal.

7. Summary Oral Statements. Upon the completion of FCC's and the practitioner's submission of testimony and evidence, first FCC and then the practitioner shall have the opportunity to make a brief closing statement.

8. Examination by Appeals Committee. Throughout the course of the hearing, the Appeals Committee may examine or question any witness giving testimony.

9. Admissibility of Evidence. The Appeals Committee has the right to refuse to consider testimony or evidence that it does not deem useful in making a decision. The rules of evidence applicable in a court of law shall not apply to the hearing.

Appeals Committee shall have sole discretion to determine what evidence shall be considered.

F. **Appeals Committee's Decision.** The Appeals Committee shall make its determination based on the information and evidence produced at the hearing. FCC shall have the initial burden of going forward to present evidence in support of its decision. Thereafter, the practitioner shall have the burden of demonstrating by clear and convincing evidence that there are no grounds for the adverse action. After the hearing, the Appeals Committee shall convene and privately discuss the evidence presented. The Appeals Committee may uphold, reject, or modify the action of FirstQIC. The Appeals Committee's decision shall be by the affirmative vote of the majority of the members of the Appeals Committee. The practitioner shall be notified in writing of the Appeals Committee's decision within five (5) business days of the decision. The decision will be effective immediately unless otherwise stated. Such notice shall include a statement of the basis for the decision.

G. **Executive Committee Review.** The FCC Executive Committee shall review the decision of the Appeals Committee and approve, reject or modify the decision. When reviewing the Appeals Committee's decision, the Executive Committee shall not reject the decision unless it finds that it was arbitrary and capricious. The practitioner shall have no right to appear before the Executive Committee.

H. **Notification of Members.** In the event of termination or suspension of participation status, FCC shall notify the members who regularly obtained health services from the practitioner.

I. **Reporting Requirements.** FCC shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq. and any other relevant federal and state statutes and regulations, whether and when any disciplinary action shall be reported to the National Practitioner Data Bank, the North Carolina Medical Board, or any other appropriate agency. FCC shall be entitled to make such determinations in its sole discretion, in accordance with such policies and procedures provided, however, that the determination shall be made in good faith. The Provider Relations Coordinator shall notify the affected practitioner, in writing, in the event such a report is made and such notification is legally required.

X. ADMINISTRATIVE RECONSIDERATION

A. **Availability of Review Process.** FCC shall make an administrative reconsideration process available to practitioners whose participation status is suspended or terminated for reasons unrelated to professional conduct or competence if (1) the practitioner notifies FCC that he or she disputes the facts upon which the action was based, or (2) the practitioner notifies FCC that he or she has additional information bearing on the action to provide to FCC for further consideration. Administrative reconsideration is not available to practitioners whose participation status is

administratively terminated for failure to complete the re-credentialing process. Providers may reapply for participation using same standards set forth for new providers.

B. Notice of Availability of Reconsideration. FCC shall provide the practitioner with a written statement of the reasons for the practitioner's denial, termination or suspension and the circumstances under which the practitioner may request an administrative reconsideration. A practitioner shall submit a written request for reconsideration within thirty (30) calendar days of the date notice of the action is provided to the practitioner.

C. Reconsideration Process. If the practitioner's request for reconsideration is consistent with Section X(A), FCC shall provide the practitioner with a copy of the information and evidence considered by FCC or FirstQIC in reaching its decision. The practitioner shall then have the opportunity to submit a written statement and any relevant written evidence to FirstQIC. In FCC's sole discretion, the reconsideration process may include an informal meeting between the practitioner and one or more representatives of FCC. FirstQIC shall consider the practitioner's statement and evidence presented in making a final decision on the action and may uphold, rescind or modify its previous action. Within ten (10) business days after FirstQIC makes a decision on the action, FCC shall provide the practitioner with a written notice of its decision and the reason(s) for its decision. The practitioner shall have no further right to appeal pursuant to Section IX.

XI. DELEGATED CREDENTIALING ORGANIZATION (DO)

A. Authority for Delegation. FCC may, in its sole discretion, delegate responsibility for credentialing to a third party. Notwithstanding delegation, FCC retains the right to make the final decision regarding the credentialing of any provider.

B. **Requirements for Delegated Organization (DO).** All DOs are required to adhere to the same requirements as described this Plan. Prior to execution of that document, FCC will conduct a review of DO's written policies and procedures concerning the delegated functions and confirm that the credentialing standards of the DO comply with FCC standards as set forth in this Plan and URAC standards. Delegation of credentialing must be specified in a written document. The agreement will include:

1. Details of responsibilities delegated to the DO and those retained by FCC;

2. Requirement that delegated services will be performed in accordance with FCC's standards and URAC requirements;

3. Requirement that the DO notify FCC of any material change in its ability to perform the delegated functions;

4. Right of FCC to conduct surveys of the DO, as needed;

5. Requirement that the DO submit periodic reports to FCC regarding performance of delegated services;

6. Recourse available to FCC if DO does not make corrections to problems identified by FCC;

7. Circumstances under which functions may be further delegated by DO; and

8. Requirement that if DO further delegates delegated functions, those functions are subject to the terms of the written agreement between FCC and DO.

C. Delegation Oversight. FCC will establish and implement an oversight mechanism for delegated credentialing. Procedures will include annual review of the DO's written credentialing policies and procedures and an audit of a random sample of DO's credentialing files to verify compliance with FCC standards. FCC will report to FirstQIC annually on the results of credentialing delegation oversight activities. FCC retains the right to make the final credentialing decision regarding any provider.

XIII. CONFIDENTIALITY

Credentialing files, whether paper or electronic, will be maintained in a confidential and secure manner. FCC implements policies and procedures to ensure security, confidentiality and limited access to credentialing information.

XIV. EFFECTIVE DATE

The effective date of this plan is the date on which changes are made and approved by FirstQIC and reported in the minutes.