Your Provider Resource Guide

Updated: December 1, 2020

FirstCarolinaCare
INSURANCE COMPANY

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Provider Operations

New Phone Numbers

There are new phone numbers for FirstCarolinaCare (FCC) members. For Medicare and transitioned commercial group members' questions about claims, member eligibility, pharmacy and prior authorization with a service date of January 1, 2021, and after:

For Medicare Advantage claims and eligibility questions with a date of service before January 1, 2021, please continue to call:

Customer Service at (844) 201-4957

For all commercial claims and eligibility questions with a date of service before January 1, 2021, and for groups before their 2021 renewal, please continue to call:

Customer Service at (800) 811-3298

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

Important Changes

On January 1, 2021, FirstCarolinaCare will begin the transition to the following:

- New vendor for claims processing: Health Alliance.
- New Pharmacy Benefits Manager (PBM): OptumRx.
- New prior authorization vendors (see page 5) and processes: Health Alliance, eviCore.
- New vendor for enrollment: Health Alliance.
- New vendor for Customer Service: Health Alliance.
- New Customer Service phone numbers.
- New member ID numbers.
- New mail-order pharmacy vendor: OptumRx.
- New specialty pharmacy vendor: CVS-Caremark.

Effective Dates

FirstMedicare Direct (Medicare Advantage)

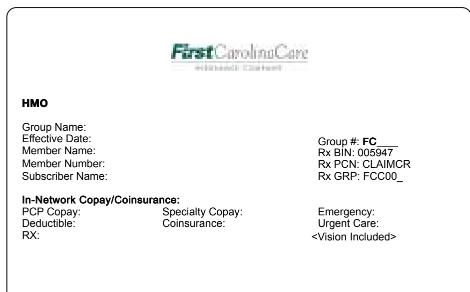
- For dates of services on or after January 1, 2021, all FirstMedicare Direct plans will transition to the new vendors and processes outlined.

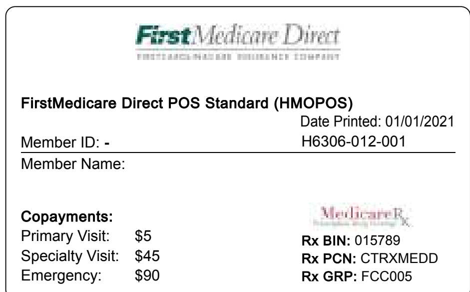
FirstCarolinaCare (Commercial)

- The effective date for each commercial plan will coincide with each group's renewal date throughout the 2021 plan year. Membership and the new processes will begin for dates of service on of after the group's renewal date.

Important Note:
It's essential that after January 1, 2021, you ask every FirstCarolinaCare 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.

If the member's group has renewed, their new ID card will look like the following:





All Medicare Advantage members will move over on January 1, 2021. Members that have transitioned to the new vendors will have an ID number that starts with 94.

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

New Claims Address and EDI

FirstMedicare Direct

- Effective January 1, 2021, all claims for FirstMedicare Direct members must be sent to:
  - EDI: FCC01
  - Paper claims to:
    - FirstMedicare Direct | P.O. Box 6003
      Urbana, IL 61803-6003

FirstCarolinaCare (Commercial)

- Effective with the group renewal date for the 2021 plan year, claims for commercial plan members (new ID card starting with 94) must be sent to:
  - EDI: FCC01
  - Paper claims to:
    - FirstCarolinaCare | P.O. Box 6003
      Urbana, IL 61803-6003

This doesn't apply to providers seeing members with MedCost as their preferred provider network. (Claims submission for Medcost network is excluded from above change.)

- For members on employer group plans that haven't transitioned to Health Alliance for claims processing (old ID card, number begins with 00), you should continue to file using:
  - EDI: 56196
  - Paper claims to:
    - FirstCarolinaCare Insurance Company
    - P.O. Box 381686
    - Birmingham, AL 35238

Claims Editing Systems

FirstCarolinaCare utilizes 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 health care 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.

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 access the prior authorization list at FirstCarolinaCare.com/Providers, as shown below. Once you log in to the portal, you can find the DME and/or medical lists when you attach to a member. Once attached, go to "View Member Details," and then choose "Medical List."

FirstCarolinaCare
INSURANCE COMPANY

HOME CONTACT

Registration

Tell us who you are

Member
Personal Representative
Employer Group
Health Care Professional
Broker

Register now to:

- Find doctors, hospitals, and pharmacies covered by your plan
- Check your spending and get estimates on treatments
- Pay bills and check claims

You'll need your member number to continue. Use a personal email, not a work email.

Create Member Account

Questions? Contact Us.

Where to Submit Your Prior Authorization

Navigate to FirstCarolinaCare for providers. The first tab in your main menu, "Request Prior Authorization," brings you here, where you can submit prior authorization requests. Use the "Where Do I File?" search to look up if you should file your prior authorization at eviCore or Altruista. There are detailed instructions available in the Prior Authorization Overview for Providers and Office Personnel PDF. To find the PDF, select Forms & Resources at the top of the provider portal and then scroll down to the Training, Manuals and Other section.

You can greatly reduce the time it takes for a review to be completed by supplying complete medical information when submitting a request for coverage and by promptly responding to requests for more information if the original request is missing something.

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 Barbara Adcock at bjadcock@FirstCarolinaCare.com or (910) 715-8115. Include your justification to be added to the fax exclusion list (for example, no internet access).

How to Determine if Item or Service Requires Prior Authorization

To determine if an item or service requires authorization, the provider's office must first attach to a member, then enter the CPT 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.

Altruista Health	eviCore
Pharmacy	Lab Management
Inpatient	Medical Oncology Pathways
Outpatient	Musculoskeletal Management
DME	Radiation Therapy Management Program
Referrals	Radiology and Cardiology
Procedures	Sleep Management

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 uses clinical guidelines from nationally respected vendors, such as InterQual® and eviCore, based on best practice, clinical data and medical literature.

InterQual®, eviCore and internal medical policies are available at Your FirstCarolinaCare for providers (Login.HealthAlliance.org/Account/Login).

Provider Lookup Links

Network Links

- MedCost: http://providers.medcost.com/MainMenu.aspx
- Participating Providers: http://cact-idirec-fhc.firsthealth.org/idirectory/applicationspecific/search.asp
- InterQual: https://www.changehealthcare.com/solutions/clinical-decision-support/interqual

Note, any prior authorization requests that span into 2021 may receive a new prior authorization number. A new notification letter will be sent to communicate the new number to providers.

Risk Adjustment

FirstMedicare Direct contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage (MA) plans. CMS payment to Health Alliance Medicare 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 the claim submitted to FirstMedicare Direct 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 FirstMedicare Direct 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.

Annual Wellness Visit and Health Risk Assessment

Original Medicare: The Medicare Annual Wellness Visit (AWV) program provides for a health risk assessment (HRA) and personalized prevention plan at no cost to Medicare beneficiaries. A "Welcome to Medicare" preventive visit is a comprehensive assessment in the first 12 months of enrolling in Medicare. CMS requires that a good faith effort be made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment. It also calls for follow-up on unsuccessful attempts to contact a member. The 90-day rule applies to initial health risk assessments for new enrollees and current enrollees who don't have a documented health risk assessment as of January 1 of the current calendar year.

FirstMedicare Direct: FirstMedicare Direct covers everything Original Medicare covers as described above but takes it a step further. In addition to a comprehensive preventive visit or the Medicare annual wellness visit, FirstMedicare Direct also covers one health risk assessment (HRA) (CPT code 96160) per calendar year. This FirstMedicare Direct HRA includes a full history and physical exam (with a care plan documented for each chronic illness), completed by a physician, physician's assistant or nurse practitioner.

The goals of the health risk assessment are to:

- Identify chronic diseases, injury risks, modifiable risk factors and urgent health needs.
- Manage the patient's care for each chronic condition through the development of a personalized care plan for each chronic condition.
- Enroll the member in Chronic Disease Management programs or Care Management as indicated.
- Healthcare Effectiveness Data and Information Set (HEDIS®) gap closure.
- CMS Star Rating program improvements.

FirstMedicare Direct also may offer providers a list of patients who need to schedule appointments and have an HRA completed, and can provide patient-specific forms with the member's diagnosis history (which may include diagnoses of conditions that are ongoing but haven't been documented in the current year). Documenting and coding all actual diagnoses and chronic conditions from year to year is important to ensure FirstMedicare Direct receives accurate risk-based reimbursement.

You can access the HRA form at FirstMedicare.com on the Provider Forms page.
Providers may complete and submit the HRA form to FirstMedicare Direct, or they may provide the full office visit note if it contains all of the information from the HRA form, including:

- Self-assessment of health status and Activities of Daily Living.
- Psychosocial status.
- Behavioral risks.
- Current and past medical diagnoses and surgical procedures.
- History (personal and family).
- Vital signs.
- Physical examination/review of systems.
- Assessment and management plan for all chronic conditions.

Providers may bill only one HRA annually. Annually is defined as calendar year (January – December) and **not** a rolling 12 months from the last time the service was rendered. (Example: A FirstMedicare Direct member could have an HRA done in November the previous year and one for the current year in January.)

FirstMedicare Direct will compensate providers $250 for each HRA completed and sent to FirstMedicare Direct, as well as reimbursement for an annual wellness visit (G0438-G0439) or annual preventive exam/physical (99396-99497), if applicable. FirstMedicare Direct also will reimburse providers for HRAs completed in connection with services reported under other Evaluation and Management codes if the HRA is fully documented. The HRA forms should be forwarded to FirstMedicare Direct by RightFax – (910) 235-7860.

For detailed information on Medicare coverage of the annual wellness visit and administration of a health risk assessment, please go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf.Forms

Point of Care (POC) Form:

A resource sheet with member information populated from CMS claims review, historical and trend data, and suspect data from clinical review. There are two types of POC forms:

- **Pre-Visit POC Form:** A POC form generated once per year designed to provide guidance for providers before and during the HRA visit. This form includes the patient's available historical clinical and diagnosis information.

- **Post-Visit POC Form:** A POC form generated after completion of an HRA and after review of coding accuracy and completeness. The provider uses this form to consider remediation of the clinical documentation and ensure accurate diagnosis and coding of all chronic conditions.

Process:

Step 1: Pre-Visit POC Forms are generated and distributed to the provider or office designee. FirstMedicare Direct will deliver, fax or send via secure email the Pre-Visit POC Forms to the office designee.

Step 2: Office schedules member for HRA visit.

Step 3: Provider reviews the Pre-Visit POC Form before the member visit and uses the form as a resource for the HRA visit.

Step 4: Provider conducts member visit and completes HRA documentation.

Step 5: Provider returns HRA documentation to FirstMedicare Direct via RightFax at (910) 235-7860. Documentation should be submitted within five days of the member visit.

Step 6: FirstMedicare Direct reviews HRA documentation. Post-Visit POC Form will be generated if there are gaps noted in the HRA or if care plans are missing.

Step 7: Office designee is notified of Post-Visit POC Form. Provider reviews. If applicable, provider uses clinical judgment for review and amendment of clinical documentation. Chart amendment occurs as indicated.

Step 8: Provider office returns amended HRA documentation, progress notes and other associated documents to FirstMedicare Direct via fax at (910) 235-7860.

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.

FirstMedicare Direct 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 Marketplace 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 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) 715-8155.

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 Descriptive 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. If you have any questions or concerns regarding the confidentiality of any documentation provided to our office for quality review purposes, please feel free to contact the director of Quality Management at (910) 715-1528.

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 on any issue with respect to the member. The appeals process varies by type of appeal – medically related or non-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. Non-medically related appeals encompass eligibility, benefit coverage and/or procedural issues.

Medical Appeal (non-drug related)
When acting on behalf of a member, a provider may call, send a written request or fax an appeal:

FirstCarolinaCare (Commercial) Phone:
(800) 481-1092

FirstMedicare Direct Phone:
(877) 210-9167

Phone number for both FCC and FirstMedicare Direct expedited medical appeals:
(844) 335-7097

Written Request:
FirstCarolinaCare Insurance Company
ATTN: Appeals Dept.
42 Memorial Dr.
Pinehurst, NC 28374
Fax: (910) 715-8197

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.)

Effective January 1, 2021, for all Medicare groups and commercial groups that have transitioned to the new claims vendor and PBM (member ID numbers starting with 94) for drug appeals (pharmacy or medical benefit drugs):

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: Member Relations Dept.
3310 Fields South Dr.
Champaign, IL 61822
Fax: (217) 902-9708

For commercial groups that haven't transitioned to the new claims or PBM system (ID card with member numbers beginning with 00), medication appeals will continue to be submitted to FirstCarolinaCare for medical benefit (provider-administered) drugs and to MedImpact (PBM) for pharmacy benefit medications. Please refer to the adverse determination/non-certification letter for full instructions.

Pharmacy Benefit Drug Appeals:

Appeals Coordinator
MedImpact
10181 Scripps Gateway Court
San Diego, CA 92131
Fax: (858) 790-6060
Phone: (800) 788-2949

Medical Benefit (Provider-Administered) Drug Appeals:

FirstCarolinaCare Insurance Company
ATTN: Appeals Dept.
42 Memorial Dr.
Pinehurst, NC 28374
Fax: (910) 715-8197
Phone: (800) 481-1092;
expedited appeals: (844) 335-7097

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

Staring January 1, 2021, FirstCarolinaCare will transition members to a new Pharmacy Benefit Manager (PBM) – OptumRx.

- OptumRx will become the PBM for all Medicare groups/members on January 1, 2021.
- OptumRx will become the PBM for commercial groups/members at the time they renew their coverage with FCC in 2021 (member numbers/ID cards starting with 94).
- MedImpact will continue to serve as the PBM for commercial groups/members until they have renewed in 2021 (member numbers/ID cards starting with 00).

PBM services and pharmacy operations will be coordinated by the Pharmacy department at Health Alliance. Health Alliance will serve 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 Committee (P&T) 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

For commercial groups that haven't transitioned to OptumRx and are still with MedImpact (ID numbers starting with 00), the process for prior authorization won't change until the group renews.

For Medicare Advantage members starting January 1, 2021, and commercial members as their groups renew (ID cards starting with 94), go to 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 Changes Mail-Order Pharmacy

- OptumRx Mail-Order Pharmacy will become the preferred mail-order pharmacy for Medicare members starting January 1, 2020, and for commercial group members at their time of renewal in 2021.
  - Commercial Group Medicare Advantage
    Commercial/HIX (844) 569-4145
    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.
- MedImpact Direct Mail Order will still be available for commercial members before their transition to OptumRx (ID numbers start with 00). Phone: (855) 873-8739.

Specialty Prescriptions

- Medicare members can use any network pharmacy to fill their specialty drug prescriptions.
- Commercial Members:
  - Members whose groups have renewed and are now with OptumRx as their PBM (ID numbers starting with 94).
    - CVS Caremark will be the preferred specialty pharmacy. Phone: Customer Service: (800) 237-2767
      Fax: (800) 323-2445
  - FirstHealth employee group members can still access specialty drugs through the FirstHealth Outpatient Pharmacy.
    Phone: (910) 715-4250.
  - Commercial group members whose groups haven't renewed and who are still with MedImpact (ID numbers starting with 00).
    - MedImpact Specialty Pharmacy will continue to be the preferred specialty pharmacy until the group renews in 2021.
      Phone: (877) 391-1103.

Provider Relations Contact Information

Contracts and fee schedules:
Barbara Adcock
bjadcock@FirstCarolinaCare.com
(910) 715-8115

Credentialing:
Susan Garner
ssgarner@FirstCarolinaCare.com
(910) 715-8131

Recredentialing:
Jennifer Kennally
jkennally@FirstCarolinaCare.com
(910) 715-8179

General questions:
Dora Lopez
dlopez@FirstCarolinaCare.com
(910) 715-8114

Questions about claims filed with EDI 561966003:
Debbie Edwards
dedwards@FirstCarolinaCare.com
(910) 715-8116

FirstCarolinaCare
INSURANCE COMPANY
GNPVFC21-resourcebk-1120