Provider Manual

EDRC 983R. 052025

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1-1 KEY CONTACTS/RESOURCES

HomeBridge® Provider Portal

Reason for Contact	Resource	Contact Information
HomeBridge®		
Admin Accounts: Create or Unlock	Provider Relations contact	Provider Experience Contact Look-up
User Accounts: Create, Reset or Unlock	Portal Administrator at your agency	Portal Administrator at your agency
Portal Related Questions	HomeBridge® Info Box	PortalInfo@carecentrix.com
Service Registration/Pre-Notification and Prior Authorization Requests		
Initial Services	HomeBridge® provider portal	www.carecentrixportal.com
Add-on Services		
Continuation of Services		
Corrections		
Status		
CareCentrix Direct		
Claims Status, Inquiries, Forms & EDI/EFT/ERA Registration		
Claim Inquiries	HomeBridge® provider portal	www.carecentrixportal.com
Claims Status		
Reconsideration and Appeals Forms		
Register for EDI		
EFT & ERA Enrollment		

General

Reason for Contact	Resource	Contact Information
Communicating with CareCentrix		
Claims Questions **Appeals & Reconsideration Status**	Blue Cross® Blue Shield® Michigan (BlueCross) Blue Care Network of Michigan (BCN)	Home Infusion: (833) 409-1288
	Sentara® Health Plans	Home Infusion: (833) 592-1091 Home Sleep: (833) 592-1092
	Wellcare®	(833) 409-1284
	Network Services Team (NST) – All other plans	(877) 725-6525
Rejection Questions	EDI Support Team	EDISupport@carecentrix.com
Provider Information Updates	Credentialing Department	Contract.Department@carecentrix.com
Patient Transitions	Transition Team	(866) 776-4617
Compliance Concerns	Compliance Hotline	(877) 848-8229
Policies and Processes	Provider Manual	Section 4-3 Utilization Management
Contractual Questions	Contracting contact	Provider Experience Contact Look-up
Patient Financial Responsibility	Patient Services Team	(800) 808-1902 Patient Financial Responsibility FAQ
Infusion Nursing Services	Infusion Nursing Team	(844) 457-9973
Provider Orientation Requests	Provider Services Team	ProviderServices@carecentrix.com

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Key Phone Numbers: Service Requests, Requests for Additional Services, Service Request Corrections

Payor	Phone Number
Mass General Brigham® Health Plan	(866) 827-5861
Blue Cross® Blue Shield® of Michigan (Blue Cross) **Blue Care Network of Michigan (BCN)**	For Home Infusion, reference links below: Blue Cross Medical Benefit Medications BCN Medical Benefit Medications
Fallon Health®	(866) 827-2469
Florida Blue/Truli Health	(877) 561-9910
Florida Blue Sleep	(855) 243-3326
Horizon® Blue Cross® Blue Shield® of New Jersey **Braven Health℠**	(855) 243-3321
Walmart® Specialty Pharmacy	(877) 453-4566
Wellcare®	(833) 409-1284

Provider Experience Contact List

https://help.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 care standards and provide and manage cost-effective health care solutions for the customer 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 CareCentrix positive and successful. To demonstrate this commitment, we have dedicated resources to support your participation in our network, and those resources are discussed further in this manual.

Valuable Provider Resources

Prior Authorization and Pre-Notification/Registration Tool – Our comprehensive and easy to use tool for providers to quickly identify which HCPCS codes require registration and/or prior authorization through CareCentrix (does not include out-of-state Blues Plan).

CareCentrix Billing Crosswalk – Identify appropriate HCPCS/Modifier combinations to help with billing for each health plan. Remember to refer to your contract to ensure you are selecting the right combination that you are contracted for.

Patient Financial Responsibility FAQ – Answer to frequently asked questions on member billing.

BCBS Pre-Fix Identification Tool – By entering in a member's 3-digit alphanumeric pre-fix found on their member ID card, our tool will route you to the member's home plan, where you can find that plan's medical policies.

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Out-of-State Blues Plan FAQ and Out-of-State Blues Plan QRG – These two documents will help providers understand the fundamentals of out-of-state Blues Plans and enables successful coordination of care for this member population and billing.

About This Provider Manual

This manual is updated periodically and 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 HomeBridge® provider portal 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 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 offers value-based home solutions to payors and health systems to help more of their members access the home care they need, when they need it. Through a single platform, CareCentrix coordinates multiple, complex home care needs for over 16 million members through a national network of approximately 6,700 provider locations, resulting in a simplified patient and physician experience. For over 25 years, CareCentrix's focus on the whole person has improved continuity of care, reduced unnecessary readmissions and unnecessary emergency department utilization, and delivered positive financial results for health plans. CareCentrix is a wholly owned subsidiary of Walgreens Boots Alliance®. For more information, please visit www.carecentrixportal.com.

Our Products and Services with Managed Networks

Durable Medical Equipment (DME) – 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 and diabetic supplies, wound care, and mobility), enteral equipment, foods (enteral pumps and medical foods), and orthotics/prosthetics.

Home Infusion Therapy – Home Infusion Therapy services include the provision of drugs, supplies and nursing administration to support infusion therapy in the home or Ambulatory Infusion Suites (AIS) of the home infusion provider. This includes coordination for both specialty pharmacy products and acute services required for post discharge such as anti-infective, catheter care and hydration.

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Home Health – The Home Health solution 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 solution focuses on care coordination and providing a quality, lower cost solution to diagnostic testing at the most appropriate site of service. In addition, iComply, a CareCentrix proprietary technology drives member adherence to therapy through proactive member engagement and support.

These products and services will be discussed in greater detail in SECTION 5-2: GUIDELINES SPECIFIC TO PROVIDER SPECIALTY.

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 website, 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 team members 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, a Walgreens Boots Alliance® company, has adopted a Code of Conduct and Ethics. Click here to review our Code of Conduct and Ethics. Network providers must adopt a Code of Conduct and Ethics that complies with applicable law and is consistent with CareCentrix's Code of Conduct and Ethics.

As specified in our Code of Conduct and Ethics, 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 customers' interests, providers must seek review from CareCentrix by contacting our Compliance Hotline by phone at 1 (877) 848-8229 or via email at Compliance@carecentrix.com.

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 reported is entitled to a

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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 qualifying services, 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 submission 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 by phone at **1 (877) 848-8229** or via email at Compliance@carecentrix.com.

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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 reporter. This policy is not intended to protect any individual giving a report which CareCentrix believes is fabricated, distorted, or exaggerated to either injure someone else or to protect reporting individual or others.

The CareCentrix Compliance Department is responsible for investigating the report. Information obtained during 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/or 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 violated 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.

Government Plans Model of Care Training Requirement

Providers that render services to patients covered under a Medicare Advantage and/or Dual Eligible Special Needs Plan (D-SNP) must conform to CMS training requirements. Provider employees and any permitted subcontractors must complete the CMS fraud, waste and abuse and general compliance training modules posted on the CMS website as required by CMS. Providers that render services to D-SNP members must also complete CareCentrix Model of Care training posted on the HomeBridge® provider portal. The training required by CMS must be completed at the time of hire or contracting and annually thereafter, and providers 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

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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, 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 Provider Agreement with CareCentrix.

Additionally, CareCentrix maintains relationships with third-party vendors to perform claim audits for specific health plans. See links below for additional information on these relationships and processes:

- Blue Cross® Blue Shield® of Michigan Home Infusion Therapy Claims Payment Integrity Vendor

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

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 two (2) calendar days prior to discharge or the second to last day of service if Home Health is not provided daily, except when the patient meets an exception to the NOMNC requirements. **IMPORTANT!** 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 of any additional Home Health services required due to the provider's failure to timely deliver a

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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 receive a NOMNC.
  - When a patient never received Medicare covered care in one of the covered settings.
  - When a service is being reduced (e.g., home health agency providing both physical therapy and occupational therapy and discontinues the occupational therapy).
  - 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)).
  - When a patient has exhausted his/her benefit.
  - 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).
  - When a patient transfers to another provider at the same level of care.
  - 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 the designated CareCentrix NOMNC fax line for the patient's plan.

Please be aware that CareCentrix may audit your records for NOMNC compliance. For more information about NOMNC requirements, including the appropriate form, signature requirements, and CareCentrix NOMNC fax lines, refer to the NOMNC training presentation posted on our HomeBridge® provider portal and the CMS website. 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.

Data Breach Notification

Providers are required to notify the CareCentrix Compliance Hotline at (877) 848-8229 or at Compliance@carecentrix.com within two (2) business days of discovering any data breach impacting the provider's systems and/or data. Such notification shall include, to the extent known, the following information:

- Date the data breach occurred and date it was discovered;
- A description of the data breach, including its cause;
- Whether CareCentrix health plan client member data was impacted and, if so, which health plan clients were impacted and how many of their members were impacted;
- Mitigation steps taken to contain the data breach; and
- Such other information as CareCentrix may reasonably request.

If any such information is not known at the time of the initial notice of data breach, provider will provide the information to CareCentrix as soon as it is known. Once the data breach has been contained and provider's systems have been secured, provider will supply CareCentrix with a written attestation from a

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third-party security company, or other party acceptable to CareCentrix, attesting to the resolution of the breach and the security of provider's systems. Failure to timely notify CareCentrix of any data breach or to provide the information required above may result in disciplinary action, which may include termination of the Provider Agreement.

2-1 PROVIDER PERFORMANCE STANDARDS

As a participant in the CareCentrix Provider Network, you are required to:

- Provide high quality, compassionate care to patients.
- Effectively and respectfully respond to patient's linguistic, cultural, and other unique needs.
- Accept and treat all patients regardless of race, ethnicity, color, national origin, age, religion, English proficiency, sex, including, sexual orientation and gender identity, health status, source of payment, cost of treatment, participation in a particular health plan customer's benefit agreement, mental or physical disability, or genetic information.
- Monitor and evaluate employee performance and services rendered to patient/members.
- 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 https://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 seven (7) days per week and respond to patient and/or CareCentrix contacts within 30 minutes of call, including weekends, evening, and holidays, unless otherwise specified by contract.
- Submit claims 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 directly for services/products unless directed to do so by CareCentrix in writing.
- Not bill the patient 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 for any Covered Services. Refer to the Provider Agreement for additional details on the limitations on billing patients. The provisions in the Provider Agreement prohibit providers from billing, charging, collecting a deposit from, seeking compensation, remuneration or reimbursement from or having any recourse against patients or persons acting on their behalf for amounts that are the payor's or CareCentrix's obligation are for the benefit of the patient and do not

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prohibit the collection of patient copayment, coinsurance or deductible amounts (the "Member Expenses") owing under the payor's plan when provider is responsible for the collection of Member Expenses.

- Except as provided below, direct patients to the patient's health plan cost estimator tools, website, or member services number when the patient requests an estimate of Member Expenses, the allowable amount, and such other cost and/or quality information pertaining to the services provided under your CareCentrix Provider Agreement that patients are entitled to receive under applicable state and/or federal laws. This will help ensure that patients have access to the information they are entitled to receive under applicable law and the information supplied to them is accurate.
    - For your convenience, below are instructions on where to direct patients to obtain estimates of Member Expenses for each plan and line of business.

Health Plan	Commercial	Medicare
Blue Cross® Blue Shield® of Michigan	BCBSM cost estimator tool.	BCBSM cost estimator tool.
Fallon Health®	Fallon Health cost estimator tool and click: **My Resources -> Sapphire365.**	Direct the patient to CareCentrix at **1 (833) 409-1288, Option 1**
Florida Blue®	Florida Blue cost estimator tool and click: **Find and Get Care -> Compare Medical Costs.**	Florida Blue cost estimator tool and click: **Find and Get Care -> Compare Medical Costs.**
Horizon®	Horizon cost estimator tool.	Horizon cost estimator tool.
Braven Health℠	Braven Health cost estimator tool.	Braven Health cost estimator tool.
Mass General Brigham® Health Plan	MGBHP cost estimator tool and click: **Billing Menu** to create a self-service estimate**.**	Direct the patient to CareCentrix at **1 (866) 827-5861, Option 2**
Sentara® Health Plans	Sentara Health Plans cost estimator tool.	Direct the patient to CareCentrix at **1 (833) 592-1091 for HIT** **1 (833) 592-1092 for Sleep**
Please note: For services reimbursed based on an MSRP rate, regardless of plan or line of business, direct the patient to CareCentrix instead of the health plan's cost estimator tools.		

- If the patient is unwilling to obtain their out-of-pocket estimate using the methods above and provider must supply the patient with an estimate, providers can contact CareCentrix to obtain the estimate.
- In the event a provider does provide an estimate of Member Expenses to a patient that is inaccurate and such estimate results in a patient's refusal to pay the actual amount of the Member Expense identified by their health plan, the following shall apply: (a) in instances where CareCentrix is responsible for collecting the Member Expense, provider shall hold CareCentrix and the member harmless and reimburse CareCentrix the difference between the provider estimate and the actual amount of the Member Expense identified by the health plan; and (b) in instances where the provider is responsible for collecting the Member Expenses, the provider shall hold CareCentrix and the member harmless and shall not collect from the patient the difference between the provider estimate and the actual amount of the Member Expense identified by the health plan.
- Except as otherwise directed by CareCentrix, not, under any circumstance, request Member Expenses.

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- When CareCentrix is responsible for collecting the Member Expenses, CareCentrix contacts the patients directly to bill and collect the Member Expenses. The patient is responsible for remitting those amounts to CareCentrix and providers are paid for authorized Covered Services at the full contracted rate in accordance with the terms of the Provider Agreement.
- When the provider is responsible for collecting the Member Expenses, the provider is paid for authorized Covered Services at the full contract rate less the applicable Member Expenses and in accordance with the terms of the provider contract. In this instance, the provider is responsible for billing the patient for the Member Expenses in accordance with applicable laws, rules and regulations, and the patient is responsible for remitting those amounts to the provider. Neither CareCentrix nor the applicable payor is responsible for any non-payment of the Member Expenses to the provider. Provider shall not waive, discount or rebate (including without limitation fee-forgiving, waiver of cost sharing or purchasing or defraying the cost of insurance or other reimbursement or financial assistance programs), any Member Expense amounts unless expressly permitted under applicable law or program requirement from a governmental authority governing the member's benefits.

The grid below outlines the party responsible for collecting the Member Expenses.

Payor	Provider	CareCentrix
Mass General Brigham® Health Plan		✓
Blue Cross® Blue Shield® of Michigan		✓
Horizon® Blue Cross® Blue Shield® of New Jersey Braven Health℠		✓
Fallon Health®		✓
Florida Blue®		✓
Sentara® Health Plans		✓
Walmart® Specialty Pharmacy		✓
Wellcare®	✓	

- 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 patient's plan, not charge the member for such services unless, in advance of the provision of the services, the patient agrees in writing to accept the financial responsibility for the services.

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- 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 the 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 and/or manufacturer recalls impacting them and facilitate the repair, replacement and/or resolution of the recall according to the guidelines issued by the manufacturer.
- 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 limited to, a spouse, domestic partner, parent, step-parent, child, grandchild, grandparent, and sibling (including natural, step, half or other legally place 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.
- Not bill patients for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by applicable law or health plan program requirements.
- Not bill patients for non-covered services, unless, in advance of the provision of such services, the patient agrees in writing to accept the financial responsibility of such services.

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, member's PHI or other personal information from outside the United States.

3-1 PROVIDER COMMUNICATIONS

CareCentrix is committed to continually supporting our network providers. We have a variety of provider orientation and ongoing training opportunities, communications and resource documents call CareCentrix Resource Connection that are available on the HomeBridge® provider portal. Additionally,

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the Provider Experience Team utilizes ProviderInfo@carecentrix.com to send provider communications from CareCentrix; be sure to mark it as a "SAFE" contact in your email system.

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 HomeBridge® provider portal 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.
- Health plan customer contracts which the provider may service.

Our Customers

Our network customers include Mass General Brigham® Health Plan, Blue Cross® Blue Shield® of Michigan and Blue Care Network® (Michigan), Fallon Health®, Florida Blue®, Horizon® Blue Cross® Blue Shield® of New Jersey, Braven Health℠, Walmart® Specialty Pharmacy, and Wellcare®. You may request a complete and current list of our customers at any time by reaching out to your Provider Relations contact. 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. Some CareCentrix customers have only contracted with CareCentrix to arrange for select home care services. Please reach out to your Contracting contact 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, after receiving your Provider ID and prior to submitting your first request through our HomeBridge® provider portal, please complete the standard CareCentrix Provider Onboarding Training. You have the option to do so either in a live training led by a clinical instructor or in a self-directed training; both last approximately two (2) hours. Your completion of this training is critical to understand how to successfully register services, request authorizations or continuation of service requests, and submit claims. Providers should also review health plan specific trainings also made available on the HomeBridge® provider portal.

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To access the webinar training, go to www.carecentrixportal.com, and click the "Review" button on the "Provider Education and Documentation" section. Locate the "Education Center" on the bottom right and click on the link to the "Provider Onboarding" or your health plan specific reference materials.

HomeBridge® Provider Portal

HomeBridge® (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 gives you access to several self-service tools.

When you access HomeBridge®, you can:

- Submit a pre-notification/register services with CareCentrix
- Request prior authorization for services or continuation of services, if applicable
- Add a service to an existing request
- Edit a request
- Upload clinical documentation
- Look up claim and request status
- Enroll in Electronic Data Interchange (EDI) for electronic claims submission
- Sign up for ERA (Electronic Remittance Advice)/EFT (Electronic Funds Transfer)
- Enroll in CareCentrix Direct
- 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 Blue Cross® Blue Shield® of Michigan and Blue Care Network®, Horizon® Blue Cross® Blue Shield® of New Jersey, Braven Health℠, Florida Blue®, Sentara® Health Plans, Walmart® Specialty Pharmacy, and Wellcare® 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 a replica of their submitted claim within the HomeBridge® provider portal.
- View the 277CA acceptance or rejection information.
- Submit a claim payment reconsideration request, and/or appeal if applicable.
- Submit claim inquiries.

Not using the portal? Register on the HomeBridge® Homepage following the instructions that best describe you below:

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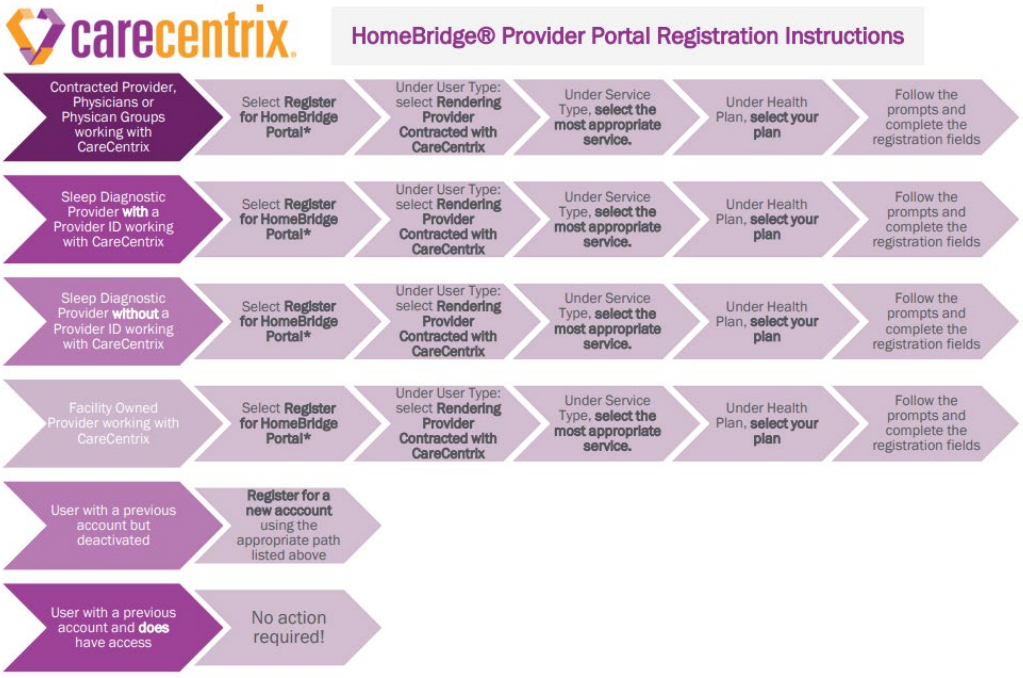

3-2 NATIONAL CREDENTIALING COMMITTEE

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 participation in the CareCentrix Provider Network.

Committee Attendance

The Credentialing Committee represents varied specialties from the Home Health care industry and comprises five voting and four 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.

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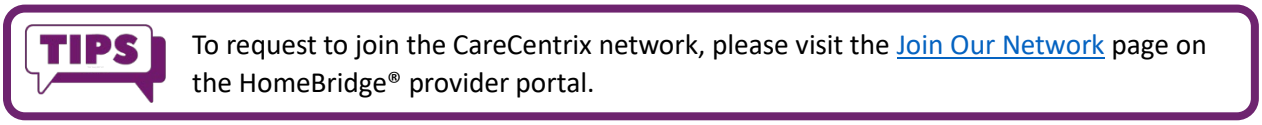
3-3 PROVIDER QUALIFICATION AND QUALITY MANAGEMENT

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, if applicable, a copy of 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, in its sole discretion, 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:
    - The implementation of the plan, analysis, and progress on QI initiatives.
    - The purpose, goals, objectives, and scope of the quality improvement program.
    - The organizational authority, organization of responsibility and general methodology.



A sample copy of our credentialing application and a checklist of materials required to be submitted with the credentialing application is set out in Attachment 1, located at the end of this Provider Manual.

For questions about the credentialing process, please send an email to our Credentialing Department at CredentialingDepartment2@carecentrix.com.

Recredentialing

CareCentrix network providers are recredentialed 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 acquired 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.

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The standard recredentialing process begins approximately six (6) months before the credentialing anniversary. Our recredentialing process requires, but is not limited to, the following:

- Completion of recredentialing application
- Copies of current licensure
- Proof of professional and general liability insurance. Required amounts 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, in its sole discretion, 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 recredentialing process may include 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 Contracting contact 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.

Quality Measurement

We assess the quality of our network providers in a variety of ways including assessing quality against industry, regulatory, and accrediting 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

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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 also take your satisfaction as a participant in the CareCentrix Provider Network seriously. 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 (JOC) 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.

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 immediately but no later than within seven (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 of the following:

- Address(es), including remit to address.
- Telephone number(s) and/or fax number(s)
- Name of key organizational contact(s)
- Name(s) of key local operations contact(s)
- Tax Identification Number
- Days/hours of operations
- Service/product capabilities
- Populations serves (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.

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4-1 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 arranged through the CareCentrix Provider Network. Pre-notification/registration refers to a process where the 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 only pre-notification/registration is required. If delegated, CareCentrix may make approval and denial decisions with respect to those services that require prior authorization. Sections 4-2 and 4-3 below discuss in more detail the pre-notification/registration, staffing and prior authorization processes.

IMPORTANT! Providers contracted with CareCentrix to render Home Health services to Wellcare® Medicare Advantage or Dual Special Needs Plans (D-SNP) members should reference Section 5-2: GUIDELINES SPECIFIC TO PROVIDER SPECIALTY in addition to the requirements outlined in Section 5.

4-2 COORDINATION OF SERVICES

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

1. A Primary Referral Source (i.e., physician, hospital discharge planner, other provider) 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 a Primary Referral Source

Unless otherwise directed, providers must submit a pre-notification/register services with CareCentrix via the HomeBridge® provider portal (www.carecentrixportal.com). For certain services, providers must also secure prior authorization.

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

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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 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 prior authorization review, and, for some other health plans, it is the provider's responsibility to request prior authorization directly from the health plan. 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, request the patient's identification card and verify eligibility and benefits with the patient's health plan prior to rendering any service. Providers must maintain documentation to evidence this verification of eligibility and benefits. CareCentrix does not conduct electronic eligibility and benefit verification and receipt of a Service Registration Form (SRF) is 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 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 rendered. 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, services and/or providers.

CareCentrix Receives Referral from a 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

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electronic application that allows providers to receive referrals quickly and entirely online. Providers who enroll in CareCentrix Direct are offered referrals preferentially to those not enrolled. For information about how to enroll in CareCentrix Direct, please reach out to your Provider Relations contact. 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 coverage area 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 guarantee 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:

1. CareCentrix receives a request for a service or item from the Primary Referral Source.
2. Except with respect to out-of-state Blues Plan members, the referral is either sent out electronically to providers via CareCentrix Direct or telephonic outreach is made to providers.
    a. The provider accepts the referral.
    b. The SRF is faxed to the provider, when applicable. Providers may opt out of receiving faxed SRF and manage all of their services requests online via the HomeBridge® provider portal. For information about how to go paperless, please reach out to your Provider Relations contact.

Regardless of the staffing route, providers must verify eligibility and benefits availability with the health plan prior to rendering any service, equipment, or supply item. Receipt of a SRF is not 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 (SRF), 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 later than twelve (12) hours prior to the agreed start of care if provider is unable to meet that start of care.
- 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.

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- Notify CareCentrix staff of changes in patient/family status within twenty-four (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 forty-eight (48) hours of request by CareCentrix.
- Respond to grievance/complaints filed against the provider within twenty-four (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 timeframes 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 seventy-two (72) hours prior to the expiration of the date span specified in the SRF, but not more than seven (7) days prior to the expiration of the date span specified in the SRF. Requests received prior to that seven (7) day timeframe may be rejected, and you 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 requests for additional services should be made via the HomeBridge® provider portal at www.carecentrixportal.com, or as directed, to the applicable health plan. HomeBridge® identifies the information required to complete such requests. The required information includes, but is not limited to, the following:

- Intake ID
- Patient's Last Name
- Service description or HCPCS code and modifier for services requested.
- Number of requested units, start and stop date of requested services.
- Medical necessity for the service requested.
- Physician orders for all services requested.

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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/or 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 submission by accessing the HomeBridge® provider portal at www.carecentrixportal.com.

Providers can view completed requests made within the last sixty (60) days. The following information is available on HomeBridge®.

- Request type – referral or authorization
- 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
- HIPPS Code, if applicable
- Episode ID, if applicable

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4-3 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 eligibly 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 healthcare 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 insurance 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 the medical coverage policies are also available on the HomeBridge® provider portal at www.carecentrixportal.com.

- Mass General Brigham® Health Plan
  - Diagnosis of Sleep Disordered Breathing in Adults and Children
  - Treatment of Sleep Disordered Breathing in Adults and Children
- Florida Blue® Medical Policies
- Horizon® Blue Cross® Blue Shield® of New Jersey
  - Home Care
  - Post-Acute Care
- Braven Health℠ Medicare Advantage
  - Home Care
  - Post-Acute Care
- Fallon Health® Medical Criteria

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  - Diagnosis of Sleep Disordered Breathing in Adults and Children
  - Treatment of Sleep Disordered Breathing in Adults and Children
- Wellcare®

Health plans update medical coverage policies regularly. Please reference their 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. Neither CareCentrix nor the payor dictate or control clinical decisions with respect to a patient's medical treatment of care. Medical care is the responsibility of the provider regardless of any coverage determination by CareCentrix or the payor. Nothing in the Provider Agreement of this Provider Manual is intended to interfere with communication between provider and a patient regarding the patient's medical condition or available treatment options.
- 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 reviews for services provided to Federal Employee Program (FEP) members or Out-of-state Blues Plan members. For Out-of-state Blues Plan 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 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.

Utilization Management Responsibilities

Providers have the following utilization management responsibilities:

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- 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 twenty-four (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 twenty-four (24) hours.
- Respond to all requests for contact from the health plan case manager within one (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 forty-eight (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 that may be requested by CareCentrix 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, the health plan or a CareCentrix designee 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 and/or inappropriate billing, including recovery through recoupment.

Upon completion of the medical and billing documentation review, CareCentrix or its designee will mail the provider a determination letter stating the finding or no finding and required next steps.

Providers that do not allow CareCentrix or its designee access to or fail to provide the requested documentation within the specified timeframe requested will result in a finding of non-compliance and the provider will be ineligible to submit an appeal for the retrospective claims review determination.

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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.

5-1 SERVICE DELIVERY

To 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. To assist providers with validating timely and quality service delivery, CareCentrix may contact patients by phone, or other method, to validate that requested services were timely delivered and provide feedback to providers 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 Center immediately if unable to continue service delivery to the patient.
- Notify CareCentrix within twenty-four (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:
    - An authorization is given for Ampicillin. When the primary care physician is contacted, the provider is notified of a drug, dosage, or frequency change.
    - An initial referral and authorization are given for diabetic teaching. The provider, upon completing the initial assessment, identifies a need for wound care visits and supplies.
    - Provider identifies the equipment is not the correct size/type to meet the patient's 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.

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- Report adverse incidents to CareCentrix within twenty-four (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 twenty-four (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 Florida Blue Members with an Aged Balance for Member Expenses

- CareCentrix and its network of DME providers will not arrange certain non-life sustaining services for Florida Blue members who:
    - have an aged balanced related to Member Expenses greater than 180 days from the initial patient invoice date;
    - are in the deductible phase of coverage (i.e., where the patient is 100% financially responsible for the service rendered); and
    - have not paid such aged balances in full or arranged for payment or a payment plan with CareCentrix.
- The list of non-life sustaining services and codes is available on the HomeBridge® provider portal. 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 HomeBridge® and accessing the “Patients” tab.
- For any dates of service on or after the date CareCentrix ceases arranging the services for these Florida Blue members:
    - Providers must not submit a request for such services to CareCentrix through the HomeBridge® provider portal 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 who is subject to suspension subsequently pays the outstanding balance or arranges for payment or a payment plan and CareCentrix resumes arranging the services for

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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 Member Expenses balance 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.

5-2 GUIDELINES SPECIFIC TO PROVIDER SPECIALTY

This section outlines the guidelines specific to the specialty area of a provider within CareCentrix. Guidelines are described for Home Health, Home Health Infusion Nursing, Home Infusion Therapy, Durable Medical Equipment 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 (two 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 of service delivery.
- 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 one (1) day, both nursing visits need to be submitted on one claim and billed as 2 units on one claim line.

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- Private Duty Nursing (PDN) specific billing and documentation requirements:
  - HCPCS codes must be billed in whole units of 1 or greater.
  - Invoiced units greater than 1 must be rounded up or down to the nearest whole number.
  - 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.
- 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 tests are not included in the CareCentrix Provider Agreement.
- The reimbursement for a skilled nursing visit includes the following routine supplies:
  - Dressing supplies - gauze pads, sterile/unsterile gloves, ABDs, Kerlix, tape
  - Betadine wipes
  - Peroxide
  - Syringes for nurse administered injections (excludes specialty syringes, special order items)
  - Lab tubes and needles for drawing lab work
  - Lubricating jelly
  - Cotton balls and alcohol sponges
  - Gloves
  - Bandages
  - Thermometers
  - Vacutainers
- 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 our HomeBridge® provider portal.
- 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 a Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN) for a Registered Nurse (RN) 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:
  i. The substitution is allowed by the patient's plan and applicable law;
  ii. The care to be rendered is within the scope of practice for the LVN/LPN, COTA and/or PTA as defined by applicable law;
  iii. The treating physician is in agreement with the substitution; and
  iv. The provider's contract includes a rate for LVNs/LPNs, COTA and/or PTA and the provider bills at that contract rate.
  v. The provider bills the appropriate HCPCS code for LVNs/LPNs, COTA and/or PTA.

Does the payor allow substitution of LVN, LPN, PTA or COTA?	
Florida Blue	Yes – LVN, LPN, PTA & COTA
Blue Cross® Blue Shield® of Michigan	Yes – PTA & COTA
Wellcare®	Yes – PTA & COTA

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Horizon® Blue Cross® Blue Shield® of New Jersey	No
Braven Health℠	No
Members receiving care outside of the state they have coverage.	Varies by home plan – Ensure you confirm you are in accordance with the home plan's medical policies by visiting the plan's website.

IMPORTANT! Not all plans associated with each payor allow for substitutions (e.g., Taft Hartley plans and plans managed by a third-party administrator, such as WebTPA). Providers should contact the payor or administrator to confirm if the substitution is permitted prior to rendering service.

- The coordinating Home Health 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 forty-eight (48) hours.
  - Obtaining and providing to CareCentrix the clinical information needed for re-authorization.
  - Notifying other involved providers of authorization decisions, eligibility issues, etc.

Wellcare® Home Health Specific Requirements

Providers contracted with CareCentrix to render Home Health services to Wellcare® Medicare Advantage or Dual Special Needs Plans (D-SNP) members are responsible for submitting a pre-notification/registration and request for authorization of continued Home Health services as referenced below. Additional requirements and guidelines are available on HomeBridge® provider portal located under the section "Provider Education". Prior to initiating services for a Wellcare® member, please confirm with the member that no other Home Health agency is rendering services to the member. Only one Home Health agency may render and bill CareCentrix for services provided to a Wellcare® member during the same episode of care. CareCentrix reserves the right to recoup amounts paid if it is determined that another Home Health agency rendered services to the member during the same episode of care.

Pre-notification/Registration

Provider must submit a pre-notification/registration to CareCentrix for every initial Home Health episode of care up to a 30-day period.

- Every pre-notification/registration must include the services to be rendered within the initial period.
- Providers must list each discipline with the number of visits per discipline.
- The start date for the pre-notification/registration should align with the date of the first billable visit.
- The pre-notification/registration can be submitted any time after completion of the initial evaluation and plan of care (signed or unsigned).

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- The pre-notification/registration must be submitted prior to claims submission, or the claim will deny; and provider is prohibited from billing the patient.
- The pre-notification/registration must be submitted prior to submitting a request for authorization of continued Home Health services.
- Upon receipt of the pre-notification/registration, CareCentrix will send the provider a Service Registration Form (SRF) to acknowledge receipt of the notification.

Reauthorization Request

If it is determined that a patient requires additional services for dates of service beyond the initial pre-notification/registration, providers will need to submit a request for authorization of continued Home Health services. CareCentrix will perform a clinical review and render a determination (approval or denial).

Providers are encouraged to submit a request for authorization of continued Home Health services at least seventy-two (72) hours prior to the end of the pre-notification/registration period or the prior authorization period.

The request should include:

- The disciplines to be provided and the number of visits per discipline up to a 30-day period.
- The total visits by discipline that are reflected in the plan of care and other supporting clinical documentation as outlined on the HomeBridge® provider portal, under the "Medical Coverage Guidelines" and resources available under "Education Center."

If it is determined that a patient requires additional services for a discipline previously approved as part of the current request, and the Low Utilization Payment Adjustment (LUPA) threshold has been met, the provider does not need to request additional units for that discipline. If the LUPA threshold is unknown, the provider must submit a request for the additional units.

Claims Payment Integrity Vendor:

CareCentrix utilizes a third-party claims payment integrity vendor responsible for identifying overpayments. Provider audits are conducted to determine if providers conformed to appropriate billing practices and billed CareCentrix appropriately for medically necessary, Covered Services as required under your contract with CareCentrix. Providers must cooperate with all such independent audits. This includes, but is not limited to, timely providing our vendor with copies of all records requested to substantiate claims for services billed to CareCentrix. Requested records must be provided to the vendor at no charge and within thirty (30) calendar days from the date on the notice of the intent to audit. If a provider fails to provide records requested by the independent auditor to substantiate services billed within the timeframe required, payments on the claims that are the subject of the record request will be determined to be an improper payment and recovered through a refund request of the overpayment or offset against other claims.

The results of claims payment integrity audits are shared with providers through a letter detailing the vendor's findings, and providers are given an opportunity to review the results. Providers will have forty-five (45) calendar days from the receipt of the audit results letter to remit payment to CareCentrix for

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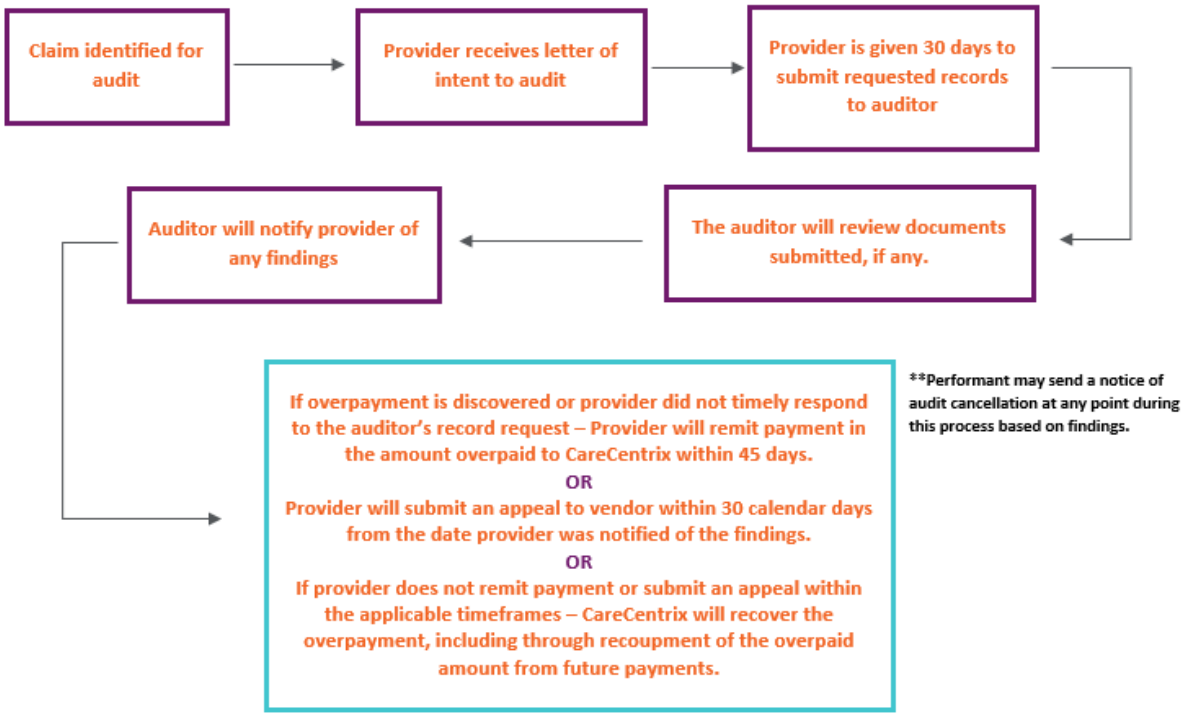
the claims identified by the vendor as overpaid. If the provider does not agree with the vendor's findings, the provider will have two (2) opportunities to appeal the findings with the vendor. Providers may appeal the findings within thirty (30) calendar days from the date on the original audit findings letter or first level appeal determination letter, as applicable. If the provider fails to submit an appeal to the vendor within that timeframe, the audit will be considered final. If the provider timely appeals, the appeal and additional information will be reviewed, and the vendor will communicate in writing the results of its review to the provider. Providers are expected to timely reimburse CareCentrix for the amounts that are determined to be overpaid by the vendor, and, if reimbursement is not timely received by CareCentrix, CareCentrix will pursue recovery of all overpayments identified by the vendor, including but not limited to, through an offset against other claims. If a provider wishes to further dispute claims integrity audit findings after the audit results are finalized, the provider must pursue external dispute resolution as provided in the Provider Manual and/or Provider Agreement with CareCentrix.

Please review the high-level process below:



Wellcare® Florida Highly Integrated Dual Eligible and Fully Integrated Dual Eligible Special Needs Plans (HIDE/FIDE) Claims

CareCentrix manages the provider relationship for all inquiries, reconsiderations, and appeals for all (HIDE/FIDE) claim transactions. For Wellcare® Florida Integrated D-SNP members, you will first receive a remit from CareCentrix communicating Wellcare's claim determination after applying the member's Medicare benefit. Subsequently, you will receive an additional remit from CareCentrix communicating Wellcare's claim determination after applying the member's Medicaid benefit.

Telehealth

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For certain payors (currently Florida Blue), 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 skilled nursing, home therapies (i.e., physical, occupational and speech), medical social worker services, and teaching and training related to durable medical equipment and supplies (e.g., insulin pump). Telehealth providers must be both audio and video capable and must only use audio and video technologies that comply with applicable law, including applicable privacy laws.

- Providers must utilize both audio and video when rendering telehealth services to the patient.
- 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 Home Health services that should be provided only in person include:
    - Private duty nursing (PDN).
    - Infusion therapy initial visit (IV insertion, some specialty therapies).
    - Negative pressure wound therapy.
    - Complex wound care.
    - Lack of member/caregiver cognition to participate in telehealth.
    - Member/caregiver inability to physically operate devices.
    - Patient does not have access to technology for the telehealth visit (e.g., device with a camera).
    - Patient does not consent to receiving telehealth services.
    - Skilled nursing required by Florida Blue Medicare Advantage patients.
    - Medical social worker services required by Florida Blue Medicare Advantage patients.
- For Florida Blue Medicare Advantage patients, an initial face to face visit is required unless care can start sooner via a telehealth visit, in which case, the in-person visit must occur within thirty (30) days.
- For all telehealth referrals, regardless of referral source, the provider is required to:
    - Review the referral to confirm the patient is clinically appropriate for telehealth services.
    - Secure consent from the patient to receive telehealth services.
    - Obtain orders from Primary Referral Source for telehealth service.
    - Determine the most appropriate form of technology for the telehealth visit.
    - 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 (Home).
- Reimbursement for telehealth services will be based on the HCPCS and modifier provided in the billing crosswalk located on the HomeBridge® provider portal.

Home Infusion Therapy

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), catheter care and hydration

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therapy. The SRF (if applicable) can be referenced to confirm the appropriate infusion therapy specific codes for billing. Otherwise, the provider should reference their contracted fee schedule. TPN, catheter care and hydration therapy include only two components: per diem and 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, or disposable pumps, 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 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.
- Ambulatory Infusion Suite (AIS) visits should be billed with place of service (POS) 12 (Home), except for Florida Blue members, whose AIS visits should be billed with POS 11 (Office) 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 and submit claims with the JW informational modifier (Drug amount discarded/not administered to any patient).
- 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 HomeBridge® provider portal. 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 (if applicable) or actual dates of patient care.
- Provider may utilize a Home Health agency contracted and credentialed with CareCentrix to perform the nursing component of an infusion case, but the nursing component must be billed by provider in conjunction with the drug and per diem.
- The per diem is determined by the type of medication. Provider should select the appropriate per diem type that corresponds with the medication type prescribed. Example: Vancomycin q8, provider should select the following per diem:
    - S9502 ANTIBIOTIC THERAPY Q8
- If there is more than one medication prescribed, the provider may bill more than one per diem, unless the medications are of the same type. In which case the provider may select a per diem for the primary medication and a multiple per diem for the secondary and/or tertiary medication. Example: Ampicillin q6 and Vancomycin q8. Provider should select the following per diems:
    - S9503 ANTIBIOTIC THERAPY Q6 primary per diem and;

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  - S9502 ANTIBIOTIC THERAPY Q8 multiple second (more than one (1) medication ordered)
- As needed, the CareCentrix Utilization Management team may make the determination on which per diem to attach to an ordered medication and change the selection made by the provider and, if appropriate, also change description codes.
- It is important to maintain an accurate record of patient registrations so that claims payment is not delayed or denied. Payment may be denied or reduced if the service billed does not match the services on the SRF (if applicable).
- Requests for additional services should not be made more than seven (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 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 for drugs appropriate for administration in the home by a certified Home Health Agency (HHA) and the administration or training for other injectable drugs appropriate for self-administration in the home.

- Upon accepting a referral, the provider will contact the patient to welcome them on service and to provide appropriate contact information.
- Within twenty-four (24) hours of each scheduled visit, the provider must confirm with the patient that all necessary medication and supplies, including the 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 possible.
  - 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.

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- Do not use the HomeBridge® provider portal 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.
- There is no need to check eligibility or benefits as the specialty pharmacy will check eligibility and benefits prior to issuing authorization to CareCentrix.
- Never, under any circumstance, tell the patient that they are not responsible for any copays, coinsurance, or deductibles. Providers are paid for authorized services in accordance with their contracted 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.
- Provider is required to fax clinical notes and documentation to CareCentrix within three (3) business days of service being rendered to (877) 254-6121.
- Provider is required to use the patient Subscriber ID listed on the SRF when submitting a claim using the following format WALMART + 9 numeric (e.g., WALMART123456789).

Blue Cross® Blue Shield® of Michigan Claims Payment Integrity Vendor

Blue Cross® Blue Shield® of Michigan utilizes a third-party claims payment integrity vendor to conduct Home Infusion Therapy (HIT) claims audits. These audits are conducted to determine if providers conformed to appropriate billing practices and billed CareCentrix appropriately for medically necessary, Covered Services as required under your contract with CareCentrix. Providers must cooperate with these audits. This includes, but is not limited to, timely providing the vendor with copies of all records requested to substantiate claims for services billed to CareCentrix. Requested records must be provided to the vendor at no charge and within twenty-five (25) calendar days from the date on the notice of audit. If a provider fails to respond to such notice of audit and record request within the timeframe required, payments on the claims that are the subject of the record request will be determined to be improper. Providers will not have a right to appeal that determination, and CareCentrix will proceed with recovering any payments made on these claims, including through an offset of future claim payments.

The vendor will review records provided in response to the audit notice and record request. CareCentrix will share the results of the vendor's audit through a letter that details the vendor's findings. Providers may dispute the vendor's findings by filing an appeal with the vendor within forty-five (45) calendar days of the date of the original audit results letter. CareCentrix will communicate to providers the results of the vendor's Level 1 Appeal decision. If the provider does not agree with the results of the Level 1 Appeal decision, the provider may submit a Level 2 Appeal request to the vendor within fifteen (15)

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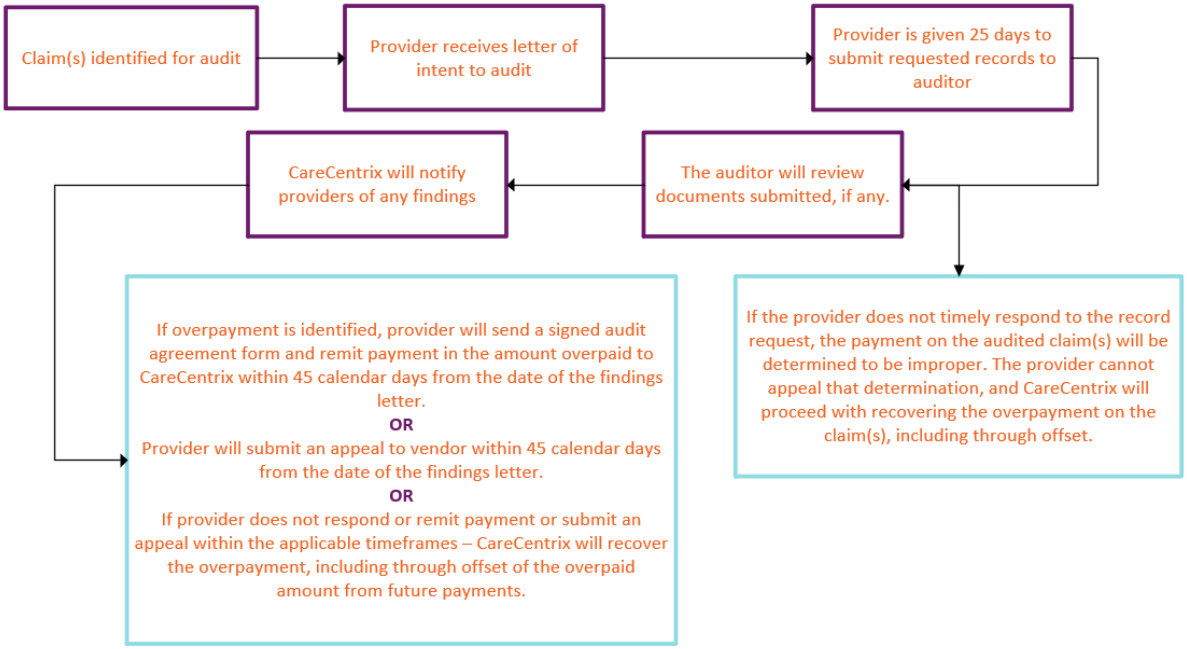
calendar days from the date on the Level 1 Appeal determination letter. Level 2 Appeals will be reviewed by an external Physicians Review Organization (PRO). Only the documentation provided in response to the initial audit record request and with the Level 1 Appeal will be reviewed by the PRO. Additional documentation cannot be submitted. You will receive the outcome of the PRO review within fifty-five (55) days from the date of the Level 2 Appeal request. Providers must pay the administrative cost of the appeal to the PRO if the audit findings are upheld, and Blue Cross will pay the administrative cost if the audit findings are overturned. **Estimated costs for a PRO review are between $318 and $360 for each vendor claim audit ID number**. If the provider fails to submit an appeal to the vendor within either of the above-referenced timeframes, the audit will be considered final.

Providers are expected to timely reimburse CareCentrix for the amounts that are determined to be overpaid by the vendor, and, if reimbursement is not timely received by CareCentrix, CareCentrix will pursue recovery of all overpayments identified by the vendor, including but not limited to, through an offset against other claims.

Please review high level process flow below:



Florida Blue® Out-of-State Ordering Physicians

Home infusion therapy services (drugs and nursing) for Florida Blue and Out-of-state Blues Plan members receiving services in Florida must be ordered by an appropriate healthcare practitioner that holds an active and unrestricted license in the state of Florida. Providers must confirm that the prescribing healthcare practitioner maintains the required Florida license via the National Plan and Provider Enumeration System (NPPES) website prior to registering the service with CareCentrix, requesting authorization from CareCentrix (when applicable) and rendering the service. Claims for home infusion therapy services for such members that are not ordered by an appropriate Florida licensed

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healthcare practitioner will be denied and not paid by either CareCentrix or Florida Blue, and providers shall not bill members with respect to any such claims.

Durable Medical Equipment (DME)

DME services consist of the following categories: Disposable Medical Surgical Supplies (e.g., bandages/dressings, ostomy supplies), Durable Medical Equipment (insulin pumps, continuous glucose monitors and 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 Rentals

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.

Custom Equipment

For custom equipment, a manufacturer's specification sheet, including retail and CareCentrix pricing, must be submitted with a request.

IMPORTANT! For custom equipment, CareCentrix may instruct the provider to complete two 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 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 three 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 twenty-one (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 forty-five (45)

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business days of receipt of the original request. If the provider experiences challenges in receiving required documentation from the patient's physician within thirty (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 one (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 ten (10) business days of receipt of the request and to complete the repairs as soon as possible and within twenty-one (21) business days of receipt of the request.

Additional information for Durable Medical Equipment:

- 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.
- **When delivering equipment or supplies to a patient, please inform them whether the items are rented or purchased. Additionally, let them know that they may receive an invoice from CareCentrix for any patient responsibility.**
- CareCentrix should be notified immediately of any purchased equipment that is unused or returned by the member before the end of the service date span specified on the SRF. Provider should submit notification using the CCX Equipment Return Form, located on the HomeBridge® provider portal under "Resources and Forms." For any unused or returned rental equipment, the provider should not bill for any remaining rental months once the item is received.
- 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 HomeBridge® under the "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
    - Oxygen
    - TENS Units
- 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.

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- 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 are 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.
- 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 with 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 Positive Airway Pressure (PAP) device providers with helping ensure patients are utilizing their sleep device in accordance with sleep therapy program guidelines, CareCentrix may contact

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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 usage.

Equipment Maintenance and Reasonable Useful Lifetime/Warranty:

Equipment maintenance is to be done in compliance with the Safe Medical Device Act, manufacturer's 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.

The Reasonable Useful Lifetime for Durable Medical Equipment is five years. If a pump has a two year-warranty and the pump breaks before two years, any repairs or replacements would be covered by the manufacturer under warranty. However, if the pump breaks after the two-year warranty expires but before five years, any repairs or replacements would be covered by the health plan as it is within useful life. Beyond five years, in the event of a non-functioning item, a replacement would be covered by the health plan.

- For a replacement DME item provided before Reasonable Useful Lifetime, but after warranty, an RA modifier is required on the claim.
- Providers should reference the Health Plan Medical Coverage Guidelines available on the HomeBridge® provider portal prior to requesting a replacement or repairs.

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 and the HomeBridge® provider portal located at www.carecentrix.com.

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.

5-3 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.

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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 HomeBridge® provider portal. 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 a SRF, if applicable, 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) documentation and billing guidelines. Such CMS documentation and billing guidelines, include but are not limited to, the guidelines that prohibit inappropriate unbundling of supplies/services, require proof of delivery (delivery tickets signed and dated by the patient), require signatures on medical records and the patient's plan of care, certificates of need/medical necessity, and eligible provider types, and that require that providers maintain and produce documentation of the patient's medical condition, including but not limited to, orders and clinical notes from the referring physician/practitioner and, as applicable, inpatient facility records that substantiate the medical necessity of the type, quantity, and duration of services or items billed. 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, including but not limited to, health plan payment policies and billing guidelines, by using the following links below:

Mass General Brigham® Health Plan

Blue Cross® Blue Shield® of Michigan and Blue Care Network®

Braven Health℠

Fallon Health®

Florida Blue®

Horizon® Blue Cross® Blue Shield® of New Jersey

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Humana®

Sentara® Health Plans

Wellcare®

For information on the National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) that are applied to Horizon® Blue Cross® Blue Shield® of New Jersey and Braven Health claims, please visit the CMS website.

If a claim is denied on the basis that the number of units billed exceeds the allowed number of units under the applicable NCCI MUE or other similar claims edit and the provider disagrees with such denial, the provider is prohibited from billing the patient for the denied amounts and must instead follow the CareCentrix reconsideration and appeals process described below to request a change to the denial determination. In connection with any such reconsideration or appeal, the provider must submit to CareCentrix the patient's clinical records that support the number of units billed. If the denial decision is upheld at both the reconsideration and appeal level, the provider can only bill the patient for the denied amounts if, in advance of the provision of the denied services/items, the patient agreed in writing to accept financial responsibility for the denied amounts.

Check Reimbursement Status

Providers should utilize the HomeBridge® provider portal to check the status of their claims.

After checking 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 8:00 a.m. and 6:00 p.m. Eastern Standard Time (ET) or as otherwise required by applicable law.

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 the claim line item.

CareCentrix uses industry standard American National Standards Institute (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 HomeBridge®.

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

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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 HomeBridge® provider portal at www.carecentrixportal.com.

For, Blue Cross® Blue Shield® of Michigan and Blue Care Network, Horizon Blue Cross® Blue Shield® of New Jersey, Braven Health, Florida Blue, Sentara® Health Plans, 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 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 non-payment to the provider.

5-4 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 Team (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. 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 normal operating procedure.

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:

If paper claim forms are used, they **must** be submitted on original OCR red and white CMS-1500 and UB-04 (CMS-1450) claims forms. All other **paper** claim form types, **including** photocopies of original forms, black and white forms, and any non-standard forms, **will be rejected.**

Professional Claim Submissions (837P or CMS 1500)

- Patient name, address, relationship to subscriber, gender, and date of birth.

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- Patient Account/Control Number (best practice is for this to be unique for each claim).
- Insurance subscriber name and ID (without the two-digit person code that is usually located on the end of the Subscriber ID).
- Place of service code.
- Primary diagnosis code - V codes (diagnosis identified after care provision) will not be accepted as the primary diagnosis code and provider is expected to follow all ICD coding rules.
- Billing provider name, address, Tax ID, NPI.
- Rendering provider name and NPI if different from billing address.
- Referring provider/physician name and NPI number.
- HCPCS and modifier combination for each claim service line that are consistent with the codes defined on the provider's contracted fee schedule, and on the CareCentrix billing crosswalk for the patient's specific health plan. Note: the modifiers must be present in the order defined on the fee schedule besides pricing modifiers and informational modifiers.
- Total charge amount for each claim service line.
- Number of invoiced units for each claim services line.
- NDC code, NDC unit of measure, and NDC quantity if drug is billed.
- Date of service (FROM and TO required); both the FROM and TO date must be before the claim receipt date.
- Whether the patient's condition is related to employment, auto accident or other accident.
- Other insurance information (if patient has other primary insurance, include other insurance subscriber name, subscriber ID, date of birth, insurance plan name, and patient's relationship to subscriber).
- Coordination of benefits information for secondary claims (explanation of payment from primary carrier); if applicable.
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD).

Additional Professional Claim Requirements:

- Include both insurance plan name and group number (if present on member's card).
- All services for the same patient from a single provider on the same date of service should be billed on a single claim.
- Claim services on a single claim should not span into a new year. If a patient has services in both December of the previous year and January of the current year, separate claims should be billed for the December services and the January services.
- Bill a single Authorization ID Number(s) for each service billed on the claim at the line level. Do not utilize the authorization field at the claim header level.
- Do not append any information to the Authorization ID Number or send more than one number per claim line.

Institutional Claim Submissions (837I or UB-04)

- Patient name, address, relationship to subscriber, gender, and date of birth.
- Patient Account/Control Number (best practice is for this to be a unique number for each claim).

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- Insurance subscriber and ID (without the two-digit person code that is usually located on the end of the Subscriber ID).
- Type of bill.
- Primary diagnosis code - V codes (diagnosis identified after care provision) will not be accepted as the primary diagnosis code and provider is expected to follow all ICD coding rules.
- Billing provider name, address, Tax ID, NPI.
- Attending provider, name and NPI (This should be the referring physician).
- Rendering provider name and NPI if different from billing and attending providers.
- Service facility location name, address, NPI.
- HCPCS and modifier combination for each claim service line that are consistent with the codes defined on the provider's contracted fee schedule, and on the CareCentrix billing crosswalk for the patient's specific health plan. Note: the modifiers must be present in the order defined on the fee schedule besides pricing modifiers and informational modifiers.
- Total charge amount for each claim service line.
- Number of invoiced units for each claim service line.
- For Medicare Advantage plans and traditional home health services, a HIPPS line must be billed with revenue code "023", billed charges of $0.00, units = "1", and date of service equal to the date of the earliest billable service on the claim.
- NDC code, NDC unit of measure, and NDC quantity if drug is billed.
- Date of service (FROM and TO required); both the FROM and TO date must be before the claim receipt date.
- Whether the patient's condition is related to employment, auto accident or other accident.
- Other insurance information (if patient has other primary insurance, include other insurance subscriber name, subscriber ID, date of birth, insurance plan name, and patient's relationship to subscriber).
- Coordination of benefits information for secondary claims (explanation of payment from primary carrier).
- Description of miscellaneous code in the line level additional information note segment (NTE*ADD).

Additional Institutional Claims Requirements:

- Include both insurance plan name and group number (if present on member's card).
- Always send the Service Registration Form (SRF)/authorization number at the header claim header level.
- Do not send more than one authorization number on the claim header level.
- Do not append any additional information to the authorization number.
- 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.

IMPORTANT! Additional Required Data Elements for Patient-Driven Groupings Model (PDGM) Claims:

- Occurrence code 50 with the appropriate Assessment Date

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- Value code 61 with the appropriate 5-digit CBSA code
- The revenue code must be compatible with the HCPCS code.

Claims missing or containing incorrect required information or billed inconsistent with the requirements of this Provider Manual will be rejected with the corresponding reason(s) for rejection. Rejected 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 HomeBridge® for updates to HCPCS codes, descriptions, and the CareCentrix billing crosswalk. The current billing crosswalk can be found at www.carecentrixportal.com under "Resources and Forms".

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's name on the related Service Registration Form (SRF).

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. Miscellaneous codes must include a generic description of the service in the service description field and the specific description in the claim line additional information note (2400 NTE*ADD.) Example: HCPCS is A4649 (Surgical supply, miscellaneous). Line note contains DIASOX SEAM FREE SOCK, LARGE, BLACK.

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.

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

With respect to applicable sales tax, as indicated above, your 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

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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 dependent(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 two and three 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 the 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 two and three will be denied based on lack of eligibility and, if CareCentrix paid a claim for services provided during months two and three, CareCentrix will recoup that payment. If, prior to receiving such services during months two and three, 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

Providers must request other coverage information from all patients and supply that other coverage information to CareCentrix on all claims. When CareCentrix's health plan customer is not the patient's primary payor, providers must bill the primary payor first. When a CareCentrix health plan customer is the secondary payor, providers must only bill CareCentrix when, under the CareCentrix health plan customer contract, CareCentrix is responsible for processing secondary claims. Otherwise, secondary claims should be billed directly to the CareCentrix health plan customer.

CareCentrix does not accept any secondary claims for the following health plans. Bill any secondary claims for patients with these plans directly to the health plan:

- Wellcare®
- Sentara® Health Plans

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Secondary claims for other health plan customers of CareCentrix will be accepted. Electronic claims must include the primary adjudication results in the COB/Secondary loops and segments. Secondary claims for patients with the following payors may NOT be submitted electronically but must be submitted via paper claims:

- Fallon Health®
- Mass General Brigham® Health Plan

Industry standard paper claim forms must include a copy of the explanation of benefits (EOB)/payment (EOP) from the primary payor. Secondary claims must be submitted to CareCentrix with the primary payor's claim processing results within the timeframe described in your Provider Agreement or within such longer period of time required by applicable law.

Medicare Primary Claims

Secondary claims for members with primary Medicare coverage will be rejected by CareCentrix. For those members who have primary coverage through Medicare, their secondary claims for Covered Services will be routed by Medicare directly to the health plan through the Medicare Crossover Process.

Subrogation

Providers must cooperate with and assist payors and patients in pursuing the recovery of funds from third parties (e.g., in connection with car accident claims), and the recovery of such funds will be the property of the respective payor or patient, as applicable, and as required by the applicable benefit plan or payor policies.

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 were as 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.

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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.

Submitting a Refund to CareCentrix

If a provider identifies an overpayment, a refund may be submitted to CareCentrix by either mail or email and must include the following information:

- Patient name
- Patient date of birth
- Insurance ID#
- Health plan
- Date of service
- Indicate full or partial overpayment.
    - If partial – please include the HCPCS code and quantity.
- Amount of overpayment
- Reason for overpayment
- Whether the refund will be paid via check or CareCentrix offset
- Contact information, in the case we need to clarify any information.

Mail your refund along with the above information to one of the following addresses:

CareCentrix
Overpayment Recovery Team
PO BOX 30719-3719
Tampa, Florida 33630

For overnight delivery:
CareCentrix
Overpayment Recovery Team
10004 N. Dale Mabry Hwy, Suite 106
Tampa, Florida 33618

Alternatively, if the refund will be paid by offset, you can submit your offset request via encrypted email to ProviderOverpaymentRecovery@carecentrix.com.

Refunds related to a Special Investigations Unit (SIU) case must be submitted following the instructions found on the SIU Letter.

5-5 COMPLAINTS, CLAIMS PAYMENT RECONSIDERATIONS, AND APPEALS

Introduction to Complaints, Claims Payments Reconsiderations, and Appeals Process

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

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Complaints

Provider complaints should be directed to your Provider Relations or Contracting contact respectively.

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.

5-6 CLAIMS PAYMENT TROUBLESHOOT

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.

Payor	Payor Specific Information
Mass General Brigham® Health Plan **Fallon Health®**	Corrected claims must be submitted on paper with "CORRECTED CLAIM" stamped or typed on the top of the paper claim form without obstructing any claim elements. • For Professional claims the frequency code of 7 must be included in box 22 under the label "RESUBMISSION CODE" and the original CareCentrix claim ID must be included in box 22 under the label "ORIGINAL REF. NO." • For Institutional claims the frequency code of 7 must be the fourth digit in box 4 and the original CareCentrix claim ID must be included in box 64. **These claims should be submitted via US Mail to:** CareCentrix – Claims PO BOX 30722-3722 Tampa, FL 33630 **Or if using Federal Express, UPS or Certified Mail:** CareCentrix – Claims 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618

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Blue Cross® Blue Shield® of Michigan and Blue Care Network® **Horizon® Blue Cross® Blue Shield® of New Jersey** **Braven Health℠** **Florida Blue®** **Sentara® Health Plans** **Walmart® Specialty Pharmacy** **Wellcare®**	Electronic corrected claims must be submitted via an 837 frequency 7, "Void & Replace" transaction. When sending a frequency 7 transaction, the original CareCentrix claim ID (Payer Claim Control Number) must be included in Loop 2300 REF*F8 Segment (Data element 127), within the 837 transaction. The patient's first name, last name, date of birth, and Subscriber ID cannot be corrected using a claim frequency 7 transaction. A frequency 8, "Void" transaction must first be sent to void the claim with the incorrect patient/subscriber data. Submit a new original claim with the new patient/subscriber ID. A frequency 7 transaction will not be accepted until the original claim has been finalized and the 835 has been sent to the provider. Any claims submitted with a claim frequency 7 when the status of the previous transaction is not equal to "Finalized by CareCentrix" will be rejected. Paper corrected claims may also be submitted. "CORRECTED CLAIM" must be stamped or typed at the top of the paper claim form without obstructing any claim elements. • For Professional claims the frequency code of 7 must be included in box 22 under the label "RESUBMISSION CODE" and the original CareCentrix claim ID must be included in box 22 under the label "ORIGINAL REF. NO." • For Institutional claims the frequency code of 7 must be the fourth digit in box 4 and the original CareCentrix claim ID must be included in box 64. **Paper claims should be submitted via US Mail to:** CareCentrix – Claims PO BOX 30722-3722 Tampa, FL 33630 **Or if using Federal Express, UPS or Certified Mail:** CareCentrix – Claims 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618

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

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Claims Inquiries

For claims covered by payors Blue Cross® Blue Shield® of Michigan and Blue Care Network®, Horizon® Blue Cross® Blue Shield® of New Jersey, Braven Health℠, Florida Blue®, Sentara® Health Plans, Walmart® Specialty Pharmacy, and Wellcare®, providers can submit claims inquiries through the HomeBridge® provider portal 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 www.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 a reconsideration, you must submit a request for reconsideration in writing using our Claim Reconsideration Form which can be found on HomeBridge® provider portal at www.carecentrixportal.com.

A CareCentrix claim reconsideration form may not be submitted for a Florida Blue FEP member claim as this plan type does not permit reconsiderations. The provider should instead submit an appeal to CareCentrix for Florida Blue 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 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 Florida Blue FEP member. The provider **should not submit** a reconsideration request for a Florida Blue FEP member claim. The provider should instead submit an appeal to CareCentrix for Florida Blue 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 claim 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.

Payor	Payor Specific Information
Mass General Brigham® Health Plan **Fallon Health®**	Providers can request a reconsideration of a claim determination in **writing** by submitting a **Claim Reconsideration Form via US Mail to:** CareCentrix – Reconsiderations PO BOX 30720-3720 Tampa, FL 33630

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	If using Federal Express, UPS or Certified Mail: CareCentrix – Reconsiderations 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
Blue Cross® Blue Shield® of Michigan or Blue Care Network® **Florida Blue®** **Horizon® Blue Cross® Blue Shield® of New Jersey** **Braven Health℠** **Sentara® Health Plans** **Walmart® Specialty Pharmacy** **Wellcare®**	Providers can submit a reconsideration of a claim determination **online** via HomeBridge® **OR** in **writing** by submitting a **Claim Reconsideration Form via US Mail to:** CareCentrix – Reconsiderations PO BOX 30720-3720 Tampa, FL 33630 **If using Federal Express, UPS or Certified Mail:** CareCentrix – Reconsiderations 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
Note: Depending on the applicable payor and claim denial reason, CareCentrix will either process the reconsideration request itself or will submit the reconsideration request to the payor for processing on behalf of the provider.	

Your request for reconsideration must be received by CareCentrix at the designated address within forty-five (45) days after the date of the 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):

Payor	Line of Business	Review Time
Blue Cross® Blue Shield® of Michigan and Blue Care Network®	Local and State	30-60 Days
Blue Cross® Blue Shield® of Michigan and Blue Care Network®	Out-of-State Blues Plan	60-90 Days
Braven Health	Out-of-State Blues Plan	60-90 Days
Florida Blue®	Local and State	30-60 Days
Florida Blue®	Out-of-State Blues Plan	60-90 Days
Horizon® Blue Cross® Blue Shield® of New Jersey	Local and State	30-60 Days
Horizon® Blue Cross® Blue Shield® of New Jersey	Out-of-State Blues Plan	60-90 Days

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Sentara® Health Plans	Commercial, Medicare Advantage, Medicaid, D-SNP and FEP	30-60 Days
Wellcare®	Medicare Advantage and D-SNP	60-90 Days

CareCentrix will communicate the plan decision to the provider within on average ten (10) days of receipt of that decision or the period of time required by applicable law if shorter. If your 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 HomeBridge®.

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.

Payor	Payor Specific Information
Mass General Brigham® Health Plan **Fallon Health®**	Providers can request a claim appeal in **writing** by submitting a **Claim Appeal Form via US Mail to**: CareCentrix – Appeals PO BOX 30721-3721 Tampa, FL 33630 **If using Federal Express, UPS or Certified Mail:** CareCentrix – Appeals 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
Blue Cross® Blue Shield® of Michigan and Blue Care Network® **Florida Blue®** **Horizon® Blue Cross® Blue Shield® of New Jersey** **Braven Health℠** **Sentara® Health Plans** **Walmart® Specialty Pharmacy** **Wellcare®**	Providers can request a claim appeal **online** via HomeBridge® **OR** in writing by submitting a **Claim Appeal Form via US Mail to**: CareCentrix – Appeals PO BOX 30721-3721 Tampa, FL 33630 **If using Federal Express, UPS or Certified Mail:** CareCentrix – Appeals 10004 N. Dale Mabry Highway Suite 106 Tampa, FL 33618
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 thirty (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

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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 thirty (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):

Payor	Line of Business	Review Time
Blue Cross® Blue Shield® of Michigan and Blue Care Network®	Local, State and FEP	30-60 Days
Blue Cross® Blue Shield® of Michigan and Blue Care Network®	Out-of-state Blues Plan	60-90 Days
Braven Health℠	Out-of-state Blues Plan	60-90 Days
Florida Blue®	Local, State and FEP	30-60 Days
Florida Blue®	Out-of-state Blues Plan	60-90 Days
Horizon® Blue Cross® Blue Shield® of New Jersey ****Including NJ Statutory Appeals**	Local, State and FEP	30-60 Days
Horizon® Blue Cross® Blue Shield® of New Jersey ****Including NJ Statutory Appeals**	Out-of-state Blues Plan	60-90 Days
Sentara® Health Plans	Commercial, Medicare Advantage, Medicaid, D-SNP, and FEP	45-75 Days
Wellcare®	Medicare Advantage and D-SNP	60-90 Days

CareCentrix will communicate the plan decision to the provider on average within ten (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 customer) 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 sixty (60) days of the date of the appeal decision letter. If the matter is not resolved within sixty (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

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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.

5-7 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.,

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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 Agreement, provider may submit a request for an appeal, along with supporting documentation, to their Contracting contact.

Your appeal must be received by CareCentrix within thirty (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 thirty (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.

5-8 OBLIGATIONS OF EMPLOYEES, PERMITTED SUBCONTRACTORS OR AGENTS

Provider's obligations under the Provider Agreement and this Provider Manual apply to provider and all of provider's employees and any permitted subcontractor or agent providing services under the Provider Agreement. Such obligations include but are not limited to the obligation to indemnify for negligent or other wrongful acts or omissions or any breach of any representation, warranty, or covenant under the Provider Agreement by any such employee or permitted subcontractor or agent.

6-1 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 Provider Relations contact.

Provider specific complaint data is tracked, trended, analyzed, and used during the recredentialing process and to promote on-going 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.

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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.

- Specific information regarding Covered Services for MA Medicaid Members can be obtained by contacting the applicable payor listed on the MA Medicaid Member's insurance identification card.
- 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.
- Provider shall cooperate with the MA Medicaid Member's Integrated Care Team (ICT) as required by applicable law.
- MA Medicaid Member health information will be treated as confidential and protected in accordance with applicable law.
- Provider shall provide assistance to MA Medicaid Members who require language assistance, including providing interpreter services as needed.
- Provider shall accept and treat all MA Medicaid Members regardless of race/ethnicity, age, English proficiency, gender, including gender identity and sexual orientation, health status, or disability.
- 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.
- Provider shall make MA Medicaid Members aware of available clinical options and all available care options.
- 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.
- 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.
- Prior authorization and/or registration is required for all services provided under the Agreement unless otherwise specified.

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- New MA Medicaid Members shall have the right to an initial continuity-of-care period as provided under applicable law.
- MA Medicaid Members have the right to access and correct medical records information maintained by provider.
- Updates to policies impacting provider are communicated through Provider Newsflashes, Provider Manual, and/or the HomeBridge® provider portal.
- 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.
- 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.
- Provider is prohibited from balance billing MA Medicaid Members as specified in the Provider Manual and this Addendum.
- CareCentrix facilitates communication to and from network providers through provider newsflashes, the HomeBridge® provider portal and/or periodic provider meetings.
- 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 thirty (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.
- 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.
- Provider shall maintain current knowledge, ability and expertise in provider's practice area as required by applicable law and at a minimum will conform with recognized managed care industry standards such as those provided by NCQA and relevant state regulations, when obtaining Continuing Medical Education (CME) credits or Continuing Education Units (CEUs) and participate in training opportunities as appropriate.

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Virginia Managed Medicaid Addendum

The following provisions are added to the Provider Manual to comply with Virginia Managed Medicaid requirements. These provisions apply only to services rendered by providers to patients covered under a Virginia Managed Medicaid plan ("VA 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.

- Specific information regarding Covered Services for VA Medicaid Members can be obtained by contacting the applicable payor listed on the MA Medicaid Member's insurance identification card.
- Under the Virginia Managed Medicaid Program, VA Medicaid Members have specified rights and shall be allowed to exercise such rights without having their treatment adversely affected. VA Medicaid Members have the right to:
    - Receive information and be furnished health care services in accordance with 42 CFR § 438.206 and 42 CFR § 438.10;
    - Be treated with respect and with due consideration for their dignity and privacy;
    - Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand;
    - Participate in decisions regarding their health care, including the right to refuse treatment;
    - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion;
    - Request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526;
- File a grievance/complain, appeal, and/or a State Fair Hearing.
    - A VA Medicaid Member, an attorney, or a VA Medicaid Member's authorized representative (provider, family member, etc.) acting on behalf of the VA Medicaid Member can file a grievance at any time, either orally or in writing. Grievances will be resolved as expeditiously as the VA Medicaid Member's health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the grievance is received. The timeframe for processing a grievance can be extended by up to fourteen (14) calendar days if the VA Medicaid Member requests the extension or if there is a need for additional information and the delay is in the VA Medicaid Member's interest.
    - A VA Medicaid Member, an attorney, or the VA Medicaid Member's authorized representative (provider, family member, etc.) acting on behalf of the VA Medicaid Member can file an appeal either orally or in writing within sixty (60) calendar days from the date on the notice of adverse benefit determination. Expedited Appeals must be resolved orally and in writing within seventy-two (72) hours from the initial receipt of the appeal. Standard Appeals must be resolved as expeditiously as the VA Medicaid Member's health condition requires, but not to exceed thirty (30) calendar days from the initial date of receipt. The timeframe for appeal processing can be extended by up to

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fourteen (14) calendar days if the VA Medicaid Member requests the extension or if there is a need for additional information and the delay is in the VA Medicaid Member's interest.

- VA Medicaid Members who have received an internal appeal decision that upholds a denial in whole or in part have the right to appeal the internal appeal decision to DMAS by requesting a formal appeal through a State Fair Hearing. The State Fair Hearing Appeal may be filed at any time after the payor's internal appeal process is exhausted but must be requested no later than 120 calendar days from the date of the payor's internal appeal decision. DMAS will resolve a standard request with ninety (90) days and an expedited request with seventy-two (72) hours. A VA Medicaid Member may request a Standard or Expedited State Fair Hearing orally or in writing to DMAS at:

  Appeals Division Department of Medical Assistance Services 600 E. Broad Street
  Richmond, Virginia 23219
  Fax Number: (804) 371-8491
  Phone: (804) 371-8488

- Provider agrees to be fully compliant with all applicable state and federal laws, regulations, and policies governing the VA Medicaid Member grievance, appeal and State Fair Hearing processes and all statutory and regulatory timelines related thereto. Providers must respond to requests for information regarding a VA Medicaid Member's grievance within five (5) business days.
- Provider agrees to obtain the VA Medicaid Member's other insurance coverage information and to bill the VA Medicaid Member's primary payor first. Provider understands and agrees that Medicaid is the secondary payor of last resort, and provider will not bill CareCentrix or the VA Medicaid payor plan first if the VA Medicaid Member has other primary coverage.
- Provider agrees not to bill a VA Medicaid Member for Medically Necessary services covered under the DMAS contract and provided during the VA Medicaid Member's period of enrollment in a VA Managed Medicaid plan. This includes those circumstances where provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. This provision shall continue to be in effect even if the VA Medicaid plan becomes insolvent. However, if a VA Medicaid Member agrees in advance of receiving the service, and in writing, to pay for a non-Medicaid Covered Service, then provider can bill for the service.
- CareCentrix will work in collaboration with providers to fully cooperate with the Quality Assessment and Performance Improvement (QAPI) program and all other requirements of payor contracts with CMS and DMAS.
- Providers may submit their credentialing and/or recredentialing applications through the Join Our Network page on the HomeBridge® provider portal.

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Attachment 1 – Credentialing Application

[SAMPLE CREDENTIALING APPLICATION FOLLOWS]

IMPORTANT! To request to join the CareCentrix network, please visit the **Join our Network section** of the HomeBridge® provider portal.

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Credentialing Application 2025 – Checklist

#	√	Please include the following documents:
1.		Current license
2.		Accreditation letter, including certification with accredited location listed, services and effective date of accreditation
3.		Medicare site survey, including any revisit survey and plan of correction letter from the state, if applicable (for THH only)
4.		Insurance Certificate: ❒ General liability: $1M/$3M each occurrence & aggregate ❒ Professional liability: $1M/$3M each occurrence & aggregate ❒ Fidelity Bond, if applicable ❒ **CareCentrix listed as a certificate holder (address: 20 Church Street - Suite 1100, Hartford, CT 06103)** ❒ All locations covered under the insurance should be listed on the certificate or the certificate should indicate it covers all subsidiaries
5.		Current copy of performance improvement
6.		Results from performance improvement activities (patient satisfaction survey results, completed patient surveys or meeting minutes are acceptable, upon network renewal
7.		Coverage area, list by county and zip code. – **in excel Zip Code List** - 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: http://www.melissadata.com/lookups/countyzip.asp **For renewals only, if adding additional states, please contact your Contract Manager**
8.		Medicare & Medicaid numbers on application
9.		NPI, taxonomy numbers, and Tax ID on application
10.		Professional liability form. Please sign and date the form. **Please note that, if the page is not applicable, you still must sign and date the form and indicate N/A.**
11.		W-9, signed and dated
12.		Provider agreement **(for initial applications only)**. 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.
13.		Fee schedule **(for initial applications only)** must be in excel (Tab 1) **Fee Schedule** - write next to any items you do not provide in the column provided **(if not applicable, you must indicate N/A)**

SAMPLE

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CREDENTIALING APPLICATION 2025

❒ 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 Telephone No.:** _____

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:

Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time:							

On Call Arrangements:

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

Coverage Area: ATTACH EXCEL

Updated 1/27/25

SAMPLE

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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 list your facility's primary and secondary service below:

Primary: _____ **Secondary:** _____

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

Do you have the experience, skills and training to treat 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:
Contact Name and Title: _____

Phone Number: _____ **Fax No:** _____

E-mail address: _____

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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: _____

New Provider Onboarding: **(training is relevant to staff performing authorizations/registrations and billing)**

Contact Name and Title: _____

Phone Number: _____

Email Address: _____

Electronic Data Interchange (EDI).

For electronic claims submission, you or your clearinghouse must be partnered with either Change Healthcare or Availity. If you are currently not using a clearinghouse, contact Availity at 1-800- AVAILITY or Change Healthcare at 1-866-369-8805. 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*)**

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

A. Accreditation:

Please check applicable accreditation & include effective date and last survey date:

✓	*Type of Accreditation*	*Effective Date*	*Last Survey Date*
	AASM		
	ABC		
	ACHC		
	BOC		
	CAHC		
	CARF		
	CHAP		
	HQAA		
	JCAHO		
	NABP		
	TCT		
	URAC		
	If other: specify:		

B. Licensure:

Please check applicable license and attach a copy:

✓	*Type of License*	*License Number and State*	*Effective Date*	*Expiration Date*
	Drug Enforcement Agency			
	Durable Medical Equipment			
	Fitters licensure			
	Home Health Agency			
	Home Sleep Therapy			
	Other - Specify			
	Oxygen License			
	Pharmacy			

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.

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C. *Medicare / Medicaid:*

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

✓	*Type of Certification*	*Identification #*	*Last Survey Date*	*Effective Date*	*Expiration Date*
	Medicare Part A				
	Medicare Part B				
	Medicaid				

D. *Insurance:*

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

✓	*Type of Coverage*	*Limit (aggregate / each occurrence)*	*Expiration Date*
	General Liability		
	Medical Malpractice/ Professional Liability		
	Fidelity Bond - Crime coverage, if applicable		
	Umbrella Policy		

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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.

Management and Organization	Yes	No
1. Does your organization maintain bylaws, charter, articles of incorporation or constitution that delineate legal authority and responsibility?		
2. Does your organization maintain written agreements to define the nature and scope of services provided?		
3. Is your organization in compliance with state and federal employment laws?		
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.*		
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 six (6) years and /or have any complaints been filed with such institutions, societies, or authorities about your organization within the past six (6) years?** *If yes, please explain.*		
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 six (6) years?** *If yes, explain and complete attached Professional liability form.*		
7. **Has your organization's insurance ever been denied or terminated by a carrier?** *If yes, explain.*		
8. Have your organization's employees completed cultural competency training? *If yes, please attach a copy of the document.*		

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9. Does your organization perform random drug screening on employees for illegal drug use?		
10. **Has there ever been any investigation or action taken against your organization's state license?** *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?** *If yes, explain and label your response as Section: IV Q#11.*		
Quality Improvement	**Yes**	**No**
12. Does your organization have a written Performance Improvement, Quality Improvement or Quality Control program that is consistent with JCAHO / CHAP / CARF / ACHC standards? Please attach copy of your QI policy and label as Section: IV Q#12.		
13. Does your organization have a formal client satisfaction survey process? Attach a copy of the survey tool and label as Section: IV Q#13.		
14. Do you monitor and track performance improvement activities (patient satisfaction survey results, completed patient surveys or meeting minutes)?		
Operations	**Yes**	**No**
15. Is your organization in compliance with the HIPAA and applicable state privacy requirements?		
16. Is patient/caregiver education provided and documented in the medical record?		
17. Do you have documentation of interdisciplinary communication based on patient's clinical status?		
18. Are periodic patient assessments performed and communicated to the physician?		
19. Do you have an Emergency Preparedness Plan specific to your locale and service types that all personnel understand and can implement if required?		
20. Do you have an inventory control process to manage the utilization of medication, supplies and equipment?		

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21. Do you conduct criminal background checks or criminal history screening of all your employees?		
22. Does your organization take fingerprints of your employees?		
Personnel Practices	**Yes**	**No**
23. Does your organization maintain current written job descriptions for all employees?		
24. 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?		
25. Does your organization have written personnel policies/procedures, e.g., employee handbook?		
26. Do you maintain current and complete personnel records for owners and staff?		
27. Does your organization maintain personnel files that include signed acknowledgement of a written confidentiality and conflict of interest policy?		
28. Do all of your organization's employees receive HIPAA compliance education upon hire and annually thereafter?		
29. Does your organization verify and document, and can you provide upon request, all appropriate licenses or certifications as required for each specific job/profession?		
30. 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?		
31. Does your organization identify classifications of employees required to maintain CPR certification?		

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32. Does your organization maintain documentation of employee orientation training, ongoing in-services and other continuing education?		
33. Does your organization check and document applicant employment history and references?		
34. Does your organization verify possession of a current driver's license and automobile insurance coverage for all appropriate employees?		
35. Do you have a completed I-9 immigration form for every applicable employee?		
36. Is the I-9 form updated **every three years?**		
37. Are your organization's personnel practices consistent with an Equal Employment Opportunity and Affirmative Action philosophy?		
38. 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?		
39. Does your credentialing process above include, at a minimum, a review and verification of credentials at least every 2-3 years?		
40. Does your organization discriminate or exclude individuals from service on the basis of race, color, national origin, gender, or handicap?		
41. Do you run monthly sanction checks on all of your employees? If no, please explain and label your response.		
Patient Records	**Yes**	**No**
42. Are the organization's patient records maintained for all patients and all services rendered?		
43. Does your organization document multi-disciplinary care conferences and care coordination with other providers?		
44. 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?		

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45. Does your organization have physician orders or prescriptions for each patient and for all services and products provided as required by law?		
46. Does your organization have a designated infection control program?		
47. Does your organization have a designated safety program?		
48. Does your organization document follow up to blood borne pathogen exposure?		
49. Are infection rates tracked and reported?		

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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.

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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

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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? ❒ Pending ❒ Settled Out of Court ❒ Found for Plaintiff ❒ Dropped ❒ Dismissed ❒ Found for Defendant	If damages were paid, either by settlement or court award, what was the amount on your behalf? Amount paid on your behalf: $_____ Amount paid by all parties: $_____ Was the amount paid by the ☐ carrier or ☐ entity?

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

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