**11 NCAC 20 .0202 CONTRACT PROVISIONS**

All contract forms shall contain provisions addressing the following:

(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) 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 that 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.

(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, 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 medical and other health records according to standards established by the carrier and as required by law.

(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:

(i) benefit exclusions;

(ii) administrative and utilization management requirements;

(iii) credential verification programs;
(iv) quality assessment programs; and
(v) 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 stipulation 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.

*History Note:* *Authority G.S. 58-2-40(1); 58-2-131; 58-39-45; 58-39-75; 58-65-25; 58-65-105; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-115; 58-67-140; 58-67-150;*
*Eff. October 1, 1996;*
*Readopted Eff. August 1, 2018.*