carecentrix

Provider Manual
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>KEY CONTACTS</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>GENERAL</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>KEY PHONE NUMBERS: SERVICE REQUESTS, REQUESTS FOR ADDITIONAL SERVICES, SERVICE REQUEST CORRECTIONS</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>NETWORK MANAGEMENT KEY CONTACTS</td>
<td>7</td>
</tr>
<tr>
<td>1-2</td>
<td>WELCOME</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>ABOUT THIS PROVIDER MANUAL</td>
<td>8</td>
</tr>
<tr>
<td>1-3</td>
<td>ABOUT CARECENTRIX</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>ABOUT CARECENTRIX</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>EMPLOYEES AND OFFICE LOCATIONS</td>
<td>10</td>
</tr>
<tr>
<td>1-4</td>
<td>CORPORATE COMPLIANCE PROGRAM</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>COMPANY OBJECTIVES AND PURPOSE OF THE COMPLIANCE PROGRAM</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>REPORTING SYSTEM</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>RESPONSE AND CORRECTIVE ACTION TO PROMOTE PROGRAM EFFECTIVENESS</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>FALSE CLAIMS</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>TRAINING</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>COMPLIANCE WITH CENTERS FOR MEDICARE &amp; MEDICAID SERVICES (CMS) NOTICE OF MEDICARE NON-COVERAGE REQUIREMENT</td>
<td>14</td>
</tr>
<tr>
<td>2-1</td>
<td>PROVIDER PERFORMANCE STANDARDS</td>
<td>16</td>
</tr>
<tr>
<td>2-2</td>
<td>USE OF OFFSHORE VENDORS</td>
<td>19</td>
</tr>
<tr>
<td>3-1</td>
<td>PROVIDER COMMUNICATIONS</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>PROVIDER MANUAL</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>OUR CUSTOMERS</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>PROVIDER ONBOARDING TRAINING</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>PROVIDER PORTAL: HOMEBRIDGE®</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>CARECENTRIX NEWSFLASHES</td>
<td>22</td>
</tr>
<tr>
<td>3-2</td>
<td>NATIONAL CREDENTIALING COMMITTEE</td>
<td>22</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td><strong>Purpose</strong></td>
<td>22</td>
</tr>
<tr>
<td></td>
<td><strong>Committee Attendance</strong></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td><strong>Committee Meeting Schedule</strong></td>
<td>23</td>
</tr>
<tr>
<td>3-3</td>
<td><strong>Provider Qualification and Quality Management</strong></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td><strong>Credentialing</strong></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td><strong>Re-Credentialing</strong></td>
<td>24</td>
</tr>
<tr>
<td></td>
<td><strong>Provider Review</strong></td>
<td>25</td>
</tr>
<tr>
<td></td>
<td><strong>Credentialing Requirements for a New Location</strong></td>
<td>26</td>
</tr>
<tr>
<td></td>
<td><strong>Credentialing Requirements for Adding a Service Category</strong></td>
<td>26</td>
</tr>
<tr>
<td></td>
<td><strong>Quality Measurement</strong></td>
<td>26</td>
</tr>
<tr>
<td></td>
<td><strong>Satisfaction Measurement</strong></td>
<td>27</td>
</tr>
<tr>
<td></td>
<td><strong>Satisfaction Measurement Report to Providers</strong></td>
<td>27</td>
</tr>
<tr>
<td>4-1</td>
<td><strong>Changes in Your Organization</strong></td>
<td>28</td>
</tr>
<tr>
<td>5-1</td>
<td><strong>Healthcare Delivery Process Introduction</strong></td>
<td>29</td>
</tr>
<tr>
<td>5-2</td>
<td><strong>Coordination of Services</strong></td>
<td>29</td>
</tr>
<tr>
<td></td>
<td><strong>Provider Receives Referral From Primary Referral Source</strong></td>
<td>30</td>
</tr>
<tr>
<td></td>
<td><strong>CareCentrix Receives Referral From Primary Referral Source</strong></td>
<td>31</td>
</tr>
<tr>
<td></td>
<td><strong>Additional Services</strong></td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Retroactive Service Requests</strong></td>
<td>35</td>
</tr>
<tr>
<td></td>
<td><strong>Inquiries</strong></td>
<td>35</td>
</tr>
<tr>
<td>5-3</td>
<td><strong>Utilization Management</strong></td>
<td>36</td>
</tr>
<tr>
<td></td>
<td><strong>The Utilization Management Process</strong></td>
<td>36</td>
</tr>
<tr>
<td></td>
<td><strong>Utilization Management Responsibilities</strong></td>
<td>39</td>
</tr>
<tr>
<td></td>
<td><strong>Retrospective Claims Review</strong></td>
<td>40</td>
</tr>
<tr>
<td></td>
<td><strong>Appealing a Denied Request</strong></td>
<td>41</td>
</tr>
<tr>
<td>6-1</td>
<td><strong>Service Delivery</strong></td>
<td>41</td>
</tr>
</tbody>
</table>
THE PROVIDER’S RESPONSIBILITY .................................................................................. 41
NON-LIFE SUSTAINING SERVICES FOR CERTAIN CIGNA AND FLORIDA BLUE MEMBERS WITH Aged COST SHARE BALANCES (EFFECTIVE JANUARY 1, 2020) .................................................................................. 43
THE PROVIDER’S DISCHARGE RESPONSIBILITIES ...................................................... 44
6-2 GUIDELINES SPECIFIC TO PROVIDER SPECIALTY ............................................... 45
HOME HEALTH ........................................................................................................... 45
HOME HEALTH INFUSION NURSING ......................................................................... 48
HOME INFUSION ......................................................................................................... 50
HOME DME ................................................................................................................ 52
HOME SLEEP ............................................................................................................. 57
DOCUMENTATION ...................................................................................................... 57
6-3 GENERAL CLAIMS AND REIMBURSEMENT INFORMATION ................................... 59
CLAIMS PROCESS ...................................................................................................... 59
CHECKING REIMBURSEMENT STATUS ..................................................................... 60
EXPLANATION OF PAYMENT (EOP) ........................................................................... 60
6-4 GENERAL BILLING REQUIREMENTS ....................................................................... 62
CLAIMS SUPPORT CENTER ......................................................................................... 62
CLAIM FORM AND CLEAN CLAIM REQUIREMENTS .................................................. 62
TIMELY FILING ........................................................................................................... 65
HEALTH EXCHANGE MEMBERS THAT RECEIVE ADVANCE PREMIUM TAX CREDITS .................................................................................................................. 66
BILLING WHEN ANOTHER PAYOR IS PRIMARY ......................................................... 67
MEDICARE PRIMARY CLAIMS .................................................................................... 67
RECOUPMENT AND ADJUSTMENTS .......................................................................... 68
6-5 COMPLAINTS, CLAIMS PAYMENT RECONSIDERATIONS, AND APPEALS ............. 69
INTRODUCTION TO COMPLAINT, CLAIMS PAYMENT RECONSIDERATION, AND APPEALS PROCESS ........................................................................................................... 69
COMPLAINTS ............................................................................................................. 69
## KEY CONTACTS

### GENERAL

<table>
<thead>
<tr>
<th>Reason for Contact</th>
<th>Resource</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add-On Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuation of Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CareCentrix Direct</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Claims and Payment

| Claims Questions | Network Services Team (NST) | For Cigna: 844-457-9969  
All Other Plans: 877-725-6525 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal &amp; Reconsideration Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejection Questions</td>
<td>EDI Support Team</td>
<td>[EDI Support Team](mailto:EDI Support Team)</td>
</tr>
<tr>
<td>Claims Inquiries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Register for EDI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EFT &amp; ERA Enrollment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Provider Portal: HomeBridge®

| User Accounts: Create, Reset, or Unlock | Portal Admin at your agency | Portal Admin at your agency |
| Portal Related Questions | Provider Portal: HomeBridge Info Box | [Portalinfo@CareCentrix.com](mailto:Portalinfo@CareCentrix.com) |

### Other

<table>
<thead>
<tr>
<th>Patient Transitions</th>
<th>Transition Team</th>
<th>1-866-776-4617</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Information Updates</td>
<td>Credentialing Department</td>
<td><a href="mailto:Contract.Department@CareCentrix.com">Contract.Department@CareCentrix.com</a></td>
</tr>
<tr>
<td>Compliance Concerns</td>
<td>Compliance Hotline</td>
<td>877-848-8229</td>
</tr>
</tbody>
</table>
Click “Provider Manual” |
See “Network Management Contact Sheet” |
| Patient Financial Responsibility | Patient Services Team | 800-808-1902 |
| Infusion Nursing Services | Infusion Nursing Team | 844-457-9973 |
| Provider Orientation Requests | Provider Services Team | [ProviderServices@carecentrix.com](mailto:ProviderServices@carecentrix.com) |
KEY PHONE NUMBERS: Service Requests, Requests for Additional Services, Service Request Corrections

<table>
<thead>
<tr>
<th>Payor</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>888-999-9641</td>
</tr>
<tr>
<td>AllWays Health Partners (formerly NHP)</td>
<td>866-827-5861</td>
</tr>
<tr>
<td>Beech Street</td>
<td>877-466-0164</td>
</tr>
<tr>
<td>Cigna</td>
<td>844-457-9969</td>
</tr>
<tr>
<td>Cofinity</td>
<td>877-466-0164</td>
</tr>
<tr>
<td>Coventry</td>
<td>877-415-7864</td>
</tr>
<tr>
<td>Fallon</td>
<td>866-827-2469</td>
</tr>
<tr>
<td>Florida Blue</td>
<td>877-561-9910</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc.</td>
<td>855-243-3321</td>
</tr>
<tr>
<td>Public Employees Insurance Agency (PEIA)</td>
<td>888-497-5337</td>
</tr>
<tr>
<td>Walmart Specialty Pharmacy</td>
<td>877-453-4566</td>
</tr>
</tbody>
</table>

NETWORK MANAGEMENT KEY CONTACTS
http://www.carecentrix.com/ProviderResources/Network_Management_Contact_List.pdf

1-2 WELCOME

Congratulations and welcome to the CareCentrix Provider Network. We are proud to work with you as we strive to meet high quality of care standards and provide and manage cost-effective health care solutions for the customers and patients served by our integrated healthcare network.

As a provider participating in our network (“Provider” or “Network Provider”), we value your services and are committed to making your experience with us as easy as possible. To demonstrate this commitment, we have dedicated resources to support your participation in our network, and those resources are discussed further in this manual.
About This Provider Manual

This manual, as updated from time to time, serves as the basis for providing services within our network. It contains both general and Health Plan specific information.

Please read this manual carefully. It explains your rights and responsibilities as a CareCentrix Network Provider. As indicated in your Provider Agreement, you are obligated to comply with the terms of this manual. Since this manual is updated regularly, we encourage you to visit our Provider Portal: HomeBridge frequently at www.carecentrixportal.com to find the most recent information.

CareCentrix does not own the various third party websites referenced in this manual and makes no representation relating to the content or accuracy of the information contained therein. You are solely responsible for your interaction with such third parties, and we encourage you to read the terms of use and privacy policies before accessing any third-party websites.

1-3 ABOUT CARECENTRIX

About CareCentrix

CareCentrix is committed to making the home the center of patient care.

We have more than 20 years of experience working with payors and providers to create programs that improve quality and lower costs by allowing patients to heal or age where they want to be: at home. We currently manage care for 26 million members for our customers through over 8,000 provider locations.

Through advanced analytics, we help determine the appropriate site for post-acute care, and provide support and coordination for patients and their families throughout care transitions, including to and from Skilled Nursing Facilities (SNFs) and through Home Health, Home Durable Medical Equipment (DME), Home Infusion, and Home Sleep services.
Our Products and Services include:

Home DME (Durable Medical Equipment) – Home DME services consist of the following categories of care: Disposable Medical Surgical Supplies (e.g., bandages/dressings, ostomy supplies), Durable Medical Equipment (insulin pumps, continuous glucose monitors & diabetic supplies, wound care and mobility), Enteral Equipment & Foods (enteral pumps and medical foods) and Orthotics/Prosthetics.

Home Infusion – Home Infusion offering includes the provision of nursing, drugs and the administration of supplies and functions to support infusion therapy in the home or Ambulatory Infusion Suite (AIS). This includes coordination for both specialty pharmacy products and acute services required for post discharge such as enteral nutrition, anti-infective and hydration.

Home Health – The Home Health (HH) product coordinates and provides clinical services in the home, including Skilled Nursing (including infusion drug administration by qualified nurses) and Physical, Occupational and Speech Therapies.

Home Sleep – The Home Sleep product delivery model focuses on care coordination and providing a quality, lower cost solution to diagnostic testing at the most appropriate site of service. In addition, through a technology driven, proactive member engagement program (iComply) the product supports and drives member adherence to therapy.

Telehealth – Telehealth services may be a component of or in lieu of an in-person home health visit using interactive audio and/or video telecommunications systems that permit real-time communication between the distant site and the patient at home, to deliver and support patient care, administrative activities and health education.
Employees and Office Locations

CareCentrix operates nationally with employees primarily located in Tampa, Florida; Hartford, Connecticut; Overland Park, Kansas; and Phoenix, Arizona. For more information, visit the CareCentrix web site, http://www.carecentrix.com.

1-4 CORPORATE COMPLIANCE PROGRAM

Company Objectives and Purpose of the Compliance Program

CareCentrix is committed to complying with all applicable legal requirements in the course of conducting its operations and expects each of its associates and network Providers to do the same. CareCentrix’s Corporate Compliance Program was developed with that commitment in mind. As part of its Corporate Compliance Program, CareCentrix maintains a Code of Ethics and Business Conduct (see Attachment 1). All network providers are required to adopt and conform to the CareCentrix Code of Ethics and Business Conduct or their own substantially similar Code. As specified in the CareCentrix Code of Ethics and Business Conduct, CareCentrix strictly prohibits conflicts of interest. Before engaging in any activity, transaction or relationship that might give rise to a conflict with CareCentrix’s or CareCentrix’s clients’ interests, providers must seek review from the CareCentrix Legal Department or Compliance Department.

One purpose of the CareCentrix Corporate Compliance Program (the “Program”) is to help prevent and detect fraudulent, noncompliant or unethical conduct and to take appropriate corrective actions upon detection of any such conduct. One activity that the Program is intended to help prevent and detect is the submission of improper, false or fraudulent claims for payment to the United States government or other health care payors as prohibited by such payors and/or as prohibited under applicable state and federal law, including applicable fraud, waste and abuse laws such as False Claims Act(s), Anti-Kickback Act(s), and the Civil Monetary Penalties law. Violation of such laws can expose a Provider to significant civil and/or criminal penalties. Whistleblower protections under some of these laws provide protections...
for individuals reporting fraud and abuse in good faith and, in some cases, the reporter is entitled to a percentage of the proceeds of the case. Refer to the section below entitled Reporting System for information on how to report suspected fraud and abuse.

Examples of improper conduct include but are not limited to:

- Billing for excessive services (not medically necessary or appropriate);

- Billing for services not rendered, not rendered as billed, and/or not used by the patient/family (e.g., supplies);

- Failing to comply with government and other payor requirements (including billing for home health agency visits to patients who are not homebound (when required) or do not require a qualifying service, submission of cost reports claiming expenses unrelated to patient care or failing to identify related parties with whom business is conducted, failure to obtain required prior authorizations or to comply with claim submissions requirements, or using staff who do not meet the payor requirements (e.g., using physical therapist assistants when the payor does not permit physical therapist assistants);

- "Upcoding" diagnoses or otherwise entering false or misleading information on assessments, orders, clinical notes, authorization requests, claims or other documents for the intent and purpose of obtaining excessive or improper payments;

- Using unlicensed or untrained staff;

- Billing for the services of a higher level practitioner than the practitioner that rendered the service;

- Falsifying physician orders or plans of care;

- Forging signatures;

- Falsifying licensure/certification or falsifying clinical records, cost reports, OASIS assessment information, or other documents for the purpose of obtaining payment, including but not limited to, documenting services not provided, backdating or falsifying dates of services, and falsifying the condition and status of a patient;
• "Split billing" among payors to circumvent payor coverage restrictions;

• Billing two or more payors for the same services resulting in a duplicate payment ("double dipping");

• Kickbacks and improper relationships with referral sources;

• Billing CareCentrix for any services provided by the Provider’s employees or permitted subcontractors to themselves or to their immediate family members. An “immediate family member” is defined to include, but not be limited to, a spouse, domestic partner, parent, step-parent, child, grandchild, grandparent, and sibling (including natural, step, half or other legally placed children).

**Reporting System**

CareCentrix is committed to contracting with a network of Providers that adheres to high ethical standards. To achieve this goal, it is essential that every employee and contractor associated with your organization is also committed to this goal and assists your company in assuring compliance. Accordingly, it is our policy that participating Providers must report potentially criminal, fraudulent or other illegal activity immediately. Please report any such activity to the CareCentrix toll-free Compliance Hotline: 877-848-8229.

Individuals who make a good faith report to the CareCentrix Compliance Hotline are protected from retaliation. CareCentrix will take reasonable steps to protect the anonymity of any such reporter and to ensure no adverse actions are taken against such reporters. This policy is not intended to protect any individual giving a report which CareCentrix reasonably believes is fabricated, distorted, or exaggerated to either injure someone else or to protect the reporting individual or others.

The CareCentrix Compliance Department is responsible for investigating the report. Information obtained in the course of any such investigation will be considered confidential but may be disclosed to third parties at the sole discretion of CareCentrix. Any Provider knowingly failing to report unlawful conduct will be subject to disciplinary action, which could include network termination.
Response and Corrective Action to Promote Program Effectiveness

After any offense is detected, CareCentrix takes reasonable steps to respond appropriately to the offense and to prevent any further similar offenses, including any necessary modifications to its Program to prevent and detect violations of law. Depending on the individual circumstances, appropriate responses may include, but shall not be limited to, recoupment of inappropriately billed amounts, placement on a corrective action plan, network termination, additional training and/or reinforcement communications, and disclosure to our customers, governmental agencies, and/or law enforcement.

False Claims

Providers are required to comply with all applicable federal and state False Claims Act statutes and regulations. Any person who violates a federal or state False Claims statute or regulation is subject to all applicable fines and penalties. Under False Claims Acts, any person who knowingly with intent to injure, defraud or deceive any insurer or a Medicare or Medicaid entity files a statement of claim or an application containing any false, incomplete or misleading information is in violation of those laws and subject to criminal penalties and/or fines.

Training

Providers that render services to patients covered under a Medicare Advantage and/or Dual Eligible Special Needs Plan (DSNP) must conform to CMS training requirements. Providers who are enrolled with CMS to provide services to Medicare Part A and Part B beneficiaries are deemed to conform to this CMS training requirement. Alternatively, providers can complete the CMS fraud waste and abuse and general compliance training modules posted at the CMS website and must maintain records of the completion of such training for the period of time required by law.

Program Integrity Audits

As part of the CareCentrix Compliance Program, CareCentrix maintains a Program Integrity Department responsible for conducting claim audits to validate that claims paid by CareCentrix were correctly billed.
and paid. Providers must cooperate with all such Program Integrity Department audits. This includes, but is not limited to, providing CareCentrix with copies of all records requested to substantiate claims for services billed to CareCentrix. Requested records must be provided to CareCentrix at no charge and within the timeframes requested by CareCentrix. If a Provider fails to provide records requested by CareCentrix to substantiate services billed within the timeframe required by CareCentrix, payments on the claims that are the subject of the record request may be reversed and recovered through a refund request or offset against other claims.

The results of CareCentrix Program Integrity Department audits are shared with Providers, and Providers are given an opportunity to review the results, respond, and provide additional information in response to the findings. If the Provider provides a response and/or additional information to CareCentrix within the timeframe required by CareCentrix as communicated in the audit results letter or otherwise agreed by CareCentrix, CareCentrix will review the response and additional information, communicate in writing its final audit results to the Provider, and pursue recovery of all identified overpayments, including but not limited to, through offset against other claims. If the Provider fails to provide a response and/or additional information to CareCentrix within the timeframe required as specified in the audit results letter or otherwise agreed by CareCentrix, the audit will be considered final, and CareCentrix will pursue recovery of all overpayments identified in the audit results letter, including but not limited to, through offset against other claims. If a Provider wishes to further dispute Program Integrity audit findings after the audit results are finalized, the Provider must pursue external dispute resolution as provided in the Provider Manual and the Provider’s agreement with CareCentrix.

Compliance with Centers for Medicare & Medicaid Services (CMS) Notice of Medicare Non-Coverage Requirement

Providers are required to comply with applicable state and federal laws. With respect to Medicare patients who are discharged from home health care, CMS requires Providers to timely issue a Notice of Medicare Non-Coverage (NOMNC) to the patient unless an exception to the NOMNC requirement applies. The following are some steps Providers should take to ensure compliance with this NOMNC requirement:
• Prior to discharging a patient from home health services, determine whether the patient is a Medicare Advantage member.

• When CareCentrix issues an adverse concurrent review medical necessity determination for requested continuation of home health services, CareCentrix will produce and supply the NOMNC to the home health Provider. In all other instances, the home health Provider will produce the NOMNC when required. The home health Provider will deliver and secure the signed and dated NOMNC in all cases.

• If the patient is a Medicare Advantage member, provide the patient with a NOMNC at least 2 calendar days prior to discharge or the second to the last day of service if home health care is not provided daily unless the patient meets an exception to the NOMNC requirement. Please note that the patient or the patient’s authorized representative must sign and date the notice. Providers are responsible and are not entitled to reimbursement for any additional home health services required due to the Provider’s failure to timely deliver a compliant NOMNC or secure the patient’s or patient’s authorized representative’s signature on a NOMNC.

• Patients who meet one of the following CMS exceptions should not receive a NOMNC:
  o When a patient never received Medicare covered care in one of the covered settings
  o When a service is being reduced (e.g., home health agency providing both physical therapy and occupational therapy and discontinues the occupational therapy)
  o When a patient is moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a Skilled Nursing Facility (SNF))
  o When a patient has exhausted his/her benefit
  o When a patient ends care on his/her own initiative (e.g., patient decides to revoke the home health benefit and return to standard Medicare coverage)
  o When a patient transfers to another provider at the same level of care
  o When a provider discontinues care for business reasons

• Utilize the approved CMS NOMNC template and complete the NOMNC as directed by CMS.
All completed, signed, and dated NOMNCs must be faxed to CareCentrix’s dedicated NOMNC fax line at 866-778-0723.

Please be aware that CareCentrix may audit your records for NOMNC compliance. Appropriate action will be taken if you fail to comply with the CMS NOMNC requirement, which may include a monitoring action plan, corrective action plan, recoupment of payment for additional services required due to the failure to timely deliver a compliant NOMNC or secure the patient’s or patient’s authorized representative’s signature on a NOMNC, and/or termination from the network. For more information about NOMNC requirements, including the appropriate form and signature requirements, please refer to the Question and Answer document posted on our Provider Portal: HomeBridge and the CMS website.

2-1 PROVIDER PERFORMANCE STANDARDS

As a participant in the CareCentrix network of Providers, you are required to:

• Provide high quality, compassionate care to patients.

• Effectively and respectfully respond to patients’ linguistic, cultural and other unique needs.

• Accept and treat all patients regardless of race, color, national origin, age, religion, English proficiency, sexual orientation, gender identity, health status or disability.

• Provide timely oral and written language assistance services at no cost to the patient for patients with limited English proficiency.

• Provide auxiliary aides and other services for patients with disabilities free of charge and in a timely manner when necessary to ensure equal opportunity to receive health care services. Such aides and services include qualified interpreters, text telephones for the hearing impaired, and providing written materials in an alternate format for the visually impaired.
• Conduct ongoing training of staff at all levels regarding culturally and linguistically appropriate service delivery. For helpful resources and training information, please reference www.thinkculturalhealth.hhs.gov.

• Maintain an appropriate business continuity and disaster recovery program as required by applicable law.

• Submit timely written notice to CareCentrix of changes in your organization as required in your Provider contract and this Provider Manual.

• Maintain 24-hour on-call coverage 7 days per week and respond to patient and/or CareCentrix contacts within 30 minutes of call, including weekends, evenings and holidays, unless otherwise specified by contract.

• Submit billing to CareCentrix at least monthly and within timely filing requirements at the designated address for claims and submit no billing to the primary Health Plan for services/products unless directed to do so by CareCentrix in writing.

• Not bill the patient/member for covered services or for services where payment is denied because you did not comply with your Provider Agreement or this Provider Manual.

• Not bill the patient/member for any covered services.

• Not, under any circumstance, request patient/member co-pays, coinsurance or deductibles (the “Patient Cost Share”). Providers are paid for authorized covered services at the full contract rate in accordance with the terms of the Provider contract. Under the Provider’s arrangement with CareCentrix, those payments are not reduced by the Patient Cost Share, and CareCentrix assumes the Provider’s burden of collecting the Patient Cost Share. To fulfill that responsibility, CareCentrix contacts the patients directly to bill and collect the Patient Cost Share, and the patient is responsible for remitting those amounts to CareCentrix.

• Provide CareCentrix with valid patient contact information, including but not limited to, patient addresses and phone numbers, to assist CareCentrix with contacting patients so that CareCentrix can perform its patient billing and other functions as specified in your Provider Agreement and this
Provider Manual. Providers must not provide CareCentrix with phone numbers that the patient indicated must not be utilized to contact the patient, including but not limited to, through an automated call.

- Promptly return to CareCentrix any overpayments for services provided under your Provider Agreement.

- For services where payment is denied because the services are not medically necessary or are not otherwise covered under the member’s plan, not charge the member for such services unless, in advance of the provision of the services, the member agrees in writing to accept the financial responsibility for the services.

- Submit medical records, quality assessment, quality improvement, clinical outcomes, program evaluation, and other reports upon request of CareCentrix personnel and cooperate fully with any audits conducted by CareCentrix. Requested records must be provided to CareCentrix at no charge to CareCentrix and within the timeframes requested by CareCentrix. If Provider fails to timely provide records requested by CareCentrix in order to substantiate services billed, payments on the claims that are the subject of the record request may be reversed and recovered through a refund request or offset. CareCentrix further reserves the right to impose a penalty of $50 per day for each day that the Provider fails to provide records within the requested timeframes.

- Participate in CareCentrix quality initiatives as requested.

- Promptly notify patients of FDA recalls impacting them and facilitate the repair, replacement and/or resolution of the recall according to the guidelines issued by the manufacturer in the FDA notification

- Adhere to all other principles, practices and procedures found in the Provider Agreement, CareCentrix Provider Manual, and contractual relationships between CareCentrix and its Health Plan customers.

- Bill CareCentrix only for services that have been provided in accordance with the applicable health plan and member benefits, medical coverage guidelines, claims requirements and applicable laws, rules and regulations.
• Not bill CareCentrix for any services provided by the Provider’s employees or permitted subcontractors to themselves or to their immediate family members. An “immediate family member” is defined to include, but not be limited to, a spouse, domestic partner, parent, step-parent, child, grandchild, grandparent, and sibling (including natural, step, half or other legally placed children). Any such services billed to CareCentrix are not payable and, to the extent such services are billed to and paid by CareCentrix, will be subject to recovery and/or recoupment by CareCentrix.

2-2 USE OF OFFSHORE VENDORS

Except as otherwise permitted by CareCentrix in writing, Provider and any of its sub-vendors, subcontractors, or agents may not (1) perform or engage with business agents to perform any functions, activities or services under its agreement with CareCentrix from a location outside the United States; or (2) send or transmit to, or access, Members’ PHI or other personal information from outside the United States.

3-1 PROVIDER COMMUNICATIONS

In keeping with our commitment to support our Network Providers, we have a variety of Provider orientation and training communications and opportunities.

Provider Manual

Our Provider Manual is intended to inform our participating providers of their responsibilities as a CareCentrix Network Provider. This Manual also serves as an ongoing reference that is updated periodically. Providers have a responsibility to ensure they are following the most up to date policies and
procedures implemented by CareCentrix. Providers must check the Provider Portal: HomeBridge (www.carecentrixportal.com) frequently for any information updates, including updates to this manual. Changes may include:

- A change in policy, process and/or procedure that impacts the Provider.
- A change in the expectations or conditions of contract(s) with CareCentrix customers.
- New carrier contracts which the Provider may service.

Our Customers

Our network customers include Aetna (Florida and Georgia), AllWays Health Partners, Beech Street, Cigna, Cofinity, Coventry, Fallon, Florida Blue, Horizon Healthcare Services, Inc., Public Employees Insurance Agency (PEIA) and Walmart Specialty Pharmacy. You may request a complete and current list of our customers at any time by contacting your Network Management Representative. Please note that, when a patient presents an insurance identification card that includes the name or logo of one of our customers and the Covered Service required by that patient is included within the scope of your Provider Agreement and our customer contract, your CareCentrix Provider Agreement will apply to that service, and you must direct claims for that service to CareCentrix for processing as specified in this Provider Manual. Note that some CareCentrix customers have only contracted with CareCentrix to arrange for select home care services. Please contact your Network Management Representative with any questions regarding the applicability of your Provider Agreement to a particular service.

Provider Onboarding Training

Our Provider Onboarding Training provides high level end to end training to include important information on Provider responsibilities and CareCentrix operational procedures as outlined in this manual. If you are a new provider, our Provider Services Department will contact you to invite you to one of the many provider Onboarding Training sessions. Network Providers may email Provider Services at ProviderServices@carecentrix.com at any time to attend a refresher session. Providers should review this
manual prior to the call to obtain the most benefit from their participation. Additional materials are provided prior to each training session.

**Provider Portal: HomeBridge®**

The Provider Portal: HomeBridge ([www.carecentrixportal.com](http://www.carecentrixportal.com)) is the best place to find the most up to date information about working with CareCentrix. In addition to providing educational resources, our Provider Portal: HomeBridge gives you access to several self-service tools. When you access our Provider Portal: HomeBridge, you can:

- Submit a pre-notification/register services with CareCentrix
- Request prior authorization for services or continuation of services
- Add a service to an existing request
- Edit a request
- Upload clinical documentation
- Look up claim and request status
- Enroll in EDI (Electronic Claims Submission)
- Sign up for ERA (Electronic Remittance Advice)/EFT (Electronic Funds Transfer)
- Enroll in CareCentrix Direct
- Review the CareCentrix claims billing crosswalk
- Access our Provider Manual
- Access self-guided Provider education tools on several topics
- Review provider newsflashes
- Chat live with a CareCentrix representative

Providers servicing patients with, PEIA, Horizon Healthcare Services, Inc., Florida Blue, Coventry and Walmart Specialty Pharmacy will have access to more information about the status of their claims and enhanced search capabilities, including:
• View current status and history of each claim submitted
• View Health Plan determination information for each claim submitted
• View a replica of their submitted claim within the Provider Portal: HomeBridge
• View the 277CA acceptance or rejection information
• Submit a claim payment reconsideration request and/or appeal
• Submit claims inquiries

Not using the portal? Register on the Provider Portal: HomeBridge portal homepage or contact your portal administrator at your agency. To register an administrator account, contact your assigned Network Management representative.

CareCentrix Newsflashes

CareCentrix uses the newsflash tool to provide updates and other important information to our network Providers, including action items that Providers are expected to comply with. Newsflashes are distributed to Providers via fax or email communication and may also available on the Provider Portal: HomeBridge. If you have any questions regarding newsflashes, please contact your Network Management Representative.

3-2 NATIONAL CREDENTIALING COMMITTEE

Purpose

The purpose of the Credentialing Committee is to review the CareCentrix credentialing plan and process for verification and review of qualifications when a Provider seeks to participate in the CareCentrix Provider network.
Committee Attendance

The Credentialing Committee represents varied specialties from the home health care industry and is comprised of 5 voting and 4 non-voting members. The CareCentrix Medical Director reviews and approves clean credentialing files for acceptance and admission into the CareCentrix Network. The Credentialing Committee does not review such files as determined by applicable law or payor requirements. “Clean” credentialing files are those files that meet all of the criteria for inclusion into the Provider Network and do not require additional review by the Committee. All other complete files are submitted to the Committee.

Committee Meeting Schedule

The Credentialing Committee generally meets monthly. Ad hoc meetings may also be scheduled to address quality issues, malpractice review, and new business requests.

3-3 PROVIDER QUALIFICATION AND QUALITY MANAGEMENT

Credentialing

Our credentialing process requires, but is not limited to, the following:

- Completed CareCentrix Credentialing Application. The application must contain a current signature of the CEO, Administrator or other appropriate designated representative, attesting that all information provided in conjunction with the application is true, correct, and complete.

- Copies of current licensure as required by applicable law.

- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate and a copy of a
current fidelity bond for fifty thousand dollars ($50,000) or other crime and theft coverage in an amount satisfactory to CareCentrix.

- Six year malpractice history.

- Copies of current accreditation or certification. For non-accredited, non-certified Providers, CareCentrix may perform a site visit.

- QA/QI program description - The quality program must address patient care in general detail, including the overall steps that are taken to maintain quality control over internal processes as they relate to patient care. Quality Improvement Plans should contain the following:

  1. The implementation of the plan, analysis and progress on QI initiatives.

  2. The purpose, goals, objectives, and scope of the quality improvement program.

  3. The organizational authority, organization of responsibility and general methodology.

A copy of our credentialing application and a checklist of the materials required to be submitted with the credentialing application is set out in Attachment 3. For questions about our credentialing process, please send an email to our Credentialing Department at CredentialingDepartment2@carecentrix.com or call 631-501-7004.

Re-Credentialing

CareCentrix Network Providers are re-credentialed every two to three years (as determined by applicable law or plan requirements). However, a Provider’s credentialing status may be evaluated by the Credentialing Committee at any time during the two to three year credentialed period, including when a Provider adds a new service category, or malpractice or quality of care/service issues are brought to the Committee’s attention. In addition, if a Provider adds or acquires a new location, subsidiary or affiliate, that location or entity must be credentialed.
When a potential quality of care or service issue is brought to the Committee’s attention, the Committee reviews the issue and, based on the findings, takes appropriate action, which may include the implementation of a corrective action plan or termination of the Provider’s participation.

The standard re-credentialing process begins approximately six months before the credentialing anniversary. Our re-credentialing process requires, but is not limited to, the following:

- Completion of re-credentialing application
- Copies of current licensure.
- Proof of professional and general liability insurance. Required limits are generally one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in aggregate.
- Six year malpractice history.
- Copies of current accreditation or certification. For non-accredited, non-certified Providers, CareCentrix may perform a site visit.
- QA/QI program description and program evaluation.

**Provider Review**

In addition to the information listed in the previous section, the re-credentialing process includes a review of the Provider’s performance during their participation with CareCentrix.

This may include but is not limited to:

- Satisfaction surveys.
- All incidents and follow-up correspondence.
- All complaints and follow-up correspondence.
- Any correspondence received complimenting the Provider’s service.
- Compliance with CareCentrix credentialing and other policies.
Credentialing Requirements for a New Location

Providers that wish to add a new location must contact their Network Management Representative in writing to request the addition of the new location. New locations must be credentialed following the initial credentialing process outlined above. CareCentrix reserves the right to refuse to add new Provider locations. Decisions are based on a variety of factors, including satisfaction of our credentialing criteria and the network’s needs at the time of the request, subject to applicable law.

Credentialing Requirements for Adding a Service Category

Providers that wish to add a new service category (i.e. DME, infusion) must notify the Network Management Department in writing. New service categories must be credentialed following the initial credentialing process outlined above. Providers must maintain the licensure necessary to provide the new service category. CareCentrix reserves the right to refuse to add new service categories. Decisions are based on a variety of factors, including satisfaction of our credentialing criteria and the network’s needs at the time of the request, subject to applicable law.

Quality Measurement

We assess the quality of our Network Providers in a variety of ways including assessing quality against industry, regulatory, and accreditation body standards.
Satisfaction Measurement

In compliance with our own policies and procedures, and in keeping with NCQA and URAC standards and the contractual requirements of our customers, we or our Health Plan customers may sample and report findings regarding:

- Patient satisfaction
- Physician satisfaction
- Customer (Health Plan) satisfaction

Such patient satisfaction surveys are used by CareCentrix, Health Plan customers and Providers for purposes of evaluating the quality of the services arranged through the CareCentrix Provider Network. In addition, we are concerned with your satisfaction as a participant in the CareCentrix Provider Network. Therefore, we may assess your satisfaction or request your input through various means, including but not limited to:

- Provider satisfaction surveys via email, web, letter and telephone
- Provider focus groups
- Joint Operating Committee meetings

Satisfaction Measurement Report To Providers

We may periodically report satisfaction data results, analyses and related quality improvement initiatives to our Network Providers for purposes of providing feedback on CareCentrix and Provider performance, to support continuous quality improvement efforts for both CareCentrix and Network Providers, and to foster improved relations between and among your patients, physicians, CareCentrix Network Providers, Health Plans and CareCentrix associates.
4-1 CHANGES IN YOUR ORGANIZATION

You must notify CareCentrix of changes in your demographic information or changes to the information submitted with your credentialing application in writing on company letterhead within 7 days of the change. The written notice should be directed to the credentialing department at the following address: Contract.Department@carecentrix.com

Changes may affect receipt of referrals and reimbursements. Please be diligent in timely reporting changes to such information including changes to the following:

- Address(es), including the remit to address
- Telephone number(s) and/or fax number(s)
- Name of key organizational contact(s)
- Names(s) of key local operations contact(s)
- Tax Identification Number
- Days/hours of operations
- Service/product capabilities
- Populations served (adults, children, geriatric)
- Service area
- Accreditation status, including revocations
- New malpractice actions
- Licensing status, including sanctions
- Liability insurance coverage
- Change in business structure or ownership
- Closure of operations/business site
- Changes in the ability to accept new patients
5-1 HEALTHCARE DELIVERY PROCESS INTRODUCTION

CareCentrix has contracts with many payors. The processes that CareCentrix applies to a given patient’s referral are based upon the specifics of the contract between CareCentrix and the applicable payor. Unless otherwise directed, CareCentrix requires pre-notification/registration with CareCentrix prior to the delivery of services, devices, items and supplies (for purposes of Section 5, collectively “Service” or “Services”) arranged through the CareCentrix provider network. Pre-notification/registration refers to a process where a Provider notifies CareCentrix of the intent to order and/or provide a particular Service. CareCentrix requires pre-notification/registration for various purposes, including but not limited to, to arrange for the requested Services in the patient’s home through a network Provider and/or to validate that Services were timely delivered in the patient’s home by the network Provider. This pre-notification/registration process is distinguished from prior authorization. CareCentrix does not make an approval or denial decision with respect to a Service for which pre-notification/registration only is required. CareCentrix makes approval and denial decisions with respect to those Services that also require prior authorization. Sections 5-2 and 5-3 below discuss in more detail the pre-notification/registration, staffing and prior authorization processes.

5-2 COORDINATION OF SERVICES

CareCentrix network Providers may receive referrals for new patients in one of two ways:

1. A Primary Referral Source, typically a physician, hospital discharge planner, other provider, etc., contacts the Provider with the referral. In all cases, subject to patient choice, CareCentrix reserves the right to select an alternative Provider to service the referral.

2. CareCentrix receives a request from the Primary Referral Source and directs the referral to the Provider.
Provider Receives Referral From Primary Referral Source

Unless otherwise directed, Providers must submit a pre-notification/register services with CareCentrix via the Provider Portal: HomeBridge (www.CareCentrixportal.com). For certain Services, Providers must also secure prior authorization.

The Provider Portal: HomeBridge identifies the information necessary to complete a pre-notification/registration and prior authorization request.

The required information generally includes, but is not limited to, the following:

A. Patient first and last name  
B. Patient date of birth  
C. Patient insurance company and insurance subscriber ID number  
D. Patient physical address (not PO Box) including zip code  
E. Patient phone number  
F. Patient gender  
G. Diagnosis  
H. If recently discharged from hospital or other inpatient setting, facility name and full address  
I. Ordering physician first and last name, full address and telephone number  
J. Service description or HCPCS code and modifier  
K. Miscellaneous codes without a known description will require the Provider to manually enter a description with request  
L. Number of requested units, start and stop date of requested authorization  
M. Medical necessity justification for the service or item requested  
N. Confirmation that physician orders exist for services for which authorization is being requested

If the Provider does not submit all of the required information, the request may not be accepted by CareCentrix or it may be pended until the required information is received by CareCentrix.
The type of review applied to a request depends on the Service and the patient’s Health Plan. For example, a Service may require prior authorization and be reviewed for medical necessity under one Health Plan but not another. For some Services and/or Health Plans, registration or pre-notification of the Service is all that is required. In some instances, CareCentrix elevates the Service to the Health Plan so the Health Plan can conduct a prior authorization review. In addition, the type of review applied may change from time to time.

Providers must in every instance, whether receiving a referral from CareCentrix or a primary referral source, verify eligibility and benefits with the patient’s Health Plan prior to providing any Service. Providers must maintain documentation to evidence this verification of eligibility and benefits. CareCentrix does not conduct electronic eligibility and benefit verification transactions, but our health plan customers do. Please remember that eligibility and benefit verification and receipt of a Service Registration Form or SRF are not a guarantee of payment for services such as, but not limited to, items provided when the member is no longer eligible or the benefit has been exhausted. Services that are not subject to a pre-service medical necessity review may be reviewed for medical necessity when a claim for such services is submitted, or through a post payment audit. If such services are not medically necessary, the claim for such services may be denied and/or any prior payments on such services may be recouped. Providers are responsible for ensuring that they maintain, and have available upon request, all documentation necessary to support the services rendered, including but not limited to, the medical necessity of such services.

Pre-notification/registration and prior authorization (when applicable), whether for the initial start of care or for continued care, must be completed prior to the service being provided. If a Provider fails to submit a pre-notification/registration and, when applicable, secure prior authorization for a Service, such Service may not be reimbursed and will not be billable to the patient. Exceptions to this requirement may exist for certain Plans.

**CareCentrix Receives Referral from Primary Referral Source**
Provider staffing is the process of identifying a Provider to meet the needs of a specific patient. Many referrals will initially be sent to the Provider via CareCentrix Direct. CareCentrix Direct is CareCentrix’s electronic application that allows Providers to receive referrals quickly and entirely on-line. Providers who enroll in CareCentrix Direct are offered referrals preferentially to those not enrolled. For information about how to enroll in CareCentrix Direct, please contact your Network Management Representative. For cases not staffed through CareCentrix Direct, a CareCentrix Provider Staffing Associate will facilitate the referral. Referrals are made based on a variety of factors, including but not limited to:

- The location where the patient will receive service and corresponding location of the Provider
- The services/products for which a Provider is credentialed to perform or supply
- The lines of business for which a Provider is credentialed (e.g. Medicaid, Medicare)
- The Provider’s ability to provide the service or item for the required start of care date

CareCentrix makes no representations or guarantees about the number of patients that will be referred to a CareCentrix Network Provider as a result of the Provider’s participation in the CareCentrix Network and reserves the right to direct and/or redirect patients to selected CareCentrix Network Providers. In addition, CareCentrix customers reserve the right to exclude certain CareCentrix Network Providers from the network accessed by their members.

The process for Provider Staffing is as follows:

A. CareCentrix receives a request for a service or item from the primary referral source.

B. Except with respect to services falling under BlueCard, the referral is either sent out electronically to Providers via CareCentrix Direct or telephonic outreach is made to Providers.

   i. The Provider accepts the referral.

   ii. The SRF is faxed to the Provider. Providers may opt out of receiving faxed SRF and manage all of their service requests online via the Provider Portal: HomeBridge. For information about how to go paperless, please contact your Network Management Representative.

Regardless of the staffing route, Providers must verify eligibility and benefit availability with the Health Plan prior to providing any service, equipment or supply item. Receipt of a Service Registration Form is
never a guarantee of payment for services/items provided and is subject to factors that include, without limitation eligibility, benefit coverage, timely and proper claims submission and compliance with the terms of the Provider Agreement and this Provider Manual. In addition, Providers must carefully consider their ability to accept every case and only do so when the Provider is confident that the patient’s needs can be met. Referral turn-backs can delay the start of care and can cause quality of care and service issues.

After accepting a referral and receiving a Service Registration Form, it is the Provider’s responsibility to abide by all of the terms of the Provider Agreement and this Provider Manual including, without limitation, the following:

- Notify the CareCentrix Care and Service Centers immediately and in no event more than 2 hours after Provider learns that the start of care/delivery must be delayed or if unable to continue the case. In all instances, the Provider should contact the Care and Service Centers prior to the start of care/delivery date to allow CareCentrix adequate time to secure an alternate Provider if needed. It is also the Provider’s responsibility to obtain approval from the patient’s physician if the start of care/delivery date is delayed.

- Render no service unless ordered by the appropriate physician.

- Provide after hours (on call) home visits as appropriate and necessary in situations that cannot be resolved by telephone consultation.

- Notify CareCentrix staff of changes in patient/family status within 24 hours upon occurrence and/or identification, including:
  
  - Illness
  - Hospitalization
  - Death
  - Any other adverse incident or change affecting continued service delivery.

- Immediately notify CareCentrix of complaints made by the patient, family, physician or Health Plan upon occurrence.
• Register and, as applicable, obtain authorization for any previously unauthorized urgent services 24 hours a day, seven days a week, 365 days per year. CareCentrix provides 24/7 on-call access for urgent situations.

• Provide assessment reports, progress reports, organizational forms or other organizational documents within 48 hours of request by CareCentrix.

• Respond to grievances/complaints filed against the Provider within 24 hours and pursue timely resolution as acceptable by CareCentrix staff.

• Notify CareCentrix if other insurance or additional sources of reimbursement are identified.

• Provide all other documentation and records, which may be requested by CareCentrix from time to time, within the time frames set forth in the request.

Additional Services

If additional dates of service and/or units or services are needed beyond the date span or units/services listed on the previously issued SRF, Providers must submit a pre-notification/registration with CareCentrix and, as applicable, secure prior authorization for the additional Services.

Except as otherwise set forth in this Provider Manual, pre-notification/registration and prior authorization requests for additional services must be submitted at least 72 hours prior to the expiration of the date span specified in the SRF, but not more than 7 days prior to the expiration of the date span specified in the SRF. Requests received prior to that 7-day timeframe may be rejected, and the Provider will be required to resubmit. Providers must confirm eligibility and benefits prior to submitting such pre-notification/registration and prior authorization requests.

Pre-notification/registration and prior authorization of requests for additional services should be made via the Provider Portal: HomeBridge at www.carecentrixportal.com. The Provider Portal: HomeBridge
identifies the information required in order to complete such requests. The required information includes, but is not limited to, the following:

i. Intake ID

ii. Patient’s Last Name

iii. Service description or HCPCS Code and modifier for services requested

iv. Number of requested units, start and stop date of requested services

v. Medical necessity for the service requested

vi. Physician orders for all services requested

If the Provider does not submit all of the required information, the request may not be accepted by CareCentrix or it may be pended until CareCentrix receives the required information.

Retroactive Service Requests

Providers must submit a pre-notification/registration and secure prior authorization, when required, for Services prior to providing/delivering the Service. If a Provider fails to submit a pre-notification/registration and secure prior authorization when required prior to providing Services, those Services may not be reimbursed and are not billable to the patient.

Inquiries

After submitting a pre-notification/registration and/or prior authorization request, Providers may check the status of their request by accessing the Provider Portal: HomeBridge at www.carecentrixportal.com

Providers can view completed requests made within the last 60 days. The following information is available on our Provider Portal: HomeBridge:
- Request type – referral or reauthorization
- Intake ID
- HCPCS and modifier combination requested/approved
- Service code
- Description of HCPCS code
- Date request received
- Status of request
  - Approved (pre-notification/registration completed or prior authorization request approved)
  - Cancelled
  - Denied
  - Denied by the Health Plan
  - In process – elevated to the Health Plan
  - In process – pending additional information
  - In process – under review
- Authorization ID if applicable
- Name of Rendering Provider (if pre-notification/registration completed or prior authorization request approved)
- Number of units for HCPCS code approved
- Unit of Measure for HCPCS code approved
- Service start and stop date

5-3 UTILIZATION MANAGEMENT

The Utilization Management Process
Utilization Management is the evaluation of the appropriateness, medical necessity and efficiency of healthcare services according to established criteria or guidelines under the provisions of the patient’s benefit plan. The following is our standard medical necessity definition:

- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member’s medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the Member’s evidence of coverage.

The above definition is subject to the requirements of the applicable plan and applicable law (for example, the mandated definition for medical necessity for Medicare and Medicaid plans will apply to patients covered under such plans; a state mandated definition for medical necessity for insured commercial plans will apply to patients covered under such plans). Medical necessity reviews can be conducted for both initial and reauthorization requests and can be required for all types of service.

Providers and patients may request that CareCentrix provide a copy of the utilization review criteria applied when completing a medical necessity review by calling CareCentrix. Providers may also provide input regarding the utilization review criteria by contacting CareCentrix direct by email at CCXMedPolicy@CareCentrix.com.

The utilization review criteria used when completing medical necessity reviews is accessible through the links to health plan medical coverage policies below. Links to these medical coverage policies are also available on the Provider Portal: HomeBridge at www.CareCentrixPortal.com.

- Aetna and Coventry
Health plans update medical coverage policies regularly. Please reference these medical coverage policies frequently to become aware of any updates. The above listed websites may also be referenced to identify clinical documentation that may be required to be submitted with a claim by the above-referenced plans.

Under the CareCentrix Utilization Management Program:

- Utilization Management decisions are made independently and impartially and based solely on the appropriateness of care and service and the existence of coverage.

- CareCentrix decisions regarding hiring, compensation, termination, or promotions of Utilization Management personnel are not based on the likelihood that the individual will support the denial of benefits.

- Performance of associates who make Utilization Management decisions is measured based on the consistent and appropriate application of the approved coverage criteria to the clinical situation presented. Performance is not measured based on redirection rates or denial rates.

- CareCentrix does not specifically reward practitioners or others for issuing denials of coverage, and financial incentives for Utilization Management decision makers do not encourage decisions.

- The services and codes for which prior authorization is required and utilization review is performed vary based upon the specifics of the contract between CareCentrix and the applicable payor. Such services and codes can vary within a particular payor based upon the type of plan or the specific employer group. For example, CareCentrix does not perform utilization review for services provided
to Federal Employee Program (FEP) members or Blue Card members. For Blue Card members, Providers secure prior authorization from the member’s home plan when required. Such services and codes subject to utilization review can also vary depending on whether the request is an original request or a request to continue services and can vary depending on the volume of services requested (if the volume requested falls below a specified volume threshold, prior authorization may not be required). In addition, with respect to those services and codes for which prior authorization is required, in certain instances, CareCentrix performs the utilization review and, in other instances, the request is elevated by CareCentrix to the payor so the payor can perform utilization review. For a list of services for which prior authorization is required, go to the CareCentrix Provider Prior Authorization tool posted on the HomeBridge Provider Portal under Resources and Forms. If you have questions about the tool or would like to obtain a copy of a listing of codes requiring prior authorization, please call 844-457-9810. To access a listing of codes requiring prior authorization for patients covered by Cigna, go to the Resources section of the Cigna for Health Professionals website.

**Utilization Management Responsibilities**

Providers have the following Utilization Management responsibilities:

- Provide and maintain appropriate documentation to establish the existence of medical necessity.

- For those services requiring prior authorization, obtain authorization prior to beginning services/products. Services performed without a required prior authorization may be denied for payment, and any such denial of payment is not billable to the patient by the Provider.

- Verify the information on the SRF (service codes, HCPCS, modifier, number of units, start and stop date, Provider name and location) upon receipt. While CareCentrix staff work to assure the accuracy of the information on the SRF, mistakes can occur. Should you identify an error, call CareCentrix within 24 hours to correct the error.

- Timely notify the patient and the patient’s referring physician that Services were authorized consistent with applicable legal and accrediting body requirements.
• Notify CareCentrix immediately if, when the Services are delivered, the diagnosis is determined to be different than the diagnosis information obtained from CareCentrix.

• Notify CareCentrix if the Services ordered will not meet the needs of the patient. You may be asked to assist in identifying alternatives and discussing with CareCentrix and the ordering physician.

• Participate in case conferences

• Respond to all requests for contact from CareCentrix within 24 hours

• Respond to all requests for contact from the Health Plan case manager within 1 business day. In most cases, CareCentrix will act as a liaison when a Health Plan case manager requests information. Providers should not initiate contact with a Health Plan case manager unless directed to do so by CareCentrix.

• If requested by CareCentrix, provide assessment reports, progress reports, organization forms or other organization documents within 48 hours of request.

• Verify all initial physician orders with the physician and obtain physician orders for additional Services as necessary.

• Provide all other documentation and records which may be requested by CareCentrix from time to time, within the time frames set forth in the request.

Retrospective Claims Review

Paid claims can be subject to retrospective audits, and Providers have the obligation to maintain and make available documentation to support the medical necessity of services rendered and billed. Such documentation must be made available to CareCentrix and/or the applicable Health Plan at no cost to CareCentrix or the Health Plan and within the timeframes requested. CareCentrix may recover any payment for services determined not to meet medical necessity or benefit requirements, including recovery through recoupment.
Appealing a Denied Request

If Services have been denied in their entirety and new and/or additional information is obtained, the Provider should contact the CareCentrix utilization management staff to relay the new information.

If Services have been denied in their entirety and there is no new information available, the patient or physician may submit an appeal to the patient’s Health Plan in accordance with the Health Plan’s appeals process or, if CareCentrix is delegated for utilization management appeals, to CareCentrix.

6-1 SERVICE DELIVERY

To help ensure seamless patient care and timely and accurate payment, it is important that a Provider clearly understand the responsibilities for service/product delivery and the discharge of patients from service.

The Provider’s Responsibility

For service/product delivery, a Provider must:

- Verify physician’s orders and obtain physician signature within the time specified by state regulations and licensure.

- Meet the start of care date set forth by CareCentrix and/or the Primary Referral source. Any inability to meet start of care or delay in start of care requires notification to CareCentrix by calling the Care and Service Centers and the referring physician as soon as the Provider becomes aware of the delay. In all instances, approval must be obtained from the patient’s physician if the start of care will be delayed. In order to assist Provider with validating timely and quality service delivery, CareCentrix may contact patients by phone to validate that requested services were timely delivered and provide feedback to Provider regarding any delays in service and/or other service issues identified.
• Obtain patient signature to validate the patient’s receipt of services/products delivered.

• Notify CareCentrix by calling the Care and Service Centers immediately if unable to continue service delivery to the patient.

• Notify CareCentrix within 24 hours if the information obtained during the CareCentrix authorization process has changed or was incorrect. The utilization management staff will review to determine if a change to an authorization is required. Examples include:
  o An authorization is given for Ampicillin. When the primary care physician is contacted, the Provider is notified of a drug, dosage or frequency change.
  o An initial referral and authorization is given for diabetic teaching. The Provider, upon completing the initial assessment, identifies a need for wound care visits and supplies.
  o DME Provider identifies the equipment is not the correct size/type to meet the patient need.

• Bill CareCentrix only for services/products that have been ordered by an appropriate physician, meet medical necessity and benefit requirements and are registered with CareCentrix. Provide after hours (on-call) home visits as appropriate and necessary in situations that cannot be resolved by telephone consultation.

• Report adverse incidents to CareCentrix within 24 hours of occurrence. *Do not contact the Health Plan unless instructed to do so by CareCentrix.*

• Report complaints and problems with services/products to CareCentrix within 24 hours of occurrence. Do not contact the Health Plan unless instructed to do so by CareCentrix.

• Comply with state and federal licensing requirements and other applicable laws.

• Conduct and document discharge planning on an on-going basis during the care and document that discharge needs were met upon discharge.

• Not auto ship supplies. Medical necessity must be confirmed and documented prior to each supply shipment.
• Not provide equipment without first confirming medical need.

• Not deliver or ship supplies unless, in advance of delivery or shipment, you have verified with the patient or their treating physician that the patient needs additional supplies.

• Discharge the patient to a Provider who is in-network with the applicable Health Plan if the patient requires ongoing services not provided by the Provider.

Non-Life Sustaining Services for Certain Cigna and Florida Blue Members with Aged Cost Share Balances (Effective January 1, 2020)

• CareCentrix and its network DME providers will not arrange certain non-life sustaining services for Cigna and Florida Blue members who:
  o have aged cost share balances greater than 180 days from the initial patient invoice date;
  o are in the deductible phase of coverage (i.e., where the patient is 100% percent financially responsible for the service rendered); and
  o have not paid such aged balances in full or arranged for payment or a payment plan with CareCentrix.

• As of January 1, 2020, such non-life sustaining services (for purposes of this section, the “Services”) include PAP and PAP supplies. The Services are subject to change.

• This does not affect any other services, including but not limited to life sustaining services, required by these patients.

• Impacted patients and their treating providers will be notified in writing at least sixty (60) days in advance of the date CareCentrix will cease arranging the Services for such patients unless the patient pays the outstanding balance or arranges for payment or a payment plan with CareCentrix. In
addition, providers can obtain information about these patients by logging into the CareCentrix Provider Portal HomeBridge and accessing the “Patients” tab.

- For any dates of service on or after the date CareCentrix ceases arranging the Services for these Cigna or Florida Blue members:
  - Providers must not submit a request for such Services to CareCentrix through the Provider Portal: HomeBridge or otherwise.
  - Any claim submitted for such Services will be administratively denied, and the provider will be prohibited from billing the patient.
  - If the patient subject to suspension subsequently pays the outstanding balance or arranges for payment or a payment plan and CareCentrix resumes arranging the Services for the patient, the Provider may submit a reconsideration for previously denied claims with dates of service on or after the date CareCentrix ceased arranging non-life sustaining services. The reconsideration of a denied claim will be processed and paid in accordance with the terms of the Provider Agreement, Provider Manual, and the patient’s health plan.

- Providers should encourage their patients to timely pay their cost share balances with CareCentrix in full or establish a payment plan.

**The Provider’s Discharge Responsibilities**

Providers are required to notify CareCentrix prior to discharging a patient in the following circumstances:

- The Provider cannot provide the services/products ordered because of lack of staffing or expertise.
- The patient relocates outside of the geographic service area.
- The patient completes the Plan of Care.
- The patient and/or family are capable of assuming care. The patient’s physician should be notified of the patient/family’s request before stopping services/picking up equipment.
The patient no longer wishes to receive services/products. The patient’s physician should be notified of the patient/family’s request before stopping services/picking up equipment.

The patient/family refuses to comply or is incapable of compliance.

The physician does not provide the needed orders.

The patient is institutionalized.

The patient expires.

Home care is no longer appropriate due to risk factors.

As applicable, Providers are required to cooperate and assist in transitioning a discharged patient’s care to another Provider in order to ensure continuity of care.

6-2 GUIDELINES SPECIFIC TO PROVIDER SPECIALTY

This section outlines the guidelines specific to the specialty area of a Provider. Guidelines are prescribed for Home Health, Home Health Infusion Nursing, Home Infusion, Home DME, and Home Sleep.

Home Health

Home Health consists of skilled nursing (intermittent and hourly), physical therapy, occupational therapy, speech therapy, social workers and home health aides.

• A visit (2 hours) is defined as an episode of service (treatment or procedure) performed in a predetermined period of time with a predictable outcome. Providers must submit a request for services to CareCentrix for any service that will be billed in excess of one visit in advance.
• Services performed on the same day with the same HCPCS and modifier combination must be billed on the same claim. For example, if two nursing visits were completed in 1 day, both nursing visits need to be submitted on one claim and billed as 2 units on one claim line.

• Private Duty Nursing (PDN) specific billing and documentation requirements:
  o HCPCS codes must be billed in whole units of 1 or greater.
  o Invoiced units greater than 1 must be rounded up or down to the nearest whole number.
  o Providers must bill the number of units of care for each date of service. If a service spans two consecutive dates (e.g., overnight care), hours must be billed for each date of service.
  o Cigna PDN Documentation Requirements
    Providers requesting authorizations and re-authorizations for PDN services must submit:
    ▪ Home Health Services Time Audit form, available on the Provider Portal: HomeBridge, to document services performed by a nurse or other health care professional during two consecutive shifts; and
    ▪ Clinical notes for the two previous weeks and the plan of care.

• Provider subcontracting is not allowed unless approved in writing by CareCentrix.

• Any laboratory tests collected by a Provider must be taken to the laboratory participating in the patient’s insurance plan. Lab studies are not included in the CareCentrix Provider Agreement.

• The reimbursement for a skilled nursing visit includes the following routine supplies:
  o Dressing supplies-gauze pads, sterile/unsterile gloves, ABDs, Kerlix, tape
  o Betadine wipes
  o Peroxide
  o Syringes for nurse administered injections (excludes specialty syringes, special order items)
  o Lab tubes and needles for drawing lab work
  o KY jelly
  o Cotton balls and alcohol sponges
  o Gloves
  o Bandages
  o Thermometers
- Excluding the list above, certain supplies may be billed to CareCentrix but pre-notification/registration and, if applicable, prior authorization is required prior to delivery. The list of supplies, itemized cost, and the amount used daily must be submitted to CareCentrix via Provider Portal: HomeBridge or phone.

- Supplies for care rendered by the patient or family are to be obtained from the insurance carrier’s supply Provider unless the nursing Provider has supplies in its contract with CareCentrix.

- In the event that the Provider wishes to substitute an Licensed Vocational Nurse (LVN)/License Practical Nurse (LPN) for a Registered Nurse or a Certified Occupational Therapy Assistant (COTA) or Physical Therapy Assistant (PTA) to support a physical or occupational therapy plan of treatment, it is the Provider’s responsibility to ensure that:

  1. The substitution is allowed by the patient’s plan and applicable law;
  2. The care to be rendered is within the scope of practice for the LVN/LPN, COTA and/or PTA as defined by applicable law;
  3. The treating physician is in Agreement with the substitution; and
  4. The Provider’s contract includes a rate for LVNs/LPNs, COTA and/or PTA and the Provider bills at that contract rate.
  5. The Provider bills the appropriate HCPCS code for LVNs/LPNs, COTA and/or PTA.

<table>
<thead>
<tr>
<th>Does the Payor allow substitution of LVN, LPN, PTA and COTA?*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aetna</strong></td>
</tr>
<tr>
<td><strong>Beech Street</strong></td>
</tr>
<tr>
<td><strong>Cigna</strong></td>
</tr>
<tr>
<td><strong>Cofinity</strong></td>
</tr>
<tr>
<td><strong>Coventry</strong></td>
</tr>
<tr>
<td><strong>Florida Blue</strong></td>
</tr>
</tbody>
</table>
* Not all plans associated with Payor allow for substitution (e.g., Taft Hartley plans and plans managed by Third Party Administrator). Provider should contact the Payor or administrator to confirm if substitution is a covered benefit prior to rendering service.

- The coordinating Provider is responsible for:
  - Coordinating services/products such that vital services/products are received in compliance with physician orders and meeting patient needs.
  - Ensuring assessment/services/products by other Providers are started after they have assessed the patient but within 48 hours.
  - Obtaining and providing to CareCentrix the clinical information needed for re-authorization.
  - Notifying other involved Providers of authorization decisions, eligibility issues, etc.

### Home Health Infusion Nursing

The Home Health Infusion Nursing Services product provides nursing services associated with drug therapy when CareCentrix is not the source for the drug. Services included in the Home Health Infusion Nursing Services product are specialty and standard drug infusion administration and the administration or training for other injectable drugs appropriate for administration in the home by a certified Home Health Agency (HHA).

- Upon accepting a referral, the Provider will contact the patient to welcome them on service and to provide appropriate contact information.

- Within 24 hours of each scheduled visit, the Provider must confirm with the patient that all necessary medication and supplies, including pump if needed, have arrived. In the event that the patient has not received all necessary medication and supplies, the Provider must contact the appropriate Specialty Pharmacy to confirm when medications and supplies will be delivered to the member and will reschedule visit as appropriate.

- In the event of any adverse reactions to the drugs being infused, Provider will:
  - Notify the prescribing physician immediately.
- Notify CareCentrix by the next business day or earlier if necessary.
- Include any details regarding the adverse reaction(s) in the clinical documentation.

- In the event there is any clinically significant deterioration in the patient’s condition, Provider will:
  - Notify the prescribing physician immediately.
  - Notify CareCentrix by the next business day or earlier if possible.
  - Include any details regarding the clinically significant deterioration in the clinical documentation.

- Walmart Specialty Pharmacy Requirements
  - Both the drug and supplies will be coordinated by Walmart Specialty Pharmacy.
  - If a first dose is being requested in the home, Provider will have a policy in place regarding administration for first dose in home.
  - Nurses performing Infusion Nursing Services must maintain CPR certification.
  - Do not use the Provider Portal: HomeBridge for reauthorization or edits to authorizations. Requests for reauthorization can be faxed directly to Walmart Specialty Pharmacy at 866-537-0877. Include the following information when requesting reauthorization:
    - Patient Intake Number
    - Patient First / Last Name
    - Walmart Subscriber ID (WALMART + 9 numeric digits)
    - Services Requested (either 99601 or 99602)
    - Start Date Requested
  - Should you need additional hours per visit due to flow rate or other patient specific criteria, please contact Walmart Specialty Pharmacy directly at 877-453-4566.
o There is no need to check eligibility or benefits as the Specialty Pharmacy will check eligibility and benefits prior to issuing authorization to CareCentrix.

o Never, under any circumstance, tell the patient/member that they are not responsible for any copays, coinsurance or deductibles. Providers are paid for authorized services in accordance with their contract rates. Those payments are not reduced by the applicable copay, coinsurance or deductible, and Walmart Specialty Pharmacy assumes the Provider’s burden of collecting these amounts. Although the patient is not responsible to pay copays, coinsurance or deductibles to the Provider since the Provider has been paid in full, the patient is responsible for remitting those amounts to Walmart Specialty Pharmacy.

o Provider is required to fax clinical notes and documentation to CareCentrix within 3 business days of the provision of service to 877-254-6121.

o Provider is required to use the patient Subscriber ID list on the SRF when submitting a claim using the following format WALMART + 9 numeric (e.g., WALMART123456789).

**Home Infusion**

Consistent with industry standards, reimbursement for medications is based on HCPCS units of measure and is Average Wholesale Price (AWP) based. Most infusion service requests consist of three components: the drug, a per diem/dispensing fee and nursing. Exceptions to this methodology are Total Parenteral Nutrition (TPN) and hydration therapy, which are reimbursed on a bundled per diem basis. Infusion therapy-specific codes for billing are provided via the SRF. TPN and hydration therapy have only a per diem code plus nursing.

The standard per diem includes:

- All administrative overhead including: on-call pay, overtime, travel and facility expenses.
- All pharmacy, warehouse and delivery expenses.

- All emergency kits, including: anaphylactic kits, extravasation kits, narcotic antidote kits, etc.

- All clinical monitoring: vital signs, lab draws, etc. Labs should be transported to the patient’s (Health Plan’s) participating laboratory.

- All infusion-related supplies including stationary, ambulatory, disposable, syringe or other infusion devices.

- Nursing is separate from the per diem and includes but is not limited to patient assessment, first dose administration, teaching, IV catheter insertion (including mid-lines and PICC lines,) and maintenance, troubleshooting of products and services, lab draws, resolving patient complaints, etc. Services performed on the same day with the same HCPCS and modifier combination must be billed on the same claim. For example, if two infusion nursing visits were completed in one day, both nursing visits need to be submitted on one claim. For Florida Blue and Horizon Healthcare Services, Inc. patients, the first visit should be billed with CPT code 99601 and the second visit on the same day should be billed using CPT code 99602.

- Ambulatory Infusion Suite (AIS) visits should be billed with place of service (POS) 12. For Florida Blue members, AIS visits should be billed with POS 11 and the ‘SS’ (Home infusion services provided in the infusion suite of the IV therapy Provider) modifier.

- Providers are responsible for managing the inventory of patient supplies. Overstocked drugs or supplies may not be reimbursed.

- If a patient or caregiver wastes medication or supplies, the Provider must notify CareCentrix and provide documentation of the events.

- Reimbursement for drugs will be based on the HCPCS unit of measure and maximum allowable costs (MAC) as calculated by CareCentrix and provided in the billing crosswalk located on the Provider Portal: HomeBridge. Generic drugs are encouraged when clinically appropriate.

- Drugs and per diems will be reimbursed on the lesser of the date span specified on the SRF or actual dates of patient care.
• Provider may utilize a home health agency contracted with CareCentrix to perform the nursing component of an infusion case. Utilization management staff will make the determination of which per diem to attach to an ordered medication. The per diem is determined by the type of medication, if there is more than one medication prescribed, and what services/products will actually be provided. Example: Ampicillin q6 and Vancomycin q8. Provider would receive the following per diems:
  o anti-infective (Ampicillin) q6 primary per diem and;  
  o anti-infective (Vancomycin) q8 multiple second (more than one (1) medication ordered)

• It is important to maintain an accurate record of patient registrations so that claim payment is not delayed or denied. Payment may be denied or reduced if the service billed does not match the services on the SRF.

• Requests for additional services should not be made more than 7 days prior to the expiration of the date span specified on the SRF. Exceptions to this rule are specialty medications, such as Immune Globulin, where additional clinical documentation and review is required by the Health Plan prior to approval.

**Home DME**

Home DME services consist of the following categories of care: Disposable Medical Surgical Supplies (e.g., bandages/dressings, ostomy supplies), Durable Medical Equipment (insulin pumps, continuous glucose monitors & diabetic supplies, wound care and mobility), Enteral Equipment & Foods (enteral pumps and medical foods) and Orthotics/Prosthetics. For some Health Plans, it may or may not include consumable supplies, orthotics and prosthetics.

• Initial requests for rental durable medical equipment should generally be for one billing month, unless the physician order or actual use period will be for less time or unless more than one billing cycle is approved. When Provider requests a rental of durable medical equipment for a member that was renting or purchased that durable medical equipment either prior to Provider’s start of care date with the member or prior to the date the member became eligible under a CareCentrix customer benefit
plan, Provider must notify CareCentrix of that prior rental or purchase, the amount previously paid for that equipment, and the prior rental period. Provider shall not request or bill and shall not be entitled to receive reimbursement for any durable medical equipment if the amount already paid for such equipment prior to Provider’s start of care date with the member or prior to the date the member became eligible with the CareCentrix customer exceeds either the purchase price or rental period maximum for that equipment under either the member’s prior benefit plan or the member’s current CareCentrix customer benefit plan. If such dollar amount or rental period did not exceed such cap, then Provider may request a continued rental of the durable medical equipment provided that the accumulator for the purchase price and rental period maximum will include the prior amounts paid and prior rental period. CareCentrix will review requests for vendor or brand-specific equipment on a case-by-case basis.

- For custom equipment, a manufacturer’s specification sheet, including retail and CareCentrix pricing, must be submitted with a request. Note: For custom equipment, CareCentrix may instruct the Provider to complete 2 claims, if required for the specific CareCentrix contract. If this requirement is not met, the all-inclusive claim will be denied.

- When a Provider receives an evaluation request for a new custom wheelchair, the Provider must communicate with the member/patient, referral source, prescribing physician and CareCentrix throughout the entire process from assessment to final fitting and delivery. The Provider must contact the patient within 3 business days to confirm receipt of the request and coordinate an evaluation visit. The Provider must complete the seating and positioning evaluation as soon as possible and no later than within 21 business days of receipt of the request, subject to the availability of a seating and positioning clinic if needed. Custom wheelchair providers must submit all clinical and evaluation documentation to CareCentrix as soon as possible after the evaluation is completed and no later than within 45 business days of receipt of the original request. If the Provider experiences challenges in receiving required documentation from the patient’s physician within 30 days of receipt of the request, the Provider must escalate the issue to CareCentrix so that CareCentrix can assist. When a provider receives a request to repair an existing wheelchair, the Provider must use best efforts to contact the member within 1 business day to confirm receipt of the request and coordinate a visit to evaluate the repair needs. The Provider must use best efforts to complete the evaluation within 10
business days of receipt of the request and to complete the repairs as soon as possible and within 21 business days of receipt of the request.

- Providers of custom wheelchairs will assist in coordinating a rental product (loaner chair) for use by the patient until a chair or repairs can be completed. Such rental must meet the patient’s medical/safety needs, and, if this cannot be accomplished, no rental should be coordinated.

- Re-authorization can be for 90 to 180 days depending upon the equipment, diagnosis and prognosis.

- CareCentrix should be notified immediately of any returned unused equipment or rental equipment returned before the end of the service date span specified on the SRF. Provider should submit notification using the CCX Equipment Returns Form located on the Provider Portal: HomeBridge.

- Provider must submit the accurate units billed based on services rendered and service date span. CareCentrix will validate the To Date and From Date span against the units billed for the services.

- CareCentrix does not accept and process claims billed by the Provider with future dates of service.

- Multiple monthly rentals submitted on the same claim should be listed on separate claim lines and billed as individual units in correct chronological order.

- CareCentrix will convert the To Date of service to equal the From Date of service for rentals for the Health Plan to accurately pay for these services. Provider will receive the updated To Date of service on the 835/EOP and in the Provider Portal: HomeBridge Remittance Advice tab.

- All equipment and supplies will be delivered and set up in accordance with the Payor’s guidelines and in compliance with all federal, state and local guidelines.

- Wheelchair pricing includes all patient evaluation, delivery, fitting and set-up.

- Supplies for the following services are included in the monthly rental and must not be billed separately (for purchased equipment, supplies should be billed directly to the patient):
  - Apnea Monitors
  - Pulse Oximeter
- Usual and necessary ventilator accessories including circuits, filters, batteries and humidifiers are included in the monthly rental unless specifically noted by the Payor in their clinical guidelines and under prescribed conditions.

- If a patient is prescribed an Oxygen concentrator only, excluding a prescription for an additional oxygen device for portability or mobility usage by the patient then Provider shall provide to the patient a "Back-up" System that is selected by CareCentrix and approved by the patient’s physician, the costs of such “Back-up” equipment are included with the rental fee for the oxygen concentrator. If a patient is prescribed a ventilator that is for use in excess of twelve (12) hours a day or if patient cannot breathe independently for four (4) consecutive hours, then patient will be provided with a "back-up" system that is in accordance with the Payor clinical guidelines and selected by CareCentrix and approved by patient's physician. CareCentrix will approve payment for the "back-up" system per the Payor guidelines. If such additional payment is permitted, in addition to the monthly rental charge for the primary ventilator, Provider will be paid an additional charge at fifty percent (50%) of the charges listed above for the “back-up” system.

- Supplies and accessories that are factory installed and required for proper operation of equipment are included in the initial purchase or rental price and should not be billed separately. Replacement supplies and accessories that are required for proper use of equipment in the capped rental category can be authorized per physician orders and patients need.

- One download per month for pneumograms, sleep studies and apnea monitors is included in the rental price. CareCentrix does not reimburse for interpretations unless specifically requested and authorized. CareCentrix does not pay for physician professional fees. These should be billed by the physician to the Health Plan.

- Provider subcontracting is not allowed under this contract, however, it is allowable for the Provider to sub-rent equipment if Provider will deliver, set-up and train patient and caregiver.
• Providers may provide an upgraded piece of equipment from that which is authorized if ordered in writing by the physician and if the patient agrees (in writing, prior to delivery) to pay the difference between the contract price and the cost of the upgrade. Providers are prohibited from disclosing their CareCentrix contracted rate to the patient and shall not market to the patient. This cost difference is billable only to the patient, not CareCentrix or the Health Plan.

• Equipment maintenance is to be done in compliance with the Safe Medical Device Act and manufacturers maintenance recommendations and noted on the patient’s records chart if done while the equipment is in use by the patient.

• CareCentrix must authorize repairs to member-owned equipment in advance of Provider providing the service.

• For all life support, sustaining or patient monitoring equipment, Providers must verify with the ordering physician all changes to orders up to and including discontinuation.

• Providers should supply the least costly alternative that meets the physician’s order and patient’s needs.

• All HCPCS codes and modifiers listed and contracted for a Provider may not be applicable to all Payor contracts.

• Respiratory Therapist (RT) visits or consultations for non-routine equipment support or set up will be authorized in accordance to the plan guidelines and charged per visit or consultation (up to two hours). Non-routine visits are visits provided in accordance with a physician’s plan of care, or are required by State regulations and not considered part of a routine set-up. Most plans do not authorize separate payment to DME Providers for routine RT visits, fittings or consultation.

• Providers are required to have as part of their operations a Disaster / Emergency Preparedness plan to protect members on service.

• To support PAP and C-PAP Providers with helping ensure patients are utilizing their sleep device in accordance with sleep therapy program guidelines, CareCentrix may contact patients by phone and/or
mail to remind such patients of the sleep therapy program guidelines and/or provide them with information on their specific PAP/C-PAP usage.

Home Sleep

Home Sleep includes select contracted Providers to participate if they satisfy and agree to the terms and conditions of the product. Product training is mandatory for the Provider to participate. Provider is reviewed for compliance and is required for continued participation. Home Sleep Providers should access educational resources and self-services tools at www.sleepsms.com.

Telehealth

For certain payors (currently Florida Blue and Cigna), Providers contracted to provide telehealth services may arrange services via telehealth when telehealth services are appropriate for the patient and patient consent is obtained.

Telehealth services may be a component of or in lieu of an in-person visit (s) for home health nursing, home therapies (i.e. physical, occupational and speech), medical social worker, and teaching and training related to durable medical equipment and supplies (e.g. Insulin Pump). Telehealth providers must be both audio and video capable. Telehealth services via audio only may only be rendered when permitted under applicable law and appropriate for the services rendered to the patient. Providers must utilize both audio and video with respect to the following telehealth services:

- Physical therapy, occupational therapy, and speech therapy
- Wound care nursing visits

- CareCentrix’s standard processes for referrals, requesting authorization, and submission of documentation apply to telehealth services.
• Providers should only provide services via telehealth when appropriate for the patient. Examples of when home health services should be provided in person include:
  o Private duty nursing (PDN)
  o Infusion therapy initial visit (IV insertion, some specialty therapies)
  o Negative pressure wound therapy
  o Complex wound care
  o Lack of member/caregiver cognition to participate in telehealth
  o Member/caregiver inability to physically operate devices
  o Patient does not have access to technology for the telehealth visit (e.g. device with a camera)
  o Patient does not consent to receiving telehealth services

• For all telehealth referrals, regardless of referral source, the Provider is required to:
  o Review the referral to confirm the patient is clinically appropriate for telehealth services.
  o Secure consent from the patient to receive telehealth services.
  o Obtain orders from Primary Referral Source for telehealth service.
  o Determine the most appropriate form of technology for the telehealth visit.
  o Provide telehealth services in accordance with all applicable laws, including but not limited to applicable licensure, telehealth, and privacy laws.

• Telehealth visits should be billed with place of service (POS) 12

• Reimbursement for telehealth services will be based on the HCPCS and modifier provided in the billing crosswalk located on the Provider Portal: HomeBridge.

Documentation

CareCentrix does not maintain medical records. Providers are required to maintain all medical records and other documentation necessary to support services rendered in accordance with applicable laws, rules, regulations, this Provider Manual and the Provider Agreement and to provide CareCentrix and Provider’s patients with access to and/or copies of such records upon request and at no charge.
6-3  GENERAL CLAIMS AND REIMBURSEMENT INFORMATION

This section of our Provider Manual will provide you with information about the claims process associated with the two claims platforms currently utilized by CareCentrix.

Claims Process

Claims are processed consistent with the services specified in the SRF issued to the Provider.

As with all plans, providers are responsible for confirming eligibility and benefits with the member’s health plan for ongoing or add-on services. Failure to do so could lead to claim rejections and denials. It is imperative to check eligibility and benefits to ensure the member’s plan has not changed.

To expedite payment of claims, the Provider should match the billable services against the SRF and the CareCentrix billing crosswalk located on the Provider Portal: HomeBridge. Claims for services, date of service or units that do not exactly match the SRF may be rejected or denied in part or in whole. Alternatively, if the Provider bills for a higher level of service, equipment or supply than the level specified in the SRF, payment may be made in accordance with the rate associated with the service, equipment or supply referenced in the SRF, and Provider will accept that rate as payment in full.

Claims will be paid based on the lower of the Provider’s usual billed charge or the contracted/negotiated rate.

Receipt of an SRF is not a guarantee of payment, and payment of services rendered is subject to the patient’s eligibility and coverage on the date of service, the medical necessity of the services rendered, coverage requirements, the applicable payor’s payment policies, including but not limited to, payor’s claim coding and bundling rules, CareCentrix’s claim coding and bundling rules and compliance with the Provider’s contract with CareCentrix. Such payment policies and claim coding and bundling rules require that services must be properly documented and billed in accordance with industry standard
documentation and coding and billing practices and the Centers for Medicare and Medicaid Services (CMS) guidelines, including but not limited to, such guidelines that prohibit inappropriate unbundling of supplies/services, require proof of delivery (delivery tickets signed and dated by the patient), and requirements regarding medical record signatures, certificates of need/medical necessity, and eligible provider types. By submitting a claim for payment to CareCentrix, the Provider is certifying that it has met the above requirements, that the service has been rendered and that it has a record of all necessary documentation to support the foregoing. Claims that are not submitted within the timeframes set forth in the Provider Agreement and in accordance with the requirements of the Provider Agreement, this Provider Manual and the applicable health plan may be denied.

Providers may access additional Health Plan specific information by using the following links below:

Aetna and Coventry
AllWays Health Partners
Cigna
Fallon
Florida Blue
Horizon Healthcare Services, Inc.
Humana
Public Employees Insurance Agency (PEIA)

Checking Reimbursement Status

Providers should utilize the Provider Portal: HomeBridge to check the status of their claims.

After checking the Provider Portal: HomeBridge, any further questions regarding the status of claims should be directed to the CareCentrix Network Services Team (NST). The NST is available Monday through Friday between the hours of 8:30 a.m. and 6:00 p.m. Eastern Standard Time.

Explanation of Payment (EOP)
An Explanation of Payment (EOP) is issued in connection with each claim for services rendered. The EOP contains detailed explanation on payments and denials for each claim line per claim/invoice.

EOPs are also used to communicate adjustments to claims that have already been processed when it is determined that additional payment will be made on the claim. An adjustment may be made as a result of a claims reconsideration request or an appeal. The amount of the adjustment will be detailed by claim line item.

CareCentrix uses industry standard ANSI Codes to communicate on 835 transmissions and EOPs. The 835 transmissions and EOPs will have ANSI Claim Adjustment Reason Codes (CARC) and Remittance Adjustment Reason Codes (RARC) when required. A CARC provides a general explanation for adjustment or denial, and a RARC provides a more detailed description of the basis for the denial. The CARC and RARC codes and descriptions can also be found on the Provider Portal: HomeBridge.

Providers may receive an EOP that includes a credit or amount due to CareCentrix. The credit will be applied against amounts due the Provider and the net amount will appear on the accompanying check.

CareCentrix offers Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT). Providers that wish to enroll in ERA and EFT can do so by downloading the enrollment form posted on our Provider Portal: HomeBridge at www.carecentrixportal.com.

For, PEIA, Horizon Healthcare Services, Inc., Florida Blue, Coventry, and Walmart Specialty Pharmacy, Providers may receive an EOP for more claim lines than originally billed. This can occur when the Health Plan or CareCentrix was required to split the claim lines in order to process the claim. In addition, in certain instances, Providers may receive more than one denial for a specific claim since CareCentrix may receive more than one denial from the Health Plan, and CareCentrix passes each such denial to the Provider. While CareCentrix acts as a billing representative of the Provider solely for purposes of submitting a claim to the Health Plan, the Provider is solely and completely responsible for the timeliness, accuracy and completeness of its claim to CareCentrix, for timely submission of all necessary documentation (including clinical documentation), for compliance with the terms of the Provider Agreement and this Provider Manual and compliance with all Health Plan billing, claim, coverage and benefit requirements. Failure to comply with any of the above may result in nonpayment to the provider.
6-4 GENERAL BILLING REQUIREMENTS

In this section, we specify our billing requirements as they relate to the address, format, form, and timeframe for claim submissions, billing when another Payor is primary, authorization requirements, adjustments, and recoupments. Compliance with our billing requirements is required and can help ensure the timely processing and reimbursement of Provider claims.

Claims Support Center

The Revenue Cycle Management Center (RCM) is responsible for the processing of Provider claims. We encourage our network Providers to submit claims to CareCentrix electronically because electronic claims can be processed more efficiently and quickly. If you choose to submit paper claims, please direct your paper claims to the address at the bottom of the SRF. Always check the SRF for the claims address, as occasionally a contract with a Health Plan will dictate a deviation from usual operating procedure. Contracted Providers are strongly encouraged to enroll in submission of electronic claims by visiting the Provider Portal: HomeBridge at www.carecentrixportal.com.

Claim Form and Clean Claim Requirements

Claims must be submitted electronically (837P or 837I) or on standard paper claims forms (CMS 1500 or UB-04). Home Health Providers must submit claims on an 837I or UB-04. Our required clean claim data elements for both electronic and paper claims include the following:

- Patient name, Subscriber ID number (including any prefix and/or suffix as appropriate), address, relationship to subscriber, gender, and date of birth
- Insurance name, group name and group number
- Subscriber name, address, and gender
- Place of service code
- Primary diagnosis code(s) - V codes will not be accepted as the primary diagnosis code and Provider is expected to follow all ICD coding rules
- Rendering Provider name, service location, and billing address
- Rendering Provider National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
- Referring Provider/physician name and NPI number (837P)
- Attending Provider/physician name and NPI number (837I)
- Individual line level charge for each service
- Number of invoiced units for each claim line
- CareCentrix HCPCS/ CPT code(s) and modifier combination
- NDC codes, NDC description, NDC unit of measure, and NDC units (i.e. prescription drugs)
- Date of service (FROM and TO required; FROM date must be before the claim receipt date and before or equal to the TO date)
- Whether the patient’s condition is related to employment, auto accident or other accident
- Other insurance information (if other insurance, include other insured’s name, date of birth, other insurer’s name, group or policy number)
- Coordination of benefits information for secondary claims (explanation of payment from primary carrier)
• Service authorization number

• Revenue Code (institutional claims)

• HIPPS code on all home health claims submitted for Medicare Advantage members

• Description of miscellaneous code

HCPCS codes must be billed in whole units of 1 or greater. Units greater than 1 must be rounded up or down to the nearest whole number. NDC quantities may be submitted in fractional units with up to 2 decimal points.

Claims missing required information, containing incorrect required information, or billed inconsistent with the requirements of this Provider Manual may not be processed. Paper claims without the correct required information may be returned, and the Provider will be informed of the information that is missing or incorrect. Claims submitted electronically without correct required information may be rejected by the clearinghouse with corresponding reasons for the rejection. Such incomplete claims must be resubmitted by the Provider to CareCentrix so that a complete or clean claim is received by CareCentrix within the original timely filing timeframe as specified below subject to applicable law.

CareCentrix reserves the right to update, modify, and/or clarify HCPCS codes in accordance with federal, state, or other regulatory bodies. It is the Provider’s responsibility to regularly check the Provider Portal: HomeBridge for updates to HCPCS codes, descriptions, and the CareCentrix billing crosswalk. The current billing crosswalk can be found at: www.carecentrixportal.com.

CareCentrix will only accept original documents for payment consideration that are typed in indelible ink without erasures, strikeovers, whiteout or stickers. Dot matrix printers should not be used when typing information onto paper claims forms. Claims with handwritten information will be rejected. Also, it is important that the name of the Provider organization and service location on the claim match the Provider name on the related SRF(s).

With regard to services delivered, the claim must include a description of the service provided (i.e. “RN visit” or “CPAP rental”) as well as the relevant HCPCS, CPT or revenue code and applicable modifier(s) found on the CareCentrix SRF or the billing crosswalk (located at www.carecentrixportal.com). Claims
without a description of the service provided will be returned. The address to which claims should be sent is found in the lower portion of the SRF. Services should be billed at the contracted rates or authorized rates as appropriate. The Provider Agreement rate is payment in full for covered services and is all inclusive. Provider is not entitled to receive additional compensation for covered services, including but not limited to, compensation for copies of records, sales tax, reports, or other services contemplated by the Provider Agreement. **No billing to the patient or Health Plan of the difference between the negotiated or contracted rate and the Provider’s list price is permitted.** If Provider’s billing system is unable to support billing at the contracted rate, the difference between the contract rate and Provider’s list price must be adjusted off Provider’s accounts receivable. Doing so can help Provider avoid repeated claims inquiries. In addition, when billing for custom equipment, the claim must reflect the full rate, the discount as negotiated, and the net price. Provider must attach to the claim the manufacturer’s specification sheet for the equipment. For custom equipment, you may be instructed to complete 2 claims if required for specific CareCentrix Health Plan contracts.

Claims submitted without all required information may be rejected or denied.

With respect to applicable sales tax, as indicated above, your network contract rate is inclusive of any applicable sales tax. It is your obligation to 1) calculate and identify that portion of your contract rate that is attributable to applicable sales tax; and 2) remit the applicable sales tax amount to the appropriate regulatory authority. You are prohibited from billing patients for applicable sales tax as your contract rate is payment in full for the services rendered.

**Timely Filing**

Clean claims must be filed at the address designated by CareCentrix within the time frame described in your Provider Agreement or within the period of time required by applicable law if longer. Claims received by CareCentrix after the filing deadline may be denied, and Providers cannot bill the patient for such services. Note that CareCentrix may pay some claims that were not submitted timely to CareCentrix if we believe there may still be time to timely bill and receive payment from the Health Plan. However,
please be aware that, if the Payor does not pay the claim in full, CareCentrix may later deny the claim for failure to timely file and recoup the prior payment.

Health Exchange Members That Receive Advance Premium Tax Credits

- Under the Affordable Care Act, health exchange members that receive an Advance Premium Tax Credit (APTC) are afforded a 90-day grace period to pay outstanding premiums. Providers can obtain grace period status information on APTC Members directly from the APTC Member’s health plan using the same means by which the health plan provides that information to its network providers. If a health plan provides this information via an online tool, please obtain access to that online tool if you do not already have it. A health plan’s toll free phone number can be obtained from the health plan member identification card.

- CareCentrix will process and pay provider claims for APTC Members and their covered dependents(s) for authorized covered services throughout the first month of the premium grace period in accordance with your provider agreement. For services provided during months 2 and 3 of the grace period, CareCentrix may pend the claims until the health plan provides CareCentrix with the information necessary to verify eligibility.

- If a claim is pended, it will remain in pended status until CareCentrix can verify eligibility with the health plan. For those members that paid the required premium timely, the pended claims for covered services will be processed for payment in accordance with your provider contract. For those APTC Members that failed to pay the required premium timely, any pended claims for services provided in months 2 and 3 will be denied on the basis of lack of eligibility and, if CareCentrix paid a claim for services provided during months 2 and 3, CareCentrix will recoup that payment. If, prior to receiving such services during months 2 and 3, the APTC Member agreed in writing to accept financial responsibility for non-covered services, you can bill the patient for the non-covered services in accordance with your provider contract.
Billing When another Payor is Primary

When a CareCentrix customer is the secondary payor and, under that CareCentrix customer contract, CareCentrix is responsible for processing secondary claims, Providers should immediately notify CareCentrix so that services can be appropriately authorized. Please note, when the CareCentrix customer is the secondary payor, any claims submitted to CareCentrix must include a copy of the related denial or explanation of benefits/payment from the primary payor. Such clean claims must be submitted to CareCentrix with the primary payor’s EOB attached within the timeframe described in your Provider Agreement or within such longer period of time required by applicable law. Secondary claims are submitted in paper format or, for specific payors including PEIA, Horizon Healthcare Services, Inc., Florida Blue, Coventry, and Walmart Specialty Pharmacy, Providers can submit secondary claims electronically by submitting the secondary loops and segments on the electronic 837.

Medicare Primary Claims

For those members where Florida Blue or Horizon Healthcare Services, Inc. is a secondary payor to Medicare, all claims for Covered Services are to be submitted directly to Medicare. Through the Medicare Crossover Process, the claim will then be routed by Medicare to Florida Blue or Horizon Healthcare Services, Inc. Florida Blue will process payments in accordance with the Patient’s Health Plan Benefits Agreements and Medicare requirements, and directly compensate the Provider in accordance with Florida Blue’s applicable Provider fee schedule equivalent to 100% of Medicare allowable rate.

The grid below provides coordination of benefit information for both authorizations and claims when the CareCentrix payor is not primary.
Recoupment and Adjustments

There may be instances in which a refund request or recoupment of an overpayment is required. For example, we reserve the right to recoup or adjust payment (or request a refund) for amounts paid for services delivered. This can occur in a number of situations, including but not limited to:

- The patient was not eligible on the date of service or the services were otherwise not covered under the patient’s Health Plan.

- The CareCentrix customer is discovered to be the secondary payor.

- The Provider did not bill CareCentrix timely and CareCentrix was unable to secure reimbursement from the Health Plan.

- Based upon a post service audit or review, the services did not meet medical necessity criteria, benefit requirements, was not authorized or were otherwise billed incorrectly.

- The Provider was paid twice for the same service or received more than the allowable amount for the service.

- The services were not reimbursable by the applicable payor or Health Plan, including but not limited to, were not reimbursable under the applicable payor’s payment policies.

- The Provider did not timely provide records requested by CareCentrix to substantiate services billed by Provider

- The Health Plan otherwise does not pay CareCentrix
Recoupments will appear on the CareCentrix Explanation of Payment (EOP)/835 as a “credit” adjustment. When applicable, we will provide appropriate information so that the Provider may bill the responsible party. Also see Service Specific Billing Requirements.

6-5 COMPLAINTS, CLAIMS PAYMENT RECONSIDERATIONS, AND APPEALS

Introduction to Complaint, Claims Payment Reconsideration, and Appeals Process

Our Complaint, Claims Payment Reconsideration, and Appeals process is a continuous process improvement mechanism that establishes a consistent process for responding to complaints and credentialing, claims payment, and other issues.

Complaints

- Provider complaints should be communicated to the appropriate Network Management Representative.

Credentialing

- Credentialing issues should be directed to our Credentialing Department at:
  
  CredentialingDepartment2@CareCentrix.com.

Utilization Management Issues

Unless otherwise indicated by CareCentrix, CareCentrix does not perform appeals of utilization management decisions, and the member appeal process is not delegated to CareCentrix. Appeals of utilization management decisions by or on behalf of the member should be directed to the appropriate payor.
6-6 CLAIMS PAYMENT ISSUES

Corrected Claims

If you receive a denial from CareCentrix, and you agree with the denial, you can correct the issue identified in the denial and resubmit the claim as a corrected claim. If submitted on paper, the corrected claim must include clearly visible markings that indicate the claim has been corrected.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Payor Specific Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Corrected claims must be submitted on paper with ‘CORRECTED’ written across the top of the claim without obstructing any claim elements. Please ensure to include the original CareCentrix claim number (box 22 of CMS1500 or box 64 of UB-04). These claims should be submitted to:</td>
</tr>
<tr>
<td>AllWays Health Partners</td>
<td>CareCentrix – Claims</td>
</tr>
<tr>
<td>Beech Street</td>
<td>PO BOX 30722-3722</td>
</tr>
<tr>
<td>Cigna</td>
<td>Tampa, FL 33630</td>
</tr>
<tr>
<td>Cofinity</td>
<td>Or if using Federal Express, UPS or Certified Mail: CareCentrix – Claims</td>
</tr>
<tr>
<td>Fallon</td>
<td>10004 N. Dale Mabry Highway</td>
</tr>
<tr>
<td></td>
<td>Suite 106</td>
</tr>
<tr>
<td></td>
<td>Tampa, FL 33618</td>
</tr>
</tbody>
</table>

| Coventry                                   | Corrected claims must be submitted electronically via an 837 frequency 7, “Void & Replace” transaction.                                                                                                                      |
| Horizon Healthcare, Inc.                   | Please note that the Subscriber ID cannot be corrected using the claim frequency 7 transaction. To submit a claim correction, a frequency 7 code should be sent to CareCentrix along with the original claim ID (Payor Claim Control Number) Loop 2300 REF*6R Segment, Field REF02, within the 837 transaction. |
| Florida Blue                               | Any claims submitted electronically with a claim frequency type code 7 when the status of the previous transaction is not equal to “Finalized by CareCentrix” will be rejected.                                             |
| PEIA                                       |                                                                                                                                                                                                                         |
| Walmart Specialty Pharmacy                 |                                                                                                                                                                                                                         |

Please note that corrected claims must be received by CareCentrix within the original timely filing timeframe in order to be payable.
Claims Inquiries

For claims covered by payors PEIA, Horizon Healthcare Services, Inc., Florida Blue, Coventry and Walmart Specialty Pharmacy, Providers can submit claims inquiries through the Provider Portal: HomeBridge to interact with the Network Services Team (NST). There are three types of claims inquiries to choose from: General, Financial and Denial. To access the claims inquiry function, visit carecentrixportal.com and click the ‘Submit a Claims Inquiry, Appeal or Reconsideration’ link.

Reconsideration

If you receive a claim determination from CareCentrix that is different from what you expected, you should first try to understand the difference and reconcile the discrepancy. If you cannot reconcile the discrepancy and wish to request reconsideration, you must submit a request for reconsideration in writing using our Claim Reconsideration Form which can be found on our Provider Portal: HomeBridge at www.carecentrixportal.com.

A claim reconsideration form may not be submitted for a Florida Blue or Horizon Healthcare Services, Inc. FEP member claim as this plan type does not permit reconsiderations. The Provider should instead submit an appeal for FEP members. In addition, for New Jersey providers that elect to initiate a New Jersey statutory claims appeal for a claim that is eligible for such appeal process and for which CareCentrix is delegated to handle such statutory claims appeals, submit an appeal using the New Jersey claims appeal form posted on the Provider Portal: HomeBridge.

Prior to submitting a reconsideration request, you should confirm:

1. If the claim was rejected or denied. Rejected claims can be resubmitted without submitting a reconsideration request.

2. If the member is a FEP member. The Provider should not submit a reconsideration request for an FEP member claim. The Provider should instead submit an appeal for FEP members.
3. If the original claim has been altered in response to the denial. Only original claims that do not require changes in response to the denial should be submitted as a claims reconsideration request. Claims requiring correction to address the issue causing the denial should be submitted as corrected claims.

Providers submitting a reconsideration should refer to the following Payor specific information.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Payor Specific Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Providers can request a reconsideration of a claim determination in writing by submitting a Claim Reconsideration Form to:</td>
</tr>
<tr>
<td>AllWays Health Partners</td>
<td>CareCentrix – Reconsiderations</td>
</tr>
<tr>
<td>Beech Street</td>
<td>PO BOX 30720-3720</td>
</tr>
<tr>
<td>Cigna</td>
<td>Tampa, FL 33630</td>
</tr>
<tr>
<td>Cofinity</td>
<td>If using Federal Express, UPS or Certified Mail:</td>
</tr>
<tr>
<td>Fallon</td>
<td>CareCentrix – Claims</td>
</tr>
<tr>
<td></td>
<td>10004 N. Dale Mabry Highway</td>
</tr>
<tr>
<td></td>
<td>Suite 106</td>
</tr>
<tr>
<td></td>
<td>Tampa, FL 33618</td>
</tr>
<tr>
<td>Coventry</td>
<td>Providers can request a reconsideration of a claim determination online via the Provider Portal: HomeBridge or in writing by submitting a Claim Reconsideration Form to:</td>
</tr>
<tr>
<td>Florida Blue</td>
<td>CareCentrix – Reconsiderations</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc.</td>
<td>PO BOX 30720-3720</td>
</tr>
<tr>
<td>PEIA</td>
<td>Tampa, FL 33630</td>
</tr>
<tr>
<td>Walmart Specialty Pharmacy</td>
<td>If using Federal Express, UPS or Certified Mail:</td>
</tr>
<tr>
<td></td>
<td>CareCentrix – Reconsiderations</td>
</tr>
<tr>
<td></td>
<td>10004 N. Dale Mabry Highway</td>
</tr>
<tr>
<td></td>
<td>Suite 106</td>
</tr>
<tr>
<td></td>
<td>Tampa, FL 33618</td>
</tr>
<tr>
<td></td>
<td>Note: Depending on the applicable payor and claim denial reason, CareCentrix will either process the reconsideration request itself or will submit the reconsideration request on behalf of the Provider for processing.</td>
</tr>
</tbody>
</table>
Your request for reconsideration must be received by CareCentrix at the designated address within **45 days after the date of our explanation of payment**, or within the period of time permitted by applicable law if longer. Notwithstanding the foregoing, CareCentrix may, in its sole discretion, waive this timely filing requirement if CareCentrix is able to timely bill and secure payment from the Health Plan with respect to the claims that are the subject of the reconsideration request.

After receipt of your completed request for reconsideration, we will research your concern and respond to you as soon as possible. For reconsideration requests that are submitted to the Health Plan on behalf of the Provider, the following review timeframes will apply (subject to applicable law):

<table>
<thead>
<tr>
<th>Payor</th>
<th>Product Type</th>
<th>Review Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Blue</td>
<td>Local and State</td>
<td>30-60 Days</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc.</td>
<td>Local and State</td>
<td>30-60 Days</td>
</tr>
<tr>
<td>Florida Blue</td>
<td>BlueCard</td>
<td>60-90 Days</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc.</td>
<td>BlueCard</td>
<td>60-90 Days</td>
</tr>
</tbody>
</table>

CareCentrix will communicate the plan decision to the provider within on average 10 days of receipt of that decision or the period of time required by applicable law if shorter. If the request for reconsideration is resolved in your favor, the claim will be adjusted and an explanation of payment (EOP) issued. If it is not resolved in your favor, you will be advised to submit an appeal in writing using our Appeal Form which can be found on our Provider Portal: HomeBridge at [www.carecentrixportal.com](http://www.carecentrixportal.com). Please note that, if changes are required to the original claim, in lieu of submitting an appeal, Providers should submit a corrected claim in accordance with our corrected claim process.
Providers submitting an appeal should refer to the following payor specific information.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Payor Specific Information</th>
<th>Payor Specific Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Providers can request a claim appeal in writing by submitting a Claim Appeal Form to:</td>
<td>CareCentrix – Appeals</td>
</tr>
<tr>
<td>AllWays Health Partners</td>
<td>PO BOX 30721-3721</td>
<td>Tampa, FL 33630</td>
</tr>
<tr>
<td>Beech Street</td>
<td>If using Federal Express, UPS or Certified Mail:</td>
<td>CareCentrix – Appeals</td>
</tr>
<tr>
<td>Cigna</td>
<td>10004 N. Dale Mabry Highway</td>
<td>Tampa, FL 33618</td>
</tr>
<tr>
<td>Cofinity</td>
<td>Suite 106</td>
<td></td>
</tr>
<tr>
<td>Fallon</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Coventry                                   | Providers can request a claim appeal online via the Provider Portal: | HomeBridge or in writing by submitting a Claim Appeal Form to: |
| Florida Blue                               | HomeBridge or in writing by submitting a Claim Appeal Form to: | CareCentrix – Appeals |
| Horizon Healthcare Services, Inc.           | PO BOX 30721-3721          | Tampa, FL 33630 |
| PEIA                                       | If using Federal Express, UPS or Certified Mail: | CareCentrix – Appeals |
| Walmart Specialty Pharmacy                | 10004 N. Dale Mabry Highway | Tampa, FL 33618 |
|                                            | Suite 106                  |                            |

Note: Depending on the applicable payor and claim denial reason, CareCentrix will either process the appeal itself or will submit the appeal on behalf of the Provider to the payor for processing.

Your appeal must be received by CareCentrix within 30 days from the date of our written notice (EOP, letter, etc.) advising that your request for reconsideration was not resolved in your favor or within the period of time permitted by law if longer. Notwithstanding the foregoing, CareCentrix may, in its sole discretion, waive this timely filing requirement if CareCentrix is able to timely bill and secure payment from the Health Plan with respect to the claims that are the subject of the appeal.
Appeals

If CareCentrix processes the appeal itself, the CareCentrix Appeals Unit will endeavor to complete the review of your appeal within 30 days of receipt of all information necessary to review your appeal or within the period of time required by applicable law if shorter. If CareCentrix submits the appeal on the Provider’s behalf to the Health Plan for processing, the timeframes specified in the grid below will apply (subject to applicable law):

<table>
<thead>
<tr>
<th>Payor</th>
<th>Product Type</th>
<th>Review Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Blue</td>
<td>Local, State and FEP</td>
<td>30-60 Days</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc. *</td>
<td>Local, State and FEP</td>
<td>30-60 Days</td>
</tr>
<tr>
<td>Florida Blue</td>
<td>BlueCard</td>
<td>60-90 Days</td>
</tr>
<tr>
<td>Horizon Healthcare Services, Inc. *</td>
<td>BlueCard</td>
<td>60-90 Days</td>
</tr>
</tbody>
</table>

CareCentrix will communicate the plan decision to the provider within on average 10 days of receipt of that decision or the period of time required by law if shorter. We will communicate the results of our review of your Appeal in writing which may include, when payment is issued, a check along with an explanation of payment.

CareCentrix Network Providers may not bill a patient or that patient’s Health Plan (if the Health Plan is a CareCentrix client) during the reconsideration or appeals process or for a balance remaining after a decision has been made on a CareCentrix Network Provider appeal.

Dispute Resolution

If the Provider is not satisfied with the resolution of the appeal, the Provider may request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute within 60 days of the date of the appeal decision letter. If the matter is not resolved within 60 days of the Provider’s written request for such negotiation, the Provider may submit the matter for resolution in accordance with the dispute resolution process.
outlined in the Provider’s contract with CareCentrix. The right to submit the matter for dispute resolution will be waived if the matter is not submitted for dispute resolution within 120 days of the date of the appeal decision letter or within the time period required by applicable law if applicable law requires a time period longer than such 120 day period. If the Provider Agreement does not provide for a specific dispute resolution mechanism, the following dispute resolution process shall apply to the extent permitted by applicable law:

**Binding Arbitration**

If, after exhausting the CareCentrix appeal process, a Provider is not satisfied with the resolution, the Provider has the option to pursue binding arbitration in accordance with the rules of the American Arbitration Association as are in effect at the time of the arbitration’s initiation. The sole and exclusive venue for any such arbitration shall be Hartford, Connecticut. In connection with the foregoing, each party shall select an arbitrator and the two arbitrators selected by the parties shall select a third, mutually agreeable arbitrator. Arbitration shall then proceed before the panel of the three arbitrators. The timeframe for discovery and hearing shall be mutually agreed upon by the parties, which agreement shall not be unreasonably withheld. Arbitration shall be the exclusive remedy for the resolution of all disputes that may arise between the parties, including but not limited to all disputes arising under the Provider Agreement. The award or decision of the arbitrators shall be final and binding. The initial filing fee shall be borne by the party initiating the claims or counter claims in arbitration. Thereafter, the cost of retaining the arbitrators shall be shared equally by the parties. Each party shall be responsible for all of its own costs associated with the arbitration including without limitation attorneys, expert, and audit fees. The arbitrators are expressly prohibited from awarding either party attorneys’ fees or any other fees, costs or expenses incurred by such party in connection with any arbitration proceeding or judgment. Judgment upon the award rendered by the arbitrators may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated pursuant to the termination provision(s) of the Agreement which termination provision(s) shall not be affected or overridden by this Binding Arbitration provision. This Binding Arbitration provision shall survive any termination of the Agreement.
6-7  CONTRACT TERMINATION

Both CareCentrix and the Provider may exercise their option to terminate the Provider Agreement in accordance with the terms of the Provider Agreement. In addition, CareCentrix may terminate the Provider Agreement or a location under the Provider Agreement in the event that Provider or a Provider location fails to comply with CareCentrix credentialing or other requirements. In the event of a termination, the Provider must comply with the Provider’s post termination continuity of care obligations as specified in the Provider Agreement, this Provider Manual and applicable law. The Provider Agreement rates will apply to authorized covered services provided during the post termination continuity of care period. Provider shall provide a list of patients currently on service at the time of the notice of termination, with a description of the services they are receiving. Provider will maintain a professional attitude regarding CareCentrix to patients and the community, regardless of the reason for the contract termination. Provider shall assist in transitioning the care of patients whose services will continue beyond the continuity of care period to new CareCentrix Network Providers (e.g., provide a case summary and status upon discharge; provide all necessary documentation (including current prescriptions) to CareCentrix or the new Provider). In the event that Provider wishes to appeal the termination of the Provider’s Contract, Provider may submit a request for an appeal, along with supporting documentation, to their Network Management Representative.

Your appeal must be received by CareCentrix within 30 days from the date of CareCentrix’s termination notice or the period of time required by law and accrediting body requirements if longer. Your appeal will be handled in accordance with any appeal processes required by applicable law and accrediting body requirements. We will endeavor to complete our review of your appeal within 30 calendar days of the date we receive your appeal or the period of time required by applicable law or accrediting body requirements if shorter. We will communicate the results of our review of your appeal in writing. If you are dissatisfied with the results of your appeal, you may request that the termination be reviewed in accordance with the Dispute Resolution and Binding Arbitration provisions set forth above.
7-1 CUSTOMER ACKNOWLEDGEMENT AND RESOLUTION MANAGEMENT

Complaint, audit and resolution management allows for the prompt resolution of inquiries, complaints and concerns expressed from an external source, whether that is a member, Provider or other complainant. As a Provider, you are expected to submit patient records or to provide additional information and documentation, as requested and at no charge, so that a complaint or audit may be investigated and resolved. It is important that documents are submitted to CareCentrix within the requested timeframe. If a request for records is received directly from a Health Plan, please notify your CareCentrix Network Management Representative.

Provider specific complaint data is tracked, trended, analyzed and used during the re-credentialing process and to promote ongoing process improvement. If an adverse trend is identified, CareCentrix may initiate appropriate corrective action. This action may be in the form of, but is not limited to, verbal counseling, written warning, a formal corrective action plan or, in the most severe instances, termination from the network. Providers are required to comply with corrective action plans required by CareCentrix to address quality of care, quality of service or other issues related to the Provider’s failure to comply with the Provider’s obligations under the Provider Contract, this Provider Manual, or applicable law.
Massachusetts Managed Medicaid Addendum

The following provisions are added to the Provider Manual to comply with Massachusetts Managed Medicaid requirements. These provisions apply only to services rendered by Providers to patients covered under a Massachusetts Managed Medicaid plan (“MA Medicaid Members”) and only to the extent required by law. To the extent this Addendum applies and there is a conflict between a provision of this Addendum and the base Provider Manual, the provision in this Addendum shall control.

1. Specific information regarding Covered Services for MA Medicaid Members can be obtained by contacting CareCentrix or the applicable Payor listed on the MA Medicaid Member’s insurance identification card.

2. Under the Massachusetts Managed Medicaid Program, MA Medicaid Members have specified rights and shall be allowed to exercise such rights without having their treatment adversely affected. MA Medicaid Members may file a grievance with the applicable Payor if Provider violates any such rights, and such Payor will resolve such grievance in accordance with the Payor’s MA Medicaid Member grievance process. Provider shall cooperate with such process and supply any information required to resolve any such grievance.

3. Provider shall cooperate with the MA Medicaid Member’s Integrated Care Team (ICT) as required by applicable law.

4. MA Medicaid Member health information will be treated as confidential and protected in accordance with applicable law.

5. Provider shall provide assistance to MA Medicaid Members who require language assistance, including providing interpreter services as needed.

6. Provider shall accept and treat all MA Medicaid Members regardless of race/ethnicity, age, English proficiency, gender identity, sexual orientation, health status, or disability.
7. Provider written communications to MA Medicaid Members regarding the services provided hereunder, including marketing materials (if any), must be submitted to CareCentrix for approval prior to distribution.

8. Provider shall make MA Medicaid Members aware of available clinical options and all available care options.

9. Provider may not charge MA Medicaid Members, CareCentrix or the Payor for any service that (a) is not a Medically Necessary Covered Service or non-covered service; (b) for which there may be other Covered Services or non-covered services that are available to meet the MA Medicaid Member’s needs; and (c) where the provider did not explain items (a) and (b) and (c), that the MA Medicaid Member will not be liable to pay Provider for the provision of any such services. Provider shall document compliance with this provision.

10. Provider shall conform to advance directive requirements as defined in 42 C.F.R. § 489.100, and pursuant to 42 C.F.R. § 422.108. CareCentrix and Payors have authority to audit the presence of advance directives in medical records.

11. Prior authorization and/or registration is required for all services provided under the Agreement.

12. New MA Medicaid Members shall have the right to an initial continuity-of-care period as provided under applicable law.

13. MA Medicaid Members have the right to access and correct medical records information maintained by Provider.

14. Updates to policies impacting Provider are communicated through Provider Newsflashes, Provider Manual, and/or the Provider Portal: HomeBridge.

15. Utilization management decisions made by CareCentrix are rendered and communicated in accordance with the process specified in the Provider Manual and timeframes required by applicable law. The frequency of any reauthorization requirement will depend on the services provided and will be identified in the authorization notification.
16. Provider may request a reconsideration of a claim determination in accordance with CareCentrix’s reconsideration and appeals process as specified in the Provider Manual. Appeals of CareCentrix utilization management decisions should be directed to the applicable Payor and will be handled in accordance with such Payor’s appeals process. Other issues will be resolved in accordance with the terms specified in Provider’s contract with CareCentrix.

17. Provider is prohibited from balance billing MA Medicaid Members as specified in the Provider Manual and this Addendum.

18. CareCentrix facilitates communication to and from network providers through Provider Newsflashes, the Provider Portal: HomeBridge and/or periodic provider meetings.

19. Except as otherwise required or authorized by CMS, the Executive Office of Health and Human Services (“EOHHS”) or by operation of law, Providers will receive 30 days advance notice in writing of policy and procedure changes that impact Provider and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and

20. CareCentrix will work in collaboration with network providers to actively improve the quality of care provided to MA Medicaid Members consistent with the quality improvement goals and all other requirements of Payor contracts with CMS and the EOHHS.
Attachment 1 – CareCentrix Code of Ethics and Business Conduct

CareCentrix is committed to conducting business with the utmost honesty and integrity. To that end, this Code of Ethics and Business Conduct has been established for all CareCentrix team members. Downstream entities (as defined by CMS) are also required to adopt and conform to this Code of Ethics and Business Conduct or their own substantially similar Code. A written policy cannot answer all questions associated with appropriate business relationships and conduct. Therefore, if you have any questions about this Code or a particular ethical, compliance or legal situation, you are encouraged to discuss the matter with your manager, Human Resources, our Compliance Officer, or our Legal Department, as appropriate.

Build Trust and Credibility

The success of our business is dependent on the trust and confidence we earn from patients, providers, our customers, other CareCentrix team members, and our shareholders. We gain credibility by adhering to our commitments, displaying honesty and integrity, and reaching company goals solely through honorable conduct. It is easy to say what we must do, but the proof is in our actions. Ultimately, we will be judged on what we do.

When considering any action, it is wise to ask: will this build trust and credibility for CareCentrix? Will it help create a working environment in which CareCentrix can succeed over the long term? Is the commitment I am making one I can follow through on? The only way we will maximize trust and credibility is by answering “yes” to those questions and by working every day to build our trust and credibility.

Respect for the Individual

We all deserve to work in an environment where we are treated with dignity and respect. CareCentrix is committed to creating such an environment because it brings out the full potential in each of us, which, in turn, contributes directly to our business success. We cannot afford to let anyone’s talents go to waste.

CareCentrix is an equal employment/affirmative action employer and is committed to providing a workplace that is free of discrimination and abusive, offensive or harassing behavior. Any team member
who feels harassed or discriminated against or who witnesses harassment or discrimination should report the incident to his or her manager or Human Resources.

Create a Culture of Open and Honest Communication

At CareCentrix, everyone should feel comfortable to speak his or her mind, particularly with respect to ethics and compliance concerns. Managers have a responsibility to create an open and supportive environment where team members feel comfortable raising such questions. We all benefit tremendously when team members exercise their power to prevent mistakes or wrongdoing by asking the right questions at the right times.

CareCentrix will investigate all reported instances of unethical or noncompliant behavior. In every instance where improper behavior is found to have occurred, CareCentrix will take appropriate action. We will not tolerate retaliation against team members who raise ethics or compliance concerns in good faith.

Team members are encouraged, in the first instance, to promptly address ethics and/or compliance issues with their managers or the Human Resources manager, as most problems can be resolved swiftly. If for any reason that is not possible or if a team member is not comfortable raising the issue with his or her manager or Human Resources, the issue should be promptly reported to the CareCentrix Compliance Hotline at 1-877-848-8229 or carecentrix@compliance.com. Incident reports are treated confidentially to the extent possible and information is shared on a need-to-know basis, consistent with conducting a thorough and fair investigation and applicable law. Reports can be submitted anonymously. Failure to timely report a compliance or ethical issue or to cooperate in the investigation of a reported compliance or ethical issue is grounds for appropriate disciplinary action.

The Right Tone at the Top

Management has the added responsibility to demonstrate, through their actions, the importance of this Code. In any business, ethical behavior does not simply happen; it is the product of clear and direct communication of behavioral expectations, modeled from the top and demonstrated by example. Again, ultimately, our actions are what matter.
To make our Code work, managers are responsible for promptly addressing ethical questions or concerns raised by team members and for taking the appropriate steps to deal with such issues. Managers should not consider team members’ ethics concerns as threats or challenges to their authority, but rather as another encouraged form of business communication. At CareCentrix, we want the ethics dialogue to become a natural part of our daily work.

Uphold the Law

CareCentrix’s commitment to integrity begins with complying with applicable laws, rules and regulations where we do business. Further, each of us must have an understanding of our company policies, laws, rules and regulations that apply to our specific roles. If you are unsure of whether a contemplated action is permitted by CareCentrix policy or applicable law, review our policy manual posted on our intranet, applicable desk level procedures, and compliance information supplied by our Compliance Department, including, but not limited to, the information posted on the Compliance tab of our intranet. When additional information is needed, seek advice from an expert, which may include, a manager, Human Resources, Compliance, or our Legal Department. You are responsible for preventing violations of law and for speaking up if you see possible violations.

Competition

We are dedicated to ethical, fair and vigorous competition. We will sell CareCentrix products and services based on their merit, superior quality, functionality and competitive pricing. We will make independent pricing and marketing decisions and will not improperly cooperate or coordinate our activities with our competitors. We will not offer or solicit improper payments or gratuities in connection with the purchase of goods or services for CareCentrix or the sales of its products or services, nor will we engage or assist in unlawful boycotts of particular customers.

Proprietary Information

It is important that we respect the property rights of others. We will not acquire or seek to acquire through improper means a competitor’s trade secrets or other proprietary or confidential information. We will not engage in unauthorized use, copying, distribution or alteration of software or other intellectual property.
Avoid Conflicts of Interest

Conflicts of Interest

We must avoid any relationship or activity that might impair, or even appear to impair, our ability to make objective and fair decisions when performing our jobs. At times, we may be faced with situations where the business actions we take on behalf of CareCentrix may conflict with our own personal or family interests. We owe a duty to CareCentrix to advance its legitimate interests when the opportunity to do so arises. We must never use CareCentrix property or information for personal gain or personally take for ourselves any opportunity that is discovered through our position with CareCentrix.

Here are some ways in which conflicts of interest could arise:

1. Hiring, promoting or transferring a family member or someone with whom you have a personal relationship if doing so would create a supervisory team member/subordinate relationship or the appearance of any other potential or actual conflict of interest.

2. Working as a team member or consultant or serving as a board member for an outside commercial company/organization which might conflict with your obligations to CareCentrix.

3. Owning (you or an immediate family member) a significant financial interest in any business that does business with, seeks to do business with or competes with CareCentrix. “Significant financial interest” is ownership of more than one percent of the outstanding securities/capital value of a business entity.

4. Placing CareCentrix business with a firm in which you or an immediate family member has a financial or other material interest.

Determining whether a conflict of interest exists is not always easy to do. Team members with a conflict of interest question should seek advice from management. Before engaging in any activity, transaction or relationship that might give rise to a conflict of interest, team members must seek review from their managers, the Legal Department, or the Compliance Department. Some unique situations may qualify as an exception to this policy. Any exceptions must be approved in writing in advance by the CareCentrix Legal Department or Compliance Department.
Gifts, Gratuities and Business Courtesies

CareCentrix is committed to competing solely on the merit of our products and services. We should avoid any actions that create a perception that favorable treatment of outside entities by CareCentrix was sought, received or given in exchange for personal business courtesies. Business courtesies include gifts, gratuities, meals, refreshments, entertainment or other benefits from persons or companies with whom CareCentrix does or may do business. We will neither give nor accept business courtesies that constitute, or could reasonably be perceived as constituting, unfair business inducements that would violate law, regulation or polices of CareCentrix or its customers, or would cause embarrassment or reflect negatively on CareCentrix’s reputation.

Accepting Business Courtesies

Most business courtesies offered to us in the course of our employment are offered because of our positions at CareCentrix. We should not feel any entitlement to accept and keep a business courtesy. Although we may not use our position at CareCentrix to obtain business courtesies, and we must never ask for them, we may accept unsolicited business courtesies that promote successful working relationships and good will with the firms that CareCentrix maintains or may establish a business relationship with.

Team members who award contracts or who can influence the allocation of business, who create specifications that result in the placement of business or who participate in negotiation of contracts must be particularly careful to avoid actions that create the appearance of favoritism or that may adversely affect the company’s reputation for impartiality and fair dealing. The prudent course is to refuse a courtesy from a supplier when CareCentrix is involved in choosing or reconfirming a supplier or under circumstances that would create an impression that offering courtesies is the way to obtain CareCentrix business.

Meals, Refreshments and Entertainment

We may accept occasional meals, refreshments, entertainment and similar business courtesies that are shared with the person who has offered to pay for the meal or entertainment, provided that:

- They are not inappropriately lavish or excessive.
• The courtesies are not frequent and do not reflect a pattern of frequent acceptance of courtesies from the same person or entity.

• The courtesy does not create the appearance of an attempt to influence business decisions, such as accepting courtesies or entertainment from a supplier whose contract is expiring in the near future.

• The team member accepting the business courtesy would not feel uncomfortable discussing the courtesy with his or her manager or co-worker or having the courtesies known by the public.

**Gifts**

Team members may accept unsolicited gifts, other than money, that conform to the reasonable ethical practices of the marketplace, including:

• Flowers, fruit baskets and other modest presents that commemorate a special occasion.

• Gifts of nominal value, such as calendars, pens, mugs, caps and t-shirts (or other novelty, advertising or promotional items).

Generally, team members may not accept compensation, honoraria or money of any amount from entities with whom CareCentrix does or may do business. Tangible gifts (including tickets to a sporting or entertainment event) that have a market value greater than $100 may not be accepted unless approval is obtained from management.

Team members with questions about accepting business courtesies should talk to their managers, Human Resources, our Legal Department or our Compliance Department.

**Offering Business Courtesies**

Any team member who offers a business courtesy must assure that it cannot reasonably be interpreted as an attempt to gain an unfair business advantage or otherwise reflect negatively upon CareCentrix. A team member may never use personal funds or resources to do something that cannot be done with CareCentrix resources. Accounting for business courtesies must be done in accordance with approved company procedures.
Other than to our government customers, for whom special rules apply, we may provide nonmonetary gifts (i.e., company logo apparel or similar promotional items) to our customers. Further, management may approve other courtesies, including meals, refreshments or entertainment of reasonable value, provided that:

- The practice does not violate any law or regulation or the standards of conduct of the recipient’s organization;
- The business courtesy is consistent with industry practice, is infrequent in nature and is not lavish; and
- The business courtesy is properly reflected on the books and records of CareCentrix.

Set Metrics and Report Results Accurately

**Accurate Public Disclosures**

We will make certain that all disclosures made in financial reports and public documents are full, fair, accurate, timely and understandable. This obligation applies to all team members, including all financial executives, with any responsibility for the preparation for such reports, including drafting, reviewing and signing or certifying the information contained therein. No business goal of any kind is ever an excuse for misrepresenting facts or falsifying records.

Team members should inform Executive Management and the Legal Department if they learn that information in any filing or public communication was untrue or misleading at the time it was made or if subsequent information would affect a similar future filing or public communication.

**Corporate Recordkeeping**

We create, retain and dispose of our company records as part of our normal course of business in compliance with all CareCentrix policies and guidelines, as well as all regulatory and legal requirements and, if applicable, all legal holds.
All corporate records must be true, accurate and complete, and company data must be promptly and accurately entered in our books in accordance with CareCentrix’s and other applicable accounting principles.

We must not improperly influence, manipulate, mislead or interfere with any auditor engaged to perform an audit of CareCentrix books, records, processes or internal controls.

**Accountability**

Each of us is responsible for knowing and adhering to the values and standards set forth in this Code and for raising questions if we are uncertain about company policy. If we are concerned whether the standards are being met or are aware of violations of the Code, we must contact the Human Resources Department, the Compliance Hotline, or the Legal Department.

CareCentrix takes seriously the standards set forth in the Code, and violations are cause for disciplinary action up to and including termination of employment.

**Be Loyal**

**Confidential and Proprietary Information**

Integral to CareCentrix’s business success is our protection of confidential company information, as well as nonpublic information entrusted to us by team members, customers and other business partners. Confidential and proprietary information includes such things as pricing and financial data, customer names/addresses or nonpublic information about other companies, including current or potential supplier and vendors. We will not disclose confidential and nonpublic information without a valid business purpose and proper authorization.

**Use of Company Resources**

Company resources, including time, material, equipment and information, are provided for company business use. Nonetheless, occasional personal use is permissible as long as it does not affect job performance or cause a disruption to the workplace.
Team members and those who represent CareCentrix are trusted to behave responsibly and use good judgment to conserve company resources. Managers are responsible for the resources assigned to their departments and are empowered to resolve issues concerning their proper use.

Generally, we will not use company equipment such as computers, copiers and fax machines in the conduct of an outside business or in support of any religious, political or other outside daily activity, except for company-requested support to nonprofit organizations. We will not solicit contributions nor distribute non-work related materials during work hours.

In order to protect the interests of the CareCentrix network and our fellow team members, CareCentrix reserves the right to monitor or review all data and information contained on a team member’s company-issued computer or electronic device, the use of the Internet or the CareCentrix intranet. We will not tolerate the use of company resources to create, access, store, print, solicit or send any materials that are harassing, threatening, abusive, sexually explicit or otherwise offensive or inappropriate.

Questions about the proper use of company resources should be directed to your manager.
<table>
<thead>
<tr>
<th>#</th>
<th>√</th>
<th>Please include the following documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>Current license</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Accreditation letter, including certification with accredited location listed, services and effective date of accreditation</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Medicare site survey, including any revisit survey and plan of correction letter from the state, if applicable (for THH only)</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Insurance Certificate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- General liability: $1M/$3M each occurrence &amp; aggregate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Professional liability: $1M/$3M each occurrence &amp; aggregate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fidelity Bond</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- <strong>CareCentrix listed as a certificate holder</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- All locations covered under the insurance should be listed on the certificate or the certificate should indicate it covers all subsidiaries</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Current copy of performance improvement</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>Results from performance improvement activities (patient satisfaction survey results, completed patient surveys or meeting minutes are acceptable, upon network renewal</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>Coverage area, list by county and zip code – <strong>in excel Zip Code List</strong> - If you cover the entire county, please type “all” under zip codes. If not, please list all zip codes covered. For assistance with zip codes by county, go to the following website: <a href="http://www.melissadata.com/lookups/countyzip.asp">http://www.melissadata.com/lookups/countyzip.asp</a></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>Medicare &amp; Medicaid numbers on application</td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>NPI, taxonomy numbers, and Tax ID on application</td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>Professional liability form. Please sign and date the form. <strong>Please note that, if the page is not applicable, you still must sign and date the form and indicate N/A.</strong></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>W-9, signed and dated</td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>Provider agreement. Please sign and return all pages of the signed contract including the regulatory addenda. Leave the effective date blank on the first page of the agreement.</td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td>Fee schedule must be in excel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. (Tab 1) <strong>Fee Schedule</strong> - write next to any items you do not provide in the column provided (if not applicable, you must indicate N/A)</td>
</tr>
</tbody>
</table>
# CREDENTIALING APPLICATION 2018

- **Initial Application**
- **Re-Cred Application**
- **Facility ID:**

## Section I.
Please complete all sections of this application

| Legal Name: ____________________________ | DBA: ____________________________ |
| Rendering NPI#: ______________________ |
| Tax ID #: ______________________________ |
| Street address: ________________________ | City: ____________________________ | State: ______ |
| Zip: _______________________________ |
| Business Telephone No.: _________________ | Business Fax No: __________________ |
| Company Website (URL): ________________ |

| Remit to Address: ____________________ | City: ____________________________ | State: ______ |
| Zip: _______________________________ |
| Billing NPI#: ________________________ |

**Language Capabilities:** 1. ___________________ 2. ___________________ 3. ___________________

- If multiple languages spoken attach list to application: (Label attachment – Language other)
- Interpreter Service Available
- American Sign Language
- Text Telephony (TTY)

## Hours of Operation:

<table>
<thead>
<tr>
<th>Day:</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## On Call Arrangements:

- Answering Service
- Live Clinician
- Voicemail
- 24 Hour on Call

## Coverage Area: ____________________________

**Type of provider:** (select the service(s) that you will provide)

- Home Health Agency
- Home Infusion Provider
- Home Medical Equipment
- Registry/Staffing
- Respiratory Therapy
- Orthotics /Prosthetics
- Home Sleep Studies
- Ambulatory Infusion Suite
☐ Other: Specify:

Please answer Yes or No to each question.

If you are an Orthotics/Prosthetics provider:
Is your office accessible for people with disabilities? ☐ Yes ☐ No
Is your office accessible to public transportation? ☐ Yes ☐ No

Are you accepting new patients? ☐ Yes ☐ No
Can you service pediatric patients ☐ Yes ☐ No
Are there any age limitations? ☐ Yes ☐ No Minimum Age: ___ Maximum Age: ___
Are there any gender restrictions? ☐ Males only ☐ Females only ☐ Both/ no restrictions

Please describe any other patient limitations: _____________________________________________

☐ Other: Specify: ________________________________________________________________

Owned By (Check all that apply): ☐ Hispanic ☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Veteran ☐ Disabled Veteran ☐ Female ☐ Male

Are you equipped to provide services for patients with:
☐ HIV/ AIDS ☐ Chronic Illness ☐ Physical Disability
☐ Mental Disability ☐ Co-occurring Disorder ☐ Homelessness
☐ ADD/ ADHD ☐ Deafness ☐ Epilepsy
☐ Autism ☐ Developmental Delay ☐ Speech & Language Impairments
☐ Blindness ☐ Down syndrome ☐ Traumatic Brain Injury
☐ Cerebral Palsy ☐ Dyslexia ☐ Other_________

Section II. Location Contacts

Credentialing Contact Name and Title: ______________________________
Phone Number: __________________________ Fax No: ______________________________
E-mail address: __________________________

For providers in California, written permission is required to use your office email address for patient communication consistent with California privacy law. If you approve the use of your office email, check YES_____ or NO _________ sign and date below.
Date __________ Approved by: ________________ Signature: ________________

Provider Portal Administrator Contact Name and Title:

Phone Number: __________________________ Fax No: ______________________________
E-mail address: __________________________

Electronic Data Interchange (EDI).
For electronic claims submission, you or your clearinghouse must be partnered with either Change Healthcare, Availity or Waystar. If you are currently not using a clearinghouse, contact Availity at 1-800- AVAILITY, Change Healthcare at 1-866-369-8805 or Waystar at 1-844-4WAYSTAR. The contact listed below will receive a complete listing of the locations that CareCentrix currently has on file with additional directions on successfully completing the CareCentrix EDI implementation process.

**Name of Clearinghouse:**
- [ ] Change Healthcare
- [ ] Availity
- [ ] Waystar
- [ ] Other – Specify (clearing house must interface with Change Healthcare, Availity or Waystar)

**EDI Contact Name and Title:**
- Phone Number: __________________________
- Fax No: __________________________
- E-mail address: __________________________

**Secure Email Communications:**
- Primary Technical Contact: ____________________
- Email Domain(s): __________________________

**Secure Email Method Preference:**
- [ ] TLS (*Transport Layer Security*)
- [ ] CRES (*Cisco Registered Envelope Service*)

**Section III.** Please complete and include supporting documentation for each section

**A. Accreditation:**
- Please check applicable accreditation & include effective date and last survey date:

<table>
<thead>
<tr>
<th>Type of Accreditation</th>
<th>Effective Date</th>
<th>Last Survey Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>AASM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CARF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HQAA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JCAHO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NABP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>URAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If other: specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. **Licensure:**

Please check applicable license and attach a copy:

<table>
<thead>
<tr>
<th>✓</th>
<th>Type of License</th>
<th>License Number and State</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drug Enforcement Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fitters licensure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Health Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home Sleep Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other - Specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxygen License</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**

I. If a main site covers a branch and the branch is not listed on the certificate, the license must be accompanied with a letter from the state verifying that the branch is covered under the main license.

II. If you provide traditional home healthcare and you are not accredited or Medicare Certified, please attach a copy of your last state licensure survey.

III. If you are servicing additional states from your location, please attach a copy of the license to the back of the application.

C. **Medicare / Medicaid:**

Please check applicable certification & include a copy of the last survey with plan of correction and acceptance letter

<table>
<thead>
<tr>
<th>✓</th>
<th>Type of Certification</th>
<th>Identification #</th>
<th>Last Survey Date</th>
<th>Effective Date</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare Part A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Part B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. **Insurance:**

Please attach copies of your current coverage; include liability limits and certificate expiration date

<table>
<thead>
<tr>
<th>✓</th>
<th>Type of Coverage</th>
<th>Limit (aggregate / each occurrence)</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Malpractice/ Professional Liability</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fidelity Bond - Crime coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Umbrella Policy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section IV: Disclosure Questions

Please answer Yes or No to each question (if not applicable, you must write N/A)
If there is a professional liability claim, you must explain it on the Professional Liability Form (section VI)
If the answer requires explanation, please submit a detailed explanation on separate sheet.

<table>
<thead>
<tr>
<th>Management and Organization</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your organization maintain bylaws, charter, articles of incorporation or constitution that delineate legal authority and responsibility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your organization maintain written agreements to define the nature and scope of services provided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is your organization in compliance with state and federal employment laws?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has your organization or any employee in your organization ever been involved in any malpractice, suits or decisions within the past six (6) years? If yes, explain and complete the attached Professional Liability Form.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has your organization been involved in any sanctions, investigations, or limitations of any kind imposed by any healthcare institution, professional healthcare society, Medicare, Medicaid, accrediting organization, managed care organization, Better Business Bureau or regulatory authority within the past five (5) years and/or have any complaints been filed with such institutions, societies, or authorities about your organization within the past five (5) years? If yes, please explain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has your organization or any of its employees, owners, directors or officers ever been named as a defendant in a criminal action or civil false claims action within the past five (5) years? If yes, explain and complete attached Professional liability form.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Has your organization’s insurance ever been denied or terminated by a carrier? If yes, explain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have your organization’s employees completed cultural competency training? If yes, please attach a copy of the document.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Does your organization perform random drug screening on employees for illegal drug use?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10. **Has there ever been any investigation or action taken against your organization’s state license?**
   
   \textit{If yes, explain}

11. **Has your organization’s license to practice or do business, or your participation in Medicare, Medicaid or any managed care organization ever been suspended, revoked, modified or terminated?**
   
   \textit{If yes, explain and label your response as Section: IV Q#11.}

<table>
<thead>
<tr>
<th>Quality Improvement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. <strong>Does your organization have a written Performance Improvement, Quality Improvement or Quality Control program that is consistent with JCAHO / CHAP / CARF / ACHC standards?</strong> Please attach copy of your QI policy and label as Section: IV Q#12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. <strong>Does your organization have a formal client satisfaction survey process?</strong> Attach a copy of the survey tool and label as Section: IV Q#13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. <strong>Do you monitor and track performance improvement activities (patient satisfaction survey results, completed patient surveys or meeting minutes)?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. <strong>Is your organization in compliance with the HIPAA and applicable state privacy requirements?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. <strong>Is patient/caregiver education provided and documented in the medical record?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. <strong>Do you have documentation of interdisciplinary communication based on patient’s clinical status?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. <strong>Are periodic patient assessments performed and communicated to the physician?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. <strong>Do you have an Emergency Preparedness Plan specific to your locale and service types that all personnel understand and can implement if required?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. <strong>Do you have an inventory control process to manage the utilization of medication, supplies and equipment?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
21. **Do you conduct criminal background checks or criminal history screening of all your employees?**

22. **Does your organization take fingerprints of your employees?**

<table>
<thead>
<tr>
<th>Personnel Practices</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. <strong>Does your organization maintain current written job descriptions for all employees?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. <strong>Does your organization maintain documentation of qualifications to perform specific job responsibilities, e.g., discipline-specific skills checklist? Can you verify and provide, upon request, documentation as required for each specific job?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. <strong>Does your organization have written personnel policies/procedures, e.g., employee handbook?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. <strong>Do you maintain current and complete personnel records for owners and staff?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. <strong>Does your organization maintain personnel files that include signed acknowledgement of a written confidentiality and conflict of interest policy?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. <strong>Do all of your organization’s employees receive HIPAA compliance education upon hire and annually thereafter?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. <strong>Does your organization verify and document, and can you provide upon request, all appropriate licenses or certifications as required for each specific job/profession?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. <strong>Does your organization require and maintain a record of all health status checks e.g. TB skin tests, chest X-rays, hepatitis immunization, for all staff as required by both state and federal regulations?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. <strong>Does your organization identify classifications of employees required to maintain CPR certification?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. <strong>Does your organization maintain documentation of employee orientation training, ongoing in-services and other continuing education?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. <strong>Does your organization check and document applicant employment history and references?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>34.</strong> Does your organization verify possession of a current driver’s license and automobile insurance coverage for all appropriate employees?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>35.</strong> Do you have a completed I-9 immigration form for every applicable employee?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>36.</strong> Is the I-9 form updated every three years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>37.</strong> Are your organization’s personnel practices consistent with an Equal Employment Opportunity and Affirmative Action philosophy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>38.</strong> Does your organization have a credentialing process in place for all licensed health practitioners employed or contracted by your organization, including part-time and full-time practitioners?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>39.</strong> Does your credentialing process above include, at a minimum, a review and verification of credentials at least every 2-3 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>40.</strong> Does your organization discriminate or exclude individuals from service on the basis of race, color, national origin, gender, or handicap?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>41.</strong> Do you run monthly sanction checks on all of your employees and permitted contractors? If no, please explain and label your response.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Records</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>42.</strong> Are the organization’s patient records maintained for all patients and all services rendered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>43.</strong> Does your organization document multi-disciplinary care conferences and care coordination with other providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>44.</strong> Does your organization maintain a copy of written patient discharge instructions in closed medical records when appropriate for patients with ongoing health care or psychosocial needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>45.</strong> Does your organization have physician orders or prescriptions for each patient and for all services and products provided as required by law?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>46.</strong> Does your organization have a designated infection control program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>47.</strong> Does your organization have a designated safety program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>48.</strong> Does your organization document follow up to blood borne pathogen exposure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>49.</strong> Are infection rates tracked and reported?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Provider Rights

Providers have the right to review information obtained by CareCentrix from any outside primary source agency to evaluate the provider’s credentialing. CareCentrix will provide such information to the provider upon request. If a provider believes that any of the information obtained from a primary source is erroneous, the provider has the right to correct such information by providing a written explanation to CareCentrix detailing the error within fourteen (14) days of the date the provider received the information from CareCentrix or such longer period of time required by law. The CareCentrix Credentialing file will then include such explanation as part of the credentialing process.

CareCentrix does not discriminate on the basis of race, religion, national origin, color, sex including gender identity, age, veteran status, disability, health status, source of payment or any other unlawful basis. All qualified providers will be given equal opportunity, and credentialing decisions are based on the applicant’s qualifications.

This application shall be construed in accordance with applicable law. To the extent any question in the application is not permitted under applicable law, the provider shall not be required to respond to the question.

Credentialing Appeals

Providers may appeal an adverse credentialing or re-credentialing decision by submitting a request for appeal in writing to CareCentrix within thirty (30) calendar days of the provider’s receipt of notice of the adverse credentialing decision or the period of time required by applicable law if longer.

CareCentrix will complete its review of the provider’s appeal within thirty (30) calendar days of the date the appeal is received by CareCentrix or the period of time required by applicable law or accrediting body requirements if shorter. The results of the review will be communicated to the provider in writing.
Section V: AUTHORIZATION AND CERTIFICATION STATEMENT

In conjunction with the credentialing process, the Applicant authorizes CareCentrix and its representative(s) to:

- Consult with any third party who may have information regarding the Applicant’s professional qualifications, credentials, clinical or service delivery competence or any other matter reasonably having a bearing on the Applicant’s ability to satisfy credentialing requirements.
- Inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures, including without limitation, that relate to credit history or financial standing by or from third parties that may be relevant to determining Applicant’s qualifications and/or performance.
- Review historical claims information with data specific to the Applicant’s qualification and/or performance.
- Release said information, as stated above, to payers, hospitals, other healthcare providers and their agents who solicit such information for the purpose of evaluating the Applicant’s qualifications.
- Conduct site visits at the Applicant’s site to determine the adequacy of facilities, office/branch procedures and related compliance to Network standards and to obtain information from the Applicant’s present and past professional liability insurance carrier(s).

The Applicant authorizes third parties to release to CareCentrix and its Representatives all communications, reports, records, statements, documents, recommendations or disclosures as may be relevant to determine whether Applicant satisfies CareCentrix credentialing requirements.

The Applicant certifies that the facts in all parts of this completed application are accurate and complete to the best of the applicant’s knowledge and understands that, if approved as a Network provider, falsified statements and/or responses on this application may be grounds for dismissal, contract termination and/or other legal action if indicated. The Applicant further certifies that the Applicant will notify CareCentrix immediately in the event that any of the information in the completed application changes.

The applicant and CareCentrix mutually agree that the application information and materials being received by either party are confidential and are intended for use only as explicitly stated above. Any other use of information and materials by either party is expressly prohibited.

________________________________________  ______________________________________
Authorized Signatory’s **Printed** Name                Title

________________________________________  ______________________________________
Authorized **Signature**                       **Date**
Section VI. In the Section below please provide detailed information about any liabilities against any of your agency’s locations, then sign and date. If there are no liabilities against any of your agency’s location, please write N/A on the first line, then sign and date.

Professional Liability Form

| Legal Name: | _________ |
| City: | _______________________ | State: | _______________________
| Rendering NPI#: | ____________________________ |

*Please complete the following information for EACH pending, settled or concluded professional liability lawsuit or arbitration file served against your agency in which you were named a party within the past six (6) years regardless of any payment made on your behalf by any Insurer. Note: Failure to provide this information will result in your application being Pended.

| Date of Occurrence: | _________ | Carrier Involved: | ____________________________ |
| What is the current status of the case? | | If damages were paid, either by settlement or court award, what was the amount on your behalf? |
| ☐ Pending | | Amount paid on your behalf: $__________ |
| ☐ Settled Out of Court | | Amount paid by all parties: $__________ |
| ☐ Found for Plaintiff | | Was the amount paid by the ☐ carrier or ☐ entity? |
| ☐ Dropped | | |
| ☐ Dismissed | | |
| ☐ Found for Defendant | | |

1) Specify the alleged claim of harm to the patient? ________________________________

________________________________________________________________________________

2) What is the nature of the allegations against your agency? ________________________________

________________________________________________________________________________

3) Provide any other details that are pertinent to the case. ________________________________

________________________________________________________________________________

4) Identify any other named parties in the case. ________________________________

________________________________________________________________________________
5) If the case is closed or settled – please briefly describe Corrective Actions taken by the agency to prevent re-occurrence:

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Authorized Signatory’s Printed Name              Title

Authorized Signature                            Date