

NORTH CAROLINA ADDENDUM

GEHA Policies & Procedures Connection Dental Network State Specific Policies & Procedures - State of North Carolina

The below policies and procedures are in addition to the contractual requirements and the GEHA Policies & Procedures for the CONNECTION Dental Network. In the event the below terms conflict with the contractual requirements or the GEHA Policies & Procedures for the CONNECTION Dental Network, the terms below shall supersede.

Appeal and Grievance Procedures

Please see Network Appeals/Grievances Policies and Procedures in the Provider Manual under the “Dentist Info” tab at connectiondental.com.

Termination Procedures

Participating Provider’s obligations under the Participating Provider Agreement shall not be assigned, delegated or transferred without the prior written consent of GEHA on behalf of the Payor (Carrier). GEHA, on behalf of the Payor (Carrier), shall notify the Participating Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

11 NCAC 20.0202(19)

Dispute Resolution Process

The process to follow to resolve contract disputes between GEHA, on behalf of the Payor (Carrier), and Participating Providers is:

1. Participating Provider appeal must be in writing.
 - a. Appeal must be submitted within six months from the date of the decision.
 - b. Included with the appeals letter shall be the EOB, copy of the actual claim and description of the dispute.
 2. Participating Provider appeal must be sent directly to the Network and not the Payor.
 3. Network shall respond in writing within 90 days of receipt of Participating Provider’s appeal.
 4. Network shall respond in writing to insurer (Carrier) and Participating Provider with a letter of decision.
- The Network reserves the right to request additional information deemed necessary in order to settle the dispute in a timely manner. If the Participating Provider disagrees with GEHA’s response to its appeal, the dispute shall be resolved by arbitration in accordance with the Participating Provider’s agreement with GEHA, unless a different mechanism is required by applicable state law or regulation.

Network Participation Procedures

Whenever any health benefit plan, subscriber contract, or policy of insurance issued by a health maintenance organization, hospital or medical service corporation, or insurer as defined by applicable law provides for coverage for, payment of, or reimbursement for any service rendered in connection with a condition or complaint that is within the scope of practice of a duly licensed dentist, a duly licensed chiropractor, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an

advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to coverage of, payment of, or reimbursement for the services, whether the services be performed by a duly licensed physician, or a provider listed in this subsection, notwithstanding any provision contained in the plan or policy limiting access to the providers. The policyholder, insured, or beneficiary shall have the right to choose the provider of services notwithstanding any provision to the contrary in any other statute, subject to the utilization review, referral, and prior approval requirements of the plan that apply to all providers for that service; provided that:

(1) In the case of plans that require the use of network providers as a condition of obtaining benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network; and

(2) In the case of plans that require the use of network providers as a condition of obtaining a higher level of benefits under the plan or policy, the policyholder, insured, or beneficiary must choose a provider of the services within the network in order to obtain the higher level of benefits.

N.C.G.S.A. § 58-50-30

At the initial offering of a preferred provider plan to the public, health care providers may submit proposals for participation in accordance with the terms of the preferred provider plan within 30 days after that offering. After that time period, any health care provider may submit a proposal, and the insurer offering the preferred provider benefit plan shall consider all pending applications for participation and give reasons for any rejections or failure to act on an application on at least an annual basis. Any health care provider seeking to participate in the preferred provider benefit plan, whether upon the initial offering or subsequently, may be permitted to do so in the discretion of the insurer offering the preferred provider benefit plan. G.S. 58-50-30 applies to preferred provider benefit plans.

N.C.G.S.A. § 58-50-56

Disclosure of Fee Schedules. – GEHA, on behalf of its insurers, makes all fee schedules available to all contracted and potentially contracted providers. The fee schedules include all allowable amounts rather than the top 30 most utilized codes.

Disclosure of Policies. – Insurers will make available to contracted providers and facilities a description of the insurer's claim submission and reimbursement policies.

Availability of Information. – Insurers will notify contracted providers and facilities in writing of the availability of information required or authorized to be provided under this section or will notify contracted providers and facilities by providing notice in the manner specified in the Participating Provider Agreement, which is by posting the information on GEHA/CONNECTION Dental Network's website at connectiondental.com under the "Payor Info" tab.

Notification of Changes. – Insurers or GEHA, on behalf of insurers, shall provide advance notice to providers and facilities of changes to the information that insurers are required to provide under this section. The notice period for a change in the schedule of fees, reimbursement policies, or submission of claims policies shall be the contractual notice period, but in no event shall the notices be given less than 30 days prior to the change. An insurer is not required to provide advance notice of changes to the information required under this section if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case, notification of the changes may be made concurrent with the implementation of the changes. Information and notice of changes may be provided in the medium selected by the insurer, including an electronic medium. However, the insurer will inform the affected contracted provider or facility of the notification method to be used by the insurer and, if the insurer uses an electronic medium to provide notice of changes required under this section, the insurer shall provide clear instructions regarding how the provider or facility may access the information contained in the notice. This subsection does not apply to any entity that writes stand alone dental insurance.

N.C.G.S.A. § 58-3-227

Proposed amendments to the Provider Agreements shall be labeled “Amendment,” signed by GEHA, and include an effective date for the proposed amendment. The Participating Provider shall have 60 days from the date of receipt to object to the proposed amendment. If the Participating Provider fails to object to the proposed amendment within 60 days, it shall become effective. If the Participating Provider objects to the proposed amendment, it will not be effective and GEHA may terminate the Agreement with 60 days’ written notice.

N.C.G.S.A. § 58-50-280

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

All claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner. Additional information beyond that contained on the uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submission of claims in writing and by electronic means.

N.C.G.S.A. § 58-3-171

For all claims denied for health care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment. This subsection does not apply to insurers subject to G.S. 58-3-225.

N.C.G.S.A. § 58-3-172

An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

- (1) Payment of the claim.
- (2) Notice of denial of the claim.
- (3) Notice that the proof of loss is inadequate or incomplete.
- (4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
- (5) Notice that coordination of benefits information is needed in order to pay the claim.
- (6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the

insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

If an insurer requests additional information under this section and the insurer does not receive the additional information within 90 days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under this section, interest on health benefit claim payments shall begin to accrue on the 31st day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This does not apply to claims for benefits that are not covered by the health benefit plan; nor does this apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than 180 days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured.

Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under this section. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider 30 days after the previous report was sent.

Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim

adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pending, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses.

N.C.G.S.A. § 58-3-225

The U.S. Office of Personnel Management (OPM) has contracting authority for both the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Health Benefits (FEHB) plans. GEHA is contracted with the OPM for both its Connection Dental Federal FEDVIP plan and GEHA Health FEHB plans.

5 U.S.C.A. § 8902

The terms of GEHA's contracts with the OPM which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relate to health insurance or plans.

5 U.S.C.A. §8902(m)(1)

State regulations of the benefits under the Pre-Existing Condition Insurance Plan are preempted under the Affordable Care Act.

The GEHA Health plan, like other FEHB medical plans, offers limited dental coverage to its members and, by law, the FEHB plans are the first Payor (before FEDVIP plans) for dental coverage provided to FEDVIP Covered Enrollees.

5 U.S.C.A. § 8954(e)

To ensure consistency in the coordination of benefits among the FEDVIP carriers, the OPM has amended its contract with GEHA to state that when treating a FEDVIP Covered Enrollee, the Plan Allowance (which, for Connection Dental Federal is defined as the amount we allow for a specific procedure) is the maximum amount that may be charged to a FEDVIP Covered Enrollee. Neither GEHA nor any FEDVIP Covered Enrollee shall be held responsible or liable for any amounts greater than the FEDVIP allowable amount for services rendered by a Participating Provider to a FEDVIP Covered Enrollee. FEDVIP Covered Enrollees cannot be billed the difference between FEDVIP Plan Allowance and the first Payor's allowance, when the first Payor's allowance is greater than the FEDVIP allowable amount. Thus, FEDVIP Covered Enrollees will only be responsible for payment of the balance of the FEDVIP Plan Allowance minus all payments made by the first Payor and GEHA. FEDVIP Covered Enrollees and GEHA will not be responsible for increased out-of-pocket costs when Covered Enrollees utilize the services of a Connection Dental Participating Provider that also participates in another Payor's PPO network. This is applicable to GEHA Connection Dental Federal, the GEHA Health Plan, and the

Pre-Existing Condition Insurance Plan of the U.S. Health and Human Services Department, under which GEHA is the third-party administrator.
FEDVIP Technical Guidance, Amendment 0005

No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract. For purposes of this section, “covered services” means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation.
N.C.G.S.A. § 58-50-290

Provider-Patient Relationship

No state-specific requirements.

Required Content in Contract

Contract notices, correspondence, and proposed amendments will be sent in writing by GEHA to the name and title of the Participating Provider listed in the signature block of the Participating Provider Agreement, and to an active practice location for that Participating Provider. Contract notices submitted by the Participating Provider to GEHA should be sent to the name and address in the signature block of the Participating Provider Agreement.

Means for sending all notices provided under the Participating Provider Agreement will be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. However, this does not prohibit the use of an electronic medium for a communication other than an amendment as agreed to by the insurer and the provider.

N.C.G.S.A. § 58-50-275

If required by applicable law, a health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider prior to execution of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

N.C.G.S.A. § 58-50-285

The Participating Provider Agreement, the attached exhibit(s), and GEHA/CONNECTION Dental Network's North Carolina Addendum represent the entire agreement and understanding between GEHA and the Participating Provider. The Agreement shall automatically be amended to comply with changes in state or federal law.

11 NCAC 20.0202(1)

If a Participating Provider Agreement is terminated or in the case of insolvency of GEHA or a Payor (Carrier), Participating Provider will cooperate in the transition of administrative duties and records to the succeeding company or provider, as the case may be. If the Payor (Carrier) provides or arranges for the delivery of health

care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge, however, there is no inpatient care provided by Participating Providers pursuant to the Participating Provider Agreement.

11 NCAC 20.0202(5)

GEHA performs the credentialing function for Participating Providers on behalf of Payors (Carriers) that use the CONNECTION Dental Network. Participating Providers must maintain licensure, accreditation and credentials sufficient to meet GEHA's credential verification program requirements and notify GEHA of subsequent changes in status of any information relating to the Provider's professional credentials.

11 NCAC 20.0202(6)

GEHA accepts notice of changes in status of professional liability insurance from Participating Providers on behalf of Payors (Carriers) that use the CONNECTION Dental Network.

11 NCAC 20.0202(7)

The Payors (Carriers) that use the CONNECTION Dental Network do not provide or arrange for the delivery of health care services on a prepaid basis.

11 NCAC 20.0202(8)

Participating Providers should arrange for call coverage and other back-up to provide service in accordance with Payors' (Carriers') policies and procedures for provider accessibility as provided to them in accordance with applicable law.

11 NCAC 20.0202(9)

Payors (Carriers) are obligated to provide a mechanism that allows Participating Providers to verify member eligibility, based on current information held by the Payor (Carrier), before rendering health care services.

11 NCAC 20.0202(10)

The fee schedule contains the entire list of allowable amounts, which is the basis for payment to the Participating Provider.

11 NCAC 20.0202(14)

Payors (Carriers) that use the CONNECTION Dental Network in North Carolina must provide data and information to Participating Providers regarding performance feedback reports or information to the provider, if compensation is related to efficiency criteria; information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs, and provider sanction policies. GEHA provides data on behalf of Payors (Carriers) regarding its credential verification program and provider sanction policies in its Provider Manual located at connectiondental.com under the "Payor Info" tab.

11 NCAC 20.0202(15)

Participating Providers are obligated to comply with the Payors' (Carriers') utilization management programs and quality management programs that are provided to Participating Providers in accordance with applicable law, except that none of these programs shall override the professional or ethical responsibility of a provider or interfere with the provider's ability to provide information or assistance to patients. Participating Providers are also obligated to comply with GEHA's credential verification program and provider sanctions program.

11 NCAC 20.0202(16)

GEHA administers and, in its sole discretion, determines the composition of the CONNECTION Dental Network and any subset thereof. Payors (Carriers) are obligated to include the name of the Participating Provider or the provider group in the provider directory distributed to its members.

11 NCAC 20.0202(17)

This agreement shall be governed by and construed in accordance with the laws of the State of North Carolina and any applicable federal law(s) relative to the Participating Providers of the CONNECTION Dental Network providing services to enrollees in the State of North Carolina.

These policies and procedures are subject to change without notification as permitted by law. Any changes in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the CONNECTION Dental Network are hereby incorporated into these policies and procedures.

Please note: Government Employees Health Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates the CONNECTION Dental Network, which is a non-risk bearing PPO network. The above policies and procedures may or may not be applicable to the CONNECTION Dental Network, depending on whether the network is included within the state-specific definitions that are applicable to state laws, rules and regulations.

GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

The following provisions of this North Carolina Addendum and any obligations of the parties created by this North Carolina Addendum are hereby incorporated into the Participating Provider Agreement by this reference. In the event of any inconsistency between the following terms and conditions and those contained in the Participating Provider Agreement, the Participating Provider Agreement shall be amended and the following terms and conditions will control.

(1) Whether the contract and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties.

(2) Definitions of technical insurance or managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in the evidence of coverage issued in conjunction with the network plan.

(3) An indication of the term of the contract.

(4) Any requirements for written notice of termination and each party's grounds for termination.

(5) The provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations shall address:

(a) Transition of administrative duties and records.

(b) Continuation of care, when inpatient care is on-going. If the carrier provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

(6) The provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials.

(7) The provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of professional liability insurance on a timely basis.

(8) With respect to member billing:

(a) If the carrier provides or arranges for the delivery of health care services on a prepaid basis under G.S. 58, Article 67, the provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service.

(b) Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

(9) Any provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility.

(10) The carrier's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the carrier, before rendering health care services. Mutually agreeable provision may be made for cases where incorrect or retroactive information was submitted by employer groups.

(11) Provider requirements regarding patients' records. The provider shall:

(a) Maintain confidentiality of enrollee medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.

(b) Maintain adequate medical and other health records according to industry and carrier standards.

(c) Make copies of such records available to the carrier and Department in conjunction with its regulation of the carrier.

(12) The provider's obligation to cooperate with members in member grievance procedures.

(13) A provision that the provider shall not discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.

(14) Provider payment that describes the methodology to be used as a basis for payment to the provider (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus).

(15) The carrier's obligations to provide data and information to the provider, such as:

(a) Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.

(b) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies. Notification of changes in these requirements shall also be provided by the carrier, allowing providers time to comply with such changes.

(16) The provider's obligations to comply with the carrier's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

(17) The provider's authorization and the carrier's obligation to include the name of the provider or the provider group in the provider directory distributed to its members.

(18) Any process to be followed to resolve contractual differences between the carrier and the provider.

(19) Provisions on assignment of the contract shall contain:

(a) The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the carrier.

(b) The carrier shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.¹¹NCAC20 0202

Last updated November 15, 2014.