

CareCentrix®

2011

Provider Manual

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1-1 WELCOME

Welcome to the CareCentrix Provider Network Panel. As one of the Providers credentialed to participate in the CareCentrix network of managed services and products, you have been qualified as a Provider of excellence. We are proud to partner with you and with our other network Providers in meeting high quality standards, providing and managing cost-effective health care solutions for the customers and patients served by our integrated healthcare network.

As a credentialed Provider within our network, you have entered into a partnership with CareCentrix that places high value on your services, products, employees and results. To demonstrate this commitment, we have dedicated resources to support your involvement in our network, and those resources are discussed further in sections on Provider orientation, training, communication and quality management mechanisms.

About This Provider Manual

This manual is intended to assist you in implementing and performing your role as a CareCentrix Provider. It is designed to serve as the basis for your orientation to our philosophy, structure and operations. It also contains instructional content requisite to optimal Provider performance and is an adjunct to the Provider Agreement. The manual has been formatted to organize future CareCentrix Provider communications, such as periodic newsletters and contract updates, into a “user friendly” system that will enable you to retain CareCentrix information in one place and access it with ease.

Please read this manual carefully. It explains your rights and responsibilities as a CareCentrix Provider, and you are contractually obligated to comply with the information herein.

1-2 ABOUT CARECENTRIX

About CareCentrix

CareCentrix is a healthcare delivery system available in all 50 states that provides ancillary care management services to payors through utilization and network management, credentialing and claims payment. We provide a seamless approach to ancillary care services through an integrated network of providers that offer skilled nursing services, occupational, physical and speech therapies, acute and chronic infusion therapy, respiratory therapy and durable medical equipment services. Our client base includes national and/or regional managed care organizations, insurance carriers, workers' compensation carriers, third-party administrators and government contractors.

CareCentrix began in 1996 as a wholly owned subsidiary of Gentiva Health Services. Towards the end of 2008, a change in the ownership occurred. Water Street Healthcare Partners, a private equity firm, acquired the controlling interest in CareCentrix and Gentiva Health Services retained a minority interest. The newly formed CareCentrix, Inc continues to conduct business utilizing the same name and operates under the existing structure, policies and procedures.

Since its beginning in 1996, CareCentrix has worked with some of the largest names in the healthcare industry, served millions of members and evolved into a business model that is designed to enhance the quality and manage the costs of post-acute care. As an integrated healthcare delivery system, CareCentrix has a network of over 4,000 credentialed ancillary care providers and employs approximately 400 associates nationally. The company is headquartered in Hartford, Connecticut, has an administrative office in Melville, NY and regional operation centers in Hartford, CT, Tampa, FL, Phoenix, AZ and Albuquerque, NM.

For more information, visit the CareCentrix web site, <http://www.carecentrix.com>.

1-3 REGIONAL CARE CENTERS

CareCentrix has three main operation sites to administer business. These operation sites are:

Hartford, CT

323 Pitkin Street

111 Founders Plaza

Suite 1600

East Hartford, CT 06108

877-725-6525

Regional Care Center – Reauthorization

877-725-6525

- Wound Care
- Specialty Programs

National Claims Center

323 Pitkin Street

111 Founders Plaza

Suite 801

East Hartford, CT 06108

877-725-6525

- Claims Submission
- Appeals Submission

Provider Resolution Team

877-725-6525

- Claims Resolution – Status, Denials, Payment Errors
- Request Duplicate EOP
- Demographic Changes

Phoenix, AZ

711 East Missouri Avenue

Suite 300

Phoenix, AZ 85014

Regional Care Center

877-725-6525

- Obtain Initial Authorization, Eligibility and Benefits

Network Management

800-666-6127, ext. 2147 (Midwest region) or 2139 (West region)

- Name/TIN Changes
- Provider Education
- New Provider Orientation
- Contracting

Tampa, FL

7725 Woodland Center Boulevard

Suite 100

Tampa, FL 33614

National Billing Center

3903 Northdale Blvd.

Suite 100E

Tampa, FL 33624

Regional Care Center

888-999-2422

- Obtain Initial Authorization, Eligibility and Benefits

Network Management

800-218-2505, ext. 2136 (Southeast region) or 2137(Northeast region)

- Name/TIN Changes
- Provider Education
- New Provider Orientation
- Contracting

Depending upon the functions delegated to CareCentrix, CareCentrix responsibilities may include:

- Intake for our health plan customers
- Provider assignment
- Utilization Management
- Claims and appeals coordination
- Data collection, compilation, analysis and reporting for health plans and Providers
- Credentialing

CareCentrix National Claims Center

The CareCentrix National Claims Center (NCC) is where Provider claims are processed and reimbursed. Claims should be sent to the address at the bottom of the authorization for services rendered to speed the reimbursement process. Always check the service authorization for the claims address, as occasionally a contract with a health plan will dictate a deviation from usual operating procedure.

1-4 CORPORATE COMPLIANCE PROGRAM

Company Objectives and Purpose of the Compliance Program

CareCentrix is committed to complying with all applicable legal requirements in the course of conducting its operations and expects each of its associates and contracted Providers to do likewise.

The purpose of the CareCentrix corporate compliance program (the “Program”) is to prevent and detect any criminal, fraudulent and other unethical and improper conduct, and to take appropriate corrective actions upon any detection of any such conduct.¹

Some of the activities the Program is intended to prevent include:

- Billing for excessive services (not medically necessary or appropriate);
- Billing for services not rendered;
- Failing to comply with government and other payor requirements (including billing for home health agency visits to patients who are not homebound or do not require a qualifying service, submission of cost reports claiming expenses unrelated to patient care or failing to identify related parties with whom business is conducted, and failure to obtain any required prior authorizations or to comply with claim submissions requirements);
- "Upcoding" diagnoses or otherwise entering false or misleading information on assessments, orders, clinical notes or other documents for the intent and purpose of obtaining excessive or disallowed payments;
- The use of unlicensed or untrained staff;
- Falsified plans of care;
- Forged signatures;
- Falsification of clinical documents and reports for the purpose of payment or licensure/certification including, but not limited to documentation of services not

¹The Program is intended to meet or exceed the requirements of the Federal Sentencing Guidelines created by the U. S. Sentencing Commission pursuant to the Sentencing Reform Act of 1984.

provided, backdating or falsifying dates of services and falsifying the condition and status of a patient;

- Failure to comply with applicable rules and regulations related to the protection and appropriate use of patient identifiable health information;
- "Split billing" among payors to circumvent payor coverage restrictions;
- Intentionally billing two or more payors for the same services resulting in a duplicate payment ("double dipping");
- Kickbacks and improper relationships with referral sources;
- Routine waivers of co-payments;
- Unlawful harassment or discrimination;
- Wage and Hour violations;
- Failing to meet other legal requirements;
- Providing services without the appropriate state licensure.

The focus of this description of the Program relates principally to preventing potential false or fraudulent claims, kickbacks and remuneration for referrals.

Reporting System

CareCentrix Senior Management is committed to credentialing a network of Providers that render services adhering to high ethical standards. To achieve these goals, it is essential that every associate employed by your agency be committed to these goals and assists your company in assuring compliance. In addition, early reporting of potentially improper activities can avert more serious harm to your company's reputation and business that would occur if such activity were to continue.

Accordingly, it is the policy of CareCentrix that participating Providers must report potentially criminal, fraudulent or other illegal activity. To help make it more convenient and less expensive for our Providers to fulfill their obligations under the Program, CareCentrix has established a corporate compliance toll-free phone number for reporting:

(877) 848-8229

Individuals who make a good faith report of known or suspected violations of law or the Program will be protected from retaliation. CareCentrix will take reasonable steps to protect the anonymity of the reporter and to ensure no adverse actions are taken against reporters.

The CareCentrix Chief Compliance Officer will take responsibility for investigating the claim. Information obtained in the course of any such investigation will be considered privileged and may be disclosed to third parties at the sole discretion of CareCentrix. Any Participating Provider knowingly failing to report unlawful conduct will be subject to disciplinary action up to and including network termination.

However, this policy is not intended to protect any individual giving a report which CareCentrix reasonably believes is knowingly fabricated, distorted, exaggerated or minimized to either injure someone else or to protect the reporting individual or others.

Response and Corrective Action to Promote Program Effectiveness

After any offense is detected, CareCentrix will take 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 your agencies placement on an Action Plan and/or Network termination, additional training and/or reinforcement communications to appropriate associates, and disclosure to governmental agencies.

1-5 False Claims Policy

Contracted Providers and their associates shall not directly or indirectly engage or participate in or cause the submission of improper, false or fraudulent claims for payment to the United States government or other healthcare payors.

General Information

Some examples of conduct which violate the CareCentrix False Claims policy are:

- Billing for services or supplies that were not provided or delivered to patients and/or were not used by the office or patient/family (e.g., supplies);
- Services provided by staff who do not meet the payor requirements, may not be billed or, if already billed, the CareCentrix Claims Department must be notified for resolution;
- Falsifying records to support improper billings, such as falsifying certificates of medical necessity, plans of treatment, OASIS assessments information (e.g., “upcoding”) and medical records to justify or support billings or payment;
- Falsification of physician’s orders, signatures or dates;
- Billing for services or supplies not furnished as billed;
- Soliciting, offering or receiving kickbacks resulting in the delivery of medically unnecessary treatment or overcharges;
- Claims containing false certifications, statements or information;
- Billing for services or supplies that are not medically necessary or for patients who are not homebound or whose care was not intermittent when these are requirements of the applicable payor;
- Falsifying cost reports by inflating costs, intentionally mischaracterizing the nature of costs, or giving wrong percentages of the services dedicated to patients;
- Duplicate billing;
- Inappropriate "split billing" of services in order to circumvent restrictions of the primary payor;
- False dating (e.g., backdating or pre-dating) of clinical notes, physician orders, or other documents used to support billing and payment.

Providers should bill for services only in compliance with the payor's coverage, documentation and billing requirements including, where applicable, that:

- The patient is homebound as defined by the specific payor(s). This is defined as the inability of the patient to leave home to obtain the needed services in another setting

due to either physical or mental conditions. (See reference manuals for specific requirements). Homebound status is documented in the clinical record via clinical assessment, discipline-specific assessment, physician's orders, clinical notes and/or other documents on a regular basis.

- Services that are provided and billed are medically reasonable and necessary and covered by the specific payor(s). Services must be consistent with standards of practice and require the knowledge and skills of the ordered discipline(s) to safely and effectively provide the care. Necessity is documented in the clinical record via clinical assessment, discipline-specific assessment, physician's orders, clinical notes and/or other documents on a regular basis.
- If required, the care is intermittent as defined by the payor. Services must be of a predictable frequency and, if skilled nursing is the qualifying skill, visits must be less than seven (7) days per week or may be seven (7) days per week for a finite and predictable time period. No split billing is allowed.
- Services must be provided in the patient's residence where required by the payor. Offices are responsible for determining if a group living arrangement meets the definition of a residence under the specific payor and if home care services may be provided in such a facility based on state licensure and payor coverage requirements/restrictions.
- Services and supplies must be covered by appropriate, valid physician orders, when required by the office's license/certification and/or the payor.

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act (FCA) was first enacted during the Civil War to fight fraud in supplying goods to the Union Army. The law has undergone a number of changes since then and now applies to any federally funded contract or program, except tax fraud. The FCA was expanded to include Medicare and Medicaid programs in 1986.

Summary of Provisions

The FCA prohibits knowingly making a false claim against the government. False claims can take the form of overcharging for a product or service, delivering less than the promised amount or type of service, delivering less than the promised amount or type of goods or services, underpaying money owed to the government and charging for one thing while providing another.

Penalties

The FCA imposes civil penalties and is not a criminal statute. Therefore, no proof of specific intent as required for violation of a criminal statute is necessary. Persons (including organizations such as hospitals) may be fined a civil penalty of not less than \$5,000 nor more than \$10,000, plus three (3) times the amount of damages sustained by the government for each false claim. The amount of damages in healthcare terms is the amount paid for each false claim that is filed.

Qui Tam (Whistleblower) Provisions

Any person may bring an action under this law (called a *qui tam* relator or whistleblower suit) in federal court. The case is initiated by causing a copy of the complaint and all available relevant evidence to be served on the federal government. The case will remain sealed for at least 60 days and will not be served on the defendant so the government can investigate the complaint. The government may obtain additional time to investigate for good cause. The government on its own initiative may also initiate a case under the FCA.

After the 60 day period, or any extensions, has expired, the government may pursue the matter in its own name, or decline to proceed. If the government declines to proceed, the person bringing the action has the right to conduct the action on their own in federal court.

If the government proceeds with the case, the *qui tam* relator bringing the action will receive between 15 and 25 percent of any proceeds, depending upon the contributions of the individual to the success of the case. If the government declines to pursue the case, and the *qui tam* relator successfully prosecutes the claim, the relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorneys fees and costs. Any case must be brought within six years of the filing of the false claim.

Non-Retaliation

Anyone initiating a *qui tam* case may not be discriminated or retaliated against in any manner by their employer by virtue of bringing the claim. Providers and their associates are authorized under the FCA to initiate court proceedings to make themselves whole for any job related losses resulting from any such discrimination or retaliation.

PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act creates administrative remedies for making false claims separate from and in addition to, the judicial or court remedy for false claims provided by the Civil False Claims Act.

The Act is quite similar to the Civil False Claims Act in many respects, but is somewhat broader and more detailed, with differing penalties. The Act deals with submission of improper “claims” or “written statements” to a federal agency.

- Specifically, a person violates this act if they know or have reason to know they are submitting a claim that is:
 - False, fictitious or fraudulent; or,
 - Includes or is supported by written statements that are false, fictitious or fraudulent; or
 - Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a result of the omission; and the person submitting the statement has a duty to include the omitted facts; or

- For payment for property or services not provided as claimed.

A violation of this prohibition carries a \$5,000 civil penalty for each such wrongfully filed claim. In addition, an assessment of two times the amount of the claim may be made, unless the claim has not actually been paid.

- A person also violates this act if they submit a written statement which they know or should know:
 - Asserts a material fact which is false, fictitious or fraudulent; or
 - Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the prohibition for submitting an improper statement carries a civil penalty of up to \$5,000.

The Role of Such Laws in Preventing and Detecting Fraud, Waste, and Abuse in Federal and State HealthCare Programs:

The laws described in this policy create a comprehensive process for controlling waste, fraud and abuse in federal and state healthcare programs by giving appropriate governmental agencies the authority to seek out, investigate and prosecute violations. Enforcement activities are pursued in three available forums: criminal, civil and administrative. This provides a broad spectrum of remedies to address the fraud and abuse problem. Moreover, whistleblower protections, such as those included in the federal Civil False Claims Act, provide protections for individuals reporting fraud and abuse in good faith. If you are aware of any such activity please notify the Compliance Department at (877) 848-8229.

Sanctions

Failure to adhere to this policy and applicable guidelines will subject Providers to disciplinary action, up to and including contract termination and notification to the applicable licensing or regulatory board.

2-1 PROVIDER RIGHTS

The Provider Manual section on Provider rights and responsibilities expands upon and clarifies the sections of the same name in your Provider contract.

As a CareCentrix Provider, you have the right to:

- Be treated with dignity, courtesy and respect by CareCentrix staff and by other Providers.
- Be oriented and trained to CareCentrix operations and the expectations therein.
- Receive continuing education and updates regarding new and existing CareCentrix carrier agreements and their expectations for Provider performance.
- Receive ongoing communications including, but not limited to, newsletters, manual updates and health plan customer updates.
- Accept or refuse cases. Acceptable reasons for refusing a case are:
 - You are unable to staff the case with reasonable expertise and continuity.
 - Upon start of care, it is determined, in conjunction with the CareCentrix Regional Care Center, that the case does not fit payor criteria.
 - Upon assessment, it is determined that the services/products require expertise beyond what you as a Provider can offer.
- Refusals based on dissatisfaction with contracted rates are considered grounds for termination in the CareCentrix network.
- Be oriented to each referred case in a concise and pertinent fashion.
- Be provided with clear expectations for utilization and performance for each case.
- Be informed of perceived performance problems to investigate and resolve the issue.

- Appeal utilization determinations on behalf of the member without concern for retribution.
- Address concerns, issues and complaints without concern for retribution.
- Receive feedback on measures of organizational and aggregate Provider and CareCentrix performance.
- Offer input into quality initiatives.
- Be represented to the professional community as a valued participant in CareCentrix operations.
- Appeal re-credentialing decisions without concern for retribution.
- Negotiate contractual agreements within the context of ethical practices.
- Be reimbursed for authorized services as outlined in the *Claims* section of this manual.

If you feel that your rights as a CareCentrix Provider have been compromised in any way, you should contact the Regional Network Manager at the appropriate Regional Care Center.

2-2 PERFORMANCE STANDARDS

As a participant in the CareCentrix network of Providers, the Provider will:

- Submit written changes regarding the following items to the Regional Network Manager:
 - Address
 - Telephone and/or fax number(s)
 - Tax identification number (Changes above should be submitted no sooner than fourteen (14) days before and no more than thirty (30) days after a change.)
 - Name of key organizational contact
 - Names of key local operations contact(s)
 - Accreditation status, *including revocations*

- Legal status; i.e., pending newly active litigation relative to CareCentrix cases (malpractice action)
- Licensing status, including sanctions
- Liability insurance coverage
- Days/hours of operation
- Service status
- Service/product capabilities
- Any sustentative change in business structure or ownership
- Addition/closure of operations/business site
- See the section *Administrative Processes* for specific directions.
- Maintain twenty-four (24) hour on-call coverage seven (7) days per week and respond to patient and/or CareCentrix contacts within thirty (30) minutes of call, including weekends, evenings and holidays, unless otherwise specified by contract.
- Notify the CareCentrix utilization staff immediately if not able to service a referred case.
- Submit billing for authorized services and/or products as delivered to the CareCentrix at least monthly but no more than weekly unless otherwise contractually stipulated.
- Submit no billing to the primary health plan for services/products delivered to CareCentrix patients unless directed to do so by CareCentrix in writing.
- PLEASE SEND ALL WRITTEN REQUESTS TO:
 - Provider Resolution Team
 - 111 Founders Plaza
 - Suite 801
 - East Hartford, CT 06108
- Do not bill or attempt to collect reimbursement from patients for services and/or products unless otherwise notified to do so by CareCentrix in writing.
- Do not have patient sign release for financial responsibility unless specifically instructed to do so.

- Do not, under any circumstance, tell the patient/member that they are not responsible for any co-pays or deductibles. Although the patient is not responsible to pay co-pays or deductibles to a Provider, CareCentrix may bill for these expenses.
- Do submit quality assessment, quality improvement, clinical outcomes and program evaluation reports upon request of CareCentrix personnel.
- Do participate in CareCentrix quality initiatives as requested.
- Do adhere to all other principles, practices and procedures found within the CareCentrix Provider Manual and contractual relationships between the CareCentrix and health plan customers.

3-1 PROVIDER ORIENTATION

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

Provider Manual

All new Providers receive a copy of this manual along with a fully executed agreement within thirty (30) days of confirmation of credentialed status. The manual is intended to allow you and others in your organization to learn the “basics” of CareCentrix participation, as well as your roles and responsibilities as a CareCentrix Provider. It also serves as an ongoing reference that is be updated periodically.

Providers will receive updates to their Provider Manual when:

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

When CareCentrix enters a new carrier contract, there is a place at the end of the manual for special report and information generated from CareCentrix meetings with Providers. Correspondence related to a specific health plan should be maintained in the section called *CareCentrix Correspondence*.

The Conference Call

A continuing resource for CareCentrix Providers is the Provider orientation conference call, which furnishes important information on Provider responsibilities and CareCentrix operational procedures as outlined in this manual. The Network Management Department will contact you to set up an orientation call at a date and time convenient for maximum participation. Providers may also request an orientation call at any time to give a refresher of this manual's contents.

The conference call is intended to give the CareCentrix network Providers a clear understanding of how CareCentrix operates, and responsibilities for a credentialed Provider. Although this conference call is loosely scripted, Providers are encouraged to ask questions at any time during the presentation. The duration of the call is approximately forty-five (45) minutes to one hour. Providers should have reviewed this manual prior to the call to obtain the most benefit from their participation.

Special Reports

The CareCentrix staff may issue special reports from time to time. These reports will summarize data or information pertinent to improving Provider/CareCentrix quality. They may include aggregate data on over-all measurement of Provider and CareCentrix performance and quality improvement initiatives.

3-2 REGIONAL PROVIDER MEETINGS

Providers will have the opportunity to participate in regional and/or local meetings convened by the Regional Network Manager from the Regional Care Center.

Purpose

Regional Provider meetings shall be used to meet these objectives:

- To foster and grow relationships with and among Providers and CareCentrix personnel.
- To problem-solve common situations and occurrences as CareCentrix grows and evolves.
- To share clinical administrative innovations that will strengthen CareCentrix and Provider capabilities.
- To meet with key local and regional health plan representatives and discuss effective use of Provider and CareCentrix services.
- To provide continued education that promotes CareCentrix efficiency and effectiveness.
- To reinforce previous education and training.
- To review initiatives and address quality issues and provides input in establishing quality.

National Claims Center
877-725-6525 Phone
111 Founders Plaza
Suite 801
East Hartford, CT 06108

Attendance

Regional Provider meetings shall be open to all Providers.

Location

Regional Provider meetings may be convened in a location at the discretion of the Regional Network Manager as approved by the Area Vice President of Network Operations.

Frequency

Regional Provider meetings shall be convened as determined by the Director of Network Management.

3-3 NATIONAL CREDENTIALING COMMITTEE**Purpose**

The National Credentialing Committee addresses credentialing issues in all Provider specialties and all states, with the goal of continuing CareCentrix role as the industry leader in home care credentialing. The purpose of the Committee is to approve and provide input in credentialing policies on an on-going basis.

The Committee's goals are:

- To promote the specific credentialing standards developed for each Provider service type.
- CareCentrix Provider application with specific questions tailored for each service type.
- Review and approve credentialing application.
 - Initial and re-credentialed

Attendance

The Committee comprises external voting members and internal CareCentrix staff that are non-voting members. The external members are physicians, representing the following specialties: Internal Medicine, Gastroenterology, Pediatrics, Surgery and Orthopedics. A current Committee membership list can be obtained from the CareCentrix credentialing department.

Meeting Schedule

The Committee meets monthly via conference call, with face-to-face meetings as called by the CareCentrix Credentialing Manager.

4-1 PROVIDER QUALIFICATION AND QUALITY MANAGEMENT

Credentialing

Required items are outlined below:

- A completed application. All Providers must complete the CareCentrix Credentialing Application. The application asks questions related to the credentials, operational, financial and quality performance information, as well as information related to types of services provided and services area. 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 and correct.
- Copies of licensure for the new office. CareCentrix requires current licensure in good standing in accordance with state statutes. CareCentrix obtains a copy of the current primary license under which the facility is operating.
- Proof of professional and general liability insurance for the new location. These policies must meet CareCentrix minimum requirements of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate. CareCentrix must verify coverage with the Provider's professional and general liability carrier(s).
- Current malpractice history. The CareCentrix National Credentialing Committee will review all malpractice claims settled against the facility, to determine whether acceptable risk exposure exists.

Re-Credentialing

All CareCentrix credentialed Providers are re-credentialed every three years. However, a Provider's credentialing status may be evaluated by the Credentialing Committee at any time during the 3 year credentialing period. This is typically done if a Provider is adding a new service category, or malpractice or quality of care/service issues are brought to the Committee's attention. The re-credentialing process begins

approximately six (6) months before the credentialing anniversary. For re-credentialing the following items are required:

- Copies of current licensure.
- A review of a current copy of the Department of Health and Human Services Cumulative Sanction Report done in-house by CareCentrix. (You are not required to submit the report). Inclusion or exclusion on the sanction listing by CMS or OIG is grounds for termination from the CareCentrix network.
- Current copies of professional and general liability insurance certificates. CareCentrix must verify coverage with the Provider's professional and general liability carrier(s).
- Malpractice history. CareCentrix will verify the malpractice claims history with the insurance carrier. The CareCentrix National Credentialing Committee then reviews the history.
- Copies of current accreditation or certification.
- For non-accredited, non-certified Providers, CareCentrix will perform a site visit.
- QA/QI program and program evaluation.

Provider Profiling

In addition to the information listed in the previous section, the re-credentialing process includes a review of the Provider's performance during their participation with CareCentrix. This may include but is not limited to:

- Satisfaction surveys.
- All incidents and follow-up correspondence.
- All complaints and follow-up correspondence.
- Any correspondence received complimenting the Provider's service.
- Compliance with CareCentrix credentialing and other policies.
- Deviations from acceptable Provider practice as identified by RCC personnel such as:
 - Refusing to accept cases for reasons including dissatisfaction with pricing and/or continued inability to staff cases.

- Billing directly to the health plan or patient.
- Services provided without authorization.
- Non-compliance with authorization determination.
- Non-compliance with start-of-care timeframes.
- Delivery of late, substandard, incorrect equipment.
- Failure to provide twenty-four (24) hour on-call access, or not being readily accessible to patient.
- Inappropriate attitude or behavior of caregiver.
- Caregiver late or does not arrive for scheduled visit.
- Patient not notified of schedule change.
- Failure to notify CareCentrix of non-acceptance of case.
- Failure to notify ordering physician of delayed services or delivery.

Please refer to the section *Problem Management* in this manual regarding notification of profiling issues.

Credentialing Requirements for a New Location

Adding a location (not expanding a service area) requires credentialing of the new location. The CareCentrix Provider must contact their Regional Network Manager to request the addition of new site locations. Required items are outlined below.

- A completed application. All Providers must complete the CareCentrix Credentialing Application. The application asks questions related to the credentials, operational, financial and quality performance information, as well as information related to types of services provided and services area. 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 and correct.
- Copies of licensure for the new office. CareCentrix requires current licensure in good standing in accordance with state statutes. CareCentrix obtains a copy of the current primary license under which the facility is operating.

- Proof of professional and general liability insurance for the new location. These policies must meet CareCentrix minimum requirements of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in aggregate. CareCentrix must verify coverage with the Provider's professional and general liability carrier(s).
- Current malpractice history. The CareCentrix National Credentialing Committee will review all malpractice claims settled against the facility, to determine whether acceptable risk exposure exists.

The review is based on information provided, and attested to, by the Provider and information obtained from the carrier.

- Copies of current accreditation award letter/certificate (if applicable).
- QA/QI program. CareCentrix will obtain a copy of the Provider's QA/QI program and program evaluation.

Credentialing Requirements for Adding a Service Category

For each site that will be adding a new service category (i.e. staffing, HME, Infusion), a written notification to the Regional Network Manager must be submitted and must include the required material for adding a new location. The license required is that which indicates licensure to provide the new service category. The information will be presented to the Credentialing Committee for determination based on the Provider's qualifications to provide that service.

Quality Measurement

The Director of Quality Management assesses quality according to industry, regulatory and accreditation and regulatory standards. Therefore we assess the quality of our Provider networks in a variety of ways, some of which may impact you, the Provider.

Satisfaction Measurement

In compliance with our own policies and procedures, and in keeping with NCQA and URAC standards and contractual requirements of our customers, we or our health plan customers will sample and report findings regarding:

- Patient satisfaction.
- Physician satisfaction.
- Customer (health plan) satisfaction.

In addition, as your partner, we are concerned with your satisfaction as a participant in CareCentrix. Therefore, we will assess your satisfaction through two means:

- Provider satisfaction surveys via email, letter and telephone.
- Provider focus groups.

Satisfaction Measurement Report To Providers

We will routinely report satisfaction data results, analyses and related quality improvement initiatives to our Providers for purposes of providing feedback on CareCentrix performance and improvement designs, and to foster improved relations between and among our patients, physicians, Providers, and health plan customers and CareCentrix management.

4-2 CHANGES IN YOUR ORGANIZATION**Demographic Changes**

Demographic changes must be requested in writing on company letter head, within a timely manner to your Regional Network Manager located at the Regional Care Center. Changes in the items may affect receipt of referrals and reimbursements. Please be diligent in reporting changes to the following:

- Address(es), including the remit to address
- Telephone number(s)
- Name of key organizational contact(s)

- Names(s) of key local operations contact(s)
- Tax Identification Number
- Days/hours of operations
- Service area

4-3 CONTRACT RENEWAL AND MODIFICATION/ RENEGOTIATION

Renewal

Contracts are automatically renewed yearly unless contested by either the Provider or CareCentrix prior to the anniversary of the effective date. Unless specified otherwise, the Provider will service all health plans contracted with CareCentrix.

Modification/Re-Negotiation

CareCentrix has the right to modify any provision of the contract upon thirty (30) days prior written notice to the Provider. Should the said modification materially affect the responsibilities or rights of the Provider, the Provider has the right to terminate the agreement with thirty (30) days prior written notice. These thirty (30) days are in addition to the thirty (30) days notice from CareCentrix.

4-4 LEAVE OF PARTICIPATION

Providers may seek a Leave of Participation from active CareCentrix Provider status by requesting and documenting the need for leave in written form as follows:

- State request for leave.
- State requested beginning and termination of leave dates.
- State reason for request.
- Submit request in writing to the Regional Network Manager

A leave of participation may be granted for no more than ninety (90) days. CareCentrix will notify Provider as to whether the request has been approved or denied.

4-5 CONTRACT TERMINATION

Both CareCentrix and the Provider may exercise their option of terminating the contract at any time upon ninety (90) days written notice to the other party. Notifications of terminations by Providers to CareCentrix should be addressed to AVP, Network Management, and Tampa, Florida.

The contract may also be terminated if:

- Any warranty, representation of material covenant of the other party is untrue as of the date of the contract or breached during the term of the contract.
- Any such breach that is capable of remediation is not remedied within fifteen (15) days after written notice to the CareCentrix AVP of Network Operations.

The AVP of Network Operations will communicate terminations initiated by CareCentrix. Termination of the contract does not release either party of any accrued liability.

Upon a termination of the contract, the Provider shall reasonably cooperate to ensure that patients are not left without medically necessary care.

These reasonable measures shall include the following:

- The Provider shall, at CareCentrix request, continue services for ninety (90) days following termination.
- The Provider shall, at CareCentrix request, provide a list of patients currently on service, with a description of the services they are receiving.
- The Provider will maintain a professional attitude regarding CareCentrix to patients and the community, regardless of the reason for the contract termination.
- The Provider shall assist in transitioning the care of patients whose services will continue beyond ninety (90) days to a new CareCentrix Provider (e.g. Provider case summary and status upon discharge).

- Provider shall, at CareCentrix request, provide prescriptions directly to CareCentrix or the new Provider.

5-1 CARECENTRIX HEALTHCARE DELIVERY PROCESS INTRODUCTION

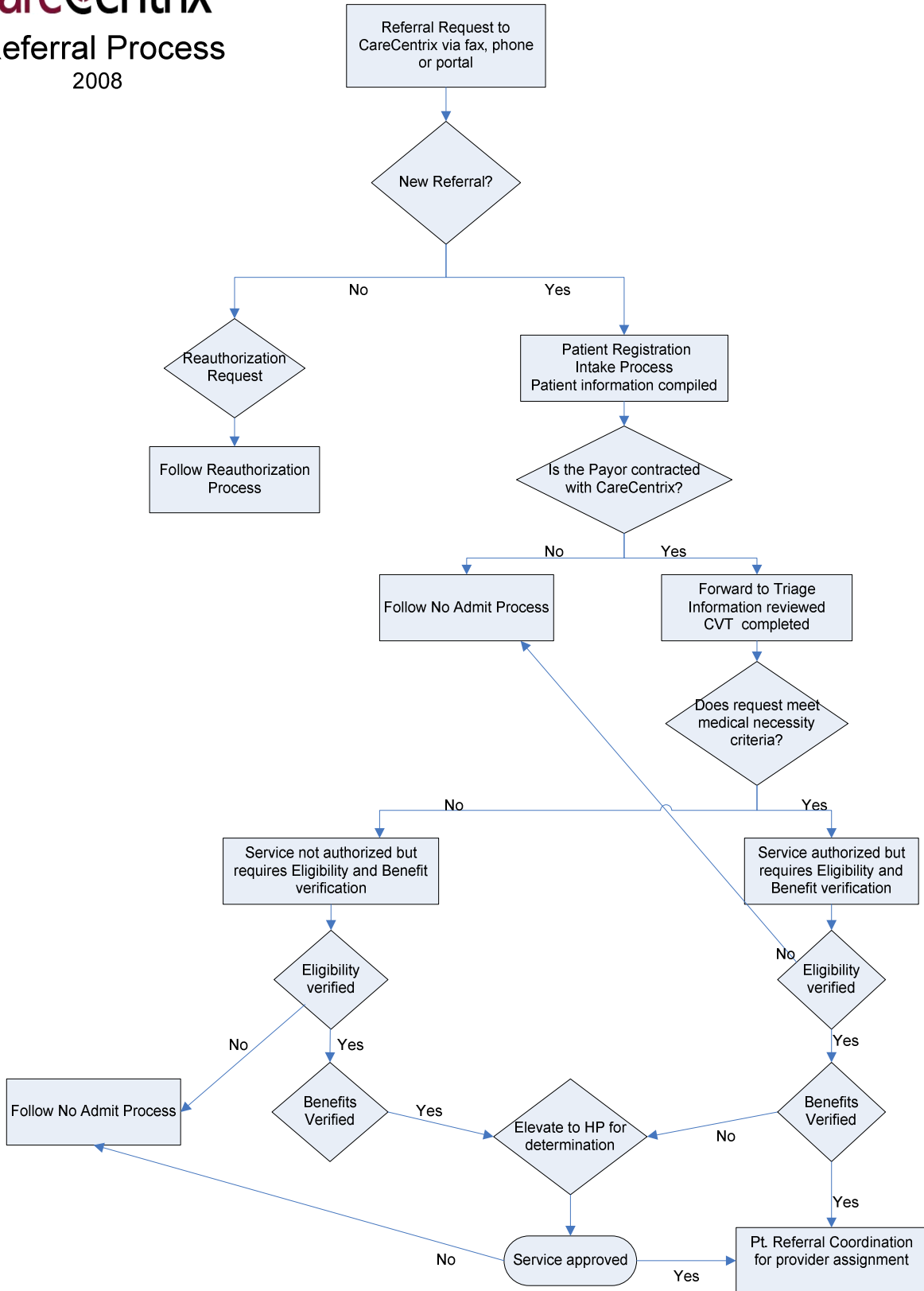
CareCentrix has contracts with many payors. The processes that CareCentrix applies to a given patient's referral are based upon the specifics of the contract between CareCentrix and the payors.

5-2 REFERRAL COORDINATION BY THE HEALTH PLAN OR HEALTHCARE DELIVERY SYSTEM

Patient Registration - Intake

Intake begins with a call from the referral source. If a call is received from a different source, CareCentrix will take the information and forward it to the health plan. If a CareCentrix network Provider receives a call for services/products that will involve CareCentrix, the Provider has the option of re-directing the caller to the insurance plan or taking the information. *A Provider that accepts the information and relays the information to CareCentrix is NOT guaranteed of receiving the case.* The insurance case manager calls CareCentrix with the information regarding the case, specifically the information listed in the intake process. He/she will have already reviewed the patient's eligibility, eligibility for services/product and requested the patient's clinical condition and the physician orders.

CareCentrix®
Referral Process
2008



The CareCentrix Intake Process

Once the referral is received, the CareCentrix Intake representative will:

- Obtain demographic information regarding the patient, site of service and support mechanisms.
- Obtain diagnosis.
- Verify that the diagnosis is related to ordered home care services/products or equipment.
- Accept request for service. CareCentrix does not take orders. However, CareCentrix will request orders at time of referral to send to accepting Provider.
- Obtain physician first, last name and telephone number (ordering & primary if necessary). Additional physician demographic will be obtained only if available by referral source.
- Verify the request for service is for services and/or products appropriately delivered in the home.
- Verify plan coverage for requested service/product as required by contract. The Provider should refer to the payor business rules for details regarding the responsible parties for verifying benefits as this varies by payor.
- Verify that requested services/products are to be coordinated by CareCentrix. If CareCentrix does not coordinate the services/products, the financially responsible payor should be contacted to determine the appropriate level and Provider of services/products.

CareCentrix Utilization Turnaround Timeframes

- Perform start of care or equipment delivery in accordance with the following Maximum Turnaround Timeframes:

Precertification/Preauthorization (initial referral)

- Urgent Services – CareCentrix will make a decision within 24 hours. Once the decision has been made the Provider will be notified within 24 hours of the authorization decision. The service must be authorized and the Provider notified within 48 hours.

- Routine services (non-urgent) – must be authorized to the Provider within three (3) business days of receipt of a complete referral. CareCentrix has two (2) business days to make an authorization decision, which is noted on the clinical verification template, completed by the triage team, and another business day to authorize services to the Provider.

Concurrent Review

- Urgent services – must be authorized to a Provider within 48 hours. CareCentrix has 24 hours to make a determination, which is noted on the clinical verification template completed by the triage team, and another 24 hours to notify the Provider of the authorization decision.
- Routine services (non-urgent) – received prior to the CareCentrix authorization end date – must be authorized to a Provider within 48 hours. CareCentrix has 24 hours to make a determination, which is noted on the clinical verification template completed by the triage team, and another 24 hours to notify the Provider of the authorization decision.
- Urgent or routine services received on or after the CareCentrix authorization end date are to be processed within 72 hours after receiving all necessary information.
- Notify the CareCentrix utilization staff immediately if the start of care/delivery must be delayed.
- Notify the CareCentrix utilization staff within two (2) hours of completion of start of care or service delivery if unable to continue the case.
- Render no service unless so authorized by the referring CareCentrix utilization staff and ordered by the primary physician. Please remember the Regional Care Centers have staff available during non-office hours for convenience.
- Assure appropriate staff training, orientation and supervision of field staff by appropriately licensed medical professionals at a frequency, which meets state, federal, and applicable industry standards.
- Notify the CareCentrix utilization staff upon if additional sources of reimbursement are available to the patient when identified.

- Provide after hours (on call) home visits as appropriate and necessary in situations that cannot be resolved by telephone consultation.
- Notify the CareCentrix utilization staff of changes in patient/family status within twenty-four (24) hours upon occurrence and/or identification, including illness, hospitalization, death or other change affecting continued service delivery.
- Follow/report patient status, progress and projected and actual date of discharge for hospitalized/institutionalized patients while on service.
- Notify the CareCentrix utilization staff of complaints made by the patient, family, physician or health plan upon occurrence.
- Report discharge data to the CareCentrix utilization staff within one (1) business day of completion of service/products.
- Routinely submit requests for service/product re-authorization at least twenty-four (24) hours **prior** to completion of authorized services/products.
- Contact the CareCentrix utilization staff **within two (2) business days** after providing unauthorized care on a non-business day or after business hours. Emergency services are defined as services provided for conditions due to illness or injury which are not life-threatening but require prompt attention and/or treatment to prevent complication to or deterioration of the enrollee's condition.
- Submit information as follows:
 - Objective reason(s) for re-authorization of services/products no later than twenty-four (24) hours prior to completion of authorized services and products.
 - Discharge summary within twenty-four (24) hours of completing service/product delivery.
 - Assessment reports, progress reports, organizational forms or other organizational documents within forty-eight (48) hours of request by CareCentrix.
- Report adverse incidents, as defined in the CareCentrix Provider Manual, *Customer Acknowledgement and Resolution Management* section, to the **CareCentrix** utilization staff immediately upon discovery.
- Respond to grievances/complaints filed against the CareCentrix Provider within two (2) business days and pursue timely resolution as acceptable by CareCentrix staff.

Provider Responsibilities

The following applies to Provider responsibilities:

- If the physician order is not included with referral information, Providers are expected to contact the physician and secure the orders.
- Patients should be referred back to their health plan's member services/products department for information regarding benefits, deductibles and co-pays. These charges may still apply, even though CareCentrix pays the Provider in full.
- Notify CareCentrix of additional sources of reimbursement when identified.
- Obtain and report patient status to CareCentrix with projected and actual date of discharge on hospitalized/institutionalized patients.

The CareCentrix Provider Assignment Process – Patient Referral Coordination

Patient Referral Coordination is the process of choosing a Provider to render services/products to a specific patient. Utilization Management staff makes decisions based on:

- The zip code of the site where the patient will receive service.
- The zip codes of the service areas for the Provider.
- The services/products for which a Provider is credentialed to perform or supply.
- Acceptance for specific start of care.

Based on these criteria, the CareCentrix computer system produces a list of Providers that can service the patient. The CareCentrix utilization staff will make a determination of which Provider will be offered the case. Depending upon the payor's directions, the CareCentrix utilization staff will:

- Call the Provider to offer the case and fax or transmit an authorization for service to the Provider that accepts the case or
- Give the health plan case manager the Provider information and then fax the authorization to provide service to the Provider after a return call from the health plan case manager.

Appeals for utilization decisions should be directed to the health plan by the patient and/or physician. Claims appeals should be submitted as per the claims section of this manual.

5-3 UTILIZATION MANAGEMENT

The CareCentrix Utilization Management Process

Utilization Management is the evaluation of the appropriateness, medical necessity and efficiency of healthcare services according to established criteria or guidelines and under the provisions of an applicable benefit plan for a patient.

When CareCentrix is responsible for the utilization review of services the following *medically necessary criteria* is utilized:

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

Medical Necessity determinations apply to initial and reauthorization requests for traditional home health (THH), home medical equipment (HME), home infusion therapy (HIT) and Orthotics & Prosthetics (O&P).

Utilization Management Responsibilities

Providers have the following responsibilities:

- Obtain verbal (written confirmation follows in twenty-four (24) hours) authorization prior to beginning services/products. Services/products performed without

authorization may be denied for payment. Denial of payment is not billable to patient by Provider.

- As our partner, it is your responsibility to verify the information on the authorization sheets (service codes, number of units, expiration date) upon receipt. While the CareCentrix utilization management staff makes every effort to assure the accuracy of the authorization sheets, mistakes occasionally occur. Should you identify an error call CareCentrix within 24 hours to correct SAF. Failure by the Provider to obtain the authorization sheet and verify services/products authorized may result in non-payment.
- Notify CareCentrix immediately if, when the services or equipment is delivered, the diagnosis is determined to be different than the diagnosis obtained from CareCentrix.
- Notify CareCentrix if the services ordered will not meet the needs of the patient. Provider to use their expertise in identifying alternatives and discussing with CareCentrix and the ordering physician.
- Notify CareCentrix of changes in patient/family status within twenty-four (24) hours (includes illness, hospitalization, death or other change affecting continued service delivery)
- 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/products as necessary. (Extending services/products or adding

new services/products requires authorization from CareCentrix. This may vary if the Provider is EDI or fully manages the EBA per payor business rules.)

- A disagreement with the service authorization should be handled by the patient through the Health Plan utilization management appeals process.
- *Although CareCentrix or the health plan may make authorization approval decisions, only the Plan makes denial determinations. Refer patients to the Health Plan to discuss denials. Since the denial was issued by the health plan only the health plan can reconsider. Health plan denials should be addressed by patient and/or physician to the health plan's Member Services. If an appeal is submitted to CareCentrix, we will document and refer to the appropriate Plan.*

Reauthorization Responsibilities

CareCentrix policy on Provider re-authorization responsibilities is as follows:

- A reauthorization is required to continue service if either 1) the date span of the authorization will be exceeded, regardless of any remaining units or 2) the authorized number of visits/units will be exceeded. Obtaining a re-authorization is the responsibility of the Provider.
- Providers must submit requests for re-authorization at least twenty-four (24) hours prior to the expiration of the authorization expiration and provide clinical status and objective reasons for re-authorization. No re-authorizations are given without a clinical update. Re-authorization can be done by phone or fax, but in either case, detailed clinical information is required. If the Provider submits information via fax, the appropriate CareCentrix *Update Form* (sample provided at end of chapter) or an internal form with the same information may be utilized.
- **Retro-Authorizations.** If a Provider fails to request a reauthorization and continues to provide services, those services performed from the expiration date to the reauthorization request are not reimbursable and are not billable to the patient.

Questions Regarding Authorization Decisions

If services/products have been authorized for less than what has been ordered, services/products have not been denied and re-authorization should be requested prior to the end of the authorization period. The clinical status of the patient, plan of treatment and treatment goals will be necessary to make a re-authorization decision. It is the Provider's responsibility to supply updated clinical information.

Appealing a Denied Request

If services/products have been denied by the Plan in their entirety and new and/or additional information is obtained, the Provider should contact the CareCentrix utilization staff to relay the new information and have the authorization request reviewed by the plan.

If services/products have been denied in their entirety and there is no new information available, the patient or physician should contact the Health Plan to determine the appeals process. **CareCentrix has not been delegated the denial process; all denials are issued by the health plan.**

5-4 SERVICE DELIVERY

It is important that a Provider clearly understand the responsibilities for service/product delivery and the discharge of patients from service. Following the steps as indicated in this section will ensure that a Provider is in compliance with CareCentrix policy and procedure.

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.

- Initiate start of care or deliver equipment within twenty-four (24) hours of acceptance of a referral for routine requests, four (4) hours for priority cases or as directed by the physician or referral source and relayed by CareCentrix.
- Notify CareCentrix immediately if start of care must be delayed.
- Notify CareCentrix within two (2) hours of start of care if unable to continue service delivery to the case.
- Notify CareCentrix within twenty-four (24) hours if the information obtained during CareCentrix registration process has changed or was incorrect. The utilization staff will review the authorization to determine if a change to the authorization is required. For example:
 - An authorization is given for Ampicillin. When the PCP is contacted, the Provider is notified of a drug, dosage or frequency change.
 - An initial referral and authorization is given for diabetic teaching. The Provider, upon completing the initial assessment, identifies a need for wound care visits and supplies.
 - HME Provider identifies the equipment is not the correct size/type to meet the patient need.
- Render only services/products that have been ordered by an appropriate physician and authorized by CareCentrix.
- Provide after hours (on-call) home visits as appropriate and necessary in situations that cannot be resolved by telephone consultation.
- Report adverse incidents to CareCentrix within twenty-four (24) hours of occurrence. *Do not contact the health plan unless instructed to do so by CareCentrix.*
- Report complaints 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.
- Conduct and document discharge planning on an on-going basis during the care and document that discharge needs were met upon discharge.
- **Contact CareCentrix** (*NOT the health plan*) for problems regarding services/products or products.

The Provider's Discharge Responsibilities

Discharge from service can be for any of the following reasons:

- The patient expires.
- The patient meets the Plan of Care.
- The patient and/or family are capable of assuming care.
- The patient no longer wishes to receive services/products. The 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 Provider cannot provide the services/products ordered and authorized, because of lack of staffing or expertise.
- The physician does not provide the needed orders.
- The patient is institutionalized.
- Home care is no longer appropriate due to risk factors.
- The patient relocates outside of the geographic service area.
- The patient refuses assignment of a Provider employee to deliver care/services/products on a discriminatory basis.

5-5 GUIDELINES SPECIFIC TO PROVIDER SPECIALTY

This section outlines the guidelines specific to the specialty area of a Provider. Guidelines are prescribed for traditional home health (THH), home infusion therapy (HIT) and home medical equipment (HME). These guidelines are standard for CareCentrix and are used by the CareCentrix referral coordinators.

Traditional Home Health (THH)

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

- A visit (2 hours) is defined as an episode of service (treatment or procedure) performed in a predetermined period of time with a predictable outcome. CareCentrix must authorize any service that will be billed in excess of one visit *in advance*.
- Provider subcontracting is not allowed under this contract (with the exception of first call pharmacies to meet start of care.)
- *Any laboratory tests collected by a CareCentrix Provider must be taken to the laboratory Provider for the patient's insurance plan. Lab studies are not included in the CareCentrix Provider contract.*
- 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
 - KY jelly
 - Cotton balls and alcohol sponges
 - Gloves
 - Band-aids
 - Thermometers
 - Vacutainers
- Supplies billed to CareCentrix require separate authorization prior to delivery. The list of supplies, itemized cost and the amount used daily must be faxed to the utilization staff for authorization.
- 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 an LVN/LPN needs to be substituted for an RN it is the Provider's responsibility to ensure that 1) the care to be rendered is within the scope of practice

for the LVN/LPN as defined by the state in which the LVN/LPN is licensed and that
2) the physician is in agreement with the substitution.

- *Rehab para-professionals (COTA, PTA) used to support a physical or occupational therapy plan of treatment must be authorized as a paraprofessional. Paraprofessionals will only be authorized where both state licensure and the health plan contract allows for them to deliver services/products.*
- The coordinating Provider is responsible for:
 - Coordinating services/products such that vital services/products are received in compliance with physician orders and meeting patient needs
 - Starting care within twenty-four (24) hours or as directed by the physician.
 - 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.

Home Infusion Therapy (HIT)

Consistent with industry standards, reimbursement for CareCentrix infusion therapy is based on the Average Wholesale Price (AWP) of drugs plus a per diem or dispensing fee. Most infusion service authorizations consist of two components: the drug and a per diem/dispensing fee. Exceptions to the dual authorization methodology are Total Parenteral Nutrition (TPN), enteral therapy and hydration therapy, which are reimbursed on a bundled per diem basis. The RCC staff provides via the service authorization form the infusion therapy-specific codes for authorization and billing to Providers. TPN, hydration therapy and enteral therapy have only a per diem code.

The standard **full service** 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) preferred laboratory.
- All infusion-related supplies including stationary, ambulatory, disposable, syringe or other infusion devices.
- All nursing visits including patient assessment, first dose administration, teaching, IV catheter insertion (including mid-lines and PICC lines,) and maintenance, troubleshooting of products and services, lab draws, resolving patient complaints, etc.
- Pharmacy only per diem includes all of the above except nursing.
- 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 needs to notify CareCentrix and provide documentation to the events. CareCentrix will evaluate the appropriateness of authorizing for this wastage.

- Reimbursement for drugs will be based on the lowest possible units of measure and maximum allowable costs (MAC) as calculated by CareCentrix. Generic drugs are encouraged when clinically possible.
- Drugs and per diems will be reimbursed on *the lesser of* authorization period or actual dates of patient care.
- ***Subcontracting is not allowed.*** The Provider must notify the CareCentrix utilization staff if any product or service is not directly provided by the employees of or from a facility owned by, the Provider BEFORE the services take place.
- RCC staff will make the determination of what per diem to attach to an ordered medication. The per diem is determined by what the medication is, if there is more than one medication and what services/products will actually be provided. Example: Ampicillin q6 and Vancomycin q8 by a full service Provider would receive the following per diems:
 - anti-infective (amp) q6 full service multiple first (more than one (1) medication ordered) and;
 - anti-infective (Vancomycin) q8 full service multiple second
- It is important to maintain an accurate record of patient authorizations so that claim payment will not be delayed or denied, as only services/products authorized by the utilization staff (exactly as they are authorized) will be reimbursed.
- Request for reauthorization should take place at least forty-eight (48) hours before the initial authorization expires, if continuation orders have been written at that time.

Home Medical Equipment (HME)

Home medical equipment is durable medical equipment that is appropriate for home use. It does not include unrelated consumable supplies, orthotics or prosthetics. However, for some health plans, it may or may not include consumable supplies, orthotics and prosthetics.

- Initial authorization for rental HME will generally be one (1) billing month, unless the physician order or actual use period will be for less time or unless the health plan approves more than one billing cycle.

- CareCentrix will review requests for vendor or brand-specific equipment on a case-by-case basis.
- For authorization of custom equipment, a manufacturer's specification sheet, including retail and CareCentrix pricing, needs to be submitted to the RCC UM staff. Note: For custom equipment, CareCentrix may instruct the Provider to complete two (2) claims, if required for the specific CareCentrix contract. If this requirement is not met, the all-inclusive claim will be denied.
- *For non-managed plans and with full EDI/EBA Provider contracts, re-authorization is the responsibility of the Provider. The Provider must verify with the patient that the equipment is still in use, that there is still a valid prescription for the equipment and verify with the physician an ongoing medical need and that the patient is receiving therapeutic benefits.*
- Re-authorization can be for ninety to one hundred eighty (90-180) days depending upon the equipment, diagnosis and prognosis. For EDI Providers, auto authorization is one (1) billing cycle.
- CareCentrix should be notified immediately of any rental equipment returned before the end of the authorization period.
- Provider should only submit claims for the actual days on billing months.
- Notification of a re-authorization request for HME is to occur five (5) days prior to authorization expiration date, unless directed otherwise by special arrangements or contractual stipulations.
- Set-up supplies required for appropriate HME operation are included in the rental rates **except for** ventilators, CPAP, BiPAP, CPM, enteral pumps and insulin pumps. Ongoing consumables related to equipment authorization require re-authorization from CareCentrix.
- 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 need to 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 they will deliver and set-up.
- Providers may provide an upgraded piece of equipment from that which is authorized *if ordered by the physician and if the patient agrees (in writing) to pay the difference between the contract price and the cost of the upgrade*. You may not market to the patient. This cost difference is billable only to the patient, not CareCentrix or the health plan.
- Equipment maintenance is to be done in compliance with the Safe Medical Device Act and manufacturers maintenance recommendations and noted on the patient's chart if done while the equipment is in use by the patient.
- CareCentrix must authorize repairs to member-owned equipment in advance.
- CareCentrix should be notified within forty-eight (48) to seventy-two (72) hours prior to discharge of equipment.
- For apnea monitors and bili-lights, a Provider must verify the equipment discharge with the physician.

Specialty Programs

Some CareCentrix contracts with health plans include the provision of specialty programs such as, but not limited to, Nurse Practitioner Assessments, disease state management and hospital early release. For these specialty programs, contracted Providers are contacted and invited to participate. Program training is mandatory for the Provider to participate.

Documentation

As an ancillary health care delivery system, CareCentrix does not maintain medical records. All medical record requests are recorded, logged and forwarded by CareCentrix to the appropriate Provider of service. CareCentrix does not promote Provider policies that prevent or inhibit members from viewing medical records. CareCentrix does not require members to be accompanied when reviewing records.

6-1 GENERAL CLAIMS AND REIMBURSEMENT INFORMATION

Claims Adjudication Process

For managed plans (i.e. HMO's), when services (i.e. RN visits) are authorized by a CareCentrix Regional Care Center, the specific service, units (i.e. 10 visits), pricing and the start and end date of the service are entered in the CareCentrix computer system and an authorization is generated. For Non-Managed, PPO and Indemnity plans, the start and end date of service will be the same.

Claims received for services provided to health plan patients serviced by CareCentrix are processed based on the authorization for managed plans or initial footprint authorization for non-managed plans. To expedite payment of claims, the Provider should match the billable services, against the hard copy authorization or initial footprint of the CareCentrix authorization before a claim is generated. Claims for services, date of service or units that do not exactly match the authorization may be denied in part or in whole.

For Managed/HMO plans, the service will be paid at the lower of the contracted/negotiated rate that is in place at the time of authorization period or the amount billed. If applicable, rate amendments may go into effect at the time of re-authorization or initial authorization if add on services. For non-managed plans, claims for services which do not match the category of the initial footprint will be denied.

Checking Reimbursement Status

Questions regarding the status of claims should be directed to the CareCentrix Provider Resolution Team (PRT). The PRT is available Monday through Friday between the hours of 9:00 a.m. and 6:00 p.m. Eastern Standard Time. The PRT phone number is 1-877-725-6525; follow the prompts for claims and service category.

Prompt Payment Laws

Our goal is to adjudicate our Provider's claims within forty-five (45) calendar days of receipt of a properly completed claim unless otherwise specified by State Law. Please do not make status calls or payment inquiries until forty-five (45) days after you reasonably expect the claim to be received by the NCC.

Explanation of Payment

The CareCentrix Explanation of Payment (EOP) is printed as a result of the claims adjudication process. EOPs will accompany each check sent to a Provider for services rendered. An EOP will also be issued if the claim is denied or if an adjustment is made to a claim already processed. The EOP (see example) details payments and denials by line item for a given invoice or claim. If the service, price, date or units on the claim are different than those authorized or on the footprint authorization that has been established by CareCentrix, the claim will be partially or totally denied. The reason for the denial will be noted on the EOP.

EOPs are also used to communicate adjustments to claims that have already been processed. An adjustment may be made as a result of an appeal the Provider has filed. The amount of the adjustment will be detailed by claim line item.

The EOP indicates the current payment made for each claim and should match the check that accompanies the EOP. The Provider may also receive an EOP that includes a credit or amount due to CareCentrix. The credit will be applied against amounts due the Provider and the net amount will appear on the accompanying check. If a Provider has a credit balance, no EOP will be generated until that has been relieved. See the EOP example at the end of this section.

Claim Appeals

Upon receipt of a payment which is different than expected, the Provider should first call the CareCentrix Provider Resolution Team. A representative will research the claim

and related payment and either answer the question or forward the Provider to the appropriate Claims Manager. The claim in question will be researched to provide a timely informed response. **Claims denied for lack of authorization cannot be billed to the patient or the health plan.** Claims denied because of plan eligibility may be billed to either the patient or any new insurance carrier the patient may have.

Claim denials may be appealed through the process described in the section *Appealing a Denied Claim*.

6-2 GENERAL BILLING REQUIREMENTS

In this section we specify the general billing requirements as they relate to format and form, frequency, authorizations, payor other than primary and take-back and adjustments. Compliance with these requirements will ensure the timely processing and reimbursement of Provider claims.

Claim Form and Format

Claims may be submitted on CMS 1500, UB-04 or other paper invoice formats and must include at least the following:

- Patient name and relationship to insured.
- Insured's name, address and social security number.
- The name, signature, rendering address, billing address and telephone number of the Provider.
- Appropriate (ICD-9) codes.
- Appropriate procedure or service codes with modifiers and written description.
- Ordering physician's name.
- Dates of service.
- Number of service units rendered by day.
- Place of service.
- Authorization or case number (if applicable).

- NDC for prescription drug therapy.
- Job related, auto or other accident information, when available.
- Information regarding other insurance coverage, when available.
- Health Plan designation

Claims missing any of the above required information can not be processed. Providers submitting claims without the required information will be notified that the claim cannot be processed and informed of what information is missing. The deadline for resubmission of claims not processed due to missing or incomplete information is subject to applicable state legislation.

CareCentrix will only accept original documents for payment consideration that are typed or printed in indelible ink without erasures, strikeovers or stickers. Also, it is important that the name of the Provider organization and service location on the claim match the Provider name on the related authorization (or footprint) form(s).

With regard to services delivered, the claim **must** include a description of the service provided (i.e. “RN visit” or “CPAP rental”) as well as the relevant HCPCS, CPT or revenue code. Claims without a description of the service provided will be returned. The address to which claims should be sent is found in the lower right-hand corner of the authorization or footprint for service form. Services should be billed at the contracted rates. **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 your billing system is unable to support billing at the contracted rate, the difference between the contract rate and your list price must be adjusted off your accounts receivable. Doing so will avoid repeated claims inquiries. In addition, when billing for custom equipment the claim should reflect the full rate, the discount as negotiated and the net price. You should attach to the claim the manufacturer’s specification sheet for the equipment. For custom equipment, CareCentrix may instruct the Provider to complete

two (2) claims if required for specific CareCentrix health plan contracts. If, when required, this claim need is not met, the all-inclusive claim may be denied.

In rare instances when sales tax is applicable, the tax must be broken out separately from the charge for the related item or identified in some manner that will alert the claims examiners as to the existence and amount of the tax charged. Failure to properly identify the tax charges may result in improper payment of claims.

Timely Filing

CareCentrix adheres to state regulations regarding prompt payment and filings. Please refer to your applicable state regulations. Unless prohibited by law, claims must be filed within forty-five (45) days unless otherwise specified by State Law. *Claims received in the CareCentrix National Claim Center after the filing deadline may be denied.*

Billing When another Payor is Primary

If the Provider becomes aware that CareCentrix is the secondary payor, the Provider should immediately notify CareCentrix so that services can be appropriately authorized. Please note that claims submitted to CareCentrix, as a secondary payor must include a copy of the related denial or explanation of benefits/payment from the primary payor.

When another payor is primary and CareCentrix is the secondary payor, claims must be submitted with the primary payor's EOB attached within 45 days of the date on the EOB (unless otherwise stipulated in your contract) or as state law mandates.

Claims for properly authorized services will be paid at the difference between the contracted Provider rate for the service provided and the amount the Provider has been reimbursed by the primary payor. Services prospectively approved will be reimbursed as authorized.

Authorization

Only services for which prior authorization or footprint (from CareCentrix for managed plans or the health plan for non-managed plans) was obtained will be reimbursed. Authorization, however, does not guarantee reimbursement. CareCentrix reserves the right to deny reimbursement for services delivered after the patient's health plan policy was terminated or for services delivered in excess of initial authorization. Additionally, claims for services that fall outside the authorized date range or which exceed the number of authorized units may be denied. See also *Recoupment and Adjustments*.

The Provider also should note that only the Provider indicated in the authorization would receive reimbursement for services rendered.

Recoupment and Adjustments

There may be instances in which recoupment of payment is initiated so that the Provider can bill the appropriate party. For example, we reserve the right to recoup or adjust payment (or request a refund) for amounts paid for services delivered. This can occur:

- If after the patient's health plan was terminated or there was some other change in the patient's eligibility, benefit or payor source.
- If CareCentrix is discovered to be secondary payor.

Refund requests and recoups will appear on the CareCentrix Explanation of Payment (EOP) as a "credit" adjustment. We will make every attempt to provide the appropriate information so that the Provider may bill the responsible party.

See also Service Specific Billing Requirements.

6-3 SERVICE SPECIFIC BILLING REQUIREMENTS

To help Providers accurately prepare and submit claims, we outline below the billing requirements for the specific service categories of traditional home health (THH), home infusion therapy (HIT) and home medical equipment (HME).

6-4 APPEALING A DENIED CLAIM

Introduction to Grievance and Appeals Process

The Complaint, Appeal and Grievance process is a mechanism to initiate a continuous process improvement and establishes a consistent guideline for responding to any customer complaint as defined.

A complaint or a grievance is defined as any instance when an external customer (a Provider, a patient or a payor) calls, writes, or otherwise communicates dissatisfaction with CareCentrix services or administrative practices. This process relates to but is not limited to the following CareCentrix departments: National Claims Center (NCC), National Billing Center (NBC), Regional Care Center (RCC) and Credentialing.

Complaints relating to possible fraudulent, illegal or unethical activities must be communicated to the hotline, (877) 848-8229, as stated in Section 1-4 of your Provider Manual.

If you receive a payment that is different than expected, you should first notify the Provider Resolution Team either verbally or in writing for the claim in question (877-725-6525). A representative will research your concern and respond to you as soon as possible. You have the right to appeal decisions made by CareCentrix regarding reimbursement and you are entitled to know your appeal rights and to have your request re-examined by a CareCentrix interdisciplinary team.

CareCentrix does not perform member appeals on utilization management decisions. **The member appeal process is not delegated to CareCentrix.** A member can appeal a payment issue to CareCentrix and it will be handled through the National Billing Center. Utilization appeals by or on behalf of the member are logged and submitted to the appropriate Payor. Other types of reconsideration requests are handled via the appropriate CareCentrix department in the same fashion as Provider appeals.

All requests for reconsideration are presented to the Provider Dispute Resolution Team (PDRT) for final review and determination. Providers also have the right to request reconsideration of credentialing decisions, which are processed through the formal Credentialing Process.

Appeal (1st) level

The verbal or written appeal request must be received within ninety (90) calendar days of receipt of the Explanation of Payment (EOP) (or as otherwise mandated by state or federal law). CareCentrix will respond in the same format as the submitted request for reconsideration (i.e. a written request will have a written response) and notify the appellant within thirty (30) calendar days.

Appeal (2nd) level

The second level appeal must be submitted in writing within thirty (30) calendar days of the written notification of the upheld 1st level appeals determination (or other timeframe as mandated by state or federal law). Request for a reconsideration of the 1st level appeal decision must be submitted to the attention of:

CareCentrix
Second Level Appeal
111 Founders Plaza, Suite 801
East Hartford, CT 06108

The written 2nd level appeal request should include:

- The patient's name and address
- The date(s) of service in question.
- The type(s) of service(s) provided
- The itemized dollar amount if applicable, for each service in question
- A copy of the original claim, CareCentrix authorization and CareCentrix EOP

We will notify the appellant in writing of the appeal determination and decision standing within thirty (30) calendar days.

2nd Level Appeal Determination Team

This team may consist of, but is not limited to, representation from the following CareCentrix departments: National Billing Center, National Claims Center, Provider Resolution Team, Regional Care Center (ad hoc) and Utilization Management (ad hoc).

A second level appeal is the final reconsideration request regarding:

- timely filing issues
- eligibility issues
- benefit issues

When CareCentrix is the delegated entity, the Payor may intercede at any time during the process.

Appeal (3rd) level

Within thirty (30) calendar days of receipt of the second level decision by the Appeals Team or as mandated by regulatory or accrediting body, the Provider may submit a request for a third level appeal, in writing, utilizing the above address to the attention of CareCentrix and denote "third level appeal." The CareCentrix Formal Appeals and Provider Dispute Resolution Committee will render a written decision within thirty (30) calendar days of receipt of the final appeal. All decisions made by CareCentrix Appeals

and Provider Dispute Resolution Committee are final unless state law dictates otherwise, in which case the applicable state regulations apply for arbitration and dispute resolution. The team may comprise the following as needed:

- Utilization Management
- Quality
- National Billing Center
- Regional Care Center
- National Claim Center
- Network Operations
- Client Services
- External Provider

It is suggested that formal 3rd level appeal requests be sent to CareCentrix certified, return-receipt mail.

The written 3rd level request should include:

- The patient's name and address
- The date(s) of service for which you are trying to receive reimbursement
- The type(s) of service(s) provided
- The itemized dollar amount for each service in question
- A copy of the original claim, CareCentrix authorization, CareCentrix EOP and 2nd level appeal decision

Expedited Appeals / Grievances

Determinations will be made within 72 hours and the Provider will be notified in writing within three (3) business days. An expedited appeal may be defined as the potential for a perceived interruption in the continuity of care or the health and well being of a member with the potential for a negative impact due to disruption in service. The expedited grievance appeal can be either verbally or in writing.

When other payors are involved in your grievance appeal, the burden of research with these entities is on the Provider, not CareCentrix. It is suggested that CareCentrix Providers mail formal appeals by certified, return-receipt mail.

CareCentrix Providers may not bill a patient or that patient's insurance company (if the insurance company is a CareCentrix client) for a balance remaining after a decision has been made on a CareCentrix Provider appeal.

Binding Arbitration

If, after exhausting all afore mentioned appeals processes, CareCentrix Providers, in accordance with applicable state regulation, have the option to pursue binding arbitration by a private arbitrator that is certified by a nationally recognized association that provides training and education in alternative dispute resolution. If CareCentrix and the Provider are unable to agree upon an arbitration association, the rules of the American Arbitration Association will apply. The arbitrator will have the experience and expertise in the healthcare field and will be selected according to the rules of the certifying association. Arbitration is binding after a hearing, within 90 calendar days a final ruling is issued. All costs of arbitration, not including attorney's fees, are shared equally by the parties.

7-1 CUSTOMER ACKNOWLEDGEMENT AND RESOLUTION MANAGEMENT

CUSTOMER ACKNOWLEDGEMENT AND RESOLUTION MANAGEMENT is a process to allow for prompt resolution of inquiries, complaints and concerns expressed from an external source, i.e. member Provider referral source.

CareCentrix utilizes a Customer Acknowledgement and Resolution Tool (CART) to track, trend and analyze inquiries, complaints and appeals. Provider complaint information is utilized during the re-credentialing process and when necessary to place sanctions on Providers for breaches in quality of care or service.

The Process

CareCentrix personnel document inquiries, complaints and appeals in the CART so that issue resolution may begin at the point of contact with the complainant.

Upon receipt of a complaint by a CareCentrix representative, a preliminary inquiry will be done to substantiate its validity. The complaint will then be logged and immediate attempts to resolve the concern, particularly for real-time issues, will be made. When an issue or complaint cannot be resolved by means of one or two phone calls to a Provider etc., the appropriate Team Leader, Provider Relations, Account Liaison or when necessary, Director of CareCentrix QM, will be brought into the resolution process. Further evaluation and fact gathering from all related parties will be accomplished as necessary, until the issue/complaint is resolved to the satisfaction of all or to the extent possible.

When a complaint regarding care or service provided by a CareCentrix contracted Provider, the Provider would be contacted as soon as possible to evaluate the complaint and to assist in the resolution process. Since CareCentrix is required to assist the health plans in meeting time frames for resolution and response, CareCentrix requires that Providers also assist in meeting those requirements. A CareCentrix Provider will receive a phone call, letter, or both, requesting information.

It is imperative that this information be provided by the requested date. A Provider may be asked to complete a resolution plan. The resolution plan addresses the issue at hand, the immediate action taken to resolve the issue, what were the results and what will be the long-range action taken to prevent reoccurrence. CareCentrix representatives will work with the Provider to assist with providing the appropriate and necessary information. A response, either verbal or written, will then be provided to the health plan (when requested).

Please note: ONLY a CareCentrix representative will provide responses to health plans. These responses are kept brief and to the point, but must be specific enough to ensure that the complaint regarding quality of care or service has been sufficiently addressed.

As stated above, complaints are assigned a level of severity. On a monthly, quarterly and yearly basis, complaint information is reviewed for trends in care or service provided by a CareCentrix contracted Provider. ***Should the number of complaints or the severity of complaints be such that an adverse trend is noted, sanctions will be placed upon the involved Provider. Sanctions may range from a verbal or written warning, placement on an action plan or for the most severe instances, suspension, termination or decredentialing.*** Details on these processes follow.

Provider complaints about CareCentrix follow the same process as described in the paragraphs above. The call or letter should be directed to Provider Relations at the Regional Care Center. A Provider that has a complaint that is not resolved at the RCC level and the Provider believes the allegation may have a serious bearing on the Provider's participation in the network is encouraged to file a complaint as follows:

- File a written statement of complaint.
- Direct the complaint to the AVP of Network Operations in Tampa, Florida.
- If the complaint has not been resolved to a Provider's satisfaction, an appeal may be made to the Vice President of CareCentrix Operations in Melville, New York. All decisions by the Vice President are final.

Profiling and Sanctioning Relating to Issues and Complaints

A plan for fulfilling the remedial requirements of the action plan will be developed.

Please note that CareCentrix reserves the right to take immediate action, including the right to sanction a Provider when there is the potential for jeopardy to patient safety or a serious quality adverse event.

On a **monthly** basis any Provider having **greater than three (3) Categories Level I or II Issues/Complaints**, will be verbally counseled regarding each issue by Regional Care Center Provider Relations Department. Provider Relations will follow up with written documentation regarding the seriousness involved.

If, at anytime during the next monthly reporting period, the Provider has, in addition to the above, (2) Category Level I or II Service Issues, the Provider will be sent a certified letter requesting a Corrective Action Plan within seventy-two (72) hours of receipt of the letter, unless an other time frame is agreed upon.

On a **monthly** basis, Corporate Provider Relations will notify Providers having greater than two (2) Category Level III issues/complaints, verbally and via certified letter, that a Corrective Action Plan must be submitted within **seventy-two (72) hours** of receipt of letter, unless another time frame has been agreed upon.

Providers falling into either of the above categories will be flagged and closely monitored to assess the need for further action.

On a **quarterly** basis, Providers not already flagged, and having **one (1) Category Level III Issue/Complaint**, will receive a letter from Provider Relations, notifying them of the seriousness involved in continued non-compliance. Those Providers will be flagged and closely monitored as above.

On a **quarterly** basis, Providers not already flagged, **having at least (9) cumulative Category Level II Service Issues, or I** will be notified verbally and via certified letter, by Provider Relations, to submit a Corrective Action Plan within **seventy-two (72) hours** of receipt of letter, unless another time frame is agreed upon.

On a **yearly** basis, a detailed analysis of Provider compliance will be generated, including a cumulative report of all information documented through the year and any sanctions. Continued Provider non-compliance will result in referral suspension or contract termination, dependent upon the severity of issues/complaints that are reported.

- A summary report of Providers that have had action plans initiated will be submitted to the National Credentialing Committee.
- A sample CareCentrix complaint resolution letter to a Provider follows.

Provider Resolution Plan

The Provider Resolution Plan (to be completed by the involved Provider/s) is for documentation of actions taken by a Provider in response to complaints received. In addition, the form will serve as a means for a Provider to document its intended follow-up to monitor the effectiveness of its actions and plan to prevent reoccurrence of it.

The intent is to obtain complete but succinct information for the payor, while assuring we meet our internal requirements for QM and Credentialing. A blank form follows the sample complaint resolution letter.

Complaint Resolution Letter

Provider Company Name

Street Address

City, State Zip

RE: COMPLAINT RESOLUTION

PROVIDER:

MEMBER ID:

DATE OF RECEIPT OF COMPLAINT:

Dear Provider:

Attached please find a copy of a communication received from a customer, regarding provision of the following services by your location.

We are requesting a response **to this communication, utilizing the attached form.** It is important that the information provided be complete.

Please forward copies of the following supportive documentation:

Please forward your response by _____ to:

(CareCentrix RCC & Name)

(Fax: #)

We look forward to working with you to ensure that our mutual customers continue to receive excellent care and services. Please call with any questions.

Sincerely,

CARECENTRIX REPRESENTATIVE

cc:

All information contained is to be considered **Confidential.**

Attachments

Provider Resolution Plan

AREA IDENTIFIED FOR IMPROVEMENT	IMMEDIATE ACTION	RESULTS	DATE COMP	LONG RANGE FOLLOW UP PLAN	DATE COMP	RESP PARTY

General Instructions

A copy of the Provider Resolution Plan will be forwarded to the involved Provider when a complaint is received involving a quality of care or service issue. Upon completion by the Provider and review by an appropriate CareCentrix representative, this form will be copied and kept for placement in the Provider file. The original will be sent to the health plan with the appropriate cover letter, when a written response is required.

Specific Instructions for Completing Provider Resolution Plan

The items shown below correspond to the column headings on the Provider Resolution Plan.

- **Area Identified for Improvement:** the appropriate CareCentrix representative prior to sending this form to the Provider will complete this section. The key issue that generated the complaint will be noted in one or two sentences. This will assist CareCentrix in assuring that the appropriate issue is addressed, and be clearly identified by the Provider in order to facilitate the appropriate response. The information documented by the Provider must meet the health plan's internal standards for Quality Management and credentialing requirements.
- **Immediate Action:** Immediate action taken by Provider to resolve the complaint at hand.
- **Results:** What were the results of the action? Was the complaint resolved to the satisfaction of all involved?
- **Date Completed:** This is the date that action was completed.
- **Long Range Follow-up Plan:** What plan has the Provider put in place for further action if necessary and/or to assure that the action taken has been effective and how will they monitor to prevent re-occurrence.
- **Date Completed:** Time frame for completion of follow-up monitoring.
- **Responsible Party:** This should be a Provider position title. Do not use names, i.e. BD (Branch Director).

Provider Appeals Documentation.

Provider Information		
(Provider Name)		(Date)
(Address)		(Contact Name)
(City)	(State)	(Zip)
		(Provider Phone #)
Patient Information		
(Patient Name)	(Patient #)	(Invoice #)
(Date of Service)		(Claim #)
*****CareCentrix use only*****		
Level I	Level II	Level III

(PLEASE CHECK REASON FOR APPEAL: DENIAL CODE-DESCRIPTION)

- No authorization for service
- Billed units exceed authorized units
- Service and/or unit of measure on the claim are not recognized
- Denied requesting payment/denial from primary payor
- Claim was not filed within the timely filing limits.
- Invalid substitution for authorized service
- Eligibility related issue.
- Other: _____

PLEASE PROVIDE THE NECESSARY ATTACHMENTS:

- _____ Service Authorization/Electronic Transmission
- _____ Prior appeal decision (if applicable)
- _____ CareCentrix Explanation of Payment (EOP)
- _____ Copy of Claim (CMS1500/UB04)
- _____ Proof of Timely Filing
- _____ Other: _____

DESCRIPTION:

Complaint Response Letter

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern;

CareCentrix has reviewed the concerns regarding the above mentioned patient and has made the following adverse determination:

The written 1st level request should include:

- The patient's name and address.
- The date(s) of service in question
- The type(s) of service(s) provided.
- The itemized dollar amount for each service for which you are trying to receive reimbursement.
- A copy of the original claim, CareCentrix authorization and CareCentrix EOP.

We will notify the appellant in writing of the determination within thirty (30) calendar days.

Please be assured that our goal is to provide optimum care and customer service for the member and/or patients through our CareCentrix organization. We continually work to improve the quality of those services.

A first level appeal must be made within ninety (90) days of receipt or Explanation of Payment (EOP) or as mandated by state or federal law to the attention of:

CareCentrix
First Level Appeals
111 Founders Plaza, Suite 801
East Hartford, CT 06108

You may also contact our Provider Resolutions Team at 1-877-725-6525 x 2321.

Sincerely,

<Associate Name>

CareCentrix National Claims Center

Complaint Receipt Notification Letter

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern;

CareCentrix is in the process of reviewing your concerns regarding the above mentioned patient.

At this time we will require additional time to make a determination regarding the concerns that you have brought to our attention.

We will notify the petitioner in writing of the determination within (30) calendar days of this notification. Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization. We continually work to improve the quality of those services.

You may also contact our Provider Resolutions Team at 1-877-725-6525 x 2321.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

First Level of Appeals Letter

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern:

CareCentrix has reviewed your Appeal Request regarding the above mentioned patient and has made the decision to uphold the prior decision.

A second level appeal must be submitted in writing within thirty (30) calendar days of receipt of reimbursement or denial for services and/or Explanation of Payment (EOP), or as mandated by regulatory or accrediting body. A request for a reconsideration of the 1st level appeal decision must be submitted to the attention of:

CareCentrix
Second Level Appeals
111 Founders Plaza, Suite 801
East Hartford, CT 06108

The written 2nd level request should include:

- The patient's name and address
- The date(s) of service in question
- The type(s) of service(s) provided
- The itemized dollar amount for each service for which you are trying to receive reimbursement
- A copy of the original claim, CareCentrix authorization and CareCentrix EOP

Second level appeals will be reviewed by the CareCentrix Second Level Appeal Determination Team. This team may consist of, but is not limited to, representation from the following CareCentrix departments: National Billing Center, National Claims Center, Provider Resolution Team, Regional Care Center and Utilization Management.

A second level appeal determination is final for reconsideration requests regarding:

- timely filing issues
- eligibility issues
- benefit issues

We will notify the petitioner in writing of the appeal determination within thirty (30) calendar days. You may also contact our Provider Resolutions Team at 1-877-725-6525 x 2321.

After exhausting the CareCentrix appeals process, and in accordance with applicable state legislation, you, the Provider, have the option to pursue binding arbitration by a private arbitrator that is. Arbitration is binding on both parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless CareCentrix and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization. We continually work to improve the quality of those services.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

Second Level of Appeals Letter

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern;

CareCentrix has reviewed your Appeal Request regarding the above mentioned patient and has made the decision to uphold the prior decision.

Within thirty (30) calendar days of receipt of the second level appeal decision, the Provider may submit a request for a third level appeal, in writing, utilizing the above address to the attention of CareCentrix and denote “third level appeal”. The CareCentrix Provider Dispute Resolution Team will then render a written decision within thirty (30) calendar days of receipt of the final appeal. All 3rd level appeal decisions are final. The Provider Dispute Resolution Team may comprise the following, as warranted:

- Credentialing
- Utilization Management
- Quality
- National Billing Center
- Regional Care Center
- National Claim Center
- Network Operations
- Client Services

- External Provider

Note that 3rd level appeal requests are formal and should be sent to CareCentrix via certified, return-receipt mail.

The written 3rd level request should include:

- The patient's name and address
- The date(s) of service in question
- The type(s) of service(s) provided
- The itemized dollar amount for each service for which you are trying to receive reimbursement
- A copy of the original claim, CareCentrix authorization, CareCentrix EOP and 2nd level appeal decision

We will notify the petitioner in writing of the determination within thirty (30) calendar days.

After exhausting the CareCentrix appeals process, and in accordance with applicable state legislation, you, the Provider, have the option to pursue binding arbitration by a private arbitrator that is. Arbitration is binding on both parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless CareCentrix and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

You may also contact our Provider Resolutions Team at 1-877-725-6525 x 2321.

Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization. We continually work to improve the quality of those services.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

Final Appeals Letter

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern:

CareCentrix has reviewed your Appeal Request regarding the above mentioned patient and has made the decision to uphold the prior decision.

This decision made by CareCentrix Provider Dispute Resolution Team is final.

After exhausting the CareCentrix appeals process, and in accordance with applicable state legislation, you, the Provider, have the option to pursue binding arbitration by a private arbitrator that is. Arbitration is binding on both parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless CareCentrix and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization and we continually strive to improve the quality of those services.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

Appeal Decision Letter - Upheld

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern:

CareCentrix has reviewed your Appeal Request regarding the above mentioned patient and has made the decision to uphold the prior decision.

This decision made by CareCentrix Provider Dispute Resolution Team is final.

After exhausting the CareCentrix appeals process, and in accordance with applicable state legislation, you, the Provider, have the option to pursue binding arbitration by a private arbitrator that is. Arbitration is binding on both parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless CareCentrix and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization and we continually strive to improve the quality of those services.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

Appeal Decision Letter - Overturned

<DATE>

<Provider Name>

<Street Address>

<City, State, Zip>

Re: <Patient Name>

Account Number: <Intake ID>

To Whom It May Concern:

CareCentrix has reviewed your Appeal Request regarding the above mentioned patient and has made the decision to approve the appeal request and overturn our prior decision.

This decision made by CareCentrix Provider Dispute Resolution Team is final.

Please be assured that our goal is to provide optimum care and customer service for patients and Providers through our CareCentrix organization and we continually strive to improve the quality of those services.

If we can provide any further clarification please do not hesitate to let us know.

Sincerely,

<Associate Name>

CareCentrix National Claim Center

8-1 GLOSSARY

Administrative issue

Any issue or complaint which involves any topic other than ones that affect quality of service or care, i.e. providing services without prior authorization, billing the patient or health plan, or a Provider consistently refusing referrals.

Appeal

The reconsideration of a prior decision; whether relayed verbally or in writing. Appeals may be related to eligibility, authorizations, benefits, timely filing, rate issues, Provider rating/status or credentialing decisions.

Emergency

Emergency is defined as a life threatening condition that may pose an immediate threat to the health and safety of consumers. CareCentrix does not require an authorization for emergency services. Emergency referrals are not within the scope of home care and the CareCentrix core business structure. There is not a circumstance in which CareCentrix would be responsible for making utilization decisions related to a life-threatening condition. Should an emergency need arise during the episode of treatment within the homecare arena, no authorization or review would be required in order for service to be rendered.

Grievance and/or Complaint

An expression of dissatisfaction either verbally or in writing from an external source, i.e., customer, Provider, or member.

Incident

Any occurrence, accident or event that:

- Is not consistent with normal client care or the routine operation of the agency.
- Did or could result in an injury to a client.

- Could result in litigation against the agency, agency employee, CareCentrix or CareCentrix employee.

Inquiry

A question asked of CareCentrix regarding claim/appeal status, payment, payment amount, check information, denial, credit balance, and referral, start of care date or authorization.

Issue

Any internal identification of an instance where it has been determined that care or services were not provided as appropriate and/or necessary, but a complaint has not been received. Issues are assigned an appropriate code for further tracking and trending.

Medically Necessary

Medically necessary is defined as the following criteria:

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

Medical Necessity - State of Hawaii RFP-MQD-2008-006 40.500

- The intervention must be used for a medical condition
- There is sufficient evidence to draw conclusions about the intervention's effects on health outcomes

- The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes
- The intervention's beneficial effects on health outcomes outweigh its expected harmful effects
- The health intervention is the most cost-effective method available to address the medical condition
- Medical condition: a disease, an illness or injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury
- Health outcomes: outcomes of medical conditions that directly affect the length or quality of a person's life
- Sufficient Evidence: considered to be sufficient to draw conclusions, if it is peer reviewed, is well controlled, directly or indirectly relates to the intervention to health outcomes, and is reproducible both within and outside of research settings.

Provider Rights / Discrimination

- CareCentrix will not discriminate against any Provider seeking qualification as a participating Provider in its Network.
- Applicants have the right to correct erroneous information submitted by another party.
- Applicants have the right to review the information contained in their credentialing file.
- Applicants have the right to receive information regarding their credentialing status, upon request. The Credentialing Department staff will respond to all requests for verification of credentialing status within one (1) business day.

Quality of Care

Any issue or complaint at any level regarding the following:

- Continuity of care
- Appropriateness of care

- Refusal of care by a Provider
- Uneducated staff/Provider

Quality of Service

Any issue or complaint at any level that affect the following:

- Accessibility of service
- Attitude of Provider
- Uneducated staff or Provider

Resolution

When an issue or complaint has been sufficiently addressed to satisfy all parties involved within the parameters of appropriate clinical practice. Or, in the case of a Provider complaint, to the satisfaction of the Provider and Network.

Urgent

Urgent is defined as a condition due to illness or injury which is not life-threatening but may require prompt attention and/or treatment to prevent complication or deterioration in the patients' condition

Utilization Management

Utilization Management is defined as the evaluation of the appropriateness, medical necessity and efficiency of healthcare services according to established criteria or guidelines and under the provisions of an applicable benefit plan for a patient.