Your Provider Resource Guide

Updated: July 15, 2023

FirstCarolinaCare
INSURANCE COMPANY

Contents

Provider Operations

Customer Service Phone Numbers

FirstMedicare Direct – Sandhills	(877) 210-9167	For Medicare Advantage members living in Moore, Montgomery, Hoke, Richmond, Scotland, Lee, Chatham, Harnett, Cumberland, Johnston and Robeson counties.
New Hanover Health Advantage	(855) 291-9336	For Medicare Advantage members living in Brunswick, New Hanover and Pender counties.
FirstMedicare Direct – Western	(800) 984-3510	For Medicare Advantage members living in Buncombe, Yancey, Transylvania, McDowell, Henderson and Madison counties.
FirstCarolinaCare – Commercial	(800) 481-1092	For all Commercially Insured members.

Important Changes

On January 1, 2023, FirstCarolinaCare began the transition to the following:

- New Provider Portal.
- New Epic Based Claim System.

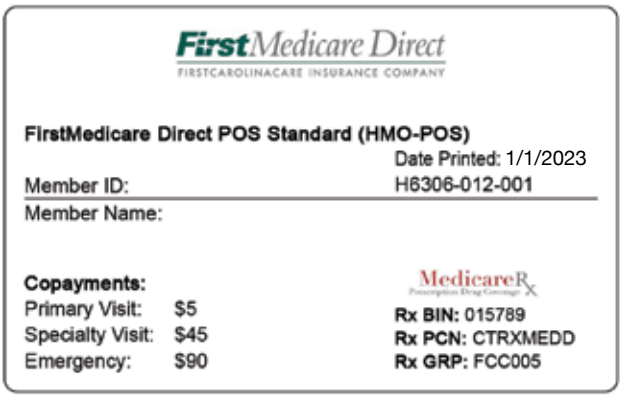
Important Reminders

- Register for Provider Portal FirstCarolinaCare.
- Sign up for Provider Flashes.
- Provider Change Form.
- Reminder: Check the back of the member's new ID card for our updated filing address and EDI Number.

ID Cards

Important Note:
It's essential that you ask every FirstCarolinaCare, New Hanover Health Advantage and FirstMedicare Direct member for their ID card at each visit to make sure you're using the appropriate phone numbers for Customer Service, benefits, claims and pharmacy services.

Examples of what a member's ID card will look like (benefits may vary):


FirstMedicare Direct
FIRSTCAROLINACARE INSURANCE COMPANY

FirstMedicare Direct POS Standard (HMO-POS)

Date Printed: 1/1/2023

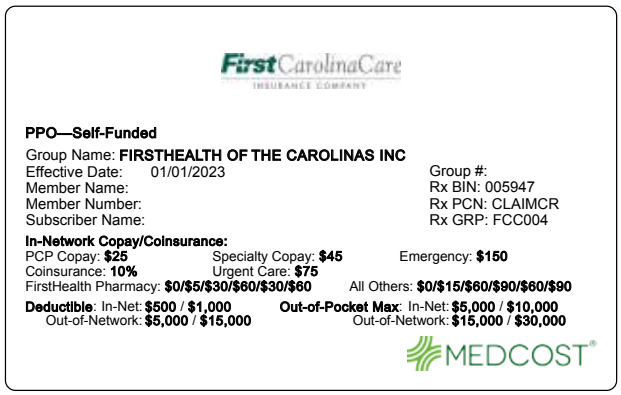
Member ID: H6306-012-001

Member Name:

Copayments:
Primary Visit: $5
Specialty Visit: $45
Emergency: $90

MedicareRx

Rx BIN: 015789
Rx PCN: CTRXMEDD
Rx GRP: FCC005


FirstCarolinaCare
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PPO—Self-Funded

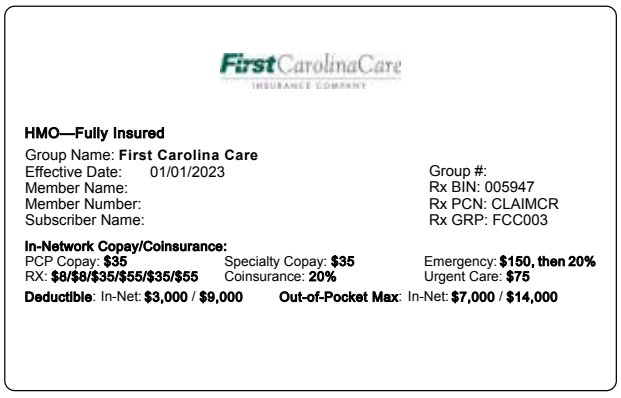
Group Name: **FIRSTHEALTH OF THE CAROLINAS INC**
Effective Date: 01/01/2023
Member Name:
Member Number:
Subscriber Name:

Group #:
Rx BIN: 005947
Rx PCN: CLAIMCR
Rx GRP: FCC004

In-Network Copay/Coinsurance:
PCP Copay: **$25** Specialty Copay: **$45** Emergency: **$150**
Coinsurance: **10%** Urgent Care: **$75**
FirstHealth Pharmacy: **$0/$5/$30/$60/$30/$60** All Others: **$0/$15/$60/$90/$60/$90**

Deductible: In-Net: **$500 / $1,000** **Out-of-Pocket Max**: In-Net: **$5,000 / $10,000**
Out-of-Network: **$5,000 / $15,000** Out-of-Network: **$15,000 / $30,000**

MEDCOST®


FirstCarolinaCare
INSURANCE COMPANY

HMO—Fully Insured

Group Name: **First Carolina Care**
Effective Date: 01/01/2023
Member Name:
Member Number:
Subscriber Name:

Group #:
Rx BIN: 005947
Rx PCN: CLAIMCR
Rx GRP: FCC003

In-Network Copay/Coinsurance:
PCP Copay: **$35** Specialty Copay: **$35** Emergency: **$150, then 20%**
RX: **$8/$8/$35/$55/$35/$55** Coinsurance: **20%** Urgent Care: **$75**
Deductible: In-Net: **$3,000 / $9,000** **Out-of-Pocket Max**: In-Net: **$7,000 / $14,000**

Providers who see members with MedCost as their preferred provider network will still file claims to MedCost. The member's current ID card must be used to determine where to call for claims information, prior authorization requirements, pharmacy benefits and enrollment.

Claims Address and EDI

FirstMedicare Direct or New Hanover Health Advantage

- Send claims to:
  - EDI: FCC01
  - Paper claims to:
    - FirstMedicare Direct
      P.O. Box 6003
      Urbana, IL 61803-6003

FirstCarolinaCare (Commercial)

- Send claims to:
  - EDI: FCC01
  - Paper claims to:
    - FirstCarolinaCare
      P.O. Box 6003
      Urbana, IL 61803-6003

MedCost

- Send claims to:
  - EDI: 56162
  - Paper claims to:
    - MedCost
      P.O. Box 25307
      Winston-Salem, NC 27114-5307

Claims Editing Systems

FirstCarolinaCare uses claims editing systems that provide an extensive set of base rules that utilize historical data to audit claims for appropriate coding guidelines.

The editing systems identify coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing, and questionable coding relationships. The systems also edit across providers in the same group or specialty per Medicare guidelines. The systems do this by utilizing a knowledge base containing more than 9 million government and industry rules, regulations and policies governing healthcare claims. The editing rules are built upon nationally recognized and accepted sources, including American Medical Association CPT guidelines, CMS guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

*Coding edit denials are not billable to the member.

Medical Management

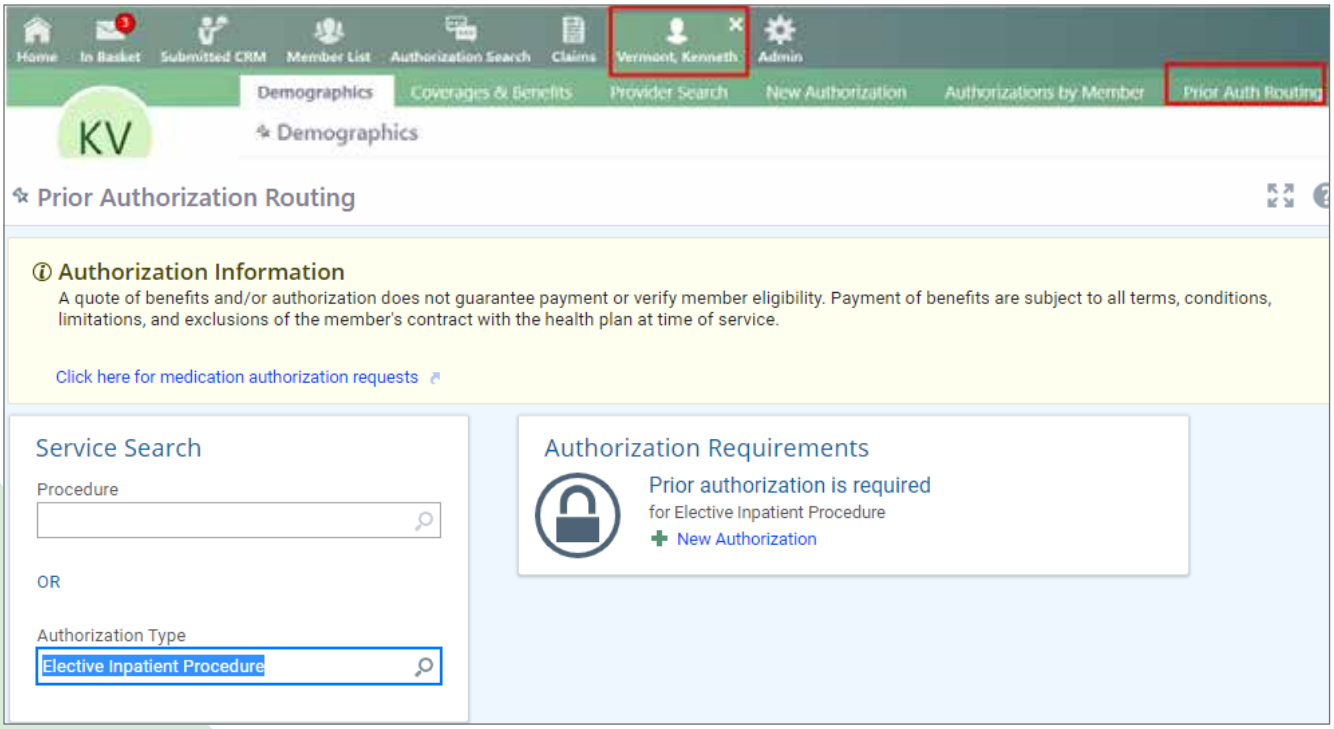
Overview

FirstCarolinaCare has a comprehensive Medical Management program administered by the Medical Management Division (MMD). The FirstCarolinaCare Utilization Management coordinators (UMCs) and care coordinators are accountable for the activities outlined in the Program Scope and Processes. These individuals work directly with the primary care providers, specialists and other providers in the FirstCarolinaCare provider network responsible for coordinating the care of our members. Selected physician medical directors provide direct utilization management and oversight for utilization and care coordination across the entire plan.

Utilization Management

Prior Authorization List

Providers can search prior authorization requirements from within the Provider Portal. Once you log into the portal, you can enter the CPT or service description on the Prior Authorization Routing tab after attaching to a member. For additional instructions of how to register and use the Provider Portal, please visit our website, FirstCarolinaCare.com/Providers/Forms.



How to Determine if Item or Service Requires Prior Authorization

Log into FirstCarolinaCare Provider Portal.

Select your member from the patient list. Once attached to the member, use the Prior Authorization Routing tab to enter the requested CPT code or authorization type to determine if the procedure requires prior authorization. If so, you will be directed to the appropriate site to start the authorization process.

There are detailed instructions available in the FCC Tapestry Link User Guide. The user guide is available on our website, Providers.MedCost.com/MainMenu.aspx.

Where to Submit Your Prior Authorization

The Provider Portal will direct you to the appropriate site to submit your prior authorization. You can greatly reduce the time it takes for a review to be completed by supplying complete medical information and attaching all supporting clinical documentation when submitting a request for coverage. Also monitor and promptly respond to requests for missing or additional information.

All Network Providers are expected to utilize the online process to submit authorizations. In rare instances, a provider may qualify for the fax exclusion list for requesting prior authorization. To request to be added to this list, contact Provider Relations at FCCPNM@FirstCarolinaCare.com or (910) 687-6500. Include your justification to be added to the fax exclusion list (for example, no internet access).

To determine if an item or service requires authorization, the provider's office must first attach to a member, then enter the CPT/HCPCS code in question. Use the "Do I Need to File?" search to look up if you should file your prior authorization at Altruista Health or eviCore.

eviCore
Lab Management
Medical Oncology Pathways
Musculoskeletal Management
Radiation Therapy Management Program
Radiology and Cardiology
Sleep Management

- Altruista Health: DME, Inpatient, Pharmacy and all other non-eviCore authorizations.

Medical Policies

The UMCs respond to coverage requests by obtaining all necessary clinical information, researching benefit plan descriptions and applying established medical necessity criteria. The MMD and eviCore use clinical guidelines from nationally respected vendors, such as InterQual®, which are based on best practice, clinical data and medical literature.

InterQual®, eviCore clinical guidelines and internal medical policies are available on the Provider Portal.

Provider Lookup Links

Network Links

- MedCost: Providers.MedCost.com/MainMenu.aspx
- Participating Providers: https://firstcarolinacare.com/find-care

Risk Adjustment

FirstCarolinaCare Insurance Company (FCC) contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) plans. CMS payment to FCC is based on risk adjustment methodology that reimburses health plans based on the health of the individual enrollee. The risk of the individual enrollee is determined by the diagnosis codes included on claims submitted to FCC and passed to CMS.

The provider's role in this process is to submit medical record documentation that's clear, concise, consistent, complete and legible. All diagnoses, supported in the medical record documentation for each encounter, must be submitted on the claim, so FCC is placing an increased emphasis on provider education and recommendations related to Hierarchical Condition Categories (HCCs), diagnoses and documentation regulations before claims submission and payment.

HCCs are given a severity ranking (a higher medical risk to the patient equals a higher ranking). It's important to follow typical coding practices, but specificity is of utmost importance, and all diagnosis codes that apply to a particular visit must be documented. The medical record documentation must support the diagnosis that was assigned within the correct data collection period by an appropriate provider type (provider visit, hospital inpatient or hospital outpatient) and an acceptable physician data source as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to ICD-10-CM Guidelines for Coding and Reporting.

Risk Adjustment Data Validation

Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the Medicare Advantage organization are supported by participating provider medical record documentation for an enrollee. The primary goals of CMS through risk adjustment data validation are to:

- Identify:
  - Confirmed risk adjustment discrepancies.
  - MA organizations in need of technical assistance to improve risk adjustment data quality.
- Measure:
  - Accuracy of risk adjustment data.
  - Impact of discrepancies on payment.
- Improve/inform:
  - Quality of risk adjustment data.
  - The CMS-Hierarchical Condition Category (CMS-HCC) model.

FCC is required to retrieve and provide medical records to CMS in a short window of time for a risk adjustment data validation audit. As a participating provider, it's mandatory that your staff members provide medical records as requested by the deadline indicated in our correspondence to accomplish this task.

Care Coordination

The care coordination program focuses on assisting with coordination of services to ensure the member is receiving the right care at the right time and right place. This includes acting as a liaison with multiple care providers, members and family. A team effort between all the involved parties allows for better continuity and consistent treatment, planning and transition of care from one level to another when indicated. Care coordinators assess, coordinate and authorize services for identified high-risk members. This coordination of care uses evidence-based clinical assessment tools to identify gaps and barriers to care and develop a plan of care specific to the member's health status, needs and goals. The careful monitoring of these members alerts the care coordinator to changes in health status and allows for proactive communication with the primary care provider or treating physician to provide early intervention, if warranted.

Potential candidates for care coordination are identified in various ways, including predictive modeling software reports, referral from a disease management program, the inpatient utilization review process and other utilization management activities. Care coordination referrals are also accepted from members, their families, discharge planners, practitioners, providers involved in a member's care and telephone advisory lines. Once identified, members are contacted and given the opportunity to participate in the program.

Through predictive modeling or referrals as noted above, the member is assigned to one of several specific programs tailored to the identified care priorities. Those programs include:

- Very-High-Risk Care Coordination: In-home* for our Medicare Advantage and Commercial members due to significant clinical and psychosocial needs.
- Complex Care Coordination: Provider-focused and geographically based delivery model for high-risk members.
- Specialty Care Coordination: Concentrated focus for members receiving care related to end-stage renal disease (ESRD), transplants, NICU, high-risk pediatrics, oncology, high-risk pregnancy and behavioral health.
- Care Transition Intervention: Facilitates a smooth adjustment from a hospital to a lower level of care, with the goal of reducing readmission.
- Disease Management: Provides population-based advice and education, focusing on self-management of the full array of chronic disease conditions.

A provider wishing to make a referral to the care coordination program may do so by contacting (910) 687-6288.

*In-home visits may be limited or not possible due to the COVID-19 pandemic. We will keep members updated with the latest information.

Quality

The Quality Management (QM) program is designed to integrate quality clinical care and service within FirstCarolinaCare and health plan partners. Quality Management works in tandem with all departments to establish, coordinate and execute a structure to support FirstCarolinaCare members to improve their health, and assess and evaluate the care and service provided.

HEDIS®

The HEDIS program comprises the measurement tools used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. It's a set of standardized performance measures designed to ensure purchasers and consumers have the information they need to reliably compare healthcare quality. The HEDIS expert panel has identified approximately 90 measures across the following six "domains" or categories of care for reporting HEDIS:

- Effectiveness of Care: Healthcare Effectiveness Data and Information Set (HEDIS) performance measures.
- Access/availability of care.
- Experience of Care: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Health Outcomes Survey (HOS).
- Utilization and risk-adjusted utilization.
- Health plan pescriptive information.
- Measures collected using Electronic Clinical Data Systems (ECDS).

Hybrid Reviews

Plans reporting HEDIS data may draw information from four sources – administrative (claims), hybrid (combination of claims and medical record review), survey (direct feedback from the member) and Electronic Clinical Data Systems (ECDS, transactional data collected directly from practitioner/provider sources). The use of hybrid methodology is very time consuming and resource intensive. But in measures where the specifications and exclusions are complicated, hybrid review often results in improved rates.

Hybrid review requires the cooperation of a plan's practitioners. FirstCarolinaCare, or a designee, may request an appointment to visit a practitioner's office to review and copy medical records for members who are part of the sample population for a specific measure. FirstCarolinaCare may also contact practitioners' offices and ask to have specific portions of the medical record sent to our office as proof of compliance with specific measures (immunization records, proof of a colonoscopy, etc.).

As part of the HEDIS review process, we may ask to copy specific portions of the medical record. This is necessary to provide proof of compliance for the measure in question to our auditors. FirstCarolinaCare keeps all medical information in confidential files accessible only on a "need-to-know" basis. No information is released to another party outside of the audit process.

HEDIS specifications for the Effectiveness of Care Measures are very explicit. Each measure specifies the ages involved for the measure as well as specific requirements each patient must meet to attain compliance. Please visit NCQA.org/HEDIS to access the current HEDIS measures.

HEDIS is an effective tool that enables us to compare our health plan with other plans across the country, but our success depends on your cooperation. Please feel free to contact our Quality Management department at (800) 851-3379, ext. 28947, with questions or concerns about HEDIS, the audit and/or medical record reviews.

Appeals and Grievances

Medical Benefits Appeals

With permission from a patient who has FirstCarolinaCare coverage, a provider may appeal a decision made by FirstCarolinaCare or eviCore on any issue with respect to the member. The appeals process varies by type of appeal – medically related or not medically related. Medically related appeals concern a prospective (pre-service) or retrospective (post-service) denial of coverage when the treatment or service doesn't meet the FCC medical necessity requirements. Not medically related appeals encompass eligibility, benefit coverage and/or procedural issues.

Medical Appeal (Not Drug Related)
When acting on behalf of a member, a provider may call customer service, send a written request or fax an appeal:

Standard Medical Appeal

Customer Service - Commercial:
(800) 481-1092

Customer Service - Medicare Advantage:
(877) 210-9167

Expedited Medical Appeal

FCC Commercial and Medicare Advantage:
(800) 500-3373

Appeals for Medications (Pharmacy Benefits and Provider-Administered Medications)
Please follow the instructions on the adverse determination/non-certification letter to determine the appropriate place to file an appeal for a medication (including prescription benefit drugs and medical benefit/provider-administered medications).

A provider may call, send a written request or fax an appeal on a member's behalf to:

Phone: (800) 500-3373

Written Request:
FirstCarolinaCare Insurance Company
ATTN: Appeals Dept.
3310 Fields South Dr.
Champaign, IL 61822
Fax: (217) 902-9708

Depending on whether you have a pharmacy or medical appeal, **the denial letter will include the steps the provider needs to follow.** For any questions, please call the appropriate number listed above for additional information.

For Commercial appeals, a **written request** for a reconsideration of the decision must be submitted within 180 days of the date of denial notice.

For Medicare appeals, a **written request** for a reconsideration of the decision must be submitted within 60 days of the date of denial notice.

Fast-Track Appeals Review: Members receiving skilled services in home health settings, a skilled nursing facility or a comparable outpatient rehabilitation facility will receive a discontinuation notice with specific instructions and timelines for filing an appeal.

Pharmacy

Pharmacy Benefit Manager

The FirstCarolinaCare Pharmacy Benefit Manager (PBM) is OptumRx®.

PBM services and pharmacy operations are coordinated by the Pharmacy department at Health Alliance™. Health Alliance serves as a delegated vendor for FirstCarolinaCare for the following activities:

- Pharmacy network development and maintenance.
- Third-party claims processor relations, contract development and management.
- Manufacturer discount contracting.
- Pharmacy and Therapeutics (P&T) Committee support.
- Drug formulary coordination and management.
- Utilization Management department clinical support. Medical Directors Committee and administrative support.
- Quality Improvement Committee support.
- Assistance in improving quality measures related to medications.
- Pharmacy utilization reporting and physician support.
- Customer Service and Claims departments support.

Pharmacy Drug Prior Authorization

Visit FirstCarolinaCare.com to submit a prior authorization request. To view the FirstCarolinaCare drug formularies online, go to FirstCarolinaCare.com and select the formulary you wish to see.

In most cases, low-cost therapies will have few or no prior authorization requirements while high-cost generic medications, brand medications and specialty medications may have several. These tools are all used to make sure members can afford the medications they receive and that FirstCarolinaCare is able to offer affordable, high-quality pharmacy care for our members and your patients.

Medicare Part D Formularies

The Medicare Part D formularies were created to assist in the management of ever-increasing costs of prescription medications. The use of formularies to provide physicians with a reference for cost-effective medical treatment has been used successfully in health insurance organizations throughout the country.

The Medicare Part D formularies were created under the guidance of physicians and pharmacists representing most specialties. The Pharmacy and Therapeutics Committee evaluates the needs of patients, use of products and cost-effectiveness as factors to determine the formulary choices. In all cases, available bioequivalence data, supply and therapeutic activity are considered.

General Exclusions of the Medicare Part D Formularies

The following aren't covered:

- Over-the-counter (OTC) medications or their equivalents.
- Drug products not listed in the Medicare Part D formularies or specifically listed as not covered.
- Any drug products used for cosmetic purposes.
- Experimental drug products or any drug product used in an experimental manner.
- Foreign drugs or drugs not approved by the U.S. Food and Drug Administration.
- Drugs used for anorexia, weight loss or weight gains.
- Fertility agents.
- Agents for hair growth.
- Agents for symptomatic relief from cough and colds.
- Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations).
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Medical supplies and items not considered drugs.
- Erectile dysfunction drugs.

Pharmacy Network Mail-Order Pharmacy

- OptumRx Mail-Order Pharmacy is the preferred mail-order pharmacy.
  - Commercial Group
    Commercial/HIX (844) 569-4145
- Medicare Advantage
  Med D (844) 569-4146.
  - Medicare members can use any network mail-order pharmacy. Call the service number at the beginning of this document if you need help locating a mail-order pharmacy.

Specialty Prescriptions

- Medicare members can use any network pharmacy to fill their specialty drug prescriptions.
- Commercial Members:
  - OptumRx Specialty
    Phone: (855) 427-4682
    Fax: (877) 342-4596
  - FirstHealth employee group members can still access specialty drugs through the FirstHealth Outpatient Pharmacy.
    Phone: (910) 715-4250.

Provider Relations Contact Information

To contact a member of the Provider Relations team:

Call us at (910) 687-6500.
Email us at FCCPNM@FirstCarolinaCare.com.

or questions regarding credentialing or provider updates, in-network providers can email us at:

FCCCredentialing@FirstCarolinaCare.com

Submit all recredentialing requests/questions to:

FCCRecredentialing@FirstCarolinaCare.com

Prospective providers can email us at:

FCC@FirstCarolinaCare.com

Provider Information Change Form

FirstCarolinaCare
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PHPNFC23-provresourcegd-0623