



Massage Therapy Provider Orientation

May 23rd, 2022

Agenda

General Overview

- North Carolina Medicaid Transformation
- Who We Are – North Carolina’s Provider Led Plan
- In Lieu of Service Definition

Important Information

- Website and Secure Portal
- Provider Relations Support
- ILOS overview
- Additional trainings and resources
- Appendix

Overview

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

OUR PILLARS



Focus on the Individual



Whole Health



Active Local Involvement

What drives our activity

OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.

We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

North Carolina's Only Physician-Led Medicaid Plan

A joint venture between Centene Corporation, the North Carolina Medical Society (NCMS), the North Carolina Community Health Center Association (NCCHCA) and the shareholders in the CCH Network to collaborate on a patient-focused, provider-led approach to Medicaid Transformation.



A first-of-its-kind partnership

Carolina Complete Health is the result of a collaboration between the North Carolina Medical Society, the North Carolina Community Health Center Association, and Centene Corporation.



Provider-led

We give doctors and FQHCs (Federally Qualified Health Centers) a voice in key policymaking. We believe providers are essential to Medicaid Transformation and are committed to helping providers remain strong and viable, especially important during the pandemic.



Patient-centered

Carolina Complete Health helps patients get the care they need, when they need it, through local, regional and community-based resources.

Carolina Complete Health Partners

North Carolina Medical Society

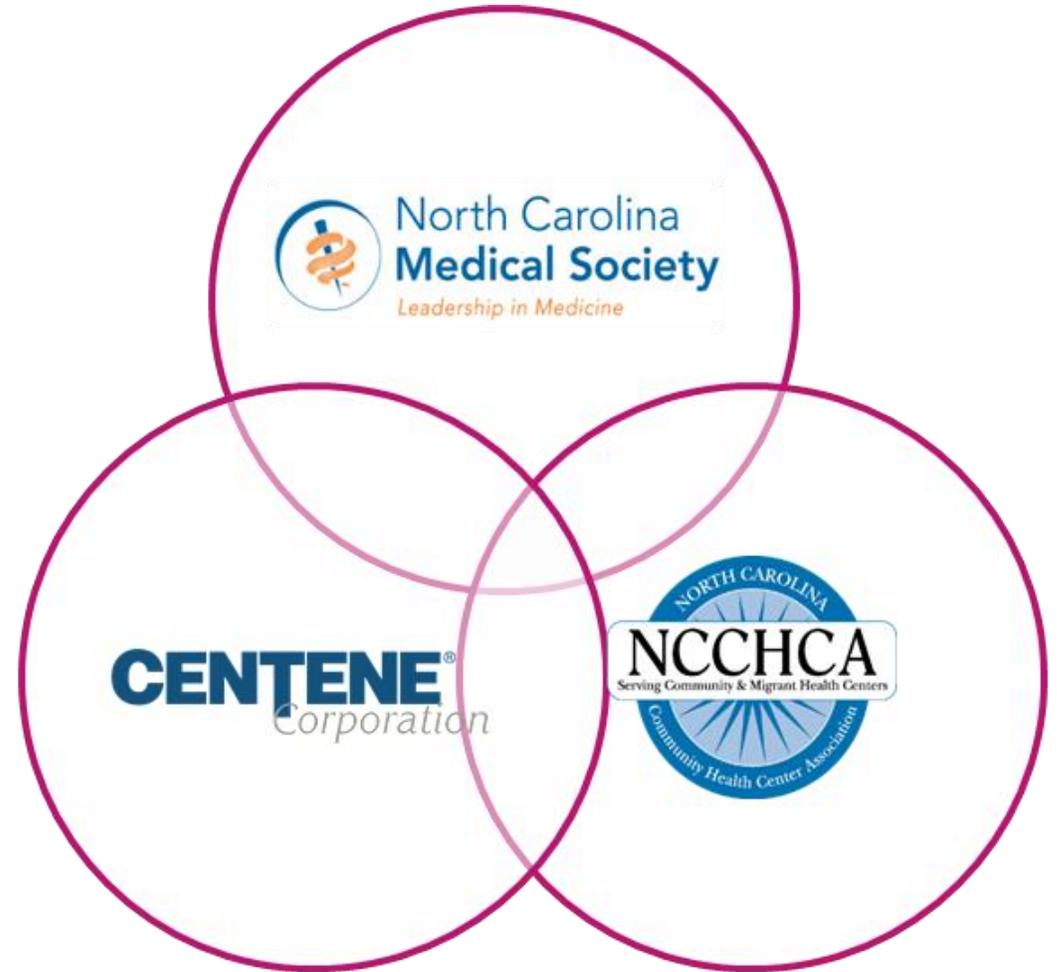
- Approximately **10,000** members
- Leading health policy in North Carolina
- Engaged in practice transformation and provider recruitment strategies
- Advocating for medically underserved and rural populations

North Carolina Community Health Center Association

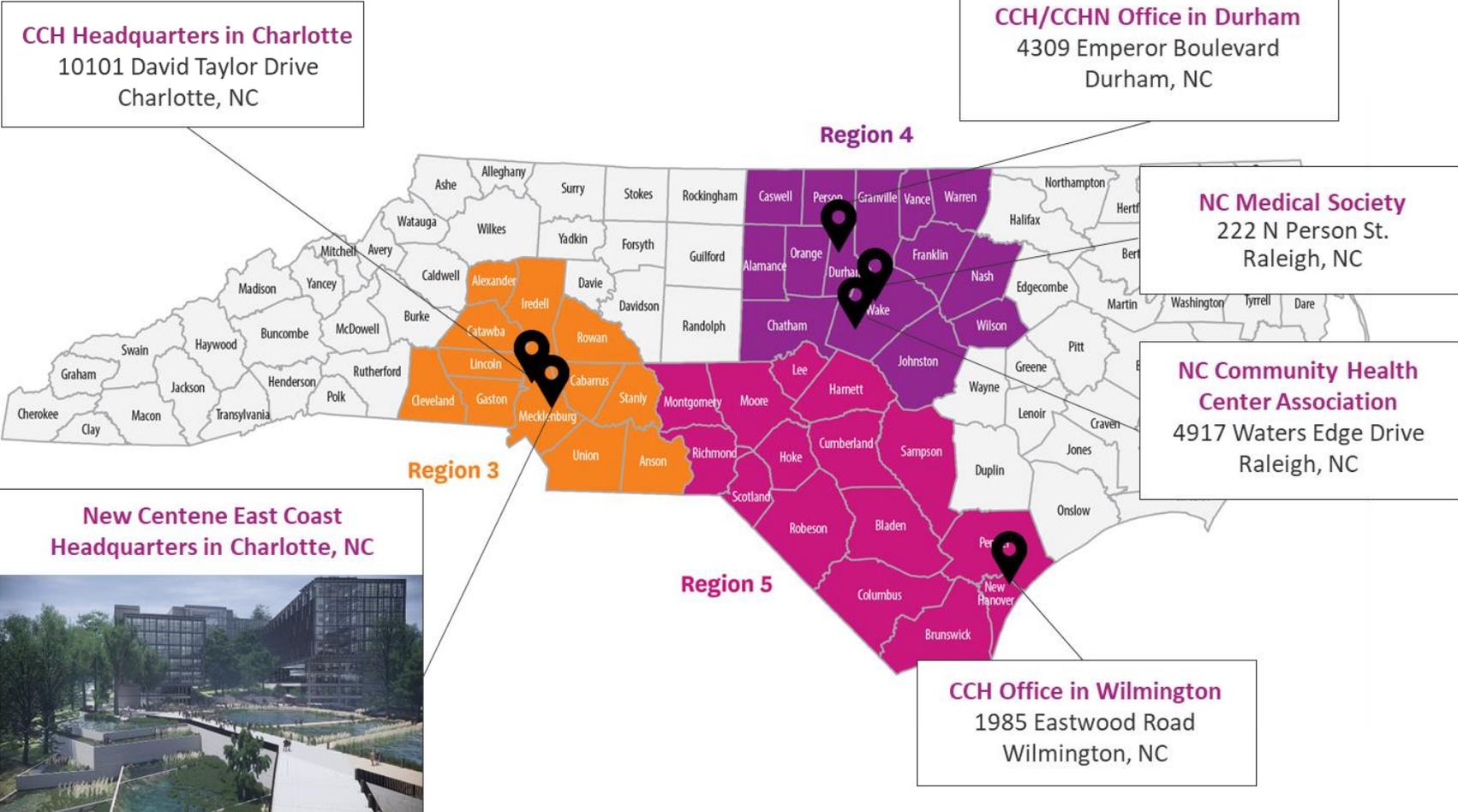
- **42** health center grantees and look-alike organizations
- Serving over **631,000** underinsured and uninsured
- **300** clinical sites across 84 North Carolina counties

Centene Corporation

- **Fortune 50** company with over 30 years' Medicaid experience
- Operates health plans in **50** states
- Over **24 million** members with Medicaid, Medicare, and ACA Marketplace
- Building new East Coast Headquarters in Charlotte



A Commitment to North Carolina



Getting Acquainted

Key Contact Information

Carolina Complete Health Network:
NetworkRelations@cch-network.com

1-833-552-3876

Online:
www.network.carolinacompletehealth.com



Provider Welcome Toolkit

Once contracted, you will receive a provider toolkit. Our tool kit contains useful information for getting started as a Carolina Complete Health provider.

While we'll cover some of that information in this presentation, your toolkit has additional information including:

- Secure Portal Guide
- Payspan Guide
- Prior Authorization Guide
- Quick Reference Guide

Electronic Funds Transfer

Payspan: A Faster, Easier Way to Get Paid

Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation.

- Improve cash flow** by getting payments faster
- Maintain control over bank accounts** by routing EFTs to the bank account(s) of your choice
- Eliminate re-keying of remittance data** by choosing how you want to receive remittance details
- Settle claims electronically** through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- Match payments to advices quickly** and easily re-associate payments with claims
- Create custom reports** including ACH summary reports, monthly summary reports, and payment reports sorted by date
- Manage multiple payers**, including any payers that are using Payspan to settle claims

Questions?
1-833-552-3876
Provider Relations can help

Please keep this information for when it's time to set up our Payspan account. At this time, you can visit payspan.carolinahc.com and click Register.

You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

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carolinacompletehealth.com

Prior Authorization Guide

How to Secure Prior Authorization

Prior-Auth Check Tool
Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization.
carolinacompletehealth.com/priorauthtool

Submit Prior Authorization
If a service requires authorization, submit via one of the following ways:

- SECURE WEB PORTAL**
provider.carolinacompletehealth.com
This is the preferred and fastest method.
Notification of authorization will be returned via phone, fax, or web.
- FAX**
1-919-670-4948
- PHONE**
1-833-552-3876

See reverse side for a list of services that require prior authorization.

Please note:

- All out-of-network services require prior authorization EXCEPT emergency services, family planning, post stabilization services, and table top x-rays.
- Failure to complete the required authorization or certification may result in a denied claim.

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NORTH CAROLINA MEDICAID PROVIDER QUICK REFERENCE GUIDE

PROVIDER SERVICES CONTACTS
Toll Free 1-833-552-3876

PROVIDER PORTAL
Website: carolinacompletehealth.com

- Patient care forms
- Prior authorization needed tool
- Provider manual
- Member resources
- Provider alert
- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

PRIOR AUTHORIZATIONS / NOTIFICATIONS
Use the Prior authorization needed tool on the carolinacompletehealth.com website to determine if prior authorization is required. Submit prior authorizations via 3 ways:

- Secure Provider Portal
- OR Fax: 1-833-238-7694
- OR Provider Services: Toll Free 1-833-552-3876

MEMBER SERVICES / ELIGIBILITY
Check member eligibility via:

- Secure Web Portal
- OR Provider Services: Toll Free 1-833-552-3876

CLAIMS / EDI
Timely Filing guidelines: 180 days from date of service. Claims can be submitted via:

- Secure Portal
- Clearinghouses
- Mail paper claims to: EDI Payor ID 68069
Carolina Complete Health
Attn: Claims, PO Box 8040
Provider Service
Farmington, MO 63640-8040

Secure Provider Portal

Secure Provider Portal

Manage patient administrative tasks quickly and easily.

- Visibility of Multiple Tax Identification Numbers (TINs)**
One point of entry allows for quick and easy access to Carolina Complete Health member information for multiple TINs/practices.
- Access Daily Patient Lists from One Screen**
One concise view allows primary care providers to scan patient lists for Carolina Complete Health member eligibility, care gaps, and much more.
- Manage Batch Claims for Free**
Submit and manage claims, including batch files, for free. View detailed Electronic Funds Transfer (EFT) payment history.
- Simplify Prior Authorization Process**
"Smart Sheets" feature prompts for required clinical information when submitting prior authorization requests.
- Additional Features to Streamline Office Operations:**
 - View patient demographics and history
 - Secure messaging between provider and Carolina Complete Health
 - Update provider demographics

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carolinacompletehealth.com

Provider Relations and Support

The **Carolina Complete Health Network Provider Relations and Support** team includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:

- Credentialing/Network status
- Claims
- Secure Portal registration and Pay Span
- Inquiries related to administrative policies, procedures, and operational issues
- Contract Questions

By calling **Carolina Complete Health** Provider Services at **1-833-552-3876** providers will be able to access real time assistance for all their service needs

You can also email Provider Relations and Support: networkrelations@cch-network.com

Website, Secure Portal, and Tools

Websites

The screenshot shows the homepage of the Carolina Complete Health website. At the top left is the logo for Carolina Complete Health. To the right of the logo is a navigation menu with links for Home, For Members, For Providers, Find A Provider, Member Login, COVID-19, and 1-833-552-3876. There is also a search bar. Below the navigation is a secondary menu with links for FOR MEMBERS, FOR PROVIDERS, ABOUT US, and CONTACT US. The main content area features a large image of a man and a boy playing basketball. A pink circular overlay on the left side of the image contains the text: "Welcome to Medicaid Managed Care" and "Choose the plan you can rely on!". Below the image, the text reads: "Welcome to Carolina Complete Health" and "At Carolina Complete Health, we've got you and your family covered with the Medicaid benefits you need – from doctor visits and hospitalization to preventive servi and prescription drug coverage. Do you need general information or have a question? Please call us at 1-833-552-3876 (TTY: 711)." The URL "www.carolinacompletehealth.com" is displayed at the bottom of the screenshot.

www.carolinacompletehealth.com

www.network.carolinacompletehealth.com

The screenshot shows the homepage of the Carolina Complete Health Network website. At the top is a navigation menu with links for Home, For Members, Contact Us, Help STATI, Pre-Auth Tool, and Provider Portal Login. Below the navigation is the Carolina Complete Health Network logo. To the right of the logo is a search bar and a contrast control (On/Off). Below the search bar is a secondary menu with links for JOIN THE NETWORK, RESOURCES, ABOUT US, and PROVIDER UPDATES. The main content area features three large images: a doctor examining a young girl's ear, a doctor talking to a woman, and a doctor talking to a young girl. Below each image is a pink button with white text: "Join the Network", "Provider Resources", and "Provider Updates".

Web-based Tools

- Web-Based Tools
 - Public site at www.carolinacompletehealth.com
 - For Providers: network.carolinacompletehealth.com
- Provider information
 - Forms
 - Provider Manual and Billing Manual
 - CCH's plan news
 - Clinical guidelines
 - Provider bulletins
 - Contract request forms
 - Provider Engagement contact information
- **Carolina Complete Health is committed to enhancing our web-based tools and technology, provider suggestions are welcome!**
 - <https://www.surveymonkey.com/r/CCHWEBSITE>

Secure Provider Portal

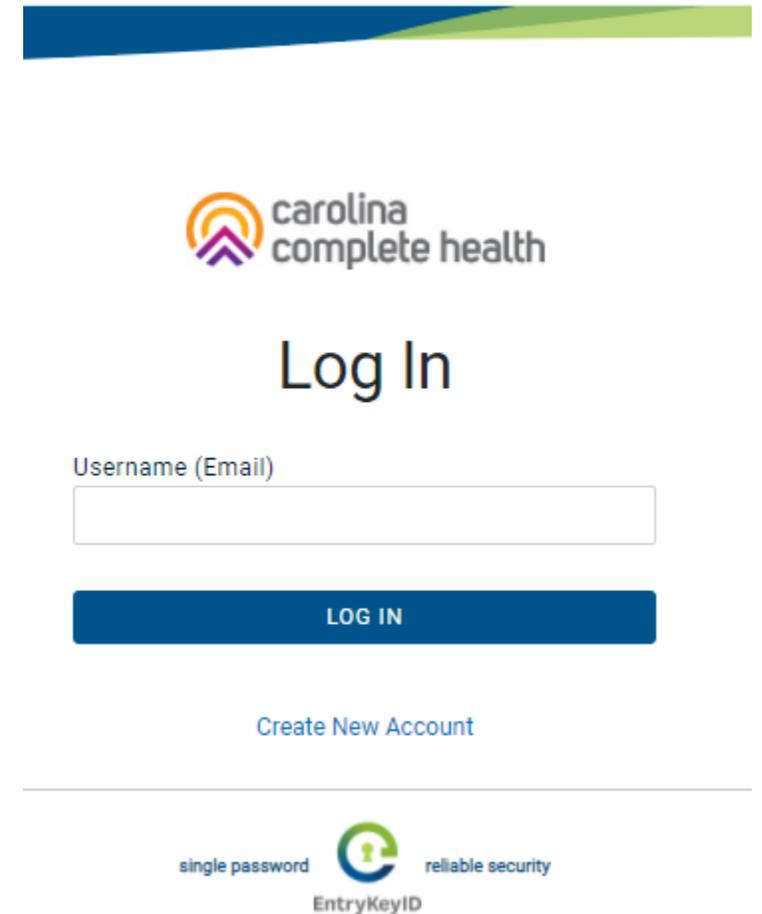
Secure Provider Portal:

- Beneficiary eligibility & patient listings
- Health records & care gaps
- Prior Authorizations
- Claims submissions & status
- Payment history
- Monthly PCP cost reports
- ...and more!

<https://provider.carolinacompletehealth.com/>

Or simply use the 'Login' button on the upper right-hand corner of our Provider website

Registration is free and easy - contact your provider network specialist to get started!



Massage Therapy as an ILOS

In Lieu of Service: Massage Therapy

- Alternative pain management via massage therapy provided by a licensed practitioner in lieu of pharmaceutical pain management with Schedule II narcotics.
- This service will require prior authorization.
- **Anticipated outcomes: reduction in chronic pain and back pain without the use of opiate therapies.**

Massage Therapy UM Guidelines

- One unit = 15 Minutes
- If you provide a one-hour massage, you bill 4 units on the claim
- A member is limited to 10 hours per year
- A provider can bill for up to 40 units per year
- Age range is 21+, however EPSDT applies!

EPSDT

Early: *Assessing and identifying problems early*

Periodic: *Checking children's health at periodic, age-appropriate intervals*

Screening: *Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems*

Diagnostic: *Performing diagnostic tests to follow up when a risk is identified*

Treatment: *Control, correct or reduce health problems found.*

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit:

- provides comprehensive and preventive health care services **for children under age 21** who are enrolled in Medicaid.
- is key to ensuring that children and adolescents **receive appropriate** preventive, dental, mental health, developmental and **specialty services**.
- makes short-term and long-term services available to recipients under 21 years of age **without many of the restrictions Medicaid imposes** for services under a waiver OR for adults (recipients 21 years of age and over).
- uses clinical practice guidelines from Bright Futures, a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) , Maternal and Child Health Bureau (MCHB).

With EPSDT, benefit limitations, such as number of units allowed per year or age restrictions, do not apply as long as the service is medically necessary.

EPSDT

EPSDT services must:

- be medically necessary to correct or ameliorate a defect, physical or mental illness or a condition that is identified through a screening examination
- be listed in section 1905(a) of the Social Security Act
- not be experimental/investigational, unsafe or considered ineffective
- adhere to the Bright Futures/AAP Periodicity Schedule for preventative, pediatric healthcare. The Periodicity Schedule is available online at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

For more on EPSDT, visit our [Education & Training](#) page.

Procedure Codes

- Procedure Code: sometimes called a CPT code, is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
- **Massage Therapy CPT Codes: 97124, 97140**
 - 97124: Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).
 - 97140: Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes.

Acknowledgement and Referral Form

- Completed by the REFERRING provider and the member.
- This is shared with the LMT as the referral for services.
- ***Best Practice: use a fax cover sheet to display provider contact information.***

Acknowledgement and Referral Form

Benefit Option available to Carolina Complete Health (CCH) members Massage Therapy for Pain

Service Goals and Objectives/Treatment Philosophies

CCH offers massage therapy provided by a licensed massage therapist as an alternative pain management strategy in lieu of pharmaceutical pain management, particularly Schedule II narcotics. This service will require prior authorization.

Description of Service/Item

CCH proposes alternative pain management via massage therapy provided by a licensed massage therapist in lieu of pharmaceutical pain management with Schedule II narcotics. This service will require prior authorization.

Anticipated Outcomes

Improved pain management with avoidance or reduction of the use of opiate therapies.

Referral Information

| | |
|---------------------|--|
| Diagnosis Code | |
| Member Name | |
| Member DOB | |
| Member Medicaid ID | |
| Member Phone Number | |

Doctor Acknowledgement

Signature

Date

Patient Acknowledgement

Signature

Date

Please keep a copy of this form for your records and send a copy to the Massage Therapist. Prior Authorization must be sent to CCH for approval. Please indicate the diagnosis code on the authorization. With approval, a member may be eligible for up to 10 hours of total care per year. For questions, please reach out to Member Services at 1-833-552-3876.

Massage Therapy Assessment Checklist

Available online: <https://network.carolinacompletehealth.com/resources/manuals-and-forms.html>

- To be completed at each session to track member's progress
- Save a copy for your records
- Share a copy back to referring provider



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10101 David Taylor Dr.
Suite 300
Charlotte, NC 28262
1-833-552-3876 (TTY 711)
carolinacompletehealth.com

Massage Therapy Assessment Checklist

Description of Service

CCH offers massage therapy provided by a licensed massage therapist as an alternative pain management strategy in lieu of pharmaceutical pain management, particularly Schedule II narcotics. This service will require prior authorization from the referring provider.

Anticipated Outcomes

Improved pain management with avoidance or reduction of the use of opiate therapies.

Massage Therapist Acknowledgement

Confirmation that I, _____, have discussed the intent of the In Lieu of Service benefit to help support the member's pain management through massage therapy and without the use of high-risk medications like opioids.

| | |
|------------------------------------|-------------|
| | |
| Message Therapist Signature | Date |

Appointment Assessment

| | |
|--|--|
| <p>1. Prior to the massage therapy appointment, utilizing the disability index, please create a baseline assessment of the member's need and pain level.</p> | |
|--|--|



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| | |
|---|--|
| <p>2. Pain scale tracked this visit, please detail.</p> | |
| <p>3. Following the massage therapy appointment, utilizing the disability index, please reassess the member's pain level. <i>Disability index expected to be assessed at the beginning and end of therapy or as indicate.</i></p> | |

Post Therapy Assessment

| | | |
|--|--------------------------|--------------------------|
| <p>Following the massage therapy, the member feels confident that this therapy session has helped reduce or avoid the need for high-risk medications like opioids.</p> | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Post Observation

| | | |
|--|--------------------------|--------------------------|
| <p>Did we achieve the goal of providing an alternative pain management? <i>If yes to post therapy assessment, we have achieved the goal.</i></p> | YES | NO |
| | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Acknowledgement

| | |
|------------------|-------------|
| | |
| Signature | Date |

Please keep a copy of this assessment for your records. A specialist provider should also coordinate care with the referring provider.

Overview of Process

1. Referring Provider and member complete the Acknowledgment and Referral Form. This is sent to the Licensed Massage Therapist (LMT) for pain management in lieu of narcotics.
2. LMT verifies member eligibility and submits an authorization* for the massage therapy ILOS.
3. LMT reaches out to the member to discuss the service and get verbal consent for treatment.
4. Once auth is approved, LMT schedules member for first visit.
5. LMT sees the member for service, checking member eligibility again, and uses the Assessment Checklist as a tool for documentation and coordination of care.
6. LMT bills for the service using CMS 1500 form and with appropriate CPT codes.
7. Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim. Payment is made via check or Electronic Funds Transfer (EFT).

*Authorization can take up to 14 days for review and notification

Portal Functionality: Check Eligibility

Quick Eligibility Check

Viewing Dashboard For : TIN [dropdown] Plan Type [dropdown] Medicaid [dropdown] GO

Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith **1** Birthdate: mm/dd/yyyy **2** **Check Eligibility** **3**

Recent Claims

| STATUS | RECEIVED DATE | MEMBER NAME | CLAIM NO. |
|--------|---------------|-------------|-----------|
| 🟢 | 05/15/2020 | [blurred] | T136 |
| 🟢 | 05/18/2020 | [blurred] | T139 |
| 🟢 | 05/18/2020 | [blurred] | T139 |
| 🟢 | 04/23/2020 | [blurred] | T114 |
| 🟢 | 04/21/2020 | [blurred] | T112 |

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Recent Activity

| Date | Activity |
|------|----------|
|------|----------|

Quick Links

Eligibility Check

The screenshot shows a web application interface for an eligibility check. At the top, there is a navigation bar with icons for Eligibility (1), Patients, Authorizations, Claims, and Messaging. Below this is a search bar with 'Viewing Eligibility For:' and two dropdown menus: 'TIN' and 'Plan Type' (set to 'Medicaid'). A green 'GO' button is to the right. The main section is titled 'Eligibility Check' and contains a form with fields for 'Date of Service' (05/27/2020), 'Member ID or Last Name' (123456789 or Smith) (2), and 'DOB' (mm/dd/yyyy) (3). A green 'Check Eligibility' button (4) and a 'Print' button are also present. Below the form is a table with columns: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, RECENT ADT, CARE GAPS, and LOG ER VISIT. The table has one row with a thumbs-up icon, the date 05/27/2020, a patient name (5), the date 05/27/2020, 'NO', and the text 'Non-compliant for annual well visit.'. The 'LOG ER VISIT' column contains an 'ER Visit?' button and a 'Remove' button.

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | RECENT ADT | CARE GAPS | LOG ER VISIT |
|----------|-----------------|-------------------|--------------|------------|--------------------------------------|------------------|
| | 05/27/2020 | >View details (5) | 05/27/2020 | NO | Non-compliant for annual well visit. | ER Visit? Remove |

If Eligibility Check is for an ER visit, click **ER Visit?**

Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

Eligibility Tips

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- **As best practice, always check member eligibility before creating a web authorization or web claim**

Prior Authorization

How to Secure a Prior Authorization

A Prior Authorization can be requested in the following three ways

1. Secure Web Portal

This is the preferred and fastest method
network.carolinacompletehealth.com
Login in the upper right-hand corner

2. Phone

1-833-552-3876

3. Fax*

Medical PA Fax: **1-833-238-7694**

*There is a specific standardize fax form available online:

<https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Current-PDF-PA-Form.pdf>

How to Secure Prior Authorization



Prior-Auth Check Tool

Use the Prior-Auth Check Tool on the website to quickly determine if a service or procedure requires prior authorization.

carolinacompletehealth.com/priorauthtool



Scan QR code for quick access to Prior-Auth Check Tool

Submit Prior Authorization

If a service requires authorization, submit via one of the following ways:



SECURE WEB PORTAL

provider.carolinacompletehealth.com

This is the preferred and fastest method.

Notification of authorization will be returned via phone, fax, or web.



FAX

1-919-670-4948



PHONE

1-833-552-3876

See reverse side for a list of services that require prior authorization.

Please note:

- All out-of-network services require prior authorization EXCEPT emergency services, family planning, post stabilization services, and table top x-rays.
- Failure to complete the required authorization or certification may result in a denied claim.

Fax Authorization for Massage Therapy

1. Complete the PA Fax Form available online (page 2 provides instructions for completion):

<https://network.carolinacompletehealth.com/resources/prior-authorization.html>

2. See the ["Tip Sheet"](#) for help

3. Fax to: **833-238-7694 Outpatient Prior Authorization Requests**

Prior Authorization Request

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be Medicaid or NC Health Choice eligible and a Carolina Complete Health member on the date of service. **See reverse side for instructions.**



| I. GENERAL INFORMATION | | | | | | | | | |
|--|-------------------|----------|-------------|---------------------------------|---|-------|--------------------------|------------------------------------|--|
| 1. Name (Last, First, M.I.) | | | | 2. Date of Birth (MM/DD/YY) | | | 3. NC Medicaid ID Number | | |
| 4. Address (Street, City, State, Zip Code) | | | | | | | | | |
| 5. Diagnosis Code | | | | | 6. Diagnosis Description | | | | |
| 7. Name and address of facility where services are to be rendered, if other than home or office | | | | | | | | | |
| II. SERVICE INFORMATION | | | | | | | FOR PLAN USE ONLY | | |
| 8. REF. NO | 9. Procedure Code | 10. From | 11. Through | 12. Description of Service/Item | 13. QTY or Units | APPR. | Denied | Amount Allowed if Priced by Report | |
| (1) | | | | | | | | | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| (5) | | | | | | | | | |
| (6) | | | | | | | | | |
| (7) | | | | | | | | | |
| (8) | | | | | | | | | |
| (9) | | | | | | | | | |
| (10) | | | | | | | | | |
| 14. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary) | | | | | | | | | |
| III. PROVIDER | | | | | IV. PRESCRIBING/PERFORMING PRACTITIONER | | | | |
| 15. Provider Name | | | | | 19. Provider Name | | | 20. Telephone | |
| 16. Address | | | | | 21. Address | | | | |
| 17. NPI and TAX ID | | | | | 22. NPI and TAX ID | | | | |
| 18. Fax Number | | | | | By submitting this form, the Provider identified in this Section V. certifies that the information given in Section I and III of this form is true, accurate, and complete. | | | | |
| V. FOR PLAN USE ONLY | | | | | | | | | |
| Denial Reason(s): Refer to table above by reference numbers (REF NO.) | | | | | | | | | |
| IF APPROVED: Services Authorized to Begin | | | | | Date | | Reviewed by Signature ▶ | | |

Please Fax Completed Form to:

| | | | | | |
|--|---------------------|---|---------------------|---------------------------------|---------------------|
| Outpatient Prior Authorization Requests | 833-238-7694 | Medical Records | 833-238-7693 | Inpatient Behavioral Health PA | 833-596-2768 |
| Initial Inpatient Requests and Face Sheets | 833-238-7690 | Physician Administered Drug Off Label Request | 833-465-1703 | Outpatient Behavioral Health PA | 833-596-2769 |
| Concurrent Records | 833-238-7692 | | | | |

Web Authorization for Massage Therapy

To begin a web authorization request:

1. Click **Authorizations**.
2. **Create Authorization**.
3. Enter **Member ID or Last Name**.
4. Enter Member's **Birthdate**.
5. Click **Find**. The web authorization request displays.

The screenshot shows the top navigation bar with 'Authorizations' selected and marked with a red circle '1'. Below the navigation bar, there are dropdown menus for 'TIN' and 'Plan Type' (set to 'Medicaid'), a 'GO' button, a 'Smart Sheets' button, and a red 'Create Authorization' button marked with a red circle '2'. Below this is a section with 'Authorizations' selected, 'Processed' and 'Errors' tabs, a 'Disclaimer' button, and a 'Filter' button. A message at the bottom reads: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.'

The screenshot shows the same interface as above, but with the search fields filled out. The 'Member ID or Last Name' field contains '123456789 or Smith' and is marked with a red circle '3'. The 'Birthdate' field contains 'mm/dd/yyyy' and is marked with a red circle '4'. The 'Find' button is marked with a red circle '5'. The rest of the interface remains the same.



Tip: You cannot create a web authorization on an ineligible member.

Web Authorization for Massage Therapy

Web Authorization

- Authorization Type-driven
- Streamlined

Select an Authorization Type:

1. Outpatient Medical
2. Therapy

Eligibility Patients Authorizations Claims Messaging

Viewing Authorizations For: TIN [] Plan Type Medicaid [] GO Smart Sheets Create Authorization

Enter Authorization

1. PROVIDER REQUEST

Select an Authorization Type []

NEXT >

Medical & BH

3. FINISH UP

Claims

Claims

Clean Claim

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions

- If a claim meets the definition above, but either of the following circumstances apply, it will not be considered a clean claim
 - A claim for which fraud is suspected
 - A claim for which a third party resource should be responsible

Claims Submission

The timely filing deadline for initial claims is 180 calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility.

Claims may be submitted in 3 ways:

1. **The Secure Provider Portal located on:**
<https://network.carolinacompletehealth.com/>
2. **Electronic Clearinghouse**
Three clearinghouses for Electronic Data Interchange (EDI) submission.
Carolina Complete Health Medical Payer ID **68069**
 - Availity
 - Change HealthCare (Formerly Emdeon)
 - Ability
3. **Mail**
Carolina Complete Health
Attn: Claims
PO Box 8040
Farmington MO 63640-8040

Claims

Viewing Dashboard For : TIN [] Plan Type [Medicaid]

Eligibility Patients Authorizations **Claims** Messaging Help

The Claims section displays claim-related information and is divided into a series of tabs.

Quick Eligibility Check for Medicaid

Member ID or Last Name: Birthdate: [Check Eligibility](#)

Recent Claims

| STATUS | RECEIVED DATE | MEMBER NAME | CLAIM NO. |
|--------|---------------|-------------|-----------|
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟡 | 04/19/2021 | [REDACTED] | U109 |

Welcome

- [Add a TIN to My ACCOUNT](#) >
- [Manage Accounts](#) >
- [Reports](#) >
- [Patient Analytics](#) >
- [Provider Analytics](#) >

Recent Activity

| Date | Activity |
|------|----------|
|------|----------|

Quick Links

Create Claim – Review and Submit

Professional Claim for [redacted] Your Progress [Progress Bar]

THIS SECTION:
Review
Please review your claim.

← Back Submit →

Almost done!
You can go back to review your claim or submit now.

Claim Id: 822 [redacted]
Member Record Number: [redacted]
Member Claim Amount Paid: [redacted]
Patient's Account Number: [redacted]

General Info [Edit](#)

Statement From Date: 01/02/2020
Statement To Date: 01/02/2020
Date of current illness, injury, pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)

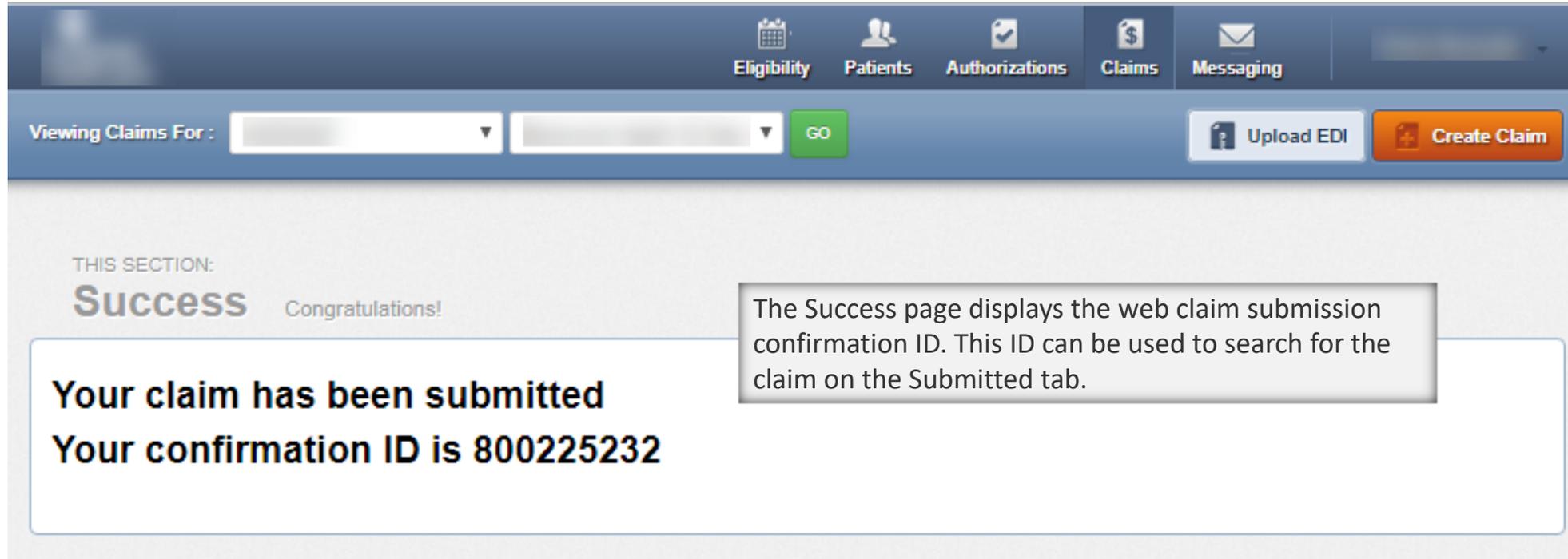
Diagnosis Codes
L739 – FOLLICULAR DISORDER UNSPECIFIED

An overview of the created claim displays for review. This is the last opportunity to edit the claim.

Click **Submit** to complete claim submission

Click **Edit**, to make changes to the claim

Create Claim – Submission Confirmation



The screenshot shows a web application interface with a dark blue header. The header contains navigation icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the header is a search bar with the text 'Viewing Claims For :', two dropdown menus, and a green 'GO' button. To the right of the search bar are two buttons: 'Upload EDI' and 'Create Claim'. The main content area is light gray and features a 'Success' message. The message reads: 'THIS SECTION: Success Congratulations! Your claim has been submitted Your confirmation ID is 800225232'. A callout box on the right side of the message explains that the ID can be used to search for the claim on the Submitted tab.

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : GO

Upload EDI Create Claim

THIS SECTION:
Success Congratulations!

Your claim has been submitted
Your confirmation ID is 800225232

The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

Claims Payment

- Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim



Medicaid Managed Care Transition Claims Payout Schedule Update



Carolina Complete Health AMH payments are paid out on:

20th of Every Month (Beginning July 20, 2021)

| Claim Type | First Claim Payment | First Claim DOS | Future Forward |
|----------------|---------------------|------------------|-----------------------------|
| Engolve Vision | July 8, 2021 | July 1 - 7, 2021 | Weekly, Wednesday |
| NIA | July 13, 2021 | July 1 - 9, 2021 | Weekly, Monday and Thursday |
| Medical | July 13, 2021 | July 1 - 9, 2021 | Weekly, Monday and Thursday |
| Pharmacy | July 14, 2021 | July 1 - 7, 2021 | Weekly, Wednesday |

Electronic Funds Transfer

To contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00 am to 8:00 pm est.

Payspan offers monthly training sessions for providers covering the following topics:

- How to Register with Payspan (New User)
- How to Add Additional Registration Codes to an Existing Payspan Account
- How to navigate through the Payspan web portal
- How to view a payment
- How to find a remit
- How to change bank account information
- How to add new users

For training links visit our website under [Resources, Claims and Billing](#)

Payspan: A Faster, Easier Way to Get Paid



Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation.

- Improve cash flow**
by getting payments faster
- Maintain control over bank accounts**
by routing EFTs to the bank account(s) of your choice
- Eliminate re-keying of remittance data**
by choosing how you want to receive remittance details
- Settle claims electronically**
through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- Match payments to advices quickly**
and easily re-associate payments with claims
- Create custom reports**
including ACH summary reports, monthly summary reports, and payment reports sorted by date
- Manage multiple payers,**
including any payers that are using Payspan to settle claims

Questions?
1-833-552-3876
Provider Relations can help

Please keep this information for when it's time to set up our Payspan account. At this time, you can visit payspanhealth.com and click Register.

You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

1-833-552-3876
carolinacompletehealth.com

Additional Resources

Additional Education and Training

- For a deeper dive into the Provider Portal, view our on-demand training!
 - [Slides, Recording](#)
- View our other onboarding trainings:
 - New Provider Orientation
 - Cultural Competency
 - Provider Compliance
 - All available on [Education & Training](#) page

Questions?
Thank you for attending!

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Appendix

Provider Portal Registration & Login

Portal Registration: provider.carolinacompletehealth.com

Tip: add no-reply@mail.entrykeyid.com to your email contacts

Log In

Username (Email)

LOG IN

Create New Account



[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene



Create Your Account

Let's get started - creating an account is quick and easy.

Email

First Name

Last Name

Language Preference

Password

Passwords must be at least 8 characters and include three of the four items below:

- One uppercase letter
- One lowercase letter
- One number
- One special character (For example: &, \$, !, *)

CREATE ACCOUNT

CANCEL

Portal Login

Log In

Username (Email)

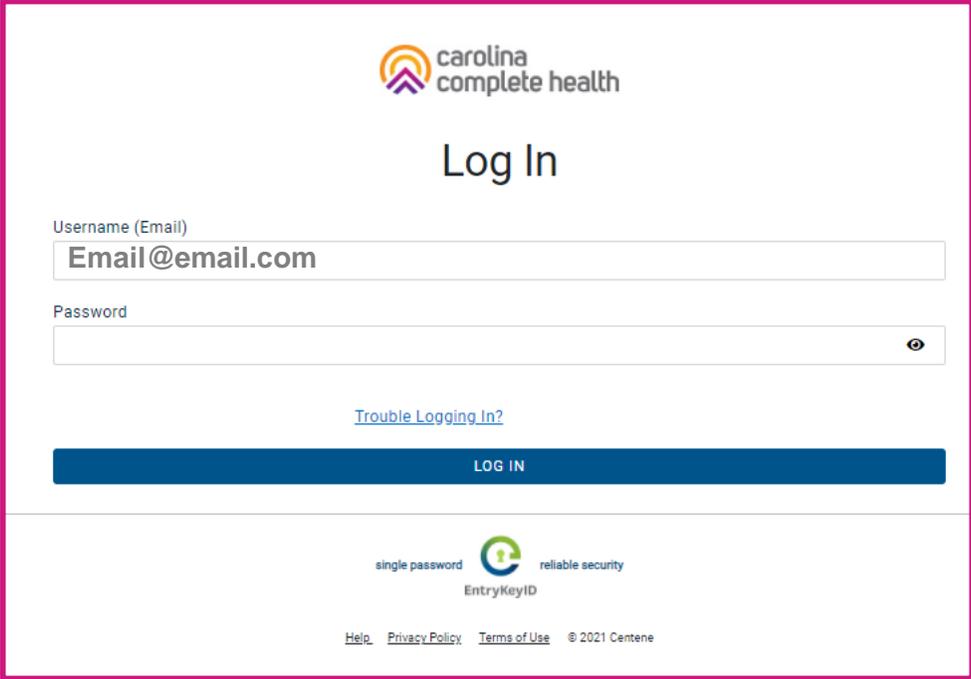
Email@email.com

LOG IN

[Create New Account](#)

single password  reliable security
EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene



The screenshot shows the Carolina Complete Health login interface. At the top right is the logo for Carolina Complete Health. Below it is the heading "Log In". There are two input fields: "Username (Email)" containing "Email@email.com" and "Password" which is currently empty. To the right of the password field is an eye icon for toggling visibility. Below the password field is a blue link that says "Trouble Logging In?". At the bottom of the form is a blue "LOG IN" button. Below the form, there is a section for "single password" and "reliable security" with the "EntryKeyID" logo. At the very bottom, there are links for "Help", "Privacy Policy", and "Terms of Use", followed by the copyright notice "© 2021 Centene".

Portal Landing Page – Unverified Portal Account

The screenshot shows the portal landing page for an unverified account. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Messaging, and Help. Below this, a section labeled "Viewing Dashboard For:" contains two dropdown menus: "TIN" (with a blank input) and "Plan Type" (set to "Medicaid"), followed by a green "GO" button. The main content area is mostly blank. On the right side, there are three panels: "Welcome" with a button "Add a TIN to My ACCOUNT >", "Recent Activity" with a table header "Date" and "Activity", and "Quick Links" with two links: "Provider Resources" and "Member Management Forms".



Tip: Until a portal account is verified, the user will only have access to Secure Messaging and Account Details.

Portal Banner

The screenshot shows a dark blue portal banner. At the top left is a blurred area for the Health Plan / Product Logo. To its right is a row of icons for Portal Functionalities: Eligibility (calendar), Patients (people), Authorizations (checkmark), Claims (dollar sign), and Messaging (envelope). Further right is a blurred area for the User's Name / Menu Options. Below this is a section for 'Viewing Dashboard For:' with two dropdown menus: 'TIN' (showing '4449') and 'Plan Type' (showing 'Medicaid'), followed by a green 'GO' button. Red dashed lines with arrows point from text labels to these elements: 'Health Plan / Product Logo' to the top left, 'Portal Functionalities' to the icons, 'Secure Messaging' to the envelope icon, 'User's Name / Menu Options' to the top right, 'TIN(s) Listing' to the TIN dropdown, and 'Plan Type Option(s)' to the Plan Type dropdown.



Tips

- Portal functionality / access is based on the user's permissions
- **Plan Type** drop-down options are automatically assigned based on how the TIN is set-up in our systems, and the products offered by the Health Plan

Portal Home Page – Verified Portal Account

Portal Banner

Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For : TIN [] Plan Type Medicaid [] GO

Quick Eligibility Check

Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy [Check Eligibility](#)

Last Five Received Claims

Recent Claims

| STATUS | RECEIVED DATE | MEMBER NAME | CLAIM NO. |
|--------|---------------|-------------|-----------|
| \$ | 05/15/2020 | [] | T136 |
| \$ | 05/18/2020 | [] | T139 |
| \$ | 05/18/2020 | [] | T139 |
| \$ | 04/23/2020 | [] | T114 |
| \$ | 04/21/2020 | [] | T112 |

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >
- Care and Risk Gaps - Daily View >

Welcome Center

Recent Activity

Date Activity

Quick Links

Portal Registration & Login Tips

- Registration is required for access to the portal
- Portal accounts cannot be shared
 - Each person within a provider organization who needs access to the portal, must complete the portal registration
- For a portal user to register, their TIN must be loaded in our systems
 - Allow at least two business days for portal to reflect updates in back-end systems
- There is no limit on the number of TINs a portal user can add to their portal account
- Portal users must log into the portal every 90 days to prevent their account from being locked due to inactivity
- The Forgot Password / Unlock Account link on the Secure Provider Portal login page, cannot be used to unlock a portal account, that is locked due to inactivity

Portal Functionality: Check Eligibility

Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

Quick Eligibility Check

The screenshot shows a web application interface for a "Quick Eligibility Check for Medicaid". At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header section with "Viewing Dashboard For : TIN" and "Plan Type" dropdown menus, with "Medicaid" selected in the Plan Type menu and a "GO" button.

The main content area is titled "Quick Eligibility Check for Medicaid". It features two input fields: "Member ID or Last Name" with the value "123456789 or Smith" (marked with a red circle 1) and "Birthdate" with the placeholder "mm/dd/yyyy" (marked with a red circle 2). A green "Check Eligibility" button (marked with a red circle 3) is positioned to the right of the birthdate field.

Below the input fields is a "Recent Claims" section with a table. The table has columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO. The data rows show a status of a green dollar sign (\$), received dates of 05/15/2020, 05/18/2020, 05/18/2020, 04/23/2020, and 04/21/2020, and claim numbers of T136, T139, T139, T114, and T112.

On the right side of the interface, there is a "Welcome" sidebar with a list of menu items: "Add a TIN to My ACCOUNT", "Manage Accounts", "Reports", "Patient Analytics", and "Provider Analytics", each with a right-pointing chevron. Below this is a "Recent Activity" section with columns for "Date" and "Activity". At the bottom of the sidebar is a "Quick Links" section.

Eligibility Check

The screenshot shows a web application interface for an eligibility check. At the top, there is a navigation bar with icons for Eligibility (1), Patients, Authorizations, Claims, and Messaging. Below this is a search bar with 'Viewing Eligibility For:' and two dropdown menus: 'TIN' and 'Plan Type' (set to 'Medicaid'). A green 'GO' button is to the right. The main section is titled 'Eligibility Check' and contains a form with fields for 'Date of Service' (05/27/2020), 'Member ID or Last Name' (123456789 or Smith) (2), and 'DOB' (mm/dd/yyyy) (3). A green 'Check Eligibility' button (4) and a 'Print' button are also present. Below the form is a table with the following columns: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, RECENT ADT, CARE GAPS, and LOG ER VISIT. The table contains one row with a thumbs-up icon, the date 05/27/2020, a patient name (5), the date 05/27/2020, 'NO', and the text 'Non-compliant for annual well visit.'. The 'LOG ER VISIT' column has an 'ER Visit?' button and a 'Remove' button. A red arrow points from the 'ER Visit?' button to a red text box at the bottom right.

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | RECENT ADT | CARE GAPS | LOG ER VISIT |
|----------|-----------------|-------------------|--------------|------------|--------------------------------------|-------------------------|
| | 05/27/2020 | >View details (5) | 05/27/2020 | NO | Non-compliant for annual well visit. | ER Visit? (4) Remove |

If Eligibility Check is for an ER visit, click **ER Visit?**

Eligibility Tips

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- As best practice, always check member eligibility before creating a web authorization or web claim

Portal Functionality: Authorizations

Authorizations

Providers are able to use the portal to submit web authorization requests and view 18 months of authorization history.

Accessing Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.

The screenshot shows a web application interface for managing authorizations. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Dashboard For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. The main content area is divided into three sections: 'Quick Eligibility Check for Medicaid' with input fields for Member ID or Last Name and Birthdate, and a 'Check Eligibility' button; 'Recent Claims' with a table showing claim details; and a 'Welcome' sidebar with navigation options like 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', 'Patient Analytics', and 'Provider Analytics'. Below the sidebar is a 'Recent Activity' section with columns for Date and Activity.

| STATUS | RECEIVED DATE | MEMBER NAME | CLAIM NO. |
|--------|---------------|-------------|-----------|
| \$ | 05/15/2020 | | T136 |
| \$ | 05/18/2020 | | T139 |
| \$ | 05/18/2020 | | T139 |
| \$ | 04/02/2020 | | T141 |



Tip: The member drives Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.

Authorizations Summary

Eligibility Patients **Authorizations** Claims Messaging Help

Viewing Authorizations For : TIN [] Plan Type Medicaid [] GO Create Authorization

Authorizations Processed Errors Disclaimer Filter

Displays authorizations submitted under TIN, for the last 90 days, regardless of how they were submitted.

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

| STATUS | AUTH ID | MEMBER | FROM DATE | TO DATE | DIAGNOSIS | AUTH TYPE | SERVICE |
|---------|---------|--------|------------|------------|-----------|------------|---------------------|
| APPROVE | IP186 | | 05/12/2020 | 12/31/9999 | M16.11 | INPATIENT | Surgical |
| APPROVE | IP190 | | 02/28/2020 | 12/31/9999 | Z79.2 | INPATIENT | Skilled Nursing |
| APPROVE | OP18 | | 02/27/2020 | 03/27/2020 | M21.961 | OUTPATIENT | Outpatient Surgery |
| APPROVE | OP18 | | 02/19/2020 | 03/21/2020 | S83.512A | OUTPATIENT | Outpatient Surgery |
| APPROVE | IP187 | | 02/17/2020 | 12/31/9999 | R10.2 | INPATIENT | Surgical |
| PEND | IP190 | | 02/11/2020 | 12/31/9999 | D57.00 | INPATIENT | Medical |
| APPROVE | IP190 | | 02/08/2020 | 12/31/9999 | J18.9 | INPATIENT | Medical |
| APPROVE | OP18 | | 02/07/2020 | 05/07/2020 | E66.01 | OUTPATIENT | Outpatient Services |
| APPROVE | IP190 | | 02/07/2020 | 02/11/2020 | J10.1 | INPATIENT | Medical |

Click an **Auth ID** to view authorization details

Click **Filter** to access filter options

Authorization Details

[Back to Authorizations](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Auth Status: APPROVE
Auth Nbr: IP19[REDACTED]
Admit Date: 05/12/2020
Provider of Service(s): [REDACTED]
Diagnosis Code(s): T21.31XA

Explanation: Pay
Auth Type: INPATIENT
Service: Surgical
Discharge Date: 05/20/2020
Procedure Code(s): 99221

Notes & Attachments: [View](#)

| Line Item | Service type | From Date | To Date | Stay Level | Location | Status | Medical Necessity | Decision Date |
|-----------|--------------|------------|------------|------------|--------------------|---------|-------------------|---------------|
| 1 | Medical | 05/12/2020 | 05/13/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/13/2020 |
| 2 | Medical | 05/13/2020 | 05/14/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/14/2020 |
| 3 | Medical | 05/14/2020 | 05/15/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/15/2020 |
| 4 | Medical | 05/15/2020 | 05/18/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/18/2020 |
| 5 | Surgical | 05/18/2020 | 05/19/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/19/2020 |
| 6 | Surgical | 05/19/2020 | 05/20/2020 | Med/Surg | Inpatient Hospital | APPROVE | Met as requested | 05/20/2020 |

[Back to Authorization List](#)

Authorization Details Links and Pop-Up

Back to Authorizations

Overview

Auth Status: APPROVE
 Auth Nbr: IP19S
 Admit Date: 05/12/2020
 Provider of Service(s): HOSPITAL

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Explanation: Pay
 Auth Type: INPATIENT
 Service: Surgical
 Discharge Date: 05/20/2020

Diagnosis Code(s): T21.31XA
 R69
 T21.11XA

Procedure Code(s): 99221
 99231

Notes & Attachments: View

Click hyperlink(s) to view additional codes

Hover your mouse over a Line Item to view the CPT, REV or HCPC code associated with it

| Line Item | Service type | From Date | Medical Necessity | Decision Date |
|-----------|--------------|------------|-------------------|---------------|
| 1 | Medical | 05/12/2020 | Met as requested | 05/13/2020 |
| 2 | Medical | 05/13/2020 | Met as requested | 05/14/2020 |
| 3 | Medical | 05/14/2020 | Met as requested | 05/15/2020 |
| 4 | Medical | 05/15/2020 | Met as requested | 05/18/2020 |

Diagnosis and Procedure Codes

Primary Diagnosis Code: T21.31XA
 Additional Diagnosis Codes: R69 T21.11XA
 Primary Procedure Code: 99221
 Additional Procedure Codes: 99221

Create Authorization (Web Authorization Request)

To begin a web authorization request:

1. Click **Authorizations**.
2. **Create Authorization**.
3. Enter **Member ID or Last Name**.
4. Enter Member's **Birthdate**.
5. Click **Find**. The web authorization request displays.

The screenshot shows the top navigation bar with 'Authorizations' highlighted and circled with a red '1'. Below the navigation bar, there are dropdown menus for 'TIN' and 'Plan Type' (set to 'Medicaid'), a 'GO' button, a 'Smart Sheets' button, and a red 'Create Authorization' button circled with a red '2'. Below this is a section with 'Authorizations' selected, 'Processed' and 'Errors' tabs, a 'Disclaimer' button, and a 'Filter' button. A message at the bottom reads: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.'

The screenshot shows the same interface as above, but with the search fields filled out. The 'Member ID or Last Name' field contains '123456789 or Smith' and is circled with a red '3'. The 'Birthdate' field contains 'mm/dd/yyyy' and is circled with a red '4'. The 'Find' button is circled with a red '5'. The 'GO' button is also visible. The message at the bottom is the same as in the previous screenshot.



Tip: You cannot create a web authorization on an ineligible member.

Create Authorization (Web Authorization Request)

Viewing Patients For : TIN Plan Type

Authorization For

DOB: MEDICAID NBR:

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-246-4358 for after-hours urgent admission, inpatient notifications or requests.

Please select Service Type.

Tip: Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

Enter Authorization

1. PROVIDER REQUEST

Select a Service Type

NEXT >

2. SERVICE LINE

3. FINISH UP

Web Authorization for Massage Therapy

Web Authorization

- Authorization Type-driven
- Streamlined

Select an Authorization Type:

1. Outpatient Medical
2. Therapy

Eligibility Patients Authorizations Claims Messaging

Viewing Authorizations For: TIN [] Plan Type Medicaid [] GO Smart Sheets Create Authorization

Enter Authorization

1. PROVIDER REQUEST

Select an Authorization Type []

NEXT >

Medical & BH

3. FINISH UP

Authorization Tips

- Always check the member's eligibility before submitting an authorization request
 - A web authorization **cannot** be submitted on an ineligible member
- **Web authorizations generally load in processing queue within seconds of submission**
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
 - This is the only way a portal user will see a web authorization error
 - Web authorization errors are uncommon, but when an error is encountered the web authorization request will not load, and thereby will not be processed
 - ❖ Please submit the authorization request by phone or fax
 - ❖ Notify the Health Plan and provide the web authorization confirmation number for research

Portal Functionality: Claims

Claims

Providers are able to use the portal to:

- Access up to 24 months of claims-related history
- Submit new claim
- Correct claims
- Batch claims

Claims

The Claims section displays claim-related information and is divided into a series of tabs.

Quick Eligibility Check for Medicaid

Member ID or Last Name: Birthdate: [Check Eligibility](#)

Recent Claims

| STATUS | RECEIVED DATE | MEMBER NAME | CLAIM NO. |
|--------|---------------|-------------|-----------|
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟢 | 04/16/2021 | [REDACTED] | U106 |
| 🟡 | 04/19/2021 | [REDACTED] | U109 |

Welcome

- [Add a TIN to My ACCOUNT](#)
- [Manage Accounts](#)
- [Reports](#)
- [Patient Analytics](#)
- [Provider Analytics](#)

Recent Activity

| Date | Activity |
|------|----------|
|------|----------|

Quick Links

Claims – Individual

The Individual tab displays claims on file under the TIN, regardless of how they were submitted.

Note: You can access up to 24 months of claim history.

GO

Upload EDI

Create Claim

Patients Authorizations Claims Messaging

Claims Individual Saved Submitted Batch Payment History Claims Audit Tool

Claims: Recent

Search: Date Range : 03/14/2021 to 04/14/2021 [Change dates](#)

Filter Search

| CLAIM NO. | CLAIM TYPE | MEMBER NAME | SERVICE DATE(S) | BILLED/PAID | CLAIM STATUS |
|----------------------|------------|-------------|-------------------------|--------------------|--------------|
| U076 | CMS-1500 | | 03/14/2021 - 03/14/2021 | \$49.00 / \$16.59 | Paid |
| U082 | CMS-1500 | | 03/14/2021 - 03/14/2021 | \$183.00 / \$70.85 | Paid |
| U075 | CMS-1500 | | 03/15/2021 - 03/15/2021 | \$297.00 / \$0.00 | Denied |
| U075 | CMS-1500 | | 03/15/2021 - 03/15/2021 | \$80.00 / \$0.00 | Pending |
| U075 | CMS-1500 | | 03/15/2021 - 03/15/2021 | \$0.00 / \$2.11 | Paid |

Click Claim Number to view claim details

Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

Claim Details

Claim Action Buttons

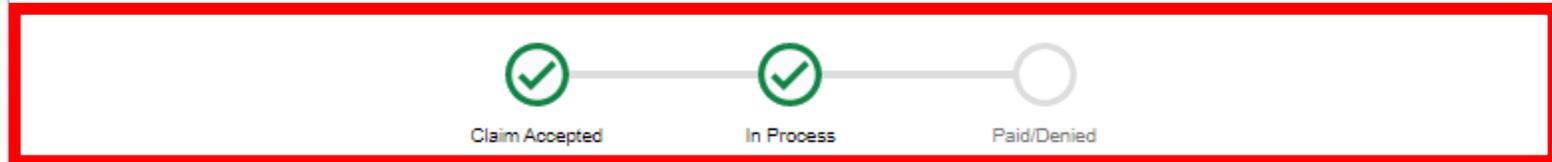
Back to Claims **Claim Details**

Claim #U [redacted]: Pending

+ Copy Claim

Claim Details display a summary of what was billed, how it was billed, and the status of the claim.

Claim Status Tracking



Claim Information

Member Provi + Copy Claim Correct Claim Appeal Claim Reconsider Claim Payment

Member Name: [redacted] Ref/Acct No.: [redacted] DOS Range: 03/23/2021 - 03/23/2021 Payment Date: [redacted] Pending Claim Amount: \$0.00

Member ID: [redacted] Servicing Provider: [redacted] Received Date: 04/14/2021 Check/EFT Number: [redacted] Total Check Amount: [redacted]

Member DOB: [redacted] Servicing NPI: [redacted] Billed Amount: \$348.00 Check Dated: [redacted]

Claim Service Line(s)

Service Lines

| Line | DOS | Proc | Dx | Modifiers | Place of Service | Charged | Paid Amount | Payment Date | Check/EFT Number | Status |
|------|------------|-------|-------|-----------|------------------|----------|-------------|--------------|------------------|---------|
| 1 | 03/23/2021 | G0439 | Z0000 | 95 | 22 | \$348.00 | \$0.00 | | | Pending |
| 2 | 03/23/2021 | G8510 | Z0000 | | 22 | \$0.00 | \$0.00 | | | Pending |

Claim Details – Finalized

Back to Claims **Claim Details**

Claim #U: Paid

+ Copy Claim Correct Claim Void/Recoup Claim Reconsider Claim

Claim Accepted In Process Paid

| Member | Provider | Claim | Most Recent Payment | |
|--------------|---------------------|----------------|---------------------|---------------------|
| Member Name: | Ref/Acct No.: | DOS Range: | Payment Date: | Paid Claim Amount: |
| Member ID: | Servicing Provider: | Received Date: | Check/EFT Number: | Total Check Amount: |
| Member DOB: | Servicing NPI: | Billed Amount: | Check Dated: | |

Service Lines

| Line | DOS | Proc | Dx | Modifiers | Place of Service | Charged | Paid Amount | Payment Date | Check/EFT Number | Status | Payment Codes |
|------|------------|-------|-------------------|-----------|------------------|----------|-------------|--------------|------------------|--------|---------------|
| 1 | 03/15/2021 | 99392 | Z00129, 25, Z6852 | | 11 | \$318.00 | \$ | 03/26/2021 | | PAID | 92 |
| 2 | 03/15/2021 | 90480 | Z23 | | 11 | \$150.00 | \$ | 03/26/2021 | | PAID | 92 |
| 3 | 03/15/2021 | 90696 | Z23 | | 11 | \$0.00 | \$0.00 | 03/26/2021 | | DENY | IE |
| 4 | 03/15/2021 | 90710 | Z23 | | 11 | \$0.00 | \$0.00 | 03/26/2021 | | DENY | IE |

Payment Description

| Payment Code | Description |
|--------------|--|
| 92 | PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES |
| IE | CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE |

Click **Correct Claim** to correct a finalized claim

Where available, click **Void/Recoup Claim** void an original claim that has already been processed, and request a full recoupment of payment

Payment Codes and Payment Description display on finalized claims

Claims – Submitted

The Submitted tab displays individual web claims, submitted via the portal.

Note: You can access up to 24 months of individual web claim submissions.

Upload EDI Create Claim

Claims Individual Saved Submitted Batch Payment History Claims Audit Tool Filter

| SUBMITTED STATUS ↑ | DATE SUBMITTED ↓ | WEB # / REF # ↑ | CLAIM NUMBER ↓ | CLAIM TYPE ↓ | MEMBER NAME ↓ | MEMBER ID ↓ | ORIGINAL CLAIM # ↑ | TOTAL CHARGES ↓ |
|--------------------|------------------|-----------------|----------------|--------------|---------------|-------------|--------------------|-----------------|
| Ⓛ | 04/13/2021 | | | CMS-1500 | | | | \$254.00 |
| Ⓛ | 04/13/2021 | | | CMS-1500 | | | | \$276.00 |
| Ⓛ | 04/13/2021 | | | CMS-1500 | | | | \$297.93 |
| Ⓛ | 04/12/2021 | | | CMS-1500 | | | | \$561.72 |
| 👍 | 04/09/2021 | | | CMS-1500 | | | | \$460.00 |
| Ⓛ | 04/07/2021 | | | CMS-1500 | | | | \$199.00 |
| Ⓛ | 04/06/2021 | | | CMS-1500 | | | | \$487.00 |
| Ⓛ | 03/26/2021 | | | CMS-1500 | | | | \$199.00 |

Click **Filter** for additional search options



Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim submission.

Portal Functionality: Claim Submission

Claim Submission – Create Claim (Individual Web Claim)

To begin an individual web claim:

1. Click **Claims**
2. Click **Create Claim**
3. Enter **Member ID or Last Name**
4. Enter Member's **Birthdate**
5. Click **Find**

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : TIN Plan Type
[Dropdown] Medicaid GO Upload EDI Create Claim

Claims Individual Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : TIN Plan Type Member ID or Last Name Birthdate
[Dropdown] Medicaid GO |123456789 or Smith mm/dd/yyyy Find

Create Claim – Claim Type Selection

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : [] Medicaid GO Upload EDI Create Claim

Choose Claim for []

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Create Claim – General Information

Professional Claim for [REDACTED]

Your Progress 

THIS SECTION:
General Info
Information about the dates of the

Throughout the claim submission process, the Progress bar will display which step you are on.

Note: On web claims, the numbered tabs in the right margin, correlate to the boxes on the:

- CMS 1500 Paper Claim Form (Professional)
- UB-04 Paper Claim Form (Institutional)

* Required field

Patient's Account Number* 26

Statement Dates* From To

Date of current Illness, Injury, Pregnancy (LMP) Select Type... 14.

Other Date Select Type... 15.

Hospitalization From To 18.

Hover mouse over tabs for additional information

Create Claim – Diagnosis Codes

Professional Claim for [REDACTED] Your Progress

THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance information.

← Back Next →

* Required field

ICD Version Indicator* ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* (Enter diagnosis code and click on Add button) 21.

L739 -- FOLLICULAR DISORDER UNSPECIFIED

←----- Click **Add Coordination of Benefits**, to submit a Secondary Claim

← Back Next →

Create Claim – Service Lines

Professional Claim for [redacted] Your Progress [Progress Bar]

THIS SECTION:
Service Lines
Enter maximum of 50 service lines.

← Back Provider Details →

Total: \$0.00 **2** Save / Update

3 + New Service Line

Your added service lines will appear here.

1 **A New Service Line**

* Required field

Dates of Service* From MM/DD/YYYY To MM/DD/YYYY 24.a

Place of Service* Select... 24.b

Emergency Yes No 24.c EMG

Procedure Code* XXXXX e,i 24.d

Modifiers XX Add Please enter the modifier and click the Add button.

Diagnosis Code(s)* L739 - FOLLICULAR DISORDER UNSPECIFIED 24.e
 Z23 - ENCOUNTER FOR IMMUNIZATION

Click + **New Service Line** to enter additional Service Line(s).

After entering or editing a Service Line, click **Save/Update**.

Create Claim – Providers

Professional Claim for [redacted] Your Progress [Progress Bar]

THIS SECTION:
Providers
Providers on this claim.

← Back Next →

* Required field

Referring Provider

NPI: [XXXXXXXXXX] Find Provider Qualifier: [Select...] 17.

Last Name or Organizational Name: [Last Name] Find Provider First Name: [First Name]

Rendering Provider

Only enter rendering provider information if not the same as Billing Provider information. 24.j

NPI: [XXXXXXXXXX] Tax ID: [] Find Provider

Taxonomy #: [XXXXXXXXXX] Last Name or Organizational Name: [Last Name] First Name: [First Name] Clear X

Billing Provider

Tax ID: [] 33.

Name* Last Name: [] NPI: [XXXXXXXXXX] Taxonomy*: [XXXXXXXXXX]

Address*: [XXXXXXXXXX] City*: [XXXXXXXXXX] State*: [Select...] Zip*: [XXXXX]



Tip: Missing Taxonomy is a common cause of processing delays and denials.

For more information, view our [Claims Submission Reminder Guide \(PDF\)](#)

Create Claim – Attachments

Professional Claim for [REDACTED] Your Progress

THIS SECTION:
Attachments
Add attachments to the claim (30MB limit). Supported types are .jpg, .tif, .pdf and .tiff

If there are no attachments, click Next.

[← Back](#) [Next →](#)

Portal users can attach up to five (5) separate documents to their web claim submissions.

Attachments

**Do NOT send password protected files. You must click ATTACH for each file being submitted.*

| | | |
|--|---|--|
| <p>File* 1</p> <p><input type="button" value="Choose File"/> No file chosen</p> | <p>Attachment Type* 2</p> <p><input type="text" value="Select Type..."/></p> | <p>3</p> <p><input type="button" value="Attach"/></p> |
|--|---|--|

There are no attached files.

If there are no attachments, click Next.

[← Back](#) [Next →](#)

Create Claim – Review and Submit

Professional Claim for [redacted] Your Progress [Progress Bar]

THIS SECTION:
Review
Please review your claim.

← Back Submit →

Almost done!
You can go back to review your claim or submit now.

Claim Id: 822 [redacted]
Member Record Number: [redacted]
Member Claim Amount Paid: [redacted]
Patient's Account Number: [redacted]

General Info [Edit](#)

Statement From Date: 01/02/2020
Statement To Date: 01/02/2020
Date of current illness, injury, pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)

Diagnosis Codes
L739 – FOLLICULAR DISORDER UNSPECIFIED

An overview of the created claim displays for review. This is the last opportunity to edit the claim.

Click **Submit** to complete claim submission

Click **Edit**, to make changes to the claim

Create Claim – Submission Confirmation

The screenshot shows a web application interface for creating a claim. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this is a search area with the text 'Viewing Claims For :', two dropdown menus, and a green 'GO' button. To the right of the search area are two buttons: 'Upload EDI' and 'Create Claim'. The main content area features a 'THIS SECTION:' header followed by 'Success' in a large font and 'Congratulations!' in a smaller font. A large white box with a blue border contains the text: 'Your claim has been submitted' and 'Your confirmation ID is 800225232'. A callout box on the right side of the main content area contains the text: 'The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.'