Carolina Complete Health and WellCare of North Carolina Merger

Provider Information Session: Behavioral Health, Specialty Therapies, and Durable Medical Equipment

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Agenda

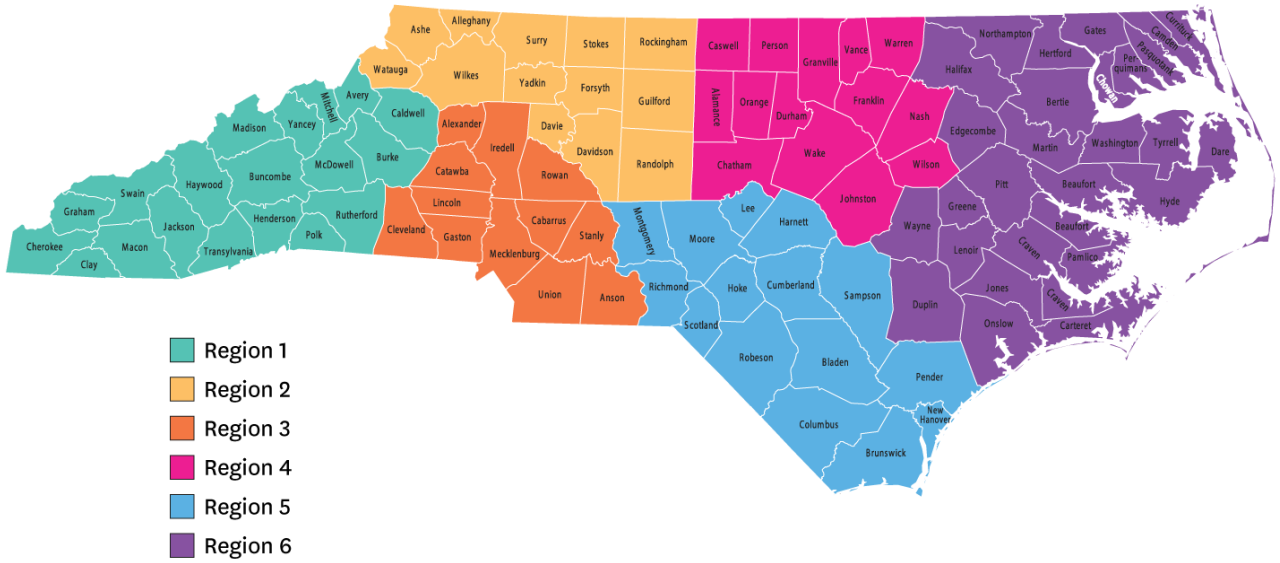
- Welcome and Introduction with Executive Team
- Contracting and Network FAQ
- Member Communications and ID Card
- Web-based Tools
- Claims and Payment
- Behavioral Health Services
- Durable Medical Equipment
- Specialty Therapy Services
- Key Contacts and Resources

Presenters and Panelists

- Dr. Therese Garrett, Behavioral Health Medical Director
- Eric Harbour, Behavioral Health Director
- Katie McKay, Sr. Director, Clinical Operations
- Stacy Kinstler, Sr. Director, Specialty Therapy Advisor Team
- Shana Burk, Manager, Specialty Therapy & Rehabilitation Services

Single Statewide **Provider-Led Entity**

- WellCare of North Carolina operates in all six regions; Carolina Complete Health operates in regions 3, 4, and 5.
- **The combined health plan, named Carolina Complete Health, will be state-wide on April 1, 2026.**
- Post-merger, the combined entity will operate in all six regions, 100 counties.



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Standard Plan members

Provider-Led Entity Governance Structure

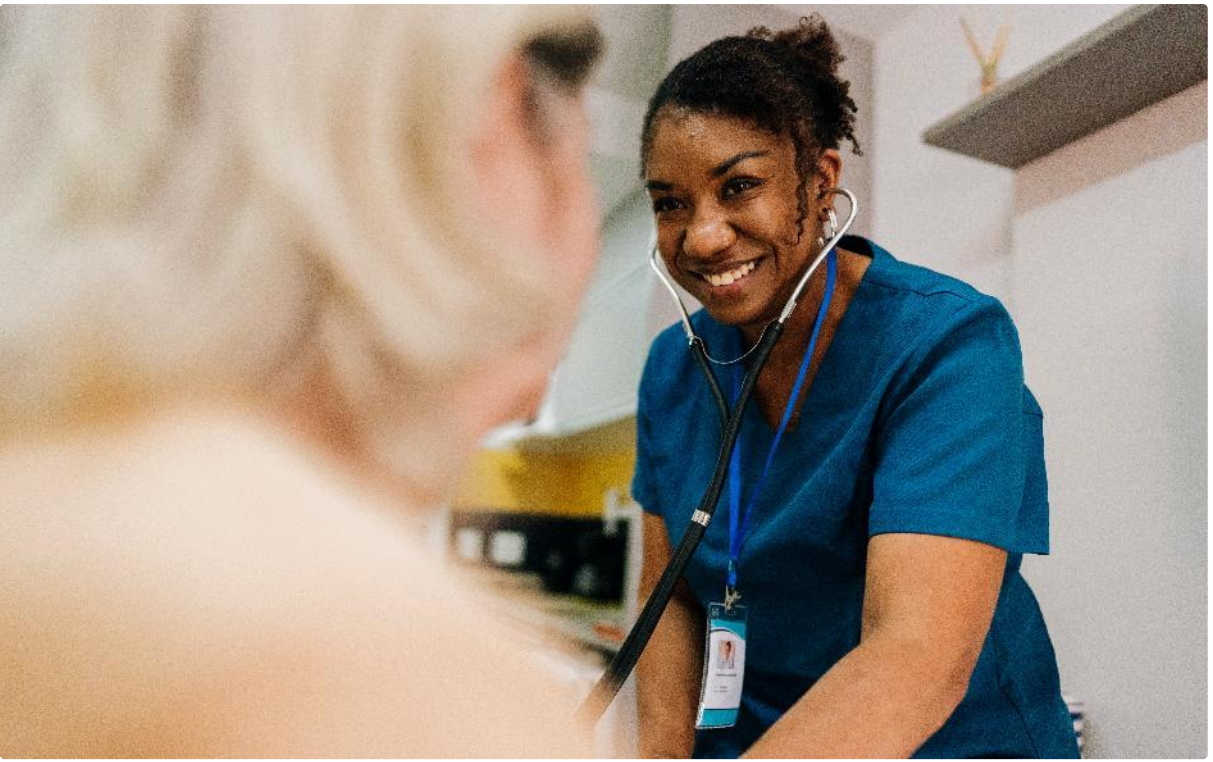
The Provider-Led Entity (PLE) gives physicians, community health centers, and other providers a strong voice in the governance and clinical policy of the Medicaid health plan and the care of its members.

The new Unified Standard Plan will retain Carolina Complete Health's structure as a Provider-Led Entity (PLE) state-wide. The PLE structure was established through a unique joint venture between Centene and the NC Medical Society in conjunction with the NC Community Health Center Association and individual Federally Qualified Health Centers. This provider ownership is operationalized through the Carolina Complete Health Network (CCHN), an organization owned in part by the NC Medical Society, NCCHCA and 27 individual health center clinics that seeks out physician and clinician expertise in medical policy and aims to give providers a voice in how to best care for their patients while reducing administrative burden.

Centene Corporation	• **Fortune 22** company with over 30 years of Medicaid experience • **#1 in Medicaid and #1 in Marketplace** in the U.S., operating in **50** states • Insures over **28 million** members
North Carolina Medical Society	• Representing physicians and PAs dedicated to enhancing the health and lives of people across North Carolina • Leading physician-informed health policy in North Carolina • Supporting practice transformation and provider recruitment strategies • Advocating for access to care in rural and medically underserved communities
NC Community Health Center Association & 27 FQHC's	• Association membership includes **over 40** Federally Qualified Health Center grantees and look-alike organizations. • Serving over **760,000** underinsured and uninsured • **600** clinical sites across 92 counties in North Carolina

carolina complete health WellCare

A Streamlined, Supportive Experience



1

Fewer Payers in Medicaid Managed Care

Combining operations to create a simpler, more efficient experience for Medicaid providers.

2

Administrative Simplification

One set of processes, policies, and systems so providers have less duplicative tasks.

3

Enhance Quality Care

Members will continue to receive the same Medicaid benefits, along with an expanded selection of value-added services.

Network and Contracting

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Important Reminder

Providers:

- No action is required for providers with active Medicaid contracts with either plan. All contracted providers will be considered **in-network** with the unified plan effective April 1, 2026, and therefore your **members will stay assigned to you.**
- Contracts for Wellcare Medicare, Ambetter of North Carolina Inc., and Tailored Plan Physical Health with Trillium and Partners remain unaffected by the merger.

Members:

- No action is required from members. All WellCare of North Carolina and Carolina Complete Health members will automatically transition to the new statewide plan and keep their Primary Care Provider.

Member Identification

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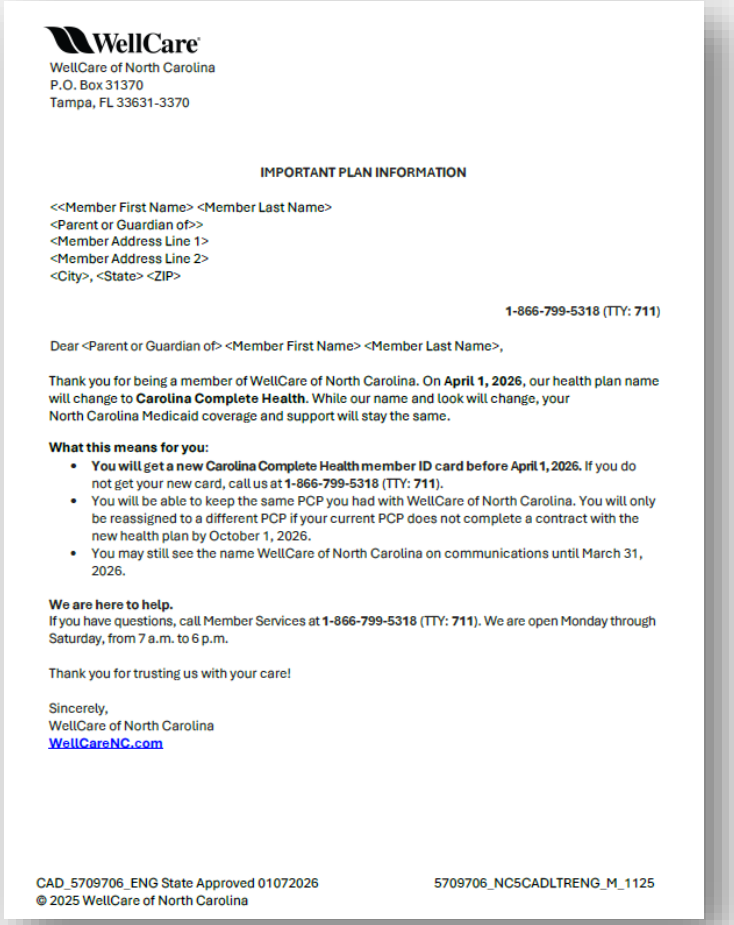
Member Communications and Impact

- WellCare members received an announcement letter in January, followed by a series of informational materials.
- These communications will ensure members understand what is changing, what is staying the same, and how to access their benefits.
- WellCare of North Carolina members will be automatically transitioned to the integrated health plan, retaining the name Carolina Complete Health, on April 1, 2026.
- Members can **continue** seeing their same Primary Care Provider.
- Members **will not** be assigned a new Medicaid ID.
- Members receive the **same benefits** plus **new and updated Value-Added Services.**



WellCare

WellCare of North Carolina
P.O. Box 31370
Tampa, FL 33631-3370

IMPORTANT PLAN INFORMATION

<<Member First Name> <Member Last Name>
<Parent or Guardian of>>
<Member Address Line 1>
<Member Address Line 2>
<City>, <State> <ZIP>

1-866-799-5318 (TTY: **711**)

Dear <Parent or Guardian of> <Member First Name> <Member Last Name>,

Thank you for being a member of WellCare of North Carolina. On **April 1, 2026**, our health plan name will change to **Carolina Complete Health**. While our name and look will change, your North Carolina Medicaid coverage and support will stay the same.

What this means for you:

- **You will get a new Carolina Complete Health member ID card before April 1, 2026.** If you do not get your new card, call us at **1-866-799-5318** (TTY: **711**).
- You will be able to keep the same PCP you had with WellCare of North Carolina. You will only be reassigned to a different PCP if your current PCP does not complete a contract with the new health plan by October 1, 2026.
- You may still see the name WellCare of North Carolina on communications until March 31, 2026.

We are here to help.
If you have questions, call Member Services at **1-866-799-5318** (TTY: **711**). We are open Monday through Saturday, from 7 a.m. to 6 p.m.

Thank you for trusting us with your care!

Sincerely,
WellCare of North Carolina
WellCareNC.com

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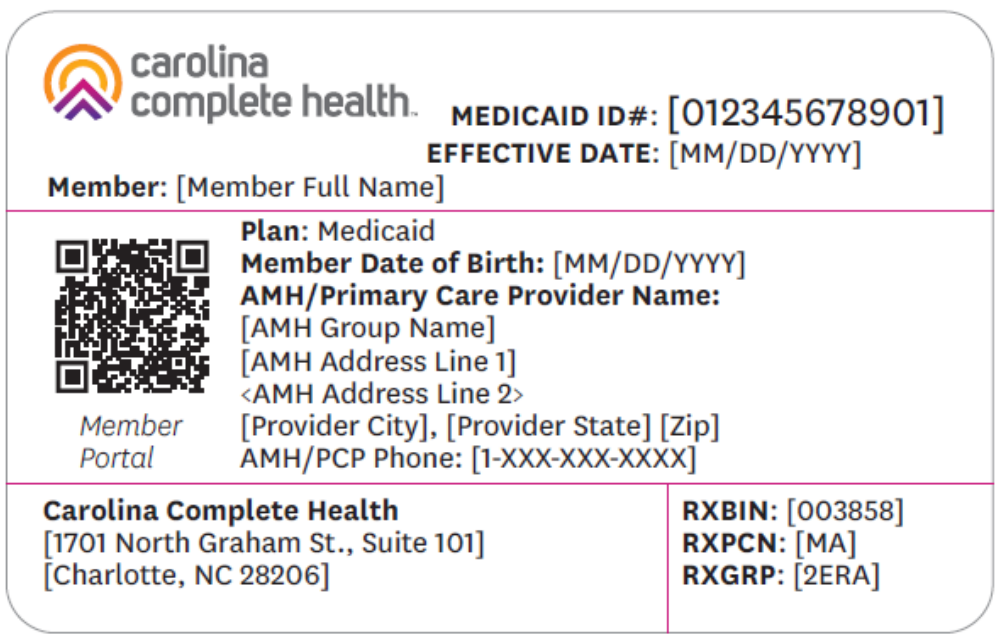
Member Identification

- Members' Medicaid ID numbers will **not change.**
- Members will receive new Carolina Complete Health ID cards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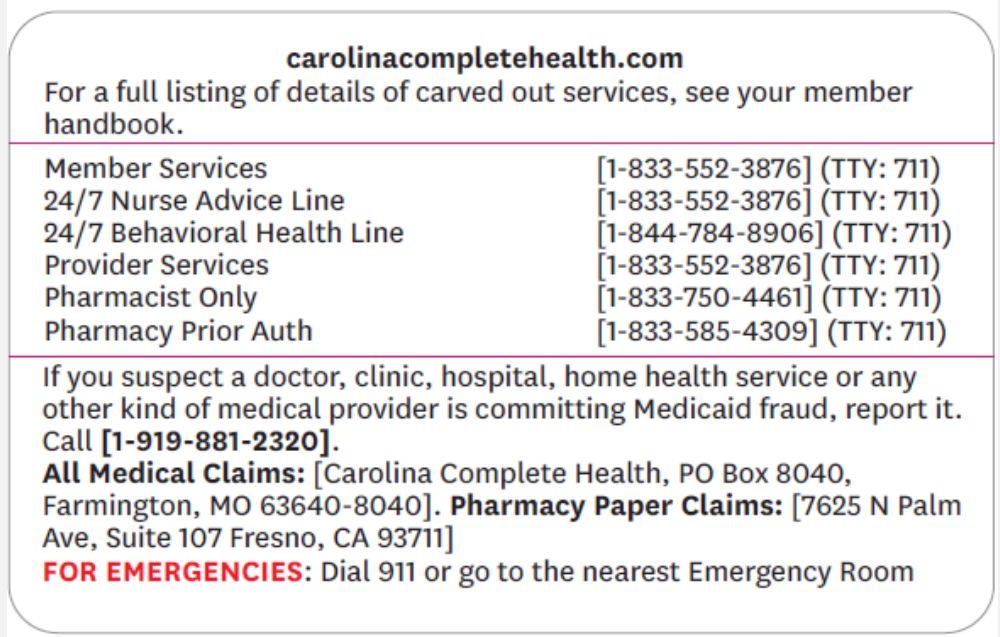
MEDICAID ID#: [012345678901]
EFFECTIVE DATE: [MM/DD/YYYY]
Member: [Member Full Name]

Member Portal

Plan: Medicaid
Member Date of Birth: [MM/DD/YYYY]
AMH/Primary Care Provider Name:
[AMH Group Name]
[AMH Address Line 1]
<AMH Address Line 2>
[Provider City], [Provider State] [Zip]
AMH/PCP Phone: [1-XXX-XXX-XXXX]

Carolina Complete Health
[1701 North Graham St., Suite 101]
[Charlotte, NC 28206]

RXBIN: [003858]
RXPCN: [MA]
RXGRP: [2ERA]


carolinacompletehealth.com
For a full listing of details of carved out services, see your member handbook.

Member Services	[1-833-552-3876] (TTY: 711)
24/7 Nurse Advice Line	[1-833-552-3876] (TTY: 711)
24/7 Behavioral Health Line	[1-844-784-8906] (TTY: 711)
Provider Services	[1-833-552-3876] (TTY: 711)
Pharmacist Only	[1-833-750-4461] (TTY: 711)
Pharmacy Prior Auth	[1-833-585-4309] (TTY: 711)

If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call **[1-919-881-2320]**.
All Medical Claims: [Carolina Complete Health, PO Box 8040, Farmington, MO 63640-8040]. **Pharmacy Paper Claims:** [7625 N Palm Ave, Suite 107 Fresno, CA 93711]
FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room

Web-based Tools

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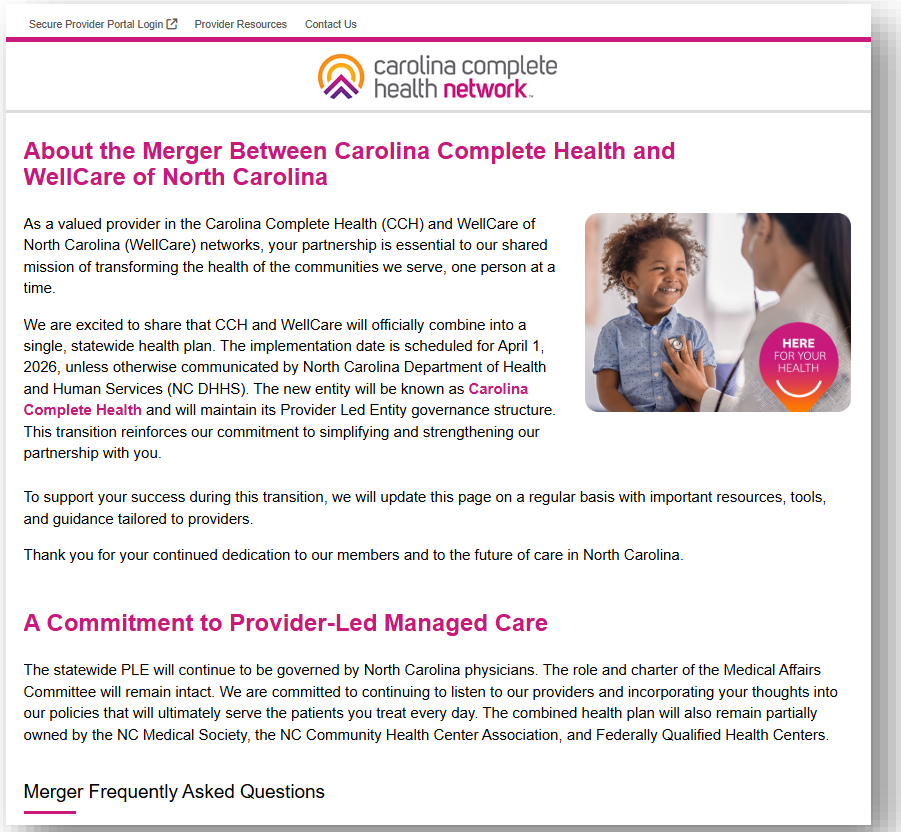
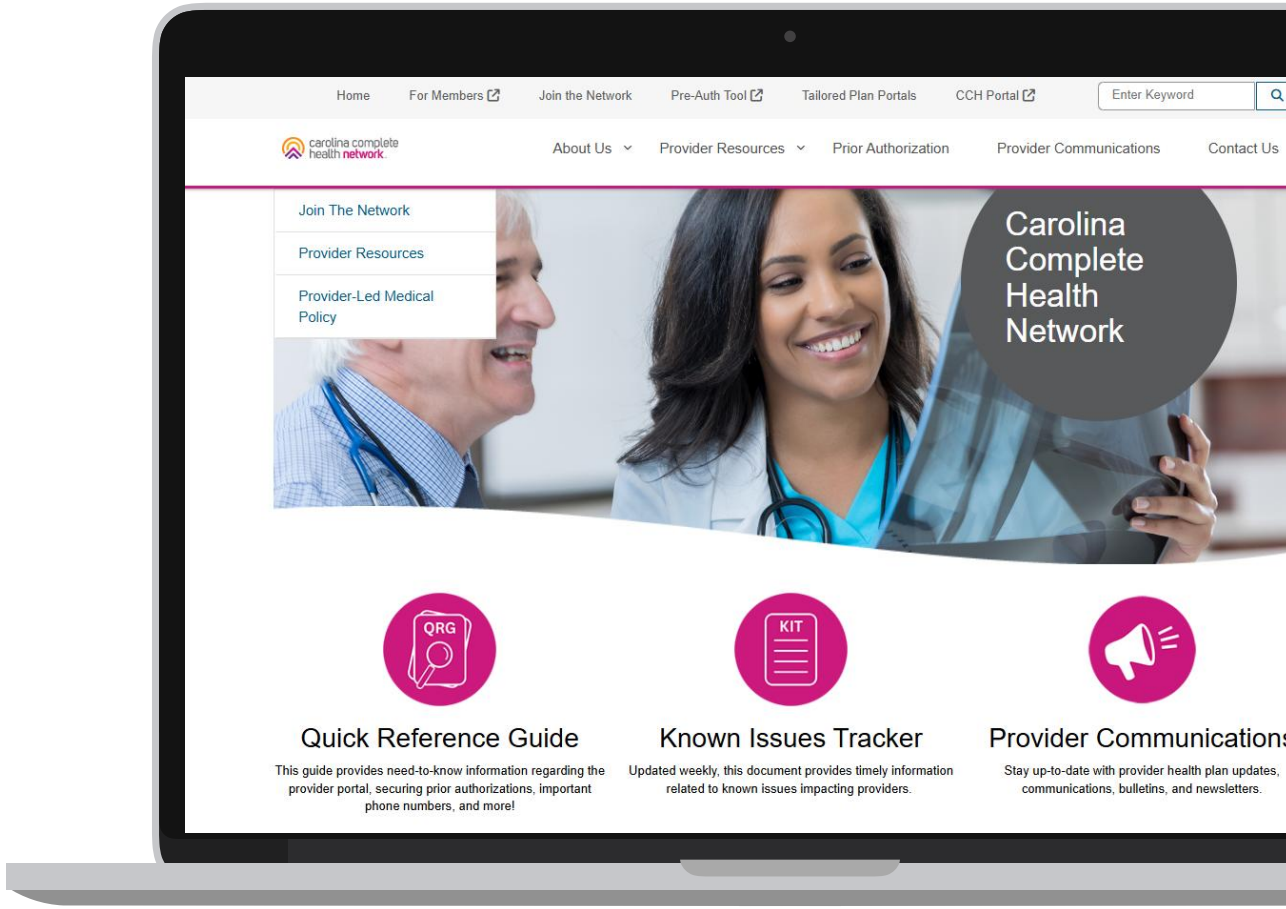
Provider Website and Integration Resources

- network.carolinacompletehealth.com
- network.carolinacompletehealth.com/merger





Availity Essentials

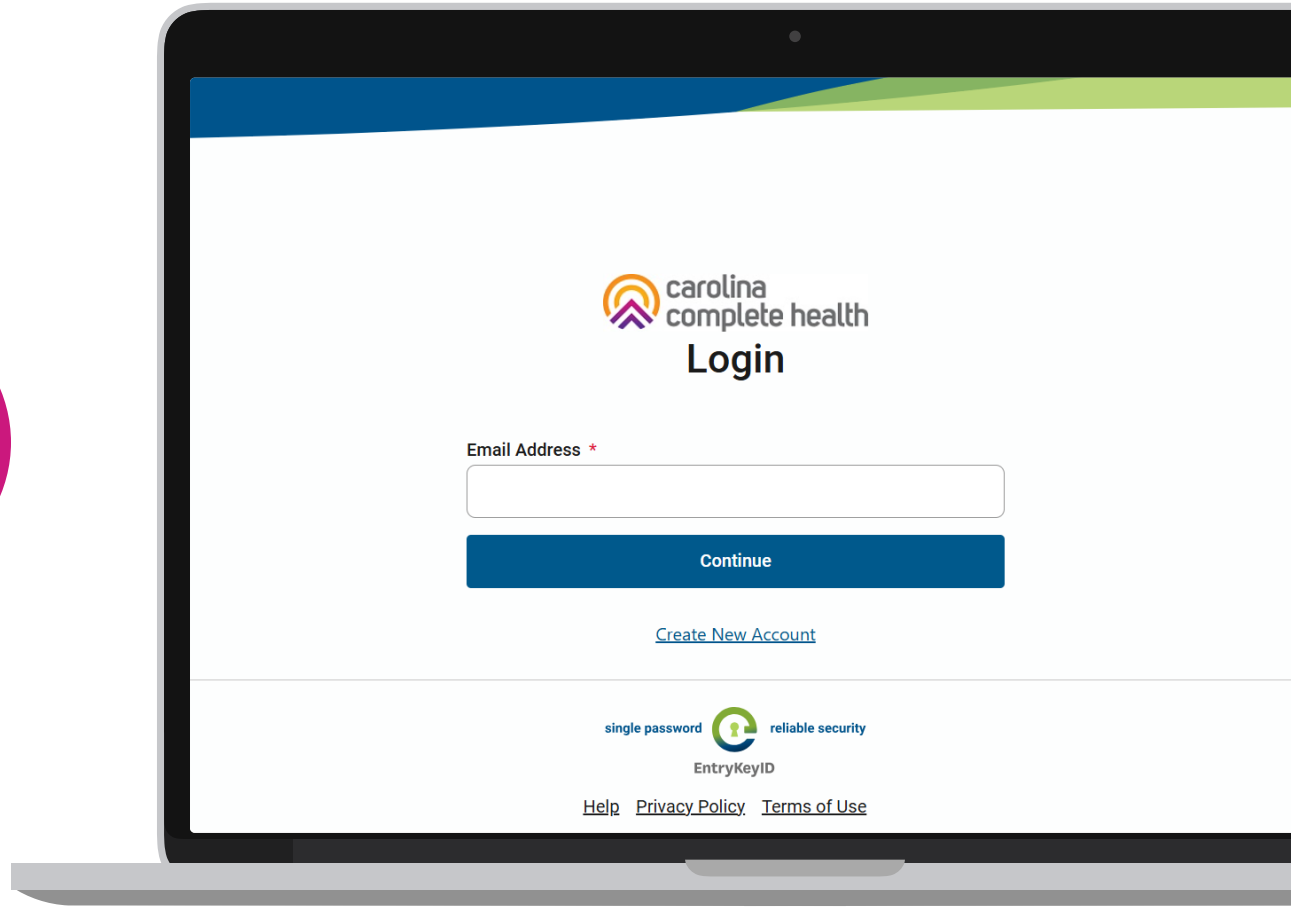
- Providers can continue using Availity Essentials: Register and Get Started with Availity Essentials
- **Chat features will be available in Availity Essentials**
- Providers Can:
  - Verify Member's Eligibility and Benefits
  - View ID Cards
  - Submit Claims
  - Check Claim Status
  - Claim Corrections
  - Remittance Viewer
  - Authorization Request/Inquiry
  - Authorization Edits
  - Submit attachments via the Attachments-New dashboard
  - Coming Soon: Claims Disputes and Appeals

Secure Provider Portal Effective 4/1/26

- New Providers may begin registering on 3/1/26!
- provider.carolinacompletehealth.com/
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Health records & care gaps
  - Prior Authorization
  - Claims submissions & status
  - Payment history
  - Monthly PCP cost reports
  - …and more!
- Secure Portal Training:
  - Provider Portal Training

  Guides:
  - Registering and Logging In
  - Submitting a Claim
  - Checking Member Eligibility and Health Record

Same Carolina Complete Health Portal in use today!



Portal Account Manager

A Portal Account Manager is a role assigned to a primary contact within a provider organization. This is up to the discretion of the practice.

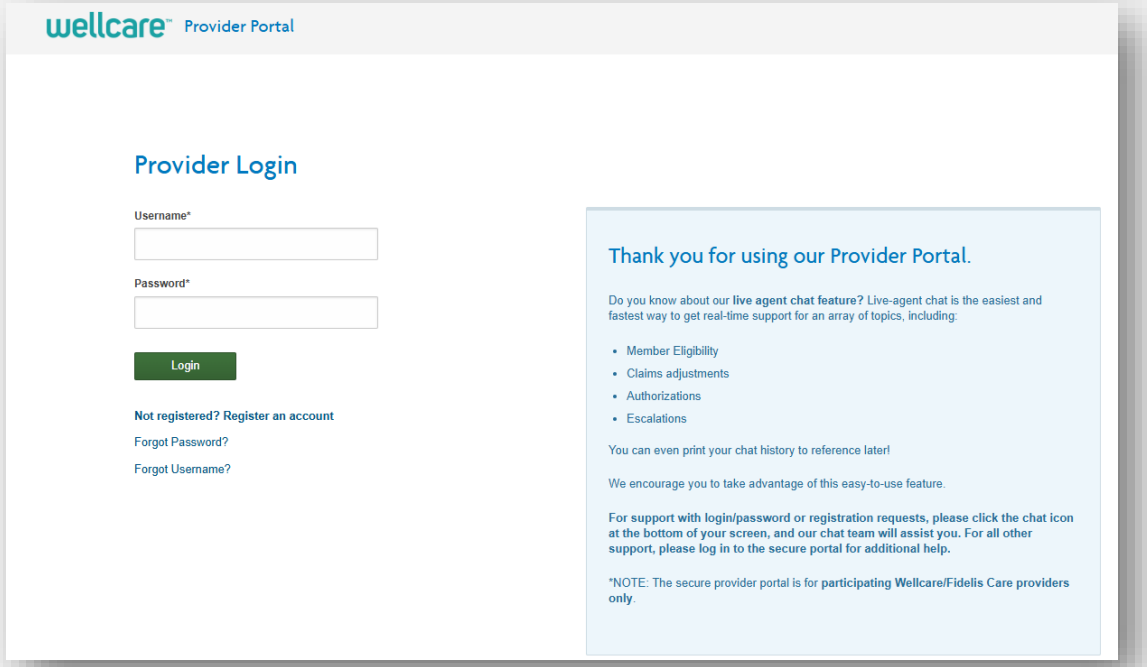
The **Portal Account Manage**r will be able to :

- ✓ Verify new portal registrations
- ✓ Disable and/or enable user's portal access
- ✓ Modify portal permissions based on the user's role within the organization

How to Assign an Account Manager:
Once an Account Manager is determined, they should register for the Carolina Complete Health Secure Provider Portal and then email providerengagement@cch-network.com to request Account Manager access. Access will be granted within 2 business days. Once approved, the Account Manager may begin verifying users within the organization.

WellCare Portal

- Legacy systems for WellCare of NC will remain operational for historical Medicaid claim access. Historical claim access will be supported for 2 years post 4/1/2026.
- No change for Wellcare Medicare: https://www.wellcare.com/north-carolina
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Care Gap submission
  - Prior Authorization
  - Claims submissions & status
  - Payment history
  - Active member lists
- Secure Portal Training:
  - New Provider Portal Overview Training | Wellcare
  - Portal Registration Guide
  - Provider Portal Claims | Wellcare
  - Submitting Medical Authorizations | Wellcare



Claims and Payment

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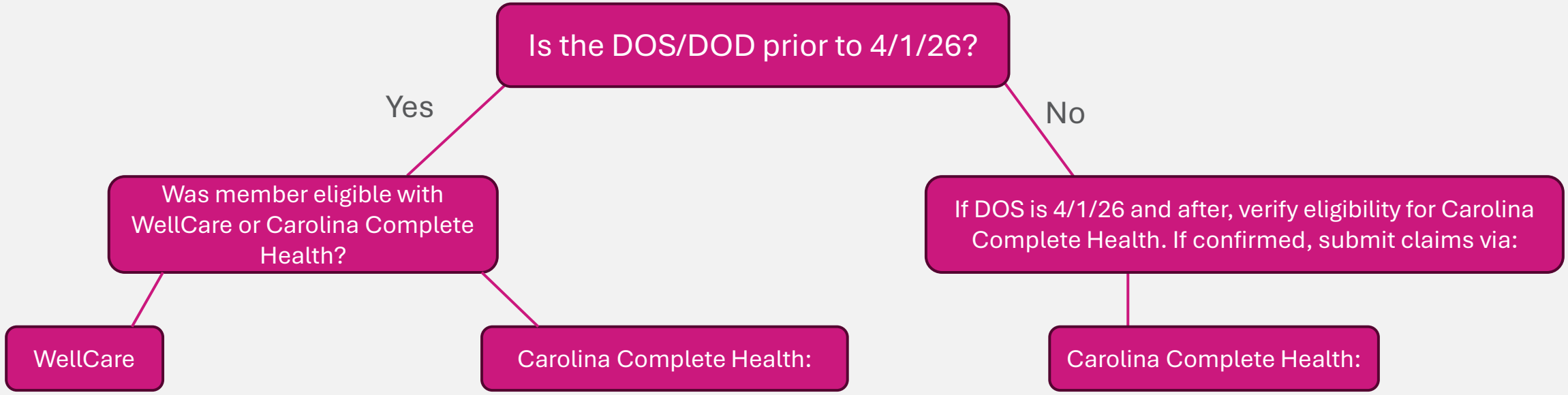
Claims Processing

- As a unified health plan, all claims will be adjudicated using Carolina Complete Health claims processing systems.
- **For dates of service 4/1/26 and after**, submit Medicaid claims using one of the following methods:
  - Availity Essentials
  - Carolina Complete Health Secure Provider Portal
  - Clearinghouse/EDI: Carolina Complete Health Payer ID 68069
  - Mail: PO Box 8040 Farmington, MO 63640-8040
- **WellCare claims with dates of service prior to 4/1/26** should be submitted using:
  - Availity Essentials
  - WellCare Secure Provider Portal
  - Clearinghouse/EDI: WellCare Payer ID 14163
  - Mail: PO Box 31224 Tampa, FL 33631-3224
- **Timely filing for first time claims is 365 calendar days from the date of service (DOS) for Professional claims and from the date of discharge for Facility claims.**

Claim Submission Decision Tree



Billing FAQ

- For physical health inpatient or observation claims that crossover the 4/1/26 transition date, who will be responsible for payment?
  - *For physical health inpatient stays, claims should not be split billed. Whomever the member is effective with at the time of admission is responsible for the entire stay.*
- How will this merger effect Tailored Plan billing?
  - *When the two health plans integrate on 4/1/2026, the relationship between Carolina Complete Health and all four Tailored Plans will not change. Vaya and Alliance will continue to pay all of their own claims. Carolina Complete Health will continue to support Trillium and Partners by processing their physical health claims. Trillium and Partners will also continue to access Carolina Complete Health's physical health network for their membership. Please note that Trillium intends to begin processing physical health claims no sooner than July 1, 2026.*
- *For more, visit: https://network.carolinacompletehealth.com/merger.html*

Check-run Schedule and Electronic Funds Transfer

- The check-run schedule occurs on **Monday, Wednesday and Friday**. Payment is issued to providers the following business day.
- Providers can continue using Payspan, a free solution that provides electronic payment and remittance.
- If providers already use Payspan for WellCare, but not Carolina Complete Health, you can add a line-of-business with a new registration code (provided by Payspan) to set up EFT/ERA with Carolina Complete Health.
  - Contact Payspan via email or phone: PayspanProviderSupport@zelis.com or 1-877-331-7154
- Providers can set up EFT for claim payments, Advanced Medical Home payments, and Tier 3 Care Management payments. Advanced Medical Home and Care Management payments are considered “ALT” payments and require a separate Payspan registration code.

Population Health and Clinical Operations

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Prior Authorizations (PA)

Transition of Care:

- For services provided to WellCare of NC members before April 1, 2026, continue submitting authorization requests through WellCare or the appropriate WellCare vendor using the WellCare NC Provider Portal, the vendor portal, fax, or phone.
- For services that will be provided *on **4/1/26 or after***, submit authorization requests to Carolina Complete Health or the integrated plan vendor (via the Carolina Complete Health provider portal, vendor portal, via fax or phone to Carolina Complete Health, or through Availity).
- Existing WellCare Prior Authorizations: Authorizations entered and approved before 4/1/2026 will be transferred to Carolina Complete Health. If a service was approved before 4/1/26 but is performed on or after 4/1/26, the claim will process correctly *when filed with Carolina Complete Health*.
  - Example – an authorization is requested and approved for a 60-day period from 3/15/26 - 6/15/26. The authorization will be valid for services provided after 4/1/26, even though it was approved while the member was covered under WCNC prior to the integration date.
  - Exception: All inpatient authorizations (Medical and Behavioral) with admit dates of 3/31/2026 or earlier and no discharge date, will remain in the WellCare systems until date of discharge.

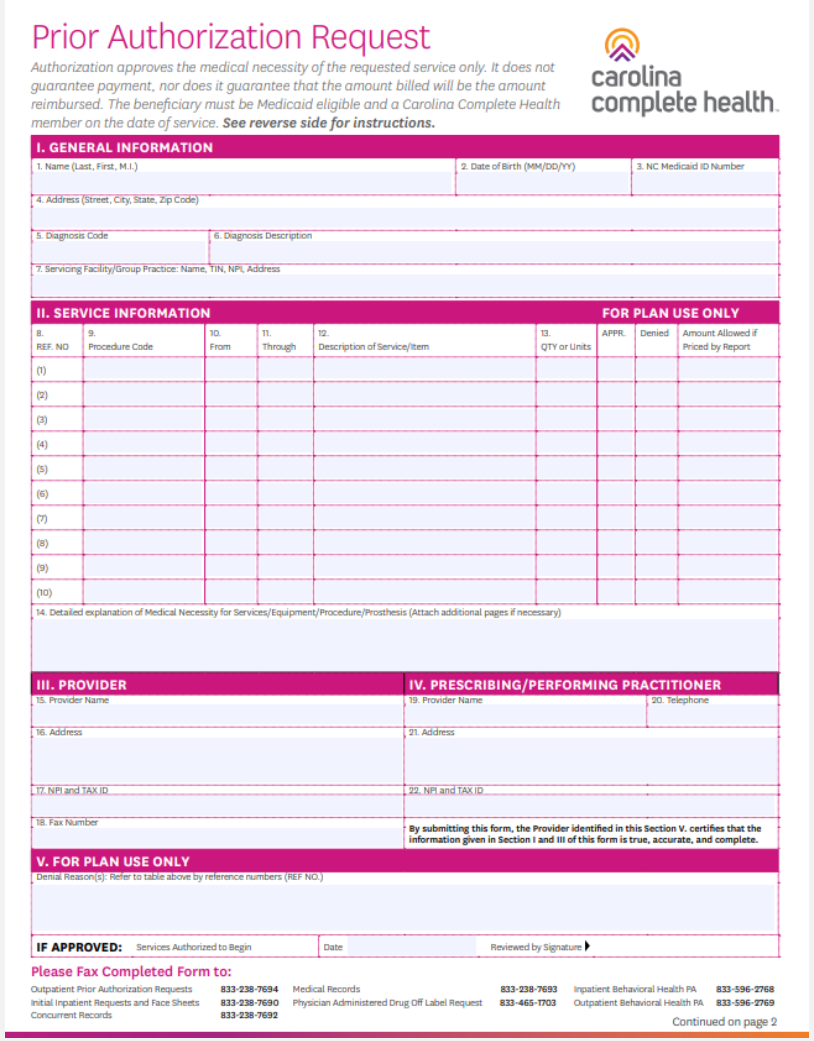
Prior Authorization Reminders

- The same UM staff and medical director teams that have been serving you for prior authorization reviews will continue to do so, as a combined team. They remain familiar with the nuances of NC Medicaid.
- Peer to peer process will mirror that of Carolina Complete Health after 4/1 for authorizations requested after that date.
- Clinical policies that will be used will be posted on the Carolina Complete Health website no later than 60 days before the 4/1/26 integration date.

Timeframe for PAs and Notifications remain the same:

- Standard Service Requests: Submit a PA fourteen (14) business days prior to date of service
- Emergent/Urgent: One (1) business day of the admission for ongoing concurrent review and discharge planning.

PA Submission Methods



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 eligible and a Carolina Complete Health member on the date of service. ***See reverse side for instructions.***

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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. Servicing Facility/Group Practice: Name, TIN, NPI, Address

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

15. Provider Name

16. Address

17. NPI and TAX ID

18. Fax Number

IV. PRESCRIBING/PERFORMING PRACTITIONER

19. Provider Name | 20. Telephone

21. Address

22. NPI and TAX ID

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

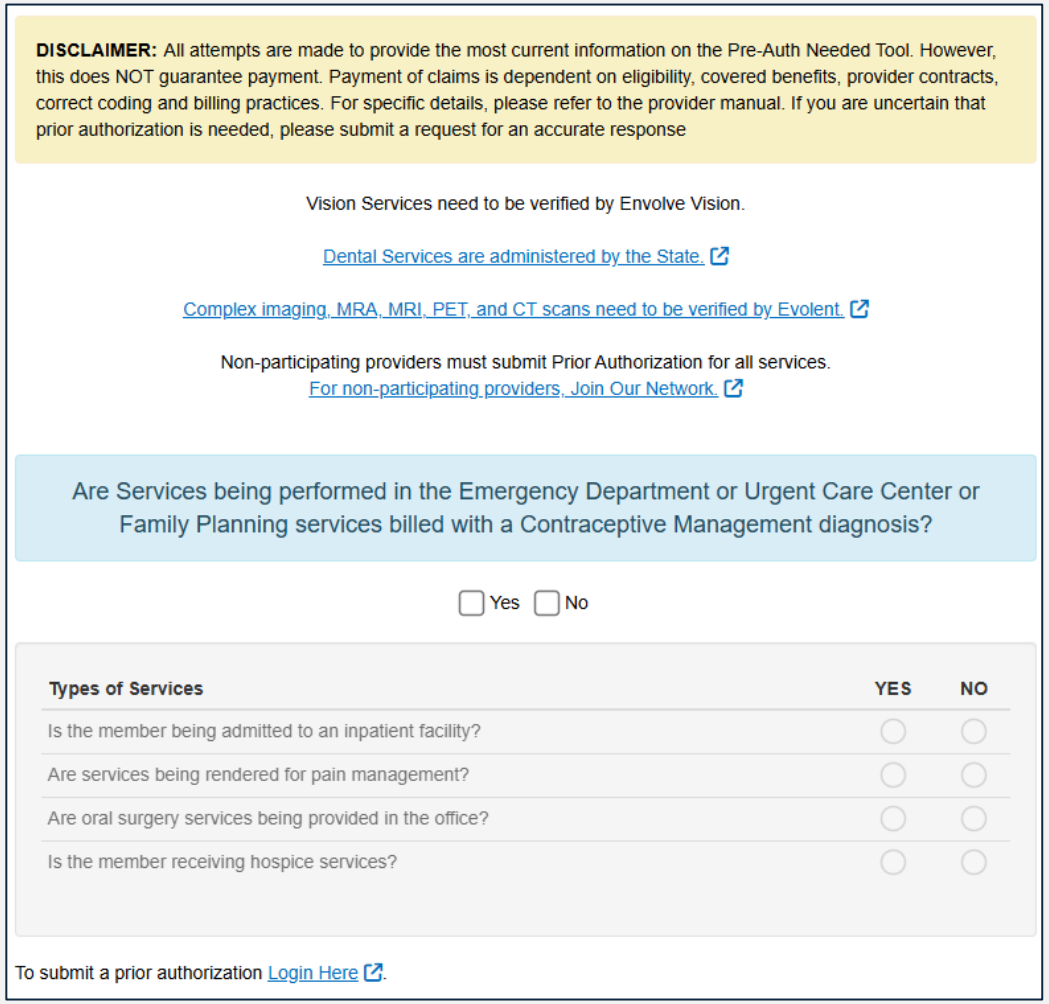
Please Fax Completed Form to:

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				

Continued on page 2

- Prior Authorization Requests can be submitted via the Secure Provider Portal, Availity Essentials, by phone or via fax.
- Provider portal: https://provider.carolinacompletehealth.com/
- Availity Essentials: https://essentials.availity.com/login
- Prior Authorizations Fax Form can be found on the Carolina Complete Health website under the Prior Authorization tab to submit via phone and fax.
- Phone: 1-833-552-3876
- Fax: Outpatient PA Requests: 833-238-7694
  Initial Inpatient Requests: 833-238-7690
  Concurrent Records: 833-238-7692
  Inpatient Behavioral Health PA: 833-596-2768.
  Outpatient Behavioral Health PA: 833-596-2769

Prior Authorizations (PA) Check Tool



DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response

Vision Services need to be verified by Envolve Vision.

Dental Services are administered by the State.

Complex imaging, MRA, MRI, PET, and CT scans need to be verified by Evolent.

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services being rendered for pain management?	○	○
Are oral surgery services being provided in the office?	○	○
Is the member receiving hospice services?	○	○

To submit a prior authorization Login Here.

- Use the Carolina Complete Health Standard Plan Pre-Auth Tool, which can be found on the Carolina Complete Health website, to check if a service or procedure requires prior authorization.
- Carolina Complete Health Standard Plan Pre-Auth Tool

Prior Authorization Reminders and Resources

- Emergency / Urgent services do not require prior authorization
- All out-of-network services and providers require prior authorization
- Failure to complete the required authorization or notification may result in denied claim
- Please include Contact Information on Authorization Requests

Provider Resources:

- How to Secure a Prior Authorization
- Carolina Complete Health Standard Plan Prior Authorization Fax Form (Also reference the PA Form Tip Sheet)
- Documentation Tips for Prior Authorization Submission
- How to View Authorizations and Assessments in the Secure Portal

Non-Covered Services and Beyond Benefit Limits

- Prior Authorization is required when:
  - A provider determines a member needs services not included in NC Medicaid covered services/procedures or products
  - A provider determines a member needs services, procedures, or products beyond the identified benefit limits.
- Prior Authorization requirements:
  - When submitting an authorization for the above, providers should fax the request and note the reason for the request:
    - “PA request due to a need beyond the benefit limit”
    - “PA review needed due to code not being found on the NC Medicaid Managed Care Covered Code list”

EXAMPLES:

Code/Description	Pre-Auth Check Tool	Benefit Limit per Policy	PA Requirement Beyond Limit/Not Covered
A6258 – Transparent film, sterile, >16 sq. in. but ≤48 sq. in., each dressing	No PA required for all providers	16 per month	PA required if member needs >16/month
T4544 – Adult-sized disposable incontinence product, protective underwear/pull-on, above extra large, each	No PA required for all providers	200 per month	PA required if member needs >200/month
A7035 – Headgear used with positive airway pressure device	No PA required for all providers	2 per year	PA required if member needs >2/year

Vendor Programs Before and After

	Current Carolina Complete Health vendor	Current WellCare of North Carolina vendor	Carolina Complete Health Integrated Plan
Radiation Oncology	None	Evolent	Evolent: effective no earlier than 5/1/26
Musculoskeletal Surgery	None	Evolent	Evolent: effective 4/1/26
Interventional Pain Management	None	Evolent	Evolent: effective 4/1/26
Advanced Imaging	Evolent	Evolent	Evolent: continue on 4/1/26 as you do today.
Physical, Occupational, Speech Therapy	None	Evolent	None. Submit directly to health plan.
Cardiovascular Procedures	None	Evolent	TurningPoint: effective no earlier than 5/1/26
Sleep Diagnostics	None	EviCore	None. Submit directly to health plan.
Genetic Testing	None	EviCore	EviCore effective no earlier than 5/1/26.
Vision Services	Centene Vision Services	Centene Vision Services	Centene Vision Services
NEMT	Modivcare	Medical Transportation Management (MTM)	Medical Transportation Management (MTM)

UM Vendor Programs for Integrated Plan

- **EviCore:** Lab Management for genetic testing
  - Clinical Guidelines
  - eviCore Provider Web Portal: https://www.evicore.com/
  - Phone: 1-888-333-8641
- **Evolent**: Radiation Oncology, Musculoskeletal Surgery, Interventional Pain Management, Advanced Imaging.
  - Web resources: https://www1.radmd.com/all-health-plans/carolina-complete-health
  - Provider Portals: https://www.evolent.com/provider-portal
    - Rad Oncology: Utilize the CarePro Provider Portal
    - Advanced Imaging, MSK, and IPM utilize the RadMD™ Provider Portal
  - Phone: 1-800-424-4889
- **TurningPoint:** Cardiovascular Procedures
  - Portal: http://www.myturningpoint-healthcare.com
  - Phone: 984-377-8573 | 855-909-5444
  - Fax: 833-986-1059

Behavioral Health (BH)

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Inpatient Psychiatric Care, Inpatient Substance Use Treatment (ASAM 4 & ASAM 4-WM) & ASAM 3.7-WM

- Inpatient Hospitalization for Psychiatric Treatment and Substance Use (ASAM 4 & ASAM 4-WM)
  - No authorization needed for the first 3 days
    - Facility to notify health plan of admission within 24 hours
- Medically Monitored Inpatient WM Services (H0010)
  - No authorization needed for the first 3 days
    - Facility to notify health plan of admission within 24 hours

Facility-Based Crisis

Service & Code(s)	Initial Authorization	Continued Stay Authorization
Professional Treatment Services in Facility-Based Crisis Programs Ages 18+ • S9484 (1 unit = 1 hour)	No authorization needed for first 7 calendar days (168 units) • Facility to notify health plan of admission within 72 hours	As medically necessary
Facility Based Crisis Service for Children and Adolescents (ages 6-17) • S9484 HA (1 unit = 1 hour)	No authorization needed for first 72 hours (72 units) • Facility to notify health plan of admission within 72 hours	

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
Partial Hospitalization • H0035 (1 unit = 1 day)	Up to 7 days • This code should be used only for primary **Mental Health** conditions (not Substance Use Disorders)	As medically necessary
Substance Abuse Intensive Outpatient Program (SAIOP) • H0015 (1 unit = 1 day)	No authorization required for the first 30 calendar days of treatment per member per State FY • Subsequent authorizations up to 30 days	
Substance Abuse Comprehensive Outpatient Treatment (SACOT) • H2035 (1 unit = 1 hour)	No authorization required for the first 30 calendar days of treatment per member per State FY • Subsequent authorizations up to 30 days	

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
Mental Health Intensive Outpatient Program (In-Lieu of Service) • S9480 (1 unit = 1 day)	Up to 12 units (within 30 calendar days) • This code should be used only for primary **Mental Health** conditions (not Substance Use Disorders)	As medically necessary
Outpatient Behavioral Health Services: Psychotherapy • 90832, 90834, 90837, 90846, 90847, 90849, and 90853	No authorization needed for first 24 (unmanaged) units per member per State FY • 24 visits is any combination of codes	As medically necessary • Authorization requests can be for up to 6 months at a time

Peer Support Services

- Peer Support Services
  - H0038, H0038 HQ (group)
  - 1 unit = 15 minutes
- Initial Authorization: No authorization needed for first 24 (unmanaged) units per member per State FY
  - Prior authorization required after 24 units, up to 90 days.
- Continued Service Authorization: As medically necessary
  - Authorization requests can be for up to 90 days at a time

Peer Support Reminders

- Peer Support is intended to support a member:
  - With goals related to their underlying MH/SUD diagnosis
  - Engage and connect to other treatments as clinically indicated
  - Building natural recovery-oriented supports
- Peer Support services include:
  - Mentoring/Coaching (teaching self-advocacy, modeling recovery and wellness activities)
  - Connecting members to community resources to assist with meeting recovery goals
  - Assisting with enhancing an individuals' natural supports to sustain recovery
- Peer Support services should:
  - Always work towards titration of services (to decrease dependency on paid supports)

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
Psychological & Neurological Testing • 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96139, and 96146.	No authorization needed for first 16 units per member per State FY	As medically necessary
Research-Based Behavioral health Treatment (RB-BHT) For Autism Spectrum Disorder • 97151 – 97157	Authorization based on medical necessity, up to 6 months • **NOTE: 97158 is not a covered NC Medicaid service. This service, if requested, will be reviewed under EPSDT criteria rather than the RB-BHT policy**	As medically necessary • Authorization requests can be for up to 6 months at a time

Behavioral Health Services That do NOT Require Prior Authorization

- Ambulatory Withdrawal Management without Extended On-Site Monitoring
  - H0014 (1 unit = 15 minutes)
- Ambulatory Withdrawal Management with Extended On-Site Monitoring
  - H0014 HF (1 unit = 15 minutes)
- Behavioral Health Urgent Care (In-Lieu of Service)
  - T2016 U5 (without observation), T2016 U8 (with observation)
  - 1 unit = 1 event
- Comprehensive Clinical Assessment
  - 90791
- Diagnostic Assessment
  - T1023
- Opioid Treatment Program Service (18+)
  - H0020 (1 unit = 1 week)
- Mobile Crisis Management
  - H2011 (1 unit = 15 minutes)

BH UM Documentation Reminders

- Providers should submit all needed documentation to support medical necessity
  - Assessments
  - Treatment Plans/Person-Centered Plans
    - Progress updates are expected for ongoing care
  - Service Orders (with appropriate credentials, per policy)
  - Discharge/Transition Plans
  - Any service specific documentation as outlined in policy
    - Behavioral Health Clinical Coverage Policies
    - In-Lieu of Services Policy

Durable Medical Equipment

Complex Rehabilitation DME

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Complex Rehabilitation DME

- Types of DME managed by the Specialty Therapy Advisor Team
  - Wheelchairs – power, manual, seating/accessories, and repairs
  - Prosthetics- Upper and Lower Extremity
  - Orthotics – Upper & Lower Extremity and Spinal
  - Hospital beds, mattresses, patient lifts
  - Pediatric or Adult Miscellaneous Equipment
    - Includes but not limited to gait trainers, standers, activity chairs, etc.
    - E1399 code is often used
  - Speech generating devices
  - Pneumatic Compression Devices for lymphedema management (codes E0650, E0651, E0652)

Clinical Policy and Required Documentation

- North Carolina Medicaid Physical Rehabilitation Equipment and Supplies, Clinical Coverage Policy No: 5A-1
  - Orders
  - Documentation of medical necessity
  - Coverage policy is very clear on most types of DME

Specialty Therapies

Physical Therapy, Occupational Therapy, Speech Therapy

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Authorizations for Specialized Therapies

Effective April 1, 2026:

- PT/OT/ST authorizations can be submitted directly to the unified health plan. Providers should submit authorization requests to the health plan through the Carolina Complete Health Secure Portal, Availity Essentials, phone or fax. Please use the Pre-Auth Tool to check on a specific service or procedure.

Required documentation includes:

- Signed orders less than 6 months old
  - Signature from MD, DO, PA, NP; can use prescriber signed POC if it is less than 6 months old
- Evaluation/Plan of Care: less than 1-year old
  - Progress Notes from the past 3 months
- For continuations: new order, progress notes, data on attendance, home program, detailed report of goal progress/goal updates

Clinical Policy

- Carolina Complete Health Provider Manual: https://network.carolinacompletehealth.com/resources/manuals-and-forms.html

- North Carolina Medicaid: Outpatient Specialized Therapies: Clinical Coverage Policy No: 10A: https://medicaid.ncdhhs.gov/10a-outpatient-specialized therapies/download?attachment

Operational Notes

- Evaluations and treatment rendered on the day of evaluation do not require prior authorization
  - Services after the day of evaluation do require prior authorization in all cases
  - There is a 5-day grace period to submit therapy authorization requests
    - For example, if a request was submitted today (3/5/26), the service dates could begin 2/28/26
  - Retroactive reviews are not generally allowed without extenuating circumstances

- 30-day extensions for authorization end dates are allowed for unused visits to be utilized; must be requested before authorization expires.

Operational Notes

- No authorization is needed when the unified health plan is the secondary payer source.
  - Authorization is needed if:
    - Primary benefits terminate
    - If primary payer benefit maximums are reached or are nearly reached
    - If primary issues a denial

Operational Notes

- Request for information: one outreach from the health plan when information is missing
- 5-day grace period from initial determination to request the following:
  - Reconsiderations: additional medical necessity review that takes place after the initial review and determination, when additional information is available that was missing at the time of the initial review.
  - Peer to Peer: scheduled therapist to therapist phone call to discuss medical necessity review and determination. Can result in a change in determination.
- 60-day window from initial determination to initiate an appeal

Operational Notes

- Authorizations are processed in visits; never units
- If a member is new to the health plan (not transferring from CCH or WellCare) and new auth is needed:
  - Send standard required documents
  - Include documentation of visits approved from other carrier
    - This is specific to dates of service auth is needed for that span the three immediate months after carrier transfer
  - Visit match can be issued for first 90 days of coverage with unified health plan

Utilization Management

- State guidelines for adults:
  - Maximum of 30 combined physical and occupational therapy visits per calendar year
  - Maximum of 30 speech therapy visits per calendar year
  - Dates of service can span up to 6 months
  - Maximum of 12 visits per authorization request

- State guidelines for pediatrics:
  - All requests for pediatric members are reviewed for medical necessity
  - Dates of service can span up to 6 months

Provider Questions

- Will prior authorizations through both companies for our pediatrics still be honored? Or will a new initial evaluation have to be done to retrieve new auth?
  - Active open authorizations will transfer over to the unified health plan. Historical authorizations(past 18 months prior to 4/1/26) will also migrate over. If a service was approved before 4/1/26 but is performed on or after 4/1/26, the claim will pay correctly when filed with Carolina Complete Health. For example, an authorization is requested and approved for a 90-day period from 3/15/26 - 6/15/26. The authorization will be valid for services provided after 4/1/26,even though it was approved while the member was covered under WellCare of NC prior to the integration date. Providers can view authorizations in the secure provider portal.
    - Claims can be sent to the unified health plan with Payer ID 68069

Provider Questions

- For patients that are multidisciplinary (Physical Therapy and Occupational Therapy) who need authorization for the same CPT codes for both therapies how do we go about submitting those so one is not denied due to duplication?
    - The health plan sets up authorizations using umbrella codes for each discipline.
        - PT is 97110, OT is 97530 and ST is 92507.
            - Other covered therapy codes can be billed for each discipline based on services provided at each visit.
            - We designate the prior authorization per these umbrella codes to ensure that each therapy discipline can be accessed for the dates of service needed.
            - Please use appropriate modifiers on claims.

Provider Questions

- How do you request a discharge for outpatient therapy? For example, the patient discharges from OT to receive OT from another provider.
  - The discharging clinic can call or fax to request that an authorization is ended early due to services ending at their facility
    - phone number 1-833-552-3876 or fax: 833.238.7694.
  - Please include:
    - member name
    - date of birth
    - authorization number
    - therapy provider and specific therapy discipline
    - date of discharge

Key Contacts and Provider Resources

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Provider Resources

- Merger Landing Page
- Provider Communications
- New Provider Orientation: 2nd Tuesday of every month, register in advance!

Key Contacts:

Carolina Complete Health Network

Provider Services: 1-833-552-3876
Provider Engagement:
providerengagement@cch-network.com
Provider Relations:
NetworkRelations@cch-network.com

WellCare of North Carolina

Provider Engagement: 1-984-867-8637
Provider Engagement Email:
NCProviderRelations@Wellcare.com

EVV, Home Health, PCS Session

- March 24, 12:00PM please register here in advance.
- This session will review billing guidance, payer ID updates, and Electronic Visit Verification requirements for Personal Care Services and Home Health providers.
- Subject matter experts will provide an overview of key changes and answer general provider questions.

Upcoming Sessions

Provider Sessions:
General Merger Info

(All sessions begin at 12PM)

- ~~March 5th~~
- March 19th
- April 2nd
- April 16th
- Register Here

Carolina Complete Health
Secure Portal Training

(All sessions begin at 12PM)

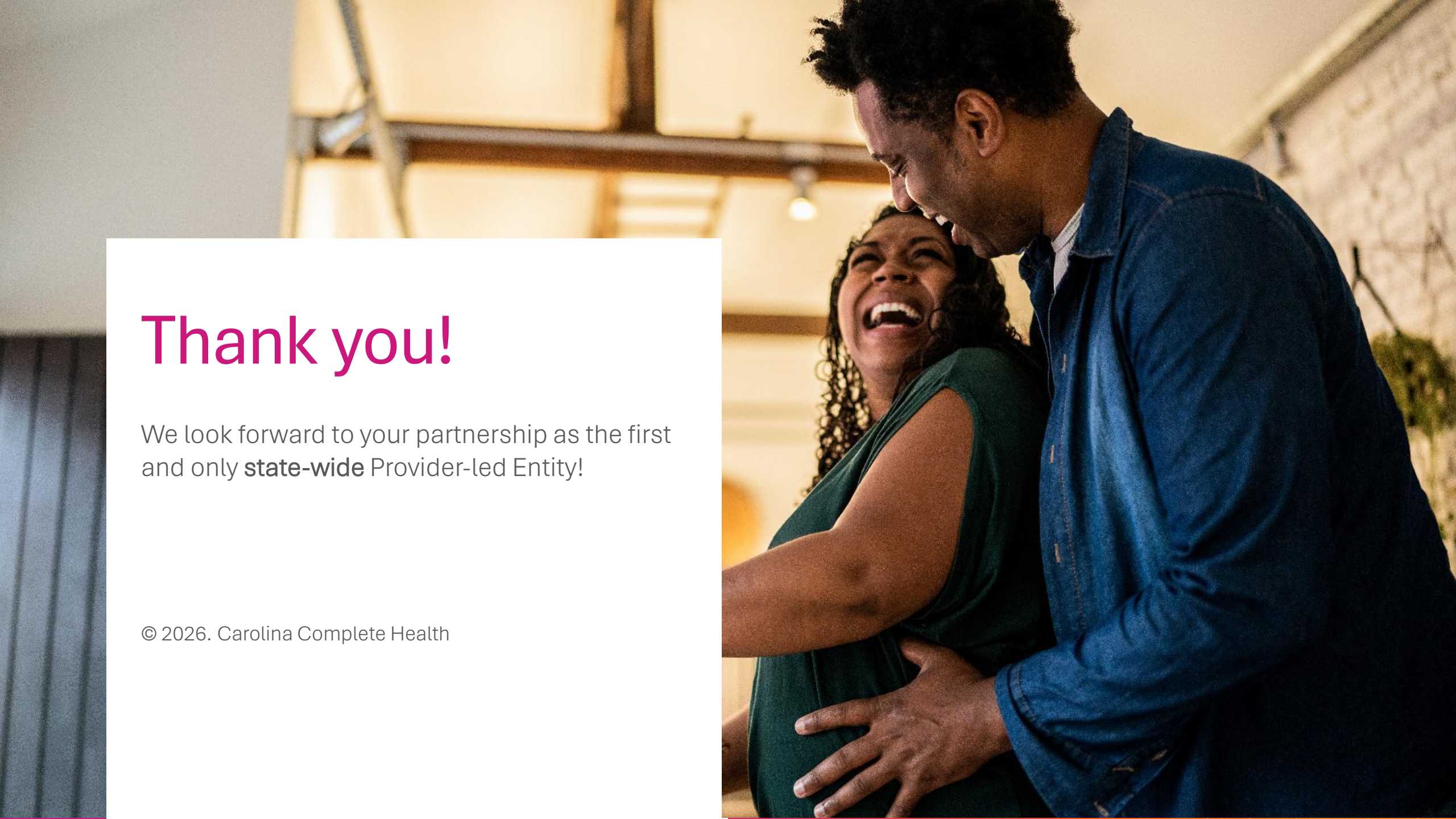
- ~~February 26th~~
- March 12th
- March 26th
- April 9th
- April 23rd
- Register Here

Evaluation

We value your feedback!

Please take a minute to let us know how we are doing.

- https://www.surveymonkey.com/r/2B8SQGG



Thank you!

We look forward to your partnership as the first and only **state-wide** Provider-led Entity!