

FirstCarolinaCare Insurance Company

PROVIDER MANUAL

Third Edition

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FirstCarolinaCare Insurance Company

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A Product of FirstHealth of the Carolinas

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I. INTRODUCTION

Welcome to FirstCarolinaCare Insurance Company (“FCC” or “FirstCarolinaCare”). FirstCarolinaCare Insurance Company (FCC) is a non-profit health insurance company formed in 1999 by FirstHealth of the Carolinas, a 501(c)(3) community-based hospital system headquartered in Pinehurst, North Carolina. Like many provider-owned health plans, FCC started out as a means to provide self-funded employee benefits for its parent organization. However, in 2000, FCC expanded its operations to offer insured group health benefits to employers in a seven county region around Pinehurst.

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 16,300 commercial group members 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.

FCC has adopted the mission statement of its parent organization, FirstHealth of the Carolinas, Inc., which is “*To care for people*”. Dedicated to supporting FirstHealth of the Carolinas' community service mission, FCC has focused on –

- Reducing the rate of growth of the uninsured;
- Keeping premiums as affordable and predictable as possible; and
- Offering a viable alternative to larger carriers.

This manual is a reference and source document for Program Requirements, which include relevant policies and procedures applicable to the following types of providers who contract or otherwise participate with FCC: FCC Providers and their office staff; FCC Hospitals; and FCC Ancillary Providers. 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.

For our HMO/POS products, FCC has entered into participating provider contracts with FirstHealth of the Carolinas, the Mid-Carolina Physician Organization (MCPO), The UNC Hospital and Physician network and other providers and facilities to provide a comprehensive network for FCC Members. FCC has contracted with the MCPO to provide certain medical management functions to maintain a setting where health care decision making remains largely with the local provider who actually provides and manages the Member's care.

For our PPO products, FCC has entered into an arrangement with Medcost to allow FCC PPO members to access providers who participate in the Medcost Preferred network.

FCC recognizes the importance of the Primary Care Provider (PCP) in coordinating the care of Members. PCPs include providers whose practices are primarily family medicine, general practice, general internal medicine, general pediatrics, obstetrics and gynecology, or gynecology only. FirstCarolinaCare seeks to foster a strong, stable relationship between Members and the PCP of their choice. Authority for clinical decision making rests with the health care provider who directly provides the care in order to foster the delivery of effective care.

Key Contact Phone Numbers

FirstCarolinaCare, Inc.	(910) 715-8100 (Main)
	(910) 715-8101 (fax)
Toll Free Access	(800) 574-8556
Customer Service	(800) 811-3298

Utilization Management & Behavioral Services (Includes Chemical Dependency)	(800) 574-8556
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Provider Relations	(910) 715-8115
	(910) 715-8101 (fax)

EDI # 56196

Key Contacts

Mailing and Physical Address:

FirstCarolinaCare
42 Memorial Drive
Pinehurst, NC 28370

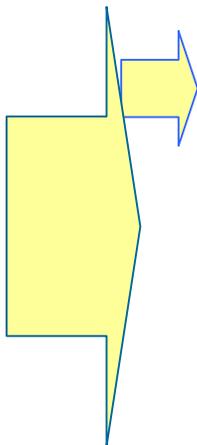
Claims/Billing Address:

FirstCarolinaCare
P. O. Box 381686
Birmingham, Alabama 35242

Plan Design of the FCC Commercial Products

FCC offers three lines of business: HMO, Point of Service (HMO), and PPO through our partnership with Medcost. This manual primarily addresses requirements for participating providers in the FCC HMO HMO/POS product; however, certain sections such as covered services and precertification, also apply to the Medcost preferred providers.

The FCC POS plan is a “dual option” plan because the Member has two options for benefit coverage – In-Network Benefits or Out-of-Network Benefits. The type of benefit coverage depends on from whom the Member chooses to seek care. If a Member seeks care from an in network provider, then In-Network benefits apply. If the Member chooses to seek care from a non-participating provider, then Out-of-Network benefits apply. FCC offers a wide range of benefit plans for employers that may include deductibles, copayments, and coinsurance. For specific information regarding a member’s benefits, please call FCC customer service at (800)-811-3298.



POS (HMO or PPO) Model

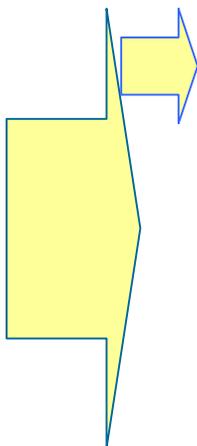
Option #1 In-Network Benefits

- ❖ Healthcare provided by In Network Provider
- ❖ Member incurs lower out-of-pocket costs
- ❖ Member files no claims

Option #2 Out-of-Network Benefits

- ❖ Claims may be filed by Member
- ❖ Healthcare provided by non-participating provider
- ❖ Member incurs higher out-of-pocket costs

Under the FCC HMO only plan, members must receive covered services from a participating provider. Generally, services provided by non-participating providers are not covered.



HMO only Model

Option #1 In-Network Benefits

- ❖ Healthcare provided by In Network Provider
- ❖ Member incurs lower out-of-pocket costs
- ❖ Member files no claims

No Option #2 Out-of-Network Benefits do not apply

- ❖ Healthcare provided by non-participating provider
- ❖ Member incurs all cost
- ❖ Claims must be filed by Member

II. CREDENTIALING/PARTICIPATING REQUIREMENTS

A. Overview

FCC's Credentialing/Recredentialing Plan applies to the selection, review, and monitoring of healthcare professionals, hospitals, facilities, and agencies that contract with FCC. The requirements and standards set forth in this plan are to fulfill FCC's obligation to FCC members to restrict participation to qualified health care practitioners and providers. Participating practitioners are required to provide recredentialing information every three years from the initial credentialing or last recredentialing date. Please see attachment A in the appendix for the most recent version of the Credentialing plan.

B. Credentialing/Recredentialing of Professionals

1. Eligible Professionals

FirstCarolinaCare will accept qualified professionals and physician extenders into the network. Credentialing/Recredentialing procedures apply to all licensed professionals who contract with FCC to provide covered services including:

- Medical Doctors (MDs);
- Doctors of Osteopathy (DOs);
- Doctors of Podiatric Medicine (DPMs);
- Doctors of Dental Surgery (DDSs);
- Physician Extenders (Physician Assistants and Nurse Practitioners) who will be listed in the FCC directory of participating providers.
- Doctors of Chiropractic (DC)
- Doctors of Optometry (OD)
- Mid-level and allied health providers including and not limited to, physical therapists, audiologists, social workers, clinical psychologists, and other mental health practitioners.

2. Delegated Credentialing

FCC may, in its sole discretion, delegate responsibility for Credentialing and Recredentialing to a group or network of professionals with which FCC has entered a contract for delegated credentialing. If credentialing/recredentialing functions with respect to an FCC Participating Provider have been delegated, the Provider should refer to the applicable credentialing/recredentialing plan of the delegated credentialing organization.

3. Fair Hearing Policy and Procedures

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.

III. ADMINISTRATIVE AND GENERAL POLICIES AND STANDARDS

A. MEDICAL RECORD STANDARDS

1. Policy:

Medical Record guidelines are established to encourage effective documentation of care rendered to Members, including providing ready access to all material information necessary to make medical determinations. Specific guidelines encourage the following goals:

- The medical record is complete and includes material elements of the Member's health history, treatment rendered and response to treatment.
- There is safe and effective transfer of care between the Primary Care Provider and the Specialty Provider, in the interest of promoting effective Member care and enhancing service between providers.
- The confidentiality of patient medical records is appropriately maintained.

2. Scope:

These guidelines apply to the medical records of all Members.

3. Procedure:

- a. In accordance with HIPAA laws, participating Providers are required to maintain a centralized medical record for each FCC member. The individual record maintained includes care provided by each Provider delivering care and documentation for care referred by such Provider to other Providers (inside or outside the FCC network).
- b. Participating Providers are required to maintain adequate policies and procedures restricting the release of patient information to only those releases that are required or permitted by applicable laws and regulations regarding the confidentiality of such information. Each patient care site must have a copy of the policy.
- c. Participating Providers must maintain the Member medical record in a current, detailed organized manner that permits effective patient care and facilitates quality review.

4. Standards:

- a. Organization: The record is to be organized as follows:
 - Each Member's medical record must be individually identified.

- The record, whether in electronic or paper form, must be secured to maintain confidentiality except as required or permitted by law.
 - The record must include a section for patient identification, which includes name, age, employer, occupation, work and home telephone numbers, insurance information and marital status.
 - All entries must contain author identification, must be dated, and all written entries must be legible.
- b. Documentation: At a minimum, the following information should be a part of the patient's medical record:
- Medication allergies and adverse reactions must be noted in a consistent, prominent place.
 - Past medical history, including use of tobacco products, alcohol and substance abuse in members.
 - A chief complaint and diagnosis or probable diagnosis
 - Summary of findings from an examination appropriate for the condition.
 - All medication prescribed (including name, dosage, frequency and duration).
 - Medications given on-site (including name, dosage, route, the site given, manufacturer and batch number)
 - Treatments, procedures and tests, and applicable results
 - Member education, recommendations and instructions given
 - A completed immunization record or notation of immunizations up to date for Members
 - A readily visible list of known material medical problems for Members with significant illness or conditions that require on-going attention and evidence that such problems have been monitored
- c. Completeness: Records are completed in a timely manner:
- The provider has a written policy in place in which the medical record is periodically checked to monitor whether all procedures ordered and referrals requested are returned and filed in the chart within a reasonable time period from the date of the visit. The policy must state that any missing items discovered during such review are further researched until the items are recovered or otherwise duplicated and placed in the appropriate chart.
 - The provider reviews and initials all test results and consultations.

B. Availability/Accessibility

FCC providers are expected to arrange for or provide services to FirstCarolinaCare members 24 hours a day, 7 days a week. FCC conducts an annual member survey with regard to member opinion related to availability and accessibility. FCC maintains availability and accessibility standards which Providers are expected to comply. For a complete copy of the most recent availability and accessibility standards, please refer to attachment (B).

C. Release of Members from a Provider's Practice

Infrequently, a FCC Provider may feel it inappropriate to continue to serve the needs of 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. We do request, however, that providers who wish to no longer treat a Member send a letter to the Member identifying that services should no longer be sought from the practice except in case of an emergency, up to 30 days from time of receipt of the notice.

D. Closing/Opening Practice to New Patients

A PCP may close his/her practice to all new patients including Members by giving 30 days prior written notice to FirstCarolinaCare. This means that a PCP may not close his or her practice to FCC 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 FirstCarolinaCare.

☞ Any new Member selecting a PCP prior to FirstCarolinaCare's receipt of written notification to close the practice must be accepted by the practice.

E. Providers' Liaison with FCC

Overview:

1. The FirstQIC is composed of FCC Providers who are appointed by the MCPO to serve as Committee members for a renewable term of one year.
2. The Committee is the principal source for FirstCarolinaCare to obtain physician input and advice on pertinent aspects of FirstCarolinaCare's programs applicable to individual providers. These aspects include but may not be limited to:
 - Medical Policy
 - Utilization Management/Quality Management
 - Provider Credentialing
 - Certain Administrative and Operational Matters
3. The committee is generally representative of medical and surgical specialties from the FirstCarolinaCare Network.

4. FirstCarolinaCare's Medical Director(s) acts as chair of the Quality Improvement Committee.
5. FirstCarolinaCare provides the Committee with staff support and other resources it may reasonably need to effectively carry out its functions. No plan staff member serves as a committee member. However, plan staff has the right to be present at all times during any committee or subcommittee meeting.
6. The First QIC Committee and/or any of its subcommittees shall keep minutes of all meetings which shall be transmitted to the FirstCarolinaCare Board of Trustees on a timely basis.

IV. REIMBURSEMENT

FirstCarolinaCare follows §NCGS 58-3-227 with regards to disclosure and notification of FCC reimbursement.

FirstCarolinaCare employs a fee-for-service reimbursement methodology to compensate FCC Providers for each covered service they render.

FirstCarolinaCare has established a schedule of fees that is attached to the Provider Participation Agreement. FCC Providers should bill FirstCarolinaCare at their own normal charge. Reimbursement will be the lesser of those charges or the agreed upon schedule of fees less any co-payments, co-insurance and/or deductible the FCC Provider must collect from the Member.

V. ENROLLEE ADMINISTRATION

A. Verification of Eligibility

Each FirstCarolinaCare Member, including dependent children and spouse, will be issued a Member Identification Card after enrollment with FirstCarolinaCare. The Member's Identification Card may be reviewed prior to rendering services. Emergency Services must not be delayed in order to verify coverage. If the FCC Provider is unable to verify the eligibility of a patient who holds himself/herself out to be a Member, the FCC 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 manual or on the appropriate section of the Member's Identification Card. If the patient is not a Member, the FCC Provider may collect all amounts due from the patient.

B. Member Identification Cards

The Member's Identification Card will include at least the following:

1. Member Name
2. Member ID Number:
This is an 10 digit number followed by a two digit suffix identifying the Member's relationship to the Employee. 00 - Employee; 01 - spouse; 02 - oldest child; 03 - next oldest child; etc.
3. Group Number (number assigned to Member's Plan)
4. Member Effective Date: Date Member's coverage became effective
5. Group Name (Subscriber's Employer Group)
6. In Network copayment amounts for PCP and Specialists, if applicable
7. Member responsibility for Emergency Department facility and ER physician
8. Member responsibility for Urgent Care facility
9. Riders to basic medical benefits
10. Address for filing claims
11. Customer Service telephone number

☞ Any questions concerning a Member's eligibility or Benefits, please call Customer Services at (800) 811-3298

C. Collection of Copayments, Coinsurance and Deductibles

1. Co-payments

Co-payments vary depending on the benefit plan. Members are responsible for paying the co-payment listed on their ID Cards. Participating Providers should collect the applicable co-payment at the time of the office visit.

☞ Co-payments should be collected at the time of service.

2. Co-insurance and deductibles

A Member may be responsible for co-insurance and deductible amounts. The amounts due from the Member vary with the benefit plan and the individual benefit. Deductibles must be met prior to FCC assuming any financial responsibility for covered services the Member receives. The Member's

responsibility will be clearly stated on the Remittance Advice received by the Participating Provider. The Provider is required to collect these from the Member.

VI. CLAIMS

A. Claims Submission

FirstCarolinaCare Participating Providers 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 rendered. Standard CMS 1500 guidelines should be used in completing all applicable fields. FCC Participating Hospitals or Ancillary Providers are required to submit to FCC a completed UB04 CMS1450 or successor claim form in order to receive payment for Covered Services rendered.

FirstCarolinaCare is capable of accepting electronic claims submission.

- FCC's Payer ID# is 56196
- To Request Electronic Remittance Advice (ERA) and/or Electronic Funds Transfers (EFT), please visit our website at: www.firstcarolinacare.com to access the required forms.

☞ Questions concerning the status of a claim should be directed to Customer Services at (800) 811-3298.

Paper Claims should be mailed to:

FirstCarolinaCare, Inc.
P.O. Box 381686
Birmingham, Alabama 35238

B. Coordination of Benefits

FirstCarolinaCare will coordinate benefits as stated in the member's Summary Plan Description or Certificate of Coverage. Coordination of benefits applies only when the Member has health care coverage under more than one plan. When FCC is the primary payor, FirstCarolinaCare will reimburse for Covered Services up to the fee maximum allowable or billed charges whichever is less (less any co-payment, co-insurance or deductible due from Member), without considering the other plan's benefits. When FirstCarolinaCare is secondary, FirstCarolinaCare will coordinate reimbursement with the other plan. In no case will FirstCarolinaCare pay more than the maximum allowable charge established by FirstCarolinaCare for such services.

C. Determination of Primary Payor

If there are two plans, and the other plan does not have rules that establish the same order of benefits as FCCI, , then the other plan will be primary.

If there are more than two plans, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

If a Member is covered under one plan as an employee and on another plan as a dependent, then the plan that covers the Member, as employee, will be primary.

If both parents who are currently married cover a dependent child then the plan of the parent whose birthday falls closest to the first of the year is primary unless a court order has designated it otherwise. This is often referred to as the "birthday rule". If both parents have the same birthday, the benefits of the plan that has covered a parent for a longer period of time are determined first.

If parents of a dependent child are either divorced or separated, and each parent has a separate plan, the plan of the parent with legal custody will be primary. If financial responsibility for the child's health care expenses have been established by court decree, then the court decree will determine which plan is primary.

If financial responsibility has not been established by court order and the parent with legal custody remarries and the step-parent covers the child as a dependent, then the order of primacy is: (1) plan of parent with legal custody; (2) plan of step-parent; and (3) plan of parent without legal custody.

If a Member is covered under a retirement health plan and is also covered under FirstCarolinaCare as an active employee, then FirstCarolinaCare will be primary and the retirement health plan will be secondary.

If benefits are available as primary benefits to a Member under Medicare or Workers' Compensation, then those benefits will be primary over FirstCarolinaCare.

If none of the above rules apply, then the plan that has covered the Member the longest will be primary.

D. Coordination of Benefits Claims Submission

The Participating Provider should file a claim first to the primary payor as determined by the rules above. If FirstCarolinaCare is determined to be secondary, then the claim should be submitted along with a copy of the primary payor payment information. If FirstCarolinaCare has information that the Member has other coverage, then FirstCarolinaCare will pend the claim until proof of payment by the primary payor is received or written information is received from the Member regarding the other coverage. It is the Member's responsibility to contact FirstCarolinaCare to update records.

E. Refunds and Recovery of Overpayments

If for any reason the Provider believes a claim has been underpaid by FCC, please notify Customer Services at (800) 811- 3298. FCC will research the payment history, and if indicated, a prompt adjustment will be made.

If an overpayment or incorrect payment has been made, FirstCarolinaCare 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 and include a Remark Code indicating why the adjustment was made.

F. Non-Payment of Claims

Questions concerning non-payment of claims or denials of claims should be directed to Customer Services at (800) 811-3298. Denials will be noted on the Explanation of Payment with a comment code detailing the reason for the denial.

G. Prompt Payment

FCC adheres to NCGS §58-3-225 regarding prompt payment of claims.

VII. PREVENTIVE SERVICES

FirstCarolinaCare promotes maintenance of optimum health and preventive services. Well care and annual physicals are encouraged. If provided in accordance with the In-Network Benefits requirements, FirstCarolinaCare covers well care and preventive services in accordance with Accountable Care Act including but not limited to:

Infants and Children

- Newborn screening for sickle cell disease, congenital hypothyroidism and phenylketonuria
- Newborn hearing screening and periodic hearing screening examinations for children through age 17
- Vision screening for children under 5 years for amblyopia, strabismus and defects in visual acuity
- Iron deficiency anemia prevention for children at increased risk of deficiency
- Screening and prevention of dental caries in preschool children
- Human immunodeficiency virus (HIV) screening and sexually transmitted infection counseling for adolescents at increased risk of infection
- Major depressive disorder screening for adolescents age 12-18
- Immunizations according to Advisory Committee on Immunization Practices recommendations.

Adults

- Immunizations according to Advisory Committee on Immunization Practices recommendations
- Colorectal cancer examinations and laboratory tests for cancer, in accordance with the American Cancer Society guidelines, for any non-symptomatic Member who is at

- least 50 years of age, or less than 50 years of age and at high risk for colorectal cancer
- Alcohol misuse screening and behavioral counseling interventions
- Counseling regarding aspirin therapy for persons at risk of coronary artery disease
- Major depressive disorder screening
- Type 2 diabetes screening
- Behavioral dietary counseling for adults with cholesterol disorders and other known risk factors for cardiovascular and diet-related chronic diseases
- Screening, counseling and interventions for obesity
- Blood pressure screening
- Human immunodeficiency virus (HIV) and sexually transmitted disease screening for adults at increased risk of infection
- Tobacco use screening, counseling and interventions

Women Only

- Examinations and laboratory tests for the early detection of cervical cancer
- Mammograms when a Provider recommends it for anyone at increased risk for breast cancer, OR one baseline mammogram at ages 35 through 39 and every year at ages 40 and older
- Breast cancer prevention counseling in high risk women
- Genetic counseling and evaluation for BRCA testing for high risk women
- Screening for asymptomatic bacteriuria between 12 and 16 weeks' gestation for all pregnant women
- Hepatitis B screening for pregnant women
- Chlamydial infection screening for sexually active non-pregnant women aged 24 and under and for pregnant women at increased risk
- Gonorrhea and syphilis screening for women at higher risk and all pregnant women
- Structured breastfeeding education and behavioral counseling to all pregnant and postpartum women to promote the initiation and continuation of breastfeeding
- Folic acid supplementation for women planning or capable of pregnancy
- Rh incompatibility screening and preventive medication for certain populations
- Bone mass measurement for women over age 60 depending on risk factors
- Surveillance tests for women at risk for ovarian cancer.

Men Only

- Prostate specific antigen (PSA) tests when a Provider recommends it;
- One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked

The preventive services listed above are Covered only when provided by Participating Providers if you are enrolled in a Point of Service or HMO plan. If you are enrolled in a PPO plan, preventive services provided by a Non-Preferred Provider will be subject to Member cost sharing.

Cost sharing (e.g., Copayments, Deductibles, Coinsurance) may apply to services provided during the same visit as the preventive services set forth above. For example, if a service listed above is provided during an office visit and that service is not the primary purpose of the visit, the Member cost sharing amount that would otherwise apply to the office visit will still apply.

For HMO and POS plans, there are no Out-of-Network benefits for preventive services, immunizations or well care.

A self-funded plan's benefit may be different than the benefits of FirstCarolinaCare Insurance Company, Inc. Check applicable plan's list of covered services to determine if well care and preventive services are included.

VIII. OB/GYN SERVICES

A. Overview

FirstCarolinaCare covers OB/GYN Services for its members, including but not limited to services listed in the Accountable Care Act.

FirstCarolinaCare's Certificate of Coverage provides the following definitions with regard to Maternity coverage:

Maternity Care

Maternity care is Covered only for the Subscriber and the Subscriber's spouse (if the spouse is a Member). Covered Services include:

- Prenatal care;
- Hospital stays;
- Birthing center care;
- Attending Provider services;
- Post-delivery care for the mother and baby if the mother and attending Provider agree to a discharge prior to 48 hours after normal delivery or for up to 96 hours after cesarean section; and
- Services for the baby for the duration of the mother's Hospital stay after childbirth.

Post delivery care is health care provided to a mother and her newborn child whose Hospital stay (upon the Member's attending Provider decision in consultation with the Member) is less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. Such care must be by a registered nurse, physician, nurse practitioner, nurse midwife or physician assistant experienced in maternal and child health in any of the following appropriate location(s) as deemed appropriate by the Member's Provider: (1) the home, a Provider's office, a Hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or (2) another setting determined appropriate under federal regulations promulgated under Title VI to Public Law 104-204.

No Precertification is required for Hospital stays for the mother and baby for up to 48 hours after normal delivery or for up to 96 hours after caesarean section. Hospital stays in excess of those periods require Precertification.

FCC will apply routine order of benefit procedures if the newborn has other valid primary

coverage that covers, without prior authorization, the 48 hours of inpatient stay following a normal vaginal delivery or 96 hours of inpatient stay following a cesarean section.

Complications of Pregnancy

Only Complications of Pregnancy are Covered for Eligible Dependents other than spouses. Health services for a Member's Complication of Pregnancy are not maternity care and are Covered for all Members on the same terms that apply to any other sickness or injury.

Diagnosis of Infertility

Services related to the diagnosis of infertility are Covered. Treatment of infertility is not a Covered Service. See Exclusions and Limitations for excluded infertility services.

Family Planning

Covered Services include examinations, consultations, procedures and other services relating to the use of contraceptive methods for the prevention of pregnancy. Covered contraceptives include intrauterine devices, diaphragms, injectable and implantable contraceptives. Removal of devices that must be removed by a Provider is Covered.

- **Complications of Pregnancy** - medical conditions whose diagnoses are separate from pregnancy, but may be caused or made more serious by pregnancy, resulting in the mother's life or health being in jeopardy or making a live birth less viable.

Examples include:

- Abruptio of placenta;
- Acute nephritis;
- Pre-eclampsia or eclampsia;
- Placenta previa;
- Poor fetal growth;
- Kidney infection;
- Emergency caesarian section, if provided in the course of treatment for a Complication of Pregnancy.
- The following conditions are not Complications of Pregnancy:
- Labor (whether or not resulting in delivery) and delivery;
- Occasional spotting;
- Symptoms that cause the Provider to order bed rest; and
- Morning sickness.

Women's Preventive Care covered at 100% beginning on or after 8/1/2012

(Benefits below apply to services provided by an IN-Network provider and must be billed with a primary diagnosis of preventive, screening, counseling or wellness)

The following contraceptive methods will be covered at 100% for women with reproductive capacity only when a prescription is required*:

- Cervical Caps
- Diaphragms
- Implantable Rods
- IUDs
- Medroxyprogesterone 150mg injection (generic only)
- Generic Oral Contraceptives**
- Ortho Evra[®] Patch**
- NuvaRing[®]**

The following screenings, preventive care and counseling services are covered at 100%:

- Annual wellness preventive visit for adult women. (Additional visit if physician determines it is medically necessary)
- Annual screening and counseling for interpersonal and domestic violence for women
- Breastfeeding support and counseling for pregnant and postpartum women
- Breastfeeding supplies for pregnant and postpartum women as below:
 - ❖ One electric or manual breast pump per pregnancy is covered if purchased from a participating durable medical equipment provider. (Hospital grade pumps are excluded and not covered).
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Human papilloma virus (HPV) DNA testing for women 30 or older every three years
- Annual HIV screening and counseling for sexually active women
- Counseling on sexually transmitted infections (STIs) for women who are sexually active.
- Education and counseling on contraceptive methods and sterilization procedures for women with reproductive capacity.

Surgical sterilization is a covered benefit for women with reproductive capacity; however, hysterectomies are excluded as they are not performed primarily for sterilization.

*Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services.

**Only applicable for a 30 day supply

B. Diagnostic Work-up for Female Infertility

The initial diagnostic work-up for female infertility is a covered service.

When billing for the diagnostic work-up of infertility, you should bill using the ICD-9 code “V26.2 Fertility Testing” as the primary diagnosis for the charges to pay correctly. Billing with an ICD-9 code in the 628 family will result in a denial of coverage, as this indicates infertility has already been diagnosed..

Other services that are often seen in a diagnostic work-up are:

E&M code	History and Physical
E&M code	Pelvic Exam
E&M Code	BBT graft
76856/76859	Ultrasound exams
85048	WBC
85651	Sed Rate
84144	Progesterone level
99070	Home Ovulation predictor
83001	FSH gonadotropin
83002	LH gonadotropin
84146	Prolactin
84402/88403	Testosterone
82160	Androsterone
84443	TSH
84143	17 Hydroxy-Progesterone
58100	Endometrial Biopsy
87070	Cervical Culture for GC, Chlamydia
86631/86632	Chlamydia Antibody
58340/74740	Hysterosalpingogram
56300	Diagnostic Laparoscopy
56350	Hysteroscopy
89300	Post Coital test
89325	Sperm antibody test
86299	IGM

C. Pregnancy and Delivery

- FirstCarolinaCare coverage of maternity services only applies to the Subscriber or the Subscriber’s spouse if the spouse is a member. Only complications of pregnancy are covered for eligible dependents other than spouses.

IX. EMERGENCY SERVICES

Emergency Services

If a Member believes that he/she has an Emergency Medical Condition, he/she should seek care from the nearest Provider. "911" emergency telephone access systems or other community emergency alert systems should be used where available. Emergency

Services will be Covered whether services are received at a Participating or Non-Participating Provider.

Examples of Emergency Medical Conditions include, but are not limited to, suspected heart attacks or strokes, uncontrolled bleeding, poisoning, major burns, prolonged loss of consciousness, head or spinal injuries, shock, or other acute conditions.

Coverage will be provided for treatment of Emergency Medical Conditions, without Precertification, until the Member's condition is stabilized. Services ordered by an emergency department Provider but received after stabilization may require Precertification, e.g. an MRI or CT scan.

For routine and follow up care related to an Emergency Medical Condition to be Covered, the Member must use a Participating Provider. Precertification requirements may apply.

If a Member is admitted for a Hospital stay directly from the emergency department, FCC should be notified of the condition and the services that the Member is receiving as soon as medically appropriate by calling the toll free Member Services number. The Hospital stay will be Covered until the Member can be transferred to a Participating Provider. If the Member does not transfer to a Participating Provider when medically appropriate, then FCC may, at its option, determine that no benefits will be paid for the remaining Hospital stay.

Services received at an Urgent Care Facility are Covered.

If a Member is unsure whether a condition is an Emergency Medical Condition or could be treated at an Urgent Care Facility or Provider's office, he/she can call the Nurse Help Line. The number is listed on the "Important Telephone Numbers" page.

X. BEHAVIORAL HEALTH SERVICES

Benefits for Behavioral Health and Substance Abuse Services differ depending on whether an Employer is a Large Employer or Small Employer. Please call Customer Service at 800-811-3298 for questions regarding whether a member's employer is a large or small employer.

Please Note: In most cases, you may determine whether the member has a small or large group by the plan name. Plan names starting with L are Large Groups. Plan names starting with S are Small groups.

Behavioral Health Services (Large Employer)

Medically Necessary Behavioral Health Services received from a licensed facility as an inpatient or provided in an outpatient setting are Covered the same as any illness or injury. Covered inpatient services include room and board and professional services furnished by Providers.

Behavioral Health Services (Small Employer)

Behavioral Health Services received at a licensed facility are Covered up to a maximum number of thirty days in any combination of inpatient days or outpatient visits per calendar year. Outpatient Behavioral Health Services are Covered up to a maximum number of thirty office visits per calendar year. These maximum numbers of days and visits do not apply for Behavioral Health Services required for the diagnoses listed below. For the following diagnoses, benefits for Behavioral Health Services are not subject to day or visit limits:

- bipolar disorder,
- major depressive disorder,
- obsessive compulsive disorder,
- paranoid and other psychotic disorder,
- schizoaffective disorder,
- schizophrenia,
- post-traumatic stress disorder,
- anorexia nervosa, and
- bulimia.

Substance Abuse Services (Large Employer)

Substance Abuse Services received at licensed facility as an inpatient or provided in an outpatient setting are Covered the same as any illness or injury. Covered inpatient services include room and board and professional services furnished by Providers.

Substance Abuse Services (Small Employer)

Subject to the coverage dollar limits stated on the Schedule of Medical Benefits, Substance Abuse Services received at a licensed facility as an inpatient or provided in an outpatient setting are Covered. Covered inpatient services include room and board and professional services furnished by Providers.

XI. Medical Management

A. FirstCarolinaCare Precertifications

Certain services may be considered cosmetic, investigational, dental, or not be covered under the Member's benefit plan. These services will generally not be approved for coverage. However, in case of doubt, the Member or Provider may request a coverage determination. Certain services require precertification by FCC, in advance of care, (other than Emergency Services). Listed are some services that require precertification:

- Inpatient
- MRI/CT
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Home Health
- Home Medical Equipment (DME) \$250.00 & above per item

- Hospice

For a complete list of services requiring precertification please go to provider services, general information at www.firstcarolinacare.com or call customer service at 800-811-3298.

This list is subject to change.

To request a benefit precertification, submit written documentation to FirstCarolinaCare via Fax 866-896-1941 or call 800-574-8556. Documentation should include at a minimum:

- Brief history
- Current clinical indications
- Pertinent lab and test data

One of our Health Resource Coordinators will review the documentation. Any additional information needed will be requested by the Health Resource Coordinator. The Medical Director(s) will then determine if:

- the procedure is appropriate for coverage under the benefit plan of the Member; or
- the procedure is not covered under the Member's benefit plan of the Member.

A member or a person acting on the member's behalf may appeal any decision of FCC and the Medical Director(s). All appeals must be in writing and may be initiated by the Member, a relative of the Member, any other representative designated by the Member or by the Member's Provider. If an appeal is about a decision that is rendered on the basis that the service is excluded by the Member's health benefit plan and it is clearly stated in the Summary Plan Description or Certificate of Coverage, then the initial decision of FCC will stand and none of the following appeal procedures will apply.

Standard Appeals

If a Member does not agree with a decision to deny Certification or Precertification of a medical service, the decision may be appealed. Members have 180 days after the Member received the decision to request an Appeal of the denial of Certification or Precertification. All Appeals will be evaluated by a Physician licensed to practice in North Carolina who was not involved in the Noncertification.

The Member (or a person acting on the Member's behalf) must write a letter to FCC to initiate an Appeal regarding services that are not needed on an expedited basis. The letter must be sent to:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Attention: Appeals and Grievance Coordinator

Within 3 business days after getting the written request for an Appeal, FCC will provide the name and telephone number of the Appeals and Grievance Coordinator. The Member will also get instructions for submitting written material for review. FCC will send a written decision within 30 days after the date FCC receives the Appeal.

Expedited Appeals

Members have the right to a more rapid or expedited Appeal of a Precertification or Certification decision if following the standard time limits would:

- seriously jeopardize the life or health of the Member,
- jeopardize the Member's ability to regain maximum function, or
- subject the Member to severe pain that cannot be adequately managed without the services subject to the appeal, in the opinion of a prudent layperson with an average knowledge of health and medicine, or in the opinion of a Provider with knowledge of the Member's condition.

The Member may call FCC at 910-715-8100 to verbally request an expedited Appeal.

For most expedited Appeals, FCC must give the Member a decision within 72 hours of FCC receiving the Appeal. If the service is related to an ongoing treatment, FCC must give the Member a decision, after consulting with a medical doctor, within 24 hours of FCC receiving the Appeal, if the care will not be completed within 24 hours.

Expedited Appeals are not available in cases where the Member has already received services.

The Member may contact the North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, 800-546-6554 (for residents of North Carolina only) or 919-733-2004 (for persons outside of North Carolina) for information about state laws regarding appeals.

Members also may contact the Managed Care Patient Assistance program by:

- email at MCPA@ncdoj.com;
- by telephone at 866-867-MCPA (6272) (toll-free for residents of North Carolina only) or 919-733-MCPA (6272) (for persons outside of North Carolina); or
- by writing to:
Managed Care Patient Assistance
Attorney General's Office
9001 Mail Service Center, Raleigh, NC 27699-9001
Physical Address: 114 West Edenton Street
Raleigh, NC 27603

If the Member does not agree with FCC's decision on any Appeal, he/she can ask for the decision to be reviewed again. This is known as a second level Grievance. The second level Grievance procedure is described below.

Grievance Procedures

First Level Grievance

A Member or someone acting on the Member's behalf may submit a Grievance which is defined

as a written complaint submitted by a Member about any of the following:

- FCC's decisions, policies or actions related to availability, delivery or quality of health care services. A written complaint submitted by a Member about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a Grievance if the exclusion of the specific service requested is clearly stated in this Certificate;
- Claims payment or handling, or reimbursement for services;
- The contractual relationship between a Member and FCC; or
- The outcome of an appeal of a Noncertification.

All Grievances should be in writing and provide all details about the Grievance, including the date of the event, place and people involved. Mail to:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Attention: Appeals and Grievance Coordinator

Within 3 business days after FCC gets a Grievance, FCC will provide the name and telephone number of the appeals and grievance coordinator. The Member will also get instructions for submitting written material for the first level Grievance review. Written material relating to the Grievance may be submitted to FCC. There is no right to attend the first level Grievance review.

FCC will send a written decision within 30 days of the date on which FCC receives the first level Grievance. The decision will include reason(s) for denial if the decision is not in the Member's favor and will also include instructions on what to do if a further review is desired.

Second Level Grievance

The Member or someone acting on his/her behalf may request second level review of (1) a decision not in the Member's favor from the first level Grievance review and (2) a decision not in the Member's favor on an Appeal of a Noncertification.

The Member or his/her representative must send a written request for a second level Grievance review. This request must be made within 30 days of receiving the first level decision. This written request must be sent to:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374
Attention: Appeals and Grievance Coordinator

After FCC gets the second level review request, FCC will send important information within 10 business days. This information will include the name and telephone number of the appeals and grievance coordinator and a statement of Member rights related to the Grievance process. These include the right:

- To ask and get from FCC all information important to the review;

- To explain his/her position to the second level review panel;
- To submit supporting material prior to and at the review meeting;
- To ask questions of any member of the review panel;
- To be helped or represented by a person of the Member's choosing, including a family member, Employer representative or lawyer; and
- To participate in the second level Grievance review via telephone conference.

The review panel will hold a review meeting within 45 days after receiving the review request. The Member will be told the meeting date at least 15 days before the meeting. The Member does not have to attend the review meeting in order to receive a full and fair review. Within 7 business days after it meets, the Member will receive a letter describing the second level review panel's decision.

A Member may ask for the second level review to take place on a faster schedule. A faster schedule is available if the time frames described above seriously put life or health at risk or put a Member's ability to regain maximum function at risk. An expedited second level review is available whether or not the initial review of the Appeal was done on a faster schedule. FCC will do the review and give the decision within 4 days after receiving all necessary information. The review meeting may take place by telephone call or through the exchange of written information.

FCC's Grievance procedure, (including the second level grievance available after an Appeal of a Noncertification) is voluntary for Members.

The North Carolina Department of Insurance is available to assist consumers with insurance related problems and questions. Questions may be directed in writing to:

North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

or by telephone at 800- 546-5664.

Members who are eligible for FCC benefits through an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) have the right to bring a civil action under section 502(2) of ERISA following an adverse decision on appeal.

External Review

In General

In addition to FCC's Appeals and Grievance Procedures, North Carolina law provides for review of Noncertification decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this voluntary service at no charge to the public. The Member or his/her representative may request an external review. The IRO's

external review decision is binding on FCC and the Member, except to the extent other remedies are available under applicable federal or state law. The Member may not file a subsequent request for an external review involving the same Noncertification decision for which a Member has already received an external review decision.

FCC will notify the Member in writing of the right to request an external review at the time of receiving:

- A Noncertification decision,
- An Appeal decision upholding a Noncertification decision, or
- A second level Grievance review decision upholding the original Noncertification.

Eligibility

In order for a Member to be eligible for external review, the NCDOI must determine the following:

- That the request is about a medical necessity determination that resulted in a Noncertification decision,
- That the Member had coverage with FCC in effect when the Noncertification decision was issued,
- That the service for which the Noncertification was issued appears to be a Covered Service under the Certificate, and
- That FCC's internal review process has been exhausted as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, the internal review process is exhausted when a Member has:

- Completed FCC's Appeal and second level Grievance review and received a written second level determination from FCC, or
- Filed a second level Grievance and unless the Member requested or agreed to a delay, have not received FCC's written decision within 60 days of the date the Member can demonstrate that the Grievance was submitted, or
- Received notification that FCC has agreed to waive the requirement to exhaust the internal Appeal and/or second level Grievance process.

If the request for a standard external review is related to a retrospective Noncertification (a Noncertification that occurs after services have been received), the Member will not be eligible to request a standard review until completing FCC's internal review process and received a written final determination from FCC.

Standard External Review

If a Member wishes to request a standard external review, he/she (or a representative) must make this request to NCDOI within 120 days of receiving FCC's written notice of final determination that the services in question are not approved. When processing the request for external review, the NCDOI will require a written, signed authorization for the release of any medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of the request for a standard external review, the NCDOI will notify the Member and his/her Provider of whether the request is complete and whether it is

accepted. If the NCDOI notifies a Member that the request is incomplete, the Member must provide all requested additional information to the NCDOI within 150 days of the date of FCC's written notice of final determination. If the NCDOI accepts the request, the acceptance notice will include:

- The name and contact information for the independent review organization (IRO) assigned to the Member's case,
- A copy of the information about his/her case that FCC has provided to the NCDOI,
- Notice that FCC will provide you with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO), and
- Notification that additional written information and supporting documentation relevant to the initial Noncertification to the assigned IRO may be accepted within 7 days of the date of the acceptance notice.

If the Member chooses to provide any additional information to the IRO, he/she must also provide that same information to FCC at the same time using the same means of communication (e.g., fax the information to FCC if faxed it to the IRO). When faxing information to FCC, it must be sent to 910-715-8102 or toll-free at 866-896-1941. For mail, the address is:

FirstCarolinaCare Insurance Company
42 Memorial Drive
Pinehurst, NC 28374

Please note that a Member may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and FCC. The NCDOI will forward this information to the IRO and FCC within two business days of receiving the additional information.

The IRO will send written notice of its determination within 45 days of the date the NCDOI received the standard external review request. If the IRO's decision is to reverse the Noncertification, FCC will reverse the Noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the Noncertification decision. If the Member is no longer enrolled in FCC at the time FCC receives notice of the IRO's decision to reverse the Noncertification, FCC will only provide coverage for those services or supplies actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

Expedited External Review

An expedited external review of a Noncertification decision may be available if the Member has a medical condition where the time required to complete either an expedited internal appeal or second-level grievance review or a standard external review would reasonably be expected to seriously jeopardize life or health or would jeopardize the ability to regain maximum function. If the Member meets this requirement, he/she may make a written request to the NCDOI for an expedited review after the Member:

- Receives a Noncertification decision from FCC AND file a request with FCC for an expedited appeal, or
- Receives an appeal decision upholding a Noncertification decision AND file a request with FCC for an expedited second level grievance review, or
- Receives a second-level grievance review decision upholding the original Noncertification.

The Member may also make a request for an expedited external review if he/she receives an adverse second-level grievance review decision concerning a Noncertification of an admission, availability of care, continued stay or Emergency Services, but has not been discharged by the Provider.

In consultation with a medical professional, the NCDOI will review the request and determine whether it qualifies for expedited review. The Member and the Provider will be notified by the NCDOI within 3 business days if the request is accepted for expedited external review. If the request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard External Review if FCC's internal review process was already completed, or (2) require the completion of FCC's internal review process before the Member may make another request for an External Review with the NCDOI. An expedited external review is not available for retrospective Noncertifications.

The IRO will communicate its decision within 4 business days after receipt of the request for an expedited external review. If the IRO's decision is to reverse the Noncertification, FCC will, within one day of receiving notice of the IRO's decision, reverse the Noncertification decision for the requested service or supply. If the Member is no longer enrolled in FCC at the time FCC receives notice of the IRO's decision to reverse the Noncertification, FCC will only provide coverage for those services or supplies actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

XII. HEALTHCARE MANAGEMENT

A. Utilization Management Program Plan

1. Purpose and Scope

FCC's Medical Management Program is designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, Providers or facilities. In issuing a decision, FCC shall obtain all information required to make the decision, including pertinent clinical information; FCC will limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of health care service.

Procedures For Precertification

Pre-Certification is the main tool used in FCC's Medical Management Program. A current list of services and items that require Precertification can be found on our website at www.firstcarolinacare.com or by calling Customer Service at 800-811-3298. This list is subject to change. Members are responsible for getting any required Precertification before receiving services. Providers usually will help with getting a Precertification. Precertification can be requested by calling the toll-free number on the FCC ID card or faxing a request to FCC. This must be done before starting any treatment

so that FCC will have time to make a decision or get more information if needed. The request must include:

- Member name;
- Member ID number;
- The name and address of any Hospital or Provider to be used; and
- Treating Provider's name.

Important Note: An additional 20% Coinsurance penalty will be applied to Claims where no Precertification is issued by FCC before the Member receives services requiring Precertification. The amount of this penalty does not count toward any Out-of-Pocket Maximum. No Precertification is needed for Emergency Services. No Precertification is needed for the routine Maternity Care Services for mother and baby described above under "Covered Services". Precertification is needed for services that extend beyond the routine maternity services described above.

Procedures For Certification

FCC may make a Certification decision during a Member's hospital stay or course of treatment (including requests for an extension of the course of treatment beyond the approved period of time). FCC must provide benefits for such services until the Member gets a mailed, faxed, or other written notice of Noncertification regarding the services. FCC shall notify the Member of the Certification decision (whether adverse or not) within 3 days after receipt of the Claim, unless the request is for Emergency Medical Services. Notification will be consistent with North Carolina law and FCC's policies and procedures. This period may be extended one time for up to 15 days if additional time is required due to a failure of the Member to submit information necessary to make the Certification decision. FCC will give the Member a Notice of Extension. The Notice of Extension will describe the additional information requested. The Member may have at least 45 days from receipt of the Notice of Extension to provide the specified information. FCC will then give a decision to the Provider and Member within 3 business days after the earlier of (a) the date FCC received the necessary information; or (b) the end of the period given to the Member to provide the information.

For Certifications requested after the Member receives health services, the Member will be notified of the decision within a reasonable period of time, but not later than 30 days after FCC's receipt of the request. This period may be extended one time by FCC for up to 30 days if additional time is required because the Member did not submit information necessary to decide the request. FCC will give the Member a Notice of Extension. The Notice of Extension will describe the necessary information and the Member may have at least 90 days from receipt of the notice to provide the necessary information. FCC will then give a decision to Member within thirty days after the earlier of (a) the date FCC received the information or (b) the end of the period given to the Member to provide the information.

Precertifications and Certifications are used only to determine benefits. They are not medical advice and do not determine the Member's eligibility or enrollment. Payment, enrollment and amount of benefits are subject to all the terms of this Certificate and the Master Employer Agreement. A Precertification or Certification may be retracted only if the determination was based on a material misrepresentation about a health condition that was knowingly made by a Member or Provider of the service, supply, or other item. Any requests for information made to members by FCC will be limited to the information necessary to make a decision on a Precertification or Certification.

Expedited Precertifications And Certifications

Members have the right to a more rapid or expedited decision on a Precertification or Certification request if following the standard time limits would:

- seriously jeopardize the life or health of the Member,
- jeopardize the Member's ability to regain maximum function, or
- subject the Member to severe pain that cannot be adequately managed without the services subject to the appeal in the opinion of a prudent layperson with an average knowledge of health and medicine, or in the opinion of a Provider with knowledge of the Member's condition.

In these cases, FCC will give the Member a decision (whether adverse or not) as soon as possible, taking into account the medical situation, but not later than 72 hours after FCC received the request unless the Member fails to provide necessary information.

If the Member does not provide necessary information, FCC will notify the Member of the specific information necessary to make a decision not later than 24 hours after FCC received the request. The Member may have up to 48 hours to provide the additional information. FCC will notify the Member of the Certification decision no later than 48 hours after the earlier of (i) FCC's receipt of the additional information or (ii) the end of the time given the Member to provide the information.

For an expedited Certification extending services already Certified, the decision will be made as soon as possible, considering the medical situation. FCC will notify the Member of the Certification decision within 24 hours after the receipt of the request by FCC. Such requests must be made to FCC within 24 hours prior to the end of the Certified time or services.

The notice of a denial of an expedited Certification or Precertification may be oral. However, written notice must be provided to the Member no later than 3 days after the oral notice. If a Member does not agree with an FCC decision denying a Certification or Precertification, an appeals procedure is available. It is described in the section titled "Appeals and Grievance Procedure."

2. Objectives

Under the current FCC Utilization Management Plan, InterQual clinical criteria are utilized by FCC. Where InterQual criteria are not available, the Medical Director will develop criteria based on a review of relevant medical research and

other plans' criteria, if available. If the clinical review criteria are developed by FCC, the guideline must identify who (names and qualifications) was involved in the development, the process used in their development, and when and how often they will be evaluated and updated. Also, if changes occur through FirstQIC, these changes should be reflected in the FirstQIC minutes.

All utilization review criteria, whether commercial or developed internally, shall be evaluated annually and updated if necessary by FCC and appropriate, actively practicing physicians with current knowledge relevant to the criteria under review. The Medical Director will ensure that all commercially available updates are implemented when available. Before implementation, all clinical criteria must be approved by the Medical Director. Medical Director approval must be documented after each review/revision. Acceptable mechanisms for documenting approval of clinical criteria are a dated attestation by the Medical Director or through minutes of FirstQIC meetings where the criteria were approved. The objectives of the UM Program are to maximize the efficient use of Member's benefits by encouraging the following goals:

- a. Covered Services are provided by contracted providers, unless the services are not available from a contracted provider or the services provided by a non-contracted provider were for an emergency condition. FCC should be notified as soon as reasonably possible regarding the use of non-contracted providers.
- b. Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to by FCC and FCC Providers, as applicable and appropriate.
- c. FCC complies with state and federal regulations applicable to Utilization management applicable to the specific FCC contracted Member populations.
- d. FCC's utilization management team includes physicians, licensed staff, and unlicensed staff who carry out the responsibilities designated for their levels of expertise.
- e. The UM Program is integrated with the QM Program, to ensure continuous quality improvement. This plan is reviewed, revised as necessary, and approved by the UM committee on an annual basis. The UM Program is approved annually by the Governing Body.

New and existing technology is evaluated according to FCC's policy and procedures.

B. QUALITY MANAGEMENT PROGRAM PLAN

Provider Contracts

- a. Contracts with Participating FCC Providers include a clause that requires participation in FCC's QM activities and adoption of FCC's QM policies and procedure.
- b. Contracts with Participating FCC Providers include provisions for access to the medical records of FCC members who are enrolled with the provider.
- c. See Appendix B for a copy of the current UM Policy and QM program

Dispute Resolution

If either a Participating Provider or FCC has a dispute related to credentialing or the Provider's participation status, such dispute is subject to the applicable provision of the credentialing/recredentialing plan.

If a Participating Provider has any other dispute with FCC, the Participating Provider shall send a written notice to FCC detailing the dispute. If the dispute is not resolved within thirty (30) days of the first notice of dispute, either party may bring an action in a court of competent jurisdiction. Provided, however, that no such action or claim may be heard in any court or forum if not brought within one year of the date of the first written notice of the dispute.

APPENDIX A: Credentialing Plan

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.

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. Mid-level and allied health 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.

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.

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

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

Provide medical or other health services in geographic locations accessible to FCC members within FCC’s approved service area;

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

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

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

Meet all credentialing requirements, as specified in this Plan.

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.

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. A new effective date will be determined for the implementation of the revised policies and procedures.

Authorities And Responsibilities

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 Credentialing Subcommittee of the Board quality management committee, FirstQIC.

FirstQIC Credentialing Sub-Committee. FirstQIC reports to the Board of Trustees, in accordance with the FirstHealth of the Carolinas and FCC bylaws. FirstQIC has designated a sub-committee thereof called the Credentialing Subcommittee. The chairperson of FirstQIC will also act as the chairperson of the Credentialing Subcommittee. The Credentialing Subcommittee shall:

1. Include at least one participating provider who has no other role in FCC management;
2. Review and discuss whether credentialed providers and applicants are meeting reasonable standards of care;
3. Access appropriate clinical peer input when discussing standards of care for a particular type of provider;
4. Enlists the assistance of the Medical Director to conduct additional review and investigation of applications when the credentialing process reveals issues that may impact quality of care or services delivered to members;

5. Has final authority to approve or disapprove credentialing/recredentialing applications;
6. Has final authority to delegate such approval authority to the Medical Director for approving clean and complete applications, provided that such authority is documented and is subject to reasonable guidelines;
7. Through an administrative coordinator, maintain minutes of all committee meetings and documents all actions;
8. Provide guidance to FCC on the overall direction of the credentialing program;
9. Evaluate and report to FirstQIC on the effectiveness of the credentialing program on an annual basis;
10. Review and approve credentialing policies and procedures; and
11. Meet as often as necessary to fulfill its responsibilities, but no less than quarterly.

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:

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;

Make recommendations regarding changes to network based on network assessment;

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

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;

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

Director of Health Services and Credentialing Coordinator. The day-to-day operations of the credentialing program are the responsibility of the Director of Health Services, who will supervise the following activities conducted by the Credentialing Coordinator:

- Ensuring compliance with all state law and regulations and accreditation standards applicable to provider credentialing;**
- Recommending and developing policies and procedures for credentialing;**
- Ensuring the confidentiality and security of all documents and materials related to credentialing and limiting access to such materials to authorized staff;**
- Ensuring the timely review of all applications and timely notification of status of applications;**
- Verifying all credentials using the procedures outlined in Section III of this Plan and related policies and procedures;**
- Communicating with applicants as necessary to complete the credentialing process and to provide written notification to applicants of committee determinations in a timely manner;**
- Submitting requests for applicant profiles to the various national monitoring agencies;**
- Maintaining a complete and accurate credentialing record for each applicant and/or provider;**
- Conducting recredentialing, as described in this Plan; and**
- Providing credentialing staff support to the Credentialing Subcommittee.**

PRACTITIONER CREDENTIALING AND RECREDENTIALING 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 Credentialing Subcommittee review as a condition of initial or continued appointment.
- B. Practitioner Credentialing Standards and Requirements.** Each applicant and recredentialed FCC Participating Provider has the burden of proving he/she meets all then-current FCC credentialing standards. FCC's Credentialing Coordinator, with the support of the Medical Director will determine whether an applicant meets the standards described below. FCC's Credentialing Coordinator will advise the Credentialing Subcommittee 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. Applicants whose license is suspended or on probationary status will not be considered eligible for credentialing. 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 Credentialing 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. 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) should be submitted with the application. Board Certification also must be primary source verified through the ABMS verification service or the American Medical Association master profile service.

Exceptions to the board certification requirement may be made at the Credentialing Subcommittee'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;
- 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.
- b. Documentation of continuing medical education (CME) hours totaling 150 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 and dermatologists. Credentialing staff will verify privileges with the primary hospital listed on the application by phone, fax, or letter. In addition, 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 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 Credentialing 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 the Credentialing Sub-Committee, 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), limitation(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 recredentialing must also meet all professional competence criteria, including, but not limited to, the following:
 - i. The absence of conduct that violates state or federal law or standards of professional conduct governing the applicant's profession;
 - ii. An appropriate work history with no significant 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;
 - iv. The absence of a NPDB Adverse Action Reports or HIPDB reports that indicates unsuitability for participation;
 - v. The absence of misrepresentation, misstatement or omission of a relevant fact 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. Recredentialing Practitioners. FCC participating practitioners are required to provide recredentialing information every three years from the initial credentialing or last recredentialing 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 recredential 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 recredentialing 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 reverification. 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 recredentialing 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 approved by action of the Medical Director.

D. Committee Action. FirstQIC or the Credentialing Sub-Committee 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 applicants denied participation status for reasons unrelated to professional conduct or competence.

I. CREDENTIALING AND RECREDENTIALING 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 Credentialing 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);
3. A copy of the facility's liability insurance policy declaration sheet;
4. Any other information necessary to determine if the facility meets FCC's participation criteria established for that type of facility;
5. 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;
6. A signed and dated statement from an authorized representative authorizing FCC to collect any information necessary to verify the information in the credentialing application;
7. Accreditation status (e.g., TJC, CARF, AAAHC, etc.).

The Credentialing Coordinator will be responsible for assuring that all information collected at the time of initial credentialing and recredentialing 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 recredentialing 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 approved by action of the Medical Director.

II. 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. exclusion from Medicare/Medicaid participation or revocation or suspension of licensure. Methods of continuous monitoring include, but are not limited to, periodic review of actions taken by licensure boards and agencies.

III. DISCIPLINARY ACTION

A. Imposition of Disciplinary Action. The Credentialing Subcommittee, 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 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 the Credentialing Subcommittee. 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.

IV. TERMINATION OF PRACTITIONERS

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

FCC credentialing staff shall provide the Credentialing Subcommittee with a summary report of all terminations and suspensions effected by Credentialing Staff. Credentialing Staff shall provide a practitioner who is terminated or suspended pursuant to this Section VII(A) with written notice of such termination or suspension and the reasons for such action. FCC's credentialing staff's decision may be reviewed by the Credentialing Subcommittee. Administrative terminations may be subject to administrative reconsideration under the terms and conditions set forth in Section X.

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

- C. Criteria for Termination.** The Credentialing Subcommittee 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 the Credentialing Subcommittee, Medical Committee or Board of Directors.

V. PROCEDURES FOR DISCIPLINE AND TERMINATION

- A. Credentialing Subcommittee 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 Credentialing Subcommittee, or if information otherwise comes to the Credentialing Subcommittee's attention which it believes suggests that discipline or termination may be appropriate, the Credentialing Subcommittee may direct credentialing staff to investigate the matter and forward the information obtained to the Credentialing Subcommittee.

The Credentialing Subcommittee may elect to request or permit the practitioner to appear before the Credentialing Subcommittee to discuss any issue relevant to the investigation. The Credentialing Subcommittee shall consider the information received and determine whether disciplinary action or termination is appropriate. The Credentialing Subcommittee 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 of any decision by the Credentialing Subcommittee to discipline or terminate. The committee's decision shall be forwarded to the Medical Committee for review, subject to any appeal rights provided herein.

- B. Notice and Effective Date of Discipline or Termination.** In the event the Credentialing Subcommittee 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 the Credentialing Subcommittee'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.

VI. APPEALS COMMITTEE PROCEDURE

- A. Appeals Committee Composition.** FCC credentialing staff shall convene an Appeals Committee made up of 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, Credentialing Subcommittee members, 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.

E. 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 the Credentialing Subcommittee. 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.

F. 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.

G. 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.

H. 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 and/or the Healthcare Integrity and Protection 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 Credentialing Coordinator shall notify the affected practitioner, in writing, in the event such a report is made and such notification is legally required.

VII. 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 recredentialing process.

- 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 the Credentialing Subcommittee in reaching its decision. The practitioner shall then have the opportunity to submit a written statement and any relevant written evidence to the Credentialing Subcommittee. In FCC's sole discretion, the reconsideration process may include an informal meeting between the practitioner and one or more representatives of FCC. The Credentialing Subcommittee 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 the Credentialing Subcommittee 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.

VIII. 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 and URAC standards.

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 on-site audit of a random sample of DO's credentialing files to verify compliance with FCC and URAC 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.

IX. 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.

X. EFFECTIVE DATE

The effective date of this plan is the date on which the FirstCarolinaCare Insurance Company Board of Trustees approves adoption of this plan as reflected in the minutes of the Board of Trustees.

Appendix B

FIRSTCAROLINACARE INSURANCE COMPANY

UTILIZATION MANAGEMENT PLAN

I. Definition, Purpose and Scope

Utilization management (UM) means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. The purpose of the FirstCarolinaCare Insurance Company (FCC) UM program is to encourage and support the provision of evidence-based health services to FCC members through the integration of accepted clinical practice guidelines into local practice patterns. FCC believes that evidence-based medicine will help ensure that members receive medically appropriate services in the most cost-effective and appropriate setting.

The UM program primarily focuses on precertification through the application of standard clinical criteria of selected services that may be subject to over- or under-utilization. FCC shall maintain a list of services requiring precertification and shall evaluate and modify the list as needed.

This document supersedes any previous written UM or quality management plan adopted by FCC, as of its effective date set forth below.

II. Program Objectives

The chief operational objective of the FCC UM program is to ensure members and/or providers receive precertification decisions in a timely manner through a consistent, fair process. This shall be accomplished through the implementation of the following:

- A. FCC shall employ a process to ensure that reviewers apply clinical criteria consistently and issue decisions in accordance with state law.
- B. Written policies and procedures will address all aspects of the UM program.
- C. Written policies and procedures will ensure only clinical information necessary to make a determination is requested, and specify procedures to follow if necessary information is not supplied by a member or provider.
- D. FCC uses documented clinical criteria for precertification that are based on clinical evidence. Criteria are periodically evaluated to assure ongoing efficacy and appropriateness in light of emerging research and practice patterns.
- E. Notification of utilization decisions shall be made timely and in accordance with state law.

- F. Written policies and procedures will set forth process for handling member appeals and grievances.
- G. Written policies and procedures are implemented to ensure the confidentiality of member personal health information, according to federal privacy regulations.
- H. Compensation to reviewers shall not be based directly or indirectly on the number or type of noncertification decisions made or contain any incentive to make particular certification decisions.
- I. State and federal laws and regulations applicable to UM are followed.
- J. UM activities are implemented by appropriately licensed and qualified staff.
- K. New and existing technology is evaluated as appropriate.
- L. The UM program is routinely assessed for efficacy and efficiency.
- M. UM activities are coordinated as appropriate with other FCC operations, including but not limited to quality improvement, credentialing, contracting, risk management and data analysis.
- N. Members and providers shall have toll free telephone access to UM staff during normal business hours, and telephone access shall be subject to written standards and regular monitoring.

III. Organizational Structure and Responsibility

- A. Governing Body: The FCC Board of Trustees has oversight over all UM activities. FCC reports UM activities to the FCC Board clinical management committee, FirstQIC, which reports on those activities to the Board of Trustees.
 - 1. Medical Director(s)
 - a. One or more medical directors may be appointed by FCC to evaluate the appropriateness of utilization review decisions. Medical directors will be physicians licensed by the State of North Carolina and will have post-residency experience in direct patient care. Physicians serving as medical director also may assist FCC in developing policies and procedures, evaluating new technology and clinical criteria, overseeing quality improvement initiatives, facilitating reviews by clinical peer reviews and educating clinical staff and participating providers.
 - b. A medical director shall chair FirstQIC. Each physician serving in the capacity of medical director must attend a minimum of 75% of all FirstQIC meetings.
 - 2. FirstQIC
 - a. FirstQIC shall be made up of participating providers, the medical director(s) and at least one member of the Board of Directors, as specified in the bylaws of FirstHealth of the Carolinas, Inc. Physician members of FirstQIC are nominated annually by the Mid-Carolinas Physician Organization (MCPO), subject to approval by the FCC Board of Trustees.

b. FirstQIC duties include:

- (i) Periodically assesses FCC's UM program efficacy and efficiency;
- (ii) Recommends key indicators related to appropriate utilization and provision of services;
- (iii) Reviews utilization data;
- (iv) Reviews and recommends modifications to clinical criteria based on local practice patterns;
- (v) Oversees quality improvement program;
- (vi) Reports on FCC UM activities on a regular basis to the Board of Trustees;
- (vii) Identification and investigation of specific and general utilization management problems especially in relation to trending patterns by providers, over-utilization and under-utilization, resource use, access, and performance;
- (viii) Monitoring of the resolution of utilization problems;
- (ix) Review of quality of care issues referred by FCC;
- (x) Review of provider education initiatives;
- (xi) Service as a provider credentialing committee; and
- (xii) Service as a credentialing appeals committee as needed.

3. Director of Health Services: The day-to-day responsibility for oversight of UM activities belongs to the FCC Director of Health Services. His/her duties include responsibility for implementing the program objectives listed in section B. above, as well as:

- a. Acting as FCC liaison with medical director(s) and participating providers;
- b. Acting as administrative coordinator for FirstQIC;
- c. Managing UM department staff;
- d. Ensuring timely submission of required reporting to the North Carolina Department of Insurance; and
- e. Reporting on UM activities to the FCC President.

4. Other UM Staff: FCC will maintain staff that is qualified, adequately trained and supervised. Staff is supported by written clinical review criteria and policies and procedures for performing the initial clinical review, including limitations on the type of data collection, intake screening and scripted clinical screening that non-clinical staff administrative staff may perform. No initial screening of certification requests are performed by non-clinical staff. FCC has policies and procedures in place addressing physician review and availability where a decision to certify a service cannot be made on the initial review.

IV. UM Program Monitoring

- A. The effectiveness of FCC's UM program is monitored periodically by the Director of Health Services with the assistance of the medical director(s). The purpose of the monitoring is to determine if the UM review activities are appropriate, effective and compliant with FCC policies and procedures and applicable law. The results of the evaluation of the UM program and any recommendations for changes to policy, procedures, committee structure, or review activities will be presented to FirstQIC for review and recommendations, then submitted to the FCC Board of Trustees for approval.

- B. Internal audits are conducted on various components of the UM program, including annual compliance reviews to determine whether UM policies and procedures and activities are in accordance with applicable state and/or federal law. Additionally, monthly audits of specific UM files are conducted for all UM staff. The audit scores are an important part of the performance evaluation process. The following elements are reviewed as a component of each employee's performance evaluation: audit scores, turnaround times, pre-certification and concurrent review productivity. Each file is assessed for the following:
 - 1. The inclusion and appropriateness of clinical rationale
 - 2. Use of the correct InterQual or other clinical criteria set
 - 3. Use of correct punctuation, grammar, and spelling in UM correspondence
 - 4. Adherence to and use of the correct system template
 - 5. Compliance with specifications relative to the number of days/encounters approved or non-certified

- C. A process is in place for annual review of the Medical Director to assess the following:
 - 1. Accessibility to UM and other FCC staff
 - 2. Legible documentation on hard copy
 - 3. Documentation in the UM system reflecting the decision
 - 4. Documentation reflecting clinical rationale in compliance with applicable clinical criteria
 - 5. Timely turnaround
 - 6. Decision forwarded to appropriate staff member

V. Quality of Care Monitoring

A process is in place for monitoring potential clinical quality of care concerns as well as potential patient safety issues identified by internal or external sources. Potential cases are referred to FirstQIC for review, evaluation, and resolution. The following are examples of events that may be monitored:

- A. Unexpected death
- B. Unplanned readmission
- C. Nosocomial infections
- D. Hospital incurred trauma
- E. Surgical complications including: unplanned return to surgery, inpatient admission following outpatient procedure, and inadequate discharge planning

VI. Member and Provider Complaint Monitoring

FCC will maintain a database of all complaints from any employer, provider, member or facility. Complaints are referred to the Director of Health Services for investigation. All complaints and the resolution are entered into a database. A summary report on is presented FirstQIC at least twice annually. A corrective action plan will be developed if it is determined that the issue was a result of an FCC policy and procedure failure.

VII. Measurement and Outcomes Data

On a quarterly basis, information is reported to FirstQIC which reflects health service utilization activity for the current compared to previous years. Data reported may include average length of stay, inpatient days per 1000, emergency department utilization, imaging and prescription drug statistics and other statistics as appropriate.

VIII. Delegated Activities

- A. FCC may contract with outside entities for the performance of certain UM activities. An initial and ongoing assessment will be performed on all entities contracted by FCC to determine compliance with FCC's policies and procedures.
- B. The Director of Health Services or a designee will be responsible for monitoring and oversight of all UM activities performed by delegated organizations (DOs). A written description of the delegated activity and the DO's accountability for these activities will be included in the delegation agreement, and FCC will monitor the effectiveness of the DO's UM program at least once each year.
- C. Each DO must comply with FCC policy and procedures containing the standards related to the delegated activity.

IX. Conflict of Interest

In order to minimize the potential for conflict of interest, FCC will have a policy whereby no UM committee member or reviewer shall participate in the review of clinical cases in which the he or she is the primary care giver, is a participant in a specific situation under review, or has any economic interest either in the care or with the healthcare professional under review.

If at any time potential for conflict of interest is identified, the Director of Health Services shall seek the objective expertise of other qualified healthcare professionals, either from other committees or from other physicians participating in the FCC network.

X. Confidentiality

A. FCC has established and enforces policies and procedures to protect the confidentiality of member records and information obtained and examined in the course of performing UM activities. Policies and procedures will be followed to assure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated thereunder. FCC ensures that the patient-specific information obtained during the UM process will be:

1. Kept confidential in accordance with applicable federal and state laws
2. Limited to only that information necessary to conduct UM activities review
3. Access limited to staff members directly involved in the review process or clerical support
4. Used solely for the purpose of UM, quality management, case management, and discharge planning
5. Shared only with those entities who have authority to receive such information

B. FCC has policies and procedures for exercising due care in compiling and releasing provider-specific data to the public. The policies and procedures address how the data is verified, how the subject is notified of the disclosure and how potential users of the data are informed about the proper use of the data.

Effective the 25th day of August, 2010.

Original Date: 06/01

Revised: 4/03, 8/23/06

QUALITY MANAGEMENT PROGRAM DESCRIPTION

Background and Mission

FirstCarolinaCare Insurance Company (FCC) is the award winning non-profit health insurance subsidiary of FirstHealth of the Carolinas, Inc., a non-profit community hospital system. Established in 2000, FCC now enrolls over 17,000 members in over 300 employer groups. Currently, FCC offers large and small group HMO, point of service and PPO plans at this time, as well as third party administrative services for self-insured health benefit plans.

FCC serves a largely rural population that is approximately 75% white, 15% African American, 7% Hispanic and 2% Native American.

FCC has adopted the mission statement of its parent organization, FirstHealth of the Carolinas, Inc., which is *"To care for people"*. Dedicated to supporting FirstHealth of the Carolinas' mission, FCC has focused on keeping premiums as affordable and predictable as possible, offering a viable alternative to larger carriers. FCC's local success has supported its expansion into other areas of the state. From its original four county service area, FCC has expanded into over 20 counties in North Carolina.

Purpose and Scope

The purpose of the FCC Quality Management Program (“QMP”) is to promote objective and systematic measurement, monitoring and evaluation of services and implements quality management activities based upon the findings. FCC will measure, monitor and evaluate:

- The quality, safety and accessibility of clinical care provided to FCC members;
- The quality and accessibility of participating practitioners and providers; and
- The quality of services provided by FCC.

The following activities are included within the scope of the QMP:

- Clinical and service quality
- Member safety and clinical risk management
- Appeals and grievances
- Physician and hospital quality
- Pharmacy management and medication safety
- Provider credentialing and recredentialing
- Utilization management (see also Utilization Management Program description)
- Access and availability to health services
- Culturally and linguistically appropriate services and materials
- Continuity and coordination of care
- Disease management and health improvement programs
- Member and provider satisfaction
- Delegation monitoring and oversight
- Member rights and responsibilities
- Privacy and confidentiality

Goals and Objectives

- Improve Member Health Status and Outcomes – through promotion of preventive care and healthy lifestyles, health education, decision making assistance, chronic disease management, and case management for members with complex health needs.
- Increase Customer Satisfaction - by prompt identification and resolution of dissatisfaction with administrative or clinical processes and evaluation of processes for improvement when appropriate.
- Improve Clinical Quality and Safety - by sharing utilization data in a supportive environment to help providers improve the safety and quality of their services, conducting continuous improvement activities devoted to improving prescription drug safety and compliance, and providing members with information that helps them monitor clinical safety in their own care.

- Improve Organizational Effectiveness - by achieving statistically significant improvements in HEDIS and CAHPS measurements and meeting or exceeding national averages.
- Improve Efficiency of Service Delivery – by promoting evidence-based care and reducing inappropriate variations in clinical care and member services.
- Improve Member Engagement - by meeting diverse cultural and linguistic needs, using diverse methods of communication and providing user-friendly self-management tools.

Organizational Structure and Responsibilities

Governing Body and Delegation of Oversight to FirstQIC

The FCC Board of Trustees has overall responsibility and authority for all quality management activities. The Board of Trustees delegates the oversight and accountability for developing and implementing all quality management programs to a standing committee of the Board authorized by the FCC bylaws, FirstQIC, which reports on those activities to the Board of Trustees.

President

The president of FCC has the ultimate responsibility for the implementation of the QMP. The president's active participation in FirstQIC ensures that FCC's service and clinical improvement initiatives receive appropriate integration and linkage to FCC's strategic planning and budgeting processes, including allocation of financial and human resources to support the QMP.

Medical Director

The FCC Medical Director provides supervisory oversight for all FCC clinical programs. The Medical Director position will be filled by a North Carolina licensed physician with certification in a specialty recognized by the American Board of Medical Specialists. The medical director leads FCC in developing clinical policies and procedures, evaluating new technology and clinical criteria, overseeing quality management initiatives, facilitating reviews by clinical peer reviewers and educating clinical staff and participating providers.

The Medical Director chairs FirstQIC and any of its sub-committees.

Director of Health Services

The day-to-day responsibility for oversight of quality management activities belongs to the Director of Health Services. His/her duties include responsibility for implementing the QMP Goals and Objectives listed above, as well as:

- Acting as administrative coordinator for FirstQIC;
- Managing clinical staff;
- Ensuring timely submission of required reporting to the North Carolina Department of Insurance and other regulatory/accreditation bodies; and
- Reporting on QMP activities to the Medical Director and FirstQIC.

QM Coordinator

The QM Coordinator assists the Medical Director, the Director of Health Services and FirstQIC in implementing the QMP. The QM Nurse/Coordinator monitors and analyzes internal and external data and prepares monthly, quarterly, and annual reports, as appropriate, for management, FirstQIC and its sub-committees.

FirstQIC

The Board committee to which the Board of Trustees has delegated oversight of quality programs is FirstQIC. The overarching responsibility of FirstQIC is to provide oversight for the QMP and the Utilization Management (“UM”) Program. Additionally, FirstQIC:

- Provides ongoing reporting to the Board of Trustees;
- Meets at least quarterly;
- Maintains approved records of all committee meetings;
- Includes at least one participating provider or receives input from participating providers;
- Provides feedback to FCC on quality management priorities and projects;
- Approves the quality improvement projects undertaken by FCC;
- Monitors progress in meeting quality management goals; and
- Reviews the scope, objectives, organization and effectiveness of the QMP at least annually and revises it as necessary.

In addition to the members required to be appointed to FirstQIC under the bylaws of FirstHealth of the Carolinas and FCC, the membership of FirstQIC shall include:

- Health Services Director
- Provider Relations Director
- Quality Coordinator
- Credentialing Coordinator
- Pharmacy manager
- Staff representative from the Quality Council

Quality Team

FirstQIC may designate sub-committees as needed that may meet on a more frequent basis than FirstQIC. Membership includes representatives from relevant functional areas in FCC. The purpose of the QI sub-committee, called the Quality Team, is to facilitate day-to-day monitoring of QI projects and related data, make recommendations for QI projects to FirstQIC, foster a culture of quality within FCC and assist with process problem identification and resolution. The membership of the Quality Team shall include:

- Medical Director
- Chief Operating Officer
- Health Services Director
- Provider Relations Director
- Compliance officer
- Pharmacy manager
- Quality coordinator

- Credentialing coordinator
- At least one staff representative from each of the following functional areas: operations, sales and health services.

Standards Applicable to Quality Management Activities

Data Monitored

FirstQIC and its sub-committees will analyze, evaluate and monitor summary data obtained as a result of the following activities:

- Accreditation or state or federal regulatory agency review: Reports and findings from accreditation or state or federal regulatory agency reviews will be analyzed to identify opportunities for process improvement.
- Appeal and grievances: The member appeal and grievance process is monitored to ensure compliance with state and federal requirements and FCC policies and procedures. An audit of appeals and grievances will be conducted on a quarterly basis.
- Utilization management programs compliance review: The FCC UM Plan describes the process for monitoring compliance with state and federal law and FCC policies and procedures regarding utilization management.
- Credentialing and recredentialing: FCC's standards for credentialing and recredentialing providers are prescribed by state regulation and described in FCC's Credentialing/Recredentialing Plan and related policies and procedures. Monitoring of compliances with the plan, policies and procedures is conducted no less than annually by means of a random audit of credentialing files.
- Chronic disease management: The objective of chronic disease management activities is to monitor the care received by member's population with certain chronic conditions such as asthma, diabetes, and cardiac disease in order to improve health status and reduce serious health problems. FCC collects relevant data about the health status of its members and develops interventions to assist members and their practitioners in managing targeted chronic conditions. FCC also evaluates the outcomes of the interventions.
- Continuity and coordination of care: To enhance coordinated and appropriate care for members, FCC monitors continuity and coordination of care among primary, specialty, and behavioral health care practitioners. Assessment of continuity and coordination of care collaboration may include, but is not limited to measurement of the following as demonstrated through the use of surveys, committee discussions reflected in minutes, medical record review, and data analysis:
 - Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care.
 - Coordination of timely access for appropriate treatment and follow-up for individuals with complex medical and/or behavioral health disorders.
 - Implementation of physical and behavioral health clinical guidelines.

- Movement of members from a termed practitioner or transition of new members from non-participating providers.
- Culturally and linguistically appropriate services and materials: FCC is dedicated to ensuring that all members, providers and employees are treated with dignity and respect concerning their values, culture, class, race, age, sexual orientation, ethnic background and religion. FCC will identify linguistic competency issues and provide non-or limited English-speaking members with timely, accurate and confidential translation services and translated written materials.
- HEDIS performance measures: HEDIS is the Healthcare Effectiveness Data Information Set, which is a comprehensive measurement tool used by FCC to evaluate the performance and effectiveness of its QMP. Annually, these data are collected, analyzed, evaluated, and compared to regional and national benchmarks. Based on the outcomes of the HEDIS measures, FCC determines its strategy for quality management activities.
- Member and provider satisfaction surveys: A major component of HEDIS critical in the evaluation process is member service outcomes through the annual member satisfaction survey – Consumer Assessment of Healthcare Providers and Systems (CAHPS). Member satisfaction also is assessed through evaluation of complaint and appeal information. FCC also measures provider satisfaction with FCC service through an annual survey.
- Member service: FCC assesses the efficiency of member services by monitoring telephone statistics and member complaints on a *monthly (?)* basis.
- Claims processing: FCC monitors speed and accuracy of claims processing on a *monthly (?)* basis.
- Pharmacy benefit manager service: FCC monitors services delegated to its pharmacy benefit manager, including claims payment, member services and utilization management and appeals on a *monthly (?)* basis.
- Utilization of health and prescription drug services
- Provider access and availability: FCC sets standards for provider availability and accessibility, monitors accessibility and availability through review of member and/or employer concerns, member surveys, annual review of its provider accessibility standards and mapping.

Documentation Standards

FCC will maintain written documentation reflecting:

- Objectives and approaches utilized in quality management activities;
- Identification and tracking and trending of performance which must include, but is not limited to access to services, complaints and satisfaction;
- Selection of measures that are quantifiable and used to establish acceptable levels of performance;
- Measurement of baseline levels of performance;
- Re-measurement of levels of performance at least annually;
- The implementation of action plans to improve or correct identified problems or meet acceptable levels of performance on measures;

- The mechanisms to communicate the results of such activities to relevant staff; and
- The mechanism to communicate the results of such activities to FirstQIC, FCC management and external audiences.

Quality Management Work Plan

A Quality Management Work Plan will be developed and implemented annually by the Quality Council and approved by FirstQIC. The QM work plan will describe at least two planned quality improvement (QI) projects and related activities for the year. At least one of the two projects must address consumer safety for the population served. If a QI project is clinical in nature, then FCC will ensure the involvement of a senior clinical staff person in judgments about the use of clinical quality measures and clinical aspects of performance. The work plan will be presented at the last FirstQIC meeting of the preceding year for approval and recommendation to the Board of Trustees.

For each quality improvement project, FCC will:

- Establish measurable goals for quality improvement;
- Design and implement strategies to improve performance;
- Establish projected time frames for meeting goals for quality improvement;
- Re-measure level of performance at least annually;
- Document changes or improvements relative to the baseline measurement; and
- Conduct an analysis if the performance goals are not met.

Annual Quality Report

The Quality Team will present to FirstQIC an annual summary and evaluation report on the effectiveness of the projects undertaken in that year's QMP. The report covers the following topics:

- Summary of monitoring and evaluation activities;
- Special studies and reports;
- Follow-up on previous studies and reports;
- Actions taken, effectiveness of those actions and demonstrated improvement in the quality of care and service provided.

After approval of the report by FirstQIC, it will be presented to the Board of Trustees, which may approve the recommendations and the report, or may make independent recommendations for action as indicated.

Program Review and Revision

The QMP is reviewed and evaluated annually and revised when necessary as recommended by the Quality Team to FirstQIC. The review includes the following considerations:

- Structure and organization of the program
- Adequacy of resources allocated to support the program

- Efficiency and effectiveness of the QM processes.

FirstQIC’s recommendations for revision to the QMP are submitted to the Board for review and approval.

External Delegation

Activities that fall within the scope of the QMP that are delegated to third parties include:

- Credentialing and recredentialing of PPO network providers to MedCost, LLC;
- Credentialing and recredentialing of UNC Physicians and Associates to UNC Healthcare;
- Peer review of medical necessity appeals to _____;
- 24/7 nurse triage/health information line to _____;
- Prescription drug formulary development/maintenance, prior authorization criteria, first and second level appeals, first level grievances and web-based pharmacy claims and benefit information to MedImpact Health Systems, Inc., a pharmacy benefit management organization.

Delegation Oversight

FCC conducts oversight for delegated functions within the scope of this QMP that includes:

- A periodic review (no less than annually) of the contractor's written policies and documented procedures and documentation of quality activities for related delegated functions;
- A process to verify no less than annually the contractor's compliance with contractual requirements and written policies and documented procedures; and
- A mechanism to monitor financial incentives to ensure that quality of care or service is not compromised.

Confidentiality

FCC has established and enforces policies and procedures to protect the confidentiality of member records and information obtained and examined in the course of performing QI activities. Policies and procedures will be followed to assure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and regulations promulgated thereunder.

FCC ensures that the member-specific information obtained during the QI process will be:

- Kept confidential in accordance with applicable federal and state laws;
- Limited to only that information necessary to conduct QI activities review;
- Access limited to staff members directly involved in the review process or clerical support;
- Used solely for the purposes of implementing this QMP; and
- Shared only with those entities who have authority to receive such information

FCC has policies and procedures for exercising due care in compiling and releasing provider-specific data to the public. The policies and procedures address how the data is verified, how the subject is notified of the disclosure and how potential users of the data are informed about the proper use of the data.