



Carolina Complete Health and WellCare of North Carolina Merger

Provider Information Session



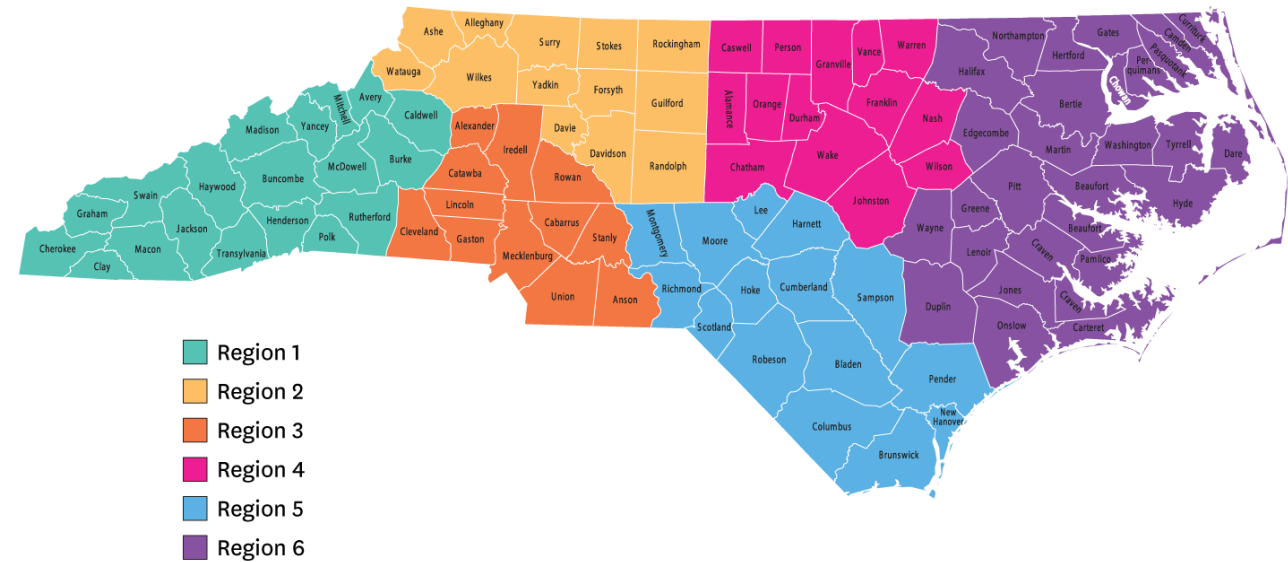
Confidential and Proprietary Information

Agenda

- Welcome and Introduction
- Contracting and Network FAQ
- Member Communications and ID Card
- Web-based Tools and Demo
- Claims and Payment
- Population Health and Clinical Operations
- Quality Program
- Key Contacts and Resources

Single Statewide Provider-Led Entity

- WellCare of North Carolina operated in all six regions; Carolina Complete Health operated in regions 3, 4, and 5.
- **As of April 1, 2026, the combined health plan, named Carolina Complete Health, is state-wide.**



~760K

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 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

Provider-Led Clinical Policy

- The Medical Affairs Committee's role and charter will remain intact.
- Carolina Complete Health's **Medical Affairs Committee (MAC)** is a sub-committee of the Carolina Complete Health Board of Directors and is comprised of a majority North Carolina Medicaid physicians.
- The MAC has board authority to make clinical policy decisions for Carolina Complete Health using feedback from specialty reviewers and clinical policy/advisory workgroups.
- **Carolina Complete Health Network** facilitates five specialty matched clinical policy/advisory workgroups:

Primary Care

Emergency Medicine

Behavioral Health

Pediatrics

Women's Health

- Current WellCare only providers will be eligible to participate in a Clinical Policy workgroup as a Carolina Complete Health provider.
- Monthly, Carolina Complete Health Network notifies providers of which policies contain proposed revisions and requests feedback from all providers.

Network and Contracting



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Contracting Q&A

Will my patients need to change their provider or their PHP?

- If you held a Medicaid contract with Carolina Complete Health or WellCare of North Carolina, you are considered in-network 4/1/26 and therefore, members will stay assigned to you.
- Former WellCare Medicaid members were automatically transitioned to the unified health plan, these members did not need to change PHPs and their benefits stayed the same.

Is there any need for re-credentialing or any additional application process to continue serving members under the merged entity?

- There is no Medicaid re-credentialing or additional application process required as part of this merger.

Does participation in one product mean I will be in-network for all Lines of Business after the merger?


- Existing contracts remain in place
- Participation does **not automatically extend across lines of business**
- Providers must **contract separately** for: Physical Health Tailored Plans, Ambetter and Wellcare Medicare. If you already held contracts with these plans, they remain unchanged.

NCTracks and Provider Enrollment Data

- NCTracks is the “system of record” for provider enrollment data for NC Medicaid.
- This data is shared with health plans to inform contracting and provider directories. If provider information is not current, then the data that flows forward to the health plans and the enrollment broker will not be accurate.
- Providers must first be enrolled with North Carolina Medicaid through NCTracks. If you are not already enrolled, you can begin the process here:
<https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html>
- NCTracks must be updated whenever provider demographic or affiliation information changes. This includes updates to email addresses, practice addresses, phone or fax numbers. NCTracks should also be updated when providers join or leave an organization to ensure the individual-to-organization affiliation is accurate.


Member Identification

- Members' Medicaid ID numbers will **not change** and will be displayed on the card.
- Members received new Carolina Complete Health ID cards
- Members assigned provider will be displayed on the card at the Group-NPI level (AMH).
- [Member Benefits and Services](#)



MEDICAID ID#: [012345678901]
EFFECTIVE DATE: [MM/DD/YYYY]

Member: [Member Full Name]



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]

Member Portal

<p>Carolina Complete Health [1701 North Graham St., Suite 101] [Charlotte, NC 28206]</p>	<p>RXBIN: [003858] RXPCN: [MA] RXGRP: [2ERA]</p>
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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

Provider Engagement Team



HERE
FOR YOUR
HEALTH

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Provider Engagement Assignments

- Our Provider Engagement team is a blend of Carolina Complete Health Network and former WellCare team members
- Each provider has a single point of contact
- View our team and assignments online:
- <https://network.carolinacompletehealth.com/about-us/provider-engagement.html>

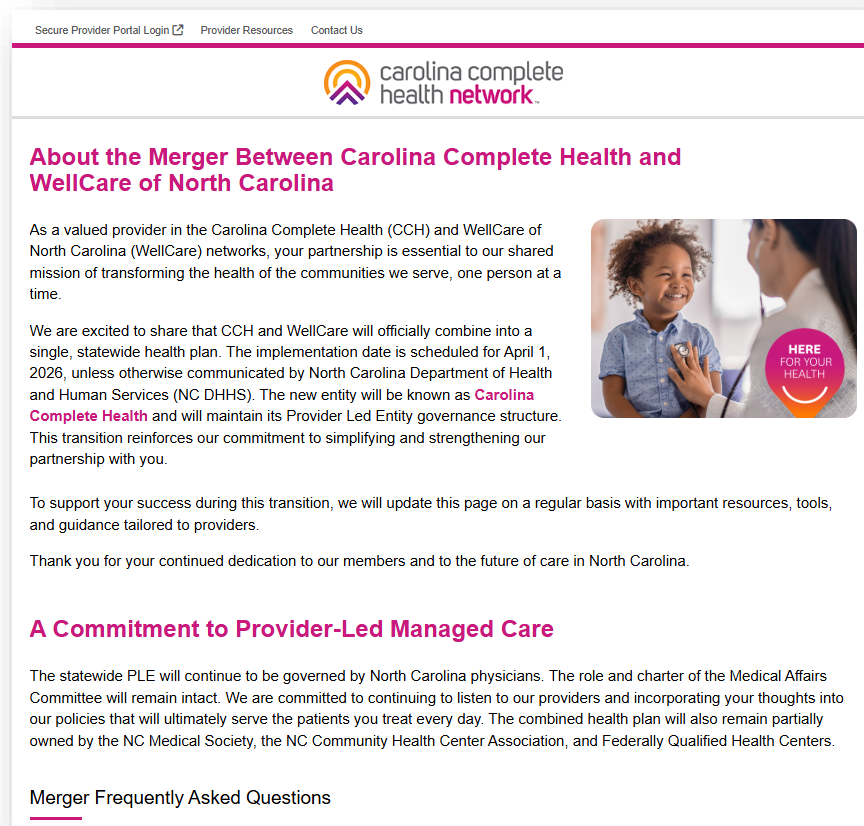
Web-based Tools




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Provider Website and Integration Resources

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




Secure Provider Portal Login [Provider Resources](#) [Contact Us](#)

 carolina complete health network.

About the Merger Between Carolina Complete Health and WellCare of North Carolina

As a valued provider in the Carolina Complete Health (CCH) and WellCare of North Carolina (WellCare) networks, your partnership is essential to our shared mission of transforming the health of the communities we serve, one person at a time.



We are excited to share that CCH and WellCare will officially combine into a single, statewide health plan. The implementation date is scheduled for April 1, 2026, unless otherwise communicated by North Carolina Department of Health and Human Services (NC DHHS). The new entity will be known as **Carolina Complete Health** and will maintain its Provider Led Entity governance structure. This transition reinforces our commitment to simplifying and strengthening our partnership with you.

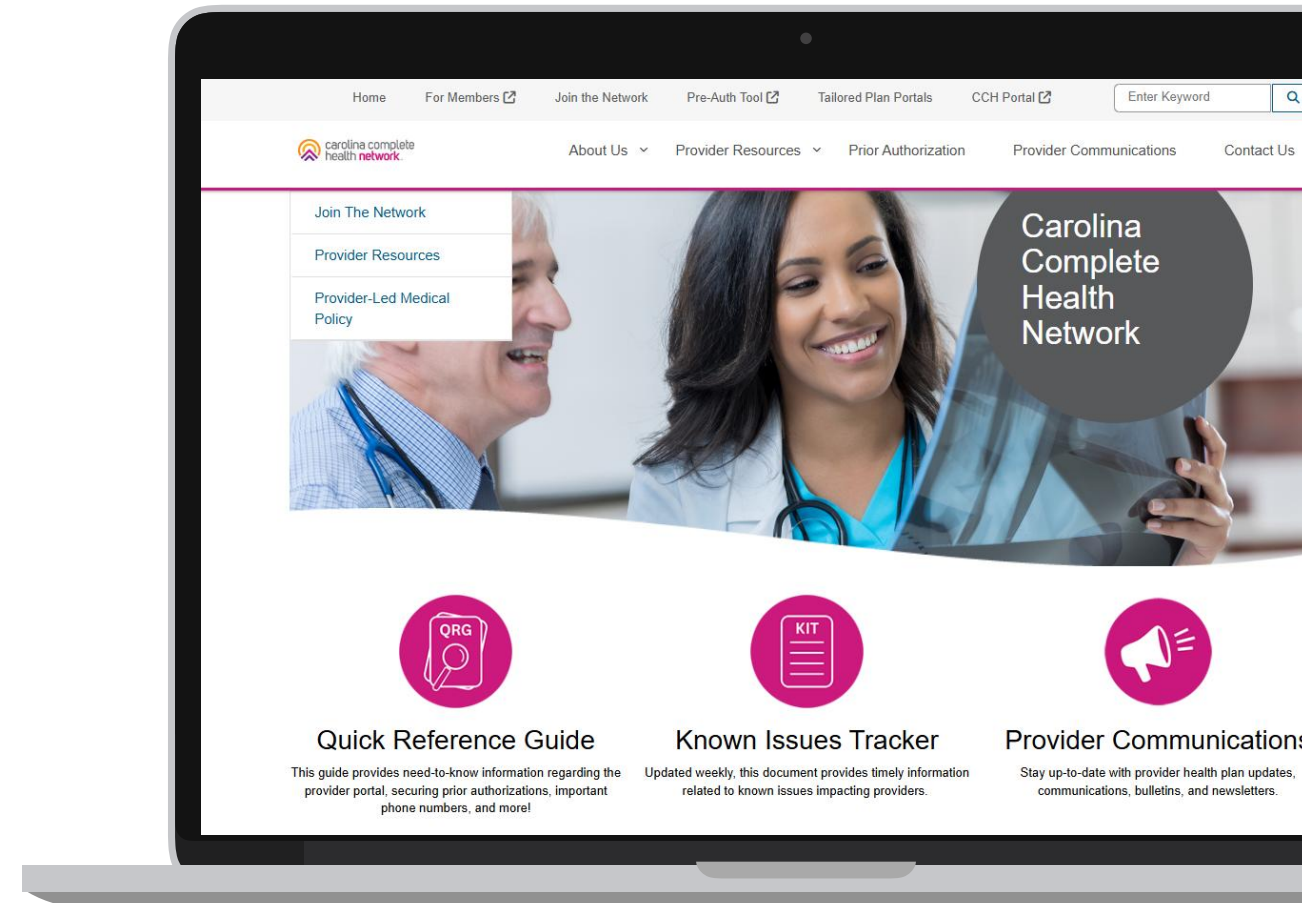
To support your success during this transition, we will update this page on a regular basis with important resources, tools, and guidance tailored to providers.

Thank you for your continued dedication to our members and to the future of care in North Carolina.


A Commitment to Provider-Led Managed Care

The statewide PLE will continue to be governed by North Carolina physicians. The role and charter of the Medical Affairs Committee will remain intact. We are committed to continuing to listen to our providers and incorporating your thoughts into our policies that will ultimately serve the patients you treat every day. The combined health plan will also remain partially owned by the NC Medical Society, the NC Community Health Center Association, and Federally Qualified Health Centers.

[Merger Frequently Asked Questions](#)




Home [For Members](#) [Join the Network](#) [Pre-Auth Tool](#) [Tailored Plan Portals](#) [CCH Portal](#)

 About Us [Provider Resources](#) [Prior Authorization](#) [Provider Communications](#) [Contact Us](#)


Carolina Complete Health Network

- [Join The Network](#)
- [Provider Resources](#)
- [Provider-Led Medical Policy](#)




Quick Reference Guide

This guide provides need-to-know information regarding the provider portal, securing prior authorizations, important phone numbers, and more!



Known Issues Tracker

Updated weekly, this document provides timely information related to known issues impacting providers.



Provider Communications

Stay up-to-date with provider health plan updates, communications, bulletins, and newsletters.

Carolina Complete Health Provider Website Overview

Home Page:

- Provider Communications
- Known Issue Tracker
- Quick Reference Guides
- Provider Announcements
- Pre-Auth Tool

Portal Links:

- Carolina Complete Health Portal
- WellCare Portal
- Tailored Plan Provider Portals

Provider Resources:

- Manuals, Forms, and Guides
- Education & Training
- Claims, Billing, & Payment
- Clinical Policies
- Behavioral Health
- Home Health & Personal Care Services
- Health Equity
- Quality Improvement
- And more...

Availity Essentials

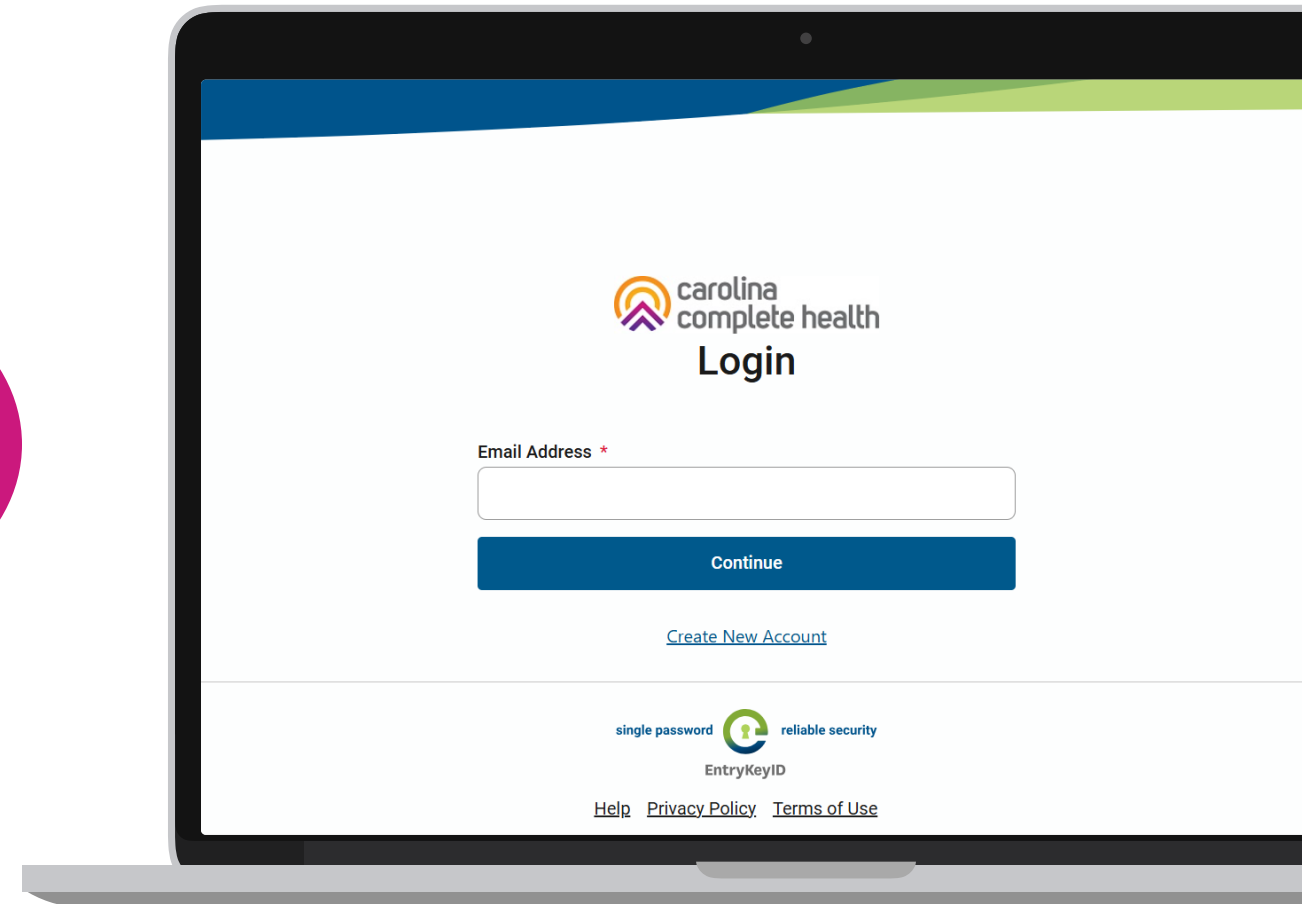
- Providers can continue using Availity Essentials: [Register and Get Started with Availity Essentials](#)
- **Chat features will be available in Availity Essentials**
- Providers Can:
 - Verify Member's Eligibility and Benefits
 - View ID Cards
 - Submit Claims
 - Check Claim Status
 - Claim Corrections
 - 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 Manager** 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](#)

wellcare™ Provider Portal

Provider Login

Username*

Password*

Login

Not registered? [Register an account](#)

[Forgot Password?](#)

[Forgot Username?](#)

Thank you for using our Provider Portal.

Do you know about our **live agent chat feature**? Live-agent chat is the easiest and fastest way to get real-time support for an array of topics, including:

- Member Eligibility
- Claims adjustments
- Authorizations
- Escalations

You can even print your chat history to reference later!

We encourage you to take advantage of this easy-to-use feature.

For support with login/password or registration requests, please click the chat icon at the bottom of your screen, and our chat team will assist you. For all other support, please log in to the secure portal for additional help.

*NOTE: The secure provider portal is for participating Wellcare/Fidelis Care providers only.

Claims and Payment

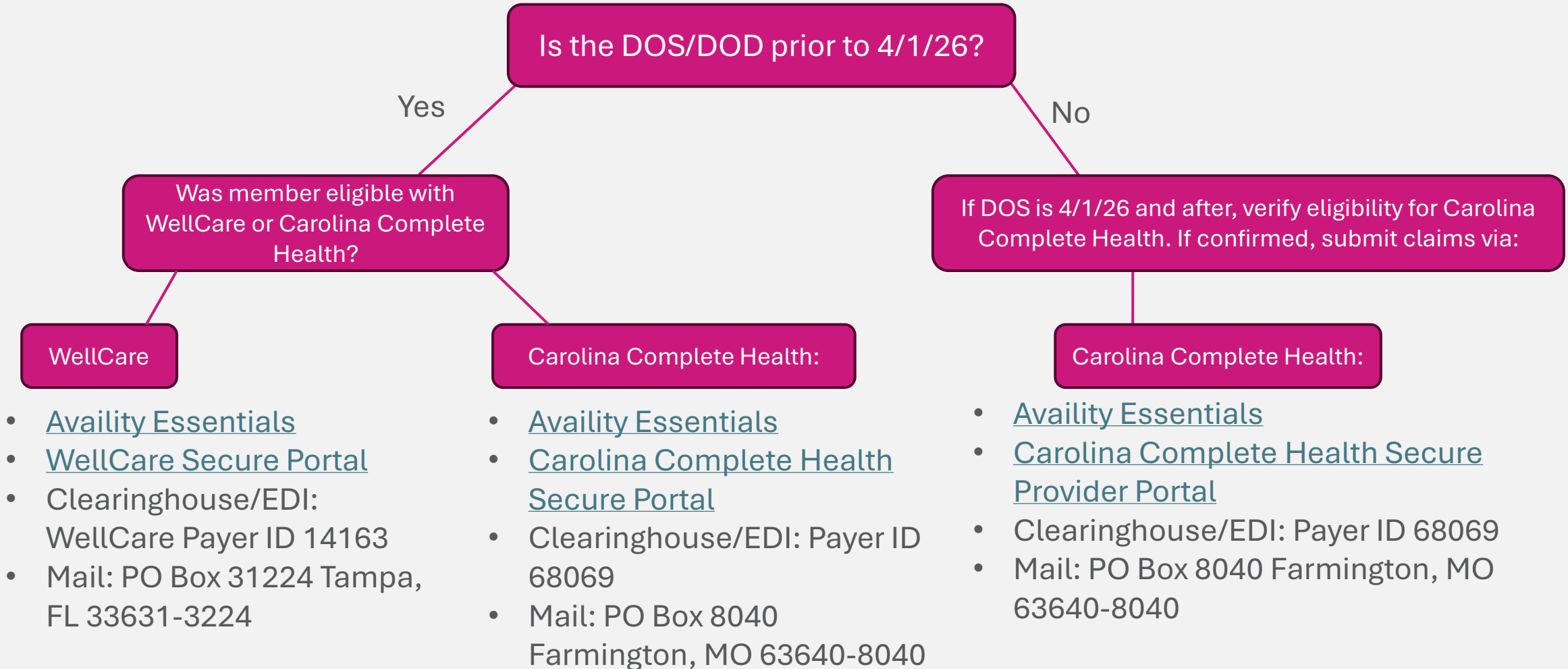


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Claims Processing

- 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:
 - [Avality 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:
 - [Avality 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



Claims Submission Reminder

- Claim Submission Reminder for Dates of Service Pre and Post 4/1/26
- For dates of service prior to 4/1/26, providers should submit Medicaid claims to former Wellcare.
- For dates of service on or after 4/1/26, submit claims to Carolina Complete Health.
- Claims submitted to the wrong entity for DOS will be rejected “**Mbr not valid on DOS.**”
- If a member’s outpatient care overlaps these two date spans, please separate the claims by DOS and submit each to the appropriate entity.
- For claims with dates of service on or after 4/1/2026, providers should submit their claims to Carolina Complete Health using one of the following methods:
 - [Availity Essentials](#)
 - [Carolina Complete Health Secure Provider Portal](#)
 - Clearinghouse/EDI: Payer ID 68069
 - Mail: PO Box 8040 Farmington, MO 63640-8040

WellCare NC Legacy Systems and Historical Claims

- Legacy systems for WellCare of NC will remain operational for **historical claim access, claim submission for DOS prior to 4/1/2026**
- Historical claim access will be supported for 2 years post 4/1/2026. Two (2) years of historical claims will be accessible via the legacy provider portal.
- For dates of service prior to 4/1/26, providers with a WellCare claim should submit via the WellCare claim submission methods within 365 days of the service.
- Claims with dates of service prior to 4/1/2026, will be subject to the existing dispute and appeals process. [Disputes and Appeals Cover Sheet](#)

Disputes:

WellCare Health Plans

Attn: Claim Payment Disputes

P.O. Box 31368

Tampa, FL 33631-3368

Appeals and Reconsiderations:

WellCare Health Plans

Attn: Appeals Department

P.O. Box 31368

Tampa, FL 33631-3368

Claim Dispute Process Effective 4/1/26

- Effective for claims with Dates of Service 4/1/26 and after, contracted providers have **90 calendar days** from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) to submit a claim dispute, unless otherwise designated by contract.
- Non-par providers have 60 calendar days from the EOP/ERA to submit a claim dispute. This was previously 365 calendar days for Carolina Complete Health.
- Claim disputes can be submitted through portal, fax, or mail:
 - Portal: provider.carolinacompletehealth.com
 - Fax: Select “Provider Claim Dispute” on the [Claim Appeal/ Disputes Form](#) and faxing the completed form to 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.
 - Mail: Select “Provider Claim Dispute” on the [Claim Appeal/ Disputes Form](#) and mail the completed form to
Carolina Complete Health
Attn: Medicaid Claim Disputes/Appeals Department
PO Box 8040
Farmington, MO 63640-8040

Claim Correction Process Effective 4/1/26

- Claim correction: when a provider needs to make a correction to the initial submission. For example, to correct invalid or incorrect information in the initial submission.
- Contracted providers have 365 calendar days from the date of service to file a timely claim correction.
- Claim corrections can be submitted through the Availity Essentials, Secure Portal, EDI, or paper claim form.

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.

Claims FAQ

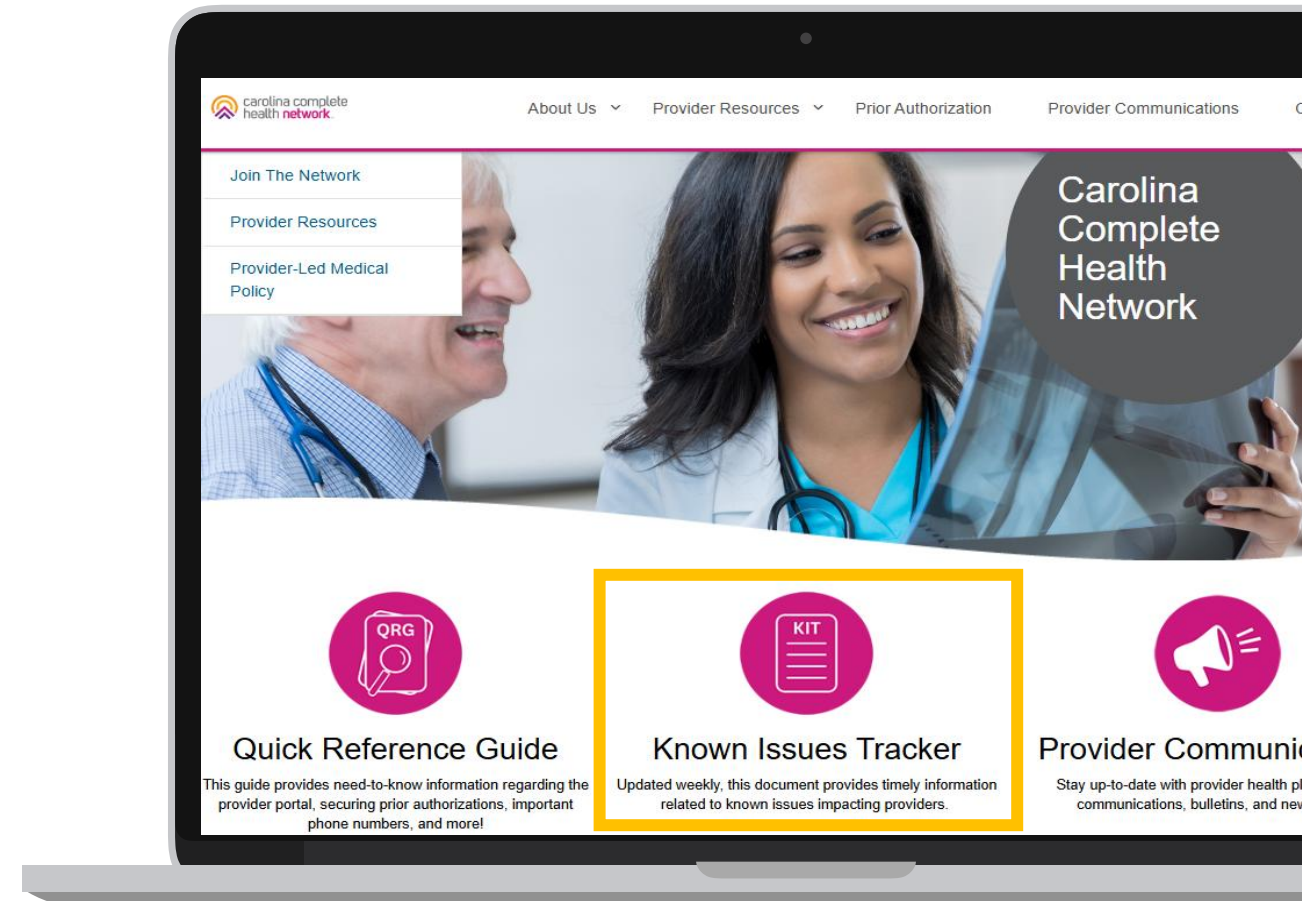
- If a patient's care spans dates of service pre and post 4/1/2026, how should that be billing?
- *For outpatient services, if a member's care overlaps these two date spans, please separate the claims by DOS and submit each to the appropriate entity.*
- *For physical health inpatient or observation stays, claims should not be split billed. Whomever the member is effective with at the time of admission is responsible for the entire stay.*

Known Issues Tracker

- Update weekly by Friday morning
- The NC Medicaid WellCare claims issues have been added to the Carolina Complete Health KIT.
- The WellCare issues can be identified under the 'Health Plan' Column and are labelled as 'WellCare (DOS Prior 4/1)'.



Status	Health Plan	Date Issue Identified
Open	WellCare (DOS Prior 4/1)	2/10/2026



PCS and HHCS Billing Basics

Personal Care Services

- EVV Required:
 - In-Home PCS services (taxonomy 253Z00000X, HA or HB modifier)
 - Claims must be submitted through HHAeXchange.
 - Claims submitted via any other source will be denied for EVV.
- Non-EVV:
 - Other PCS services (i.e Congregate Care settings) can be billed through the CCH Secure Provider Portal.
 - Claims can be submitted through the portal or Availity Essentials

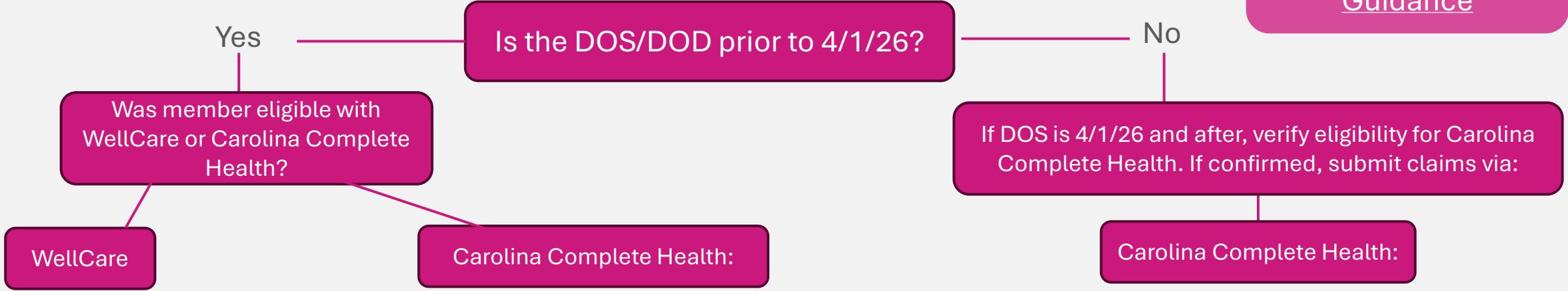
Home Health Services

- Home Health Care Services may be billed directly to the health plan or submitted via EVV.
- For dates of service 4/1/26 and after, if billing directly:
 - [Availity Essentials](#)
 - [Carolina Complete Health Secure Portal](#)
 - Clearinghouse/EDI: Payer ID 68069
 - Mail: PO Box 840 Farmington, MO 63640-8040
- EVV visit data is required for HHCS and must be submitted

[View Provider Guide for Merger Billing Guidance](#)

EVV Claim Submission Decision Tree

[View Provider Guide for Merger Billing Guidance](#)



- The visit and claim will need to be confirmed and billed against the WellCare NC contract
- If using HHAExchange, select the member record associated with WellCare. Members previously covered by WellCare of North Carolina will show a “discharged” status in the HHAX portal under the WellCare NC record.
- If using third party EVV use HHAX Payer IDs:
 - WellCare PCS Payer ID: 23937
 - WellCare HHCS Payer ID: 57538

- The visit and claim will need to be confirmed and billed against the Carolina Complete Health contract with the Carolina Complete Health member record.
- If using third party EVV use HHAX Payer IDs:
 - Carolina Complete Health PCS Payer ID: 24075
 - Carolina Complete Health HHCS Payer ID: 57535

- For PCS subject to EVV billing:
 - Submit via HHAExchange with the Carolina Complete Health member record
 - Or if using third party EVV, submit to Carolina Complete Health PCS Payer ID 24075
- For PCS in congregate care settings:
 - Submit per diem claims directly to Carolina Complete Health For Home Health Care Services
 - Submit via HHAExchange with Carolina Complete Health member record or
 - If using third party EVV, submit with HHX Payer ID 57535 for Carolina Complete Health HHCS or
 - Submit claim to Carolina Complete Health directly

Population Health and Clinical Operations



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Prior Authorizations (PA)

Transition of Care:

- Existing WellCare Prior Authorizations: Authorizations entered and approved before 4/1/2026 were 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.

For Services 4/1/26 and 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).

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 are posted online: <https://network.carolinacompletehealth.com/clinicalpolicy>

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.



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	14. APPR.	15. Denied	16. 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				


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- 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

Prior Authorization Check

Enter Service Code *

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

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](#), [Avality Essentials](#), phone or fax. Please use the Pre-Auth Tool to check on a specific service or procedure.

Required documentation includes:

- Signed MD Order within the last 6 months
- Evaluation/progress notes from the past 3 months Plan of Care
- For continuations: new order (if previous is signed & dated longer than 6 months ago) and an updated plan of care stating frequency and duration of therapy.
- [PT/OT/ST FAQ](#)

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 5/1/26
Sleep Diagnostics	None	EviCore	None. Submit directly to health plan.
Genetic Testing	None	EviCore	EviCore effective 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

Prior Auth FAQ: Outpatient Behavioral Health

- Carolina Complete Health allows 24 unmanaged visits for BH outpatient psychotherapy for any combination of the following codes: 90832, 90834, 90837, 90846, 90847, 90849, and 90853
- Units will NOT reset to zero on 04/01/2026
- All visits will reset on July 1, 2026 and every July 1 thereafter.
- For more information view our [FAQ on Behavioral Health and ABA](#)
- Also view: [BH Auth Guidelines Document](#)

Requesting Initial PCS

- To request an independent assessment for a member, the MD caring for the member should complete [Carolina Complete Health's 3051 Form](#). The completed form should be submitted via fax to 1-833-706-0238:
 - *The form must have the referring practitioner's signature. Signature stamps are not acceptable. The signature must be handwritten to be acceptable.*
- The member's medical provider should re-submit the 3051 form on an annual basis and as needed for a change in medical/functional condition which often occurs during a hospitalization or changes in support.
 - *All new referrals and medical change of status requests will require the referring entity to provide both the medical diagnosis description and diagnosis codes.*
- PCS Providers do not need to request re-authorization of PCS services. This is supported by LTSS Care Managers and the Utilization Management team directly.
 - *Medical Providers may receive a request to submit an updated 3051. Please respond promptly if requested to continue services.*
- For more information, view our PCS, Home Health, EVV training from March 24: [Slides \(PDF\)](#), [Recording](#)

Centene Vision Services

- All vision services are submitted to **Centene Vision**
- Eye Health Manager (available 24/7) centenevision.com/logon
 - Verify member eligibility and benefits
 - File claims and review claim status
 - Use audit tools
 - Download, research, and reprint EOPs
- Nash Optical Plant continues to fabricate Medicaid eyeglasses, therefore continue obtaining PA through NCTracks for eyeglasses.
- After the glasses are dispensed to the member, submit the claim for dispensing fee to CNC Vision.
- [Program Specific Clinical Coverage Policies](#)
- Medical eye services are submitted to Carolina Complete Health

7.2 Provision of Service

Optical providers shall extend the services of routine eye exams and visual aid fitting and dispensing for a Medicaid beneficiary if these same services are extended to a private patient in the same practice or business.

- a. If both routine eye exams and visual aids are not available in the provider's office for all patients, the provider shall inform the beneficiary prior to services being offered or scheduled. The beneficiary shall be given the option to select a provider who will provide both services.
- b. If the beneficiary elects to have the exam, a written prescription for the lenses must be given or offered to the beneficiary at the time of the exam. The prescribing provider shall not withhold the prescription pending payment for the routine eye exam or previously unpaid Medicaid or private bills.

Chiropractic Care


- Chiropractic Care continues to be a covered Medicaid benefit. [Chiropractors should follow all guidelines as outlined in policy 1F Chiropractic Services](#)
- Providers should always use the [Prior Authorization Lookup Tool](#) to confirm whether a prior authorization is required before rendering services.
- For chiropractic services, prior authorization is required only for non-participating providers for the following CPT codes: 98940, 98941, 98942, & 98943. Participating providers do not require prior authorization for these codes.
- Authorizations should be submitted via the Carolina Complete Health Secure Provider Portal, Availity Essentials, by phone or via fax.

Prior Authorization Check

Enter Service Code *

Q 98940

Check Prior Authorization Requirement

 **Code: 98940 - CHIROPRACTIC MANIP TX; SPINAL 1-2 REGIONS**
Pre-authorization required for non-participating providers only.

Conditional

To submit a prior authorization [Login Here](#)

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](tel:1-833-552-3876)
- Provider Engagement: View the regional contact list [here](#) or contact directly at: providerengagement@cch-network.com
- Provider Relations: NetworkRelations@cch-network.com
- Historical claim issues for DOS prior to 4/1 can be sent to: NCProviderRelations@Wellcare.com

Upcoming Sessions



Provider Info Sessions

(All sessions begin at 12PM)

- ~~February 19: [Slides \(PDF\)](#), [Recording](#)~~
- ~~March 5th: BH/DME/PT/OT/ST
[Slides \(PDF\)](#), [Recording](#)~~
- ~~March 19: [Slides \(PDF\)](#)~~
- ~~March 24th: EVV/PCS/HH: [Slides \(PDF\)](#), [Recording](#)~~
- ~~April 16th~~
- Nest sessions: April 30th and May 14th
[Register Here](#)



Carolina Complete Health Secure Portal Training

(All sessions begin at 12PM)

- ~~February 26
[View slides \(PDF\)](#), [Recording](#)~~
- ~~March 12~~
- ~~March 26~~
- ~~April 9~~
- April 23
- [Register Here](#)

Carolina Complete Health Quality Connection

- Formerly known as “Wednesdays with WellCare”
- This ongoing provider education series features new, timely, and informative topics each week. We invite subject matter experts to present and share information tailored to providers’ needs.
- This series is held **every Wednesday from 2:00 to 2:30 pm.**
- [Join Meeting](#)

Tuesdays at Two

- Carolina Complete Health is excited to continue the "Tuesdays at Two," a Continuity of Care Plus (CoC+) Information Session.
- Please join us each week to learn more about what's new for 2026 and how you can use the CoC+ program to support quality continuity of care for our members.
- This is held every Tuesday from 2-3 PM.
- [Join Meeting](#)

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!

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Appendix

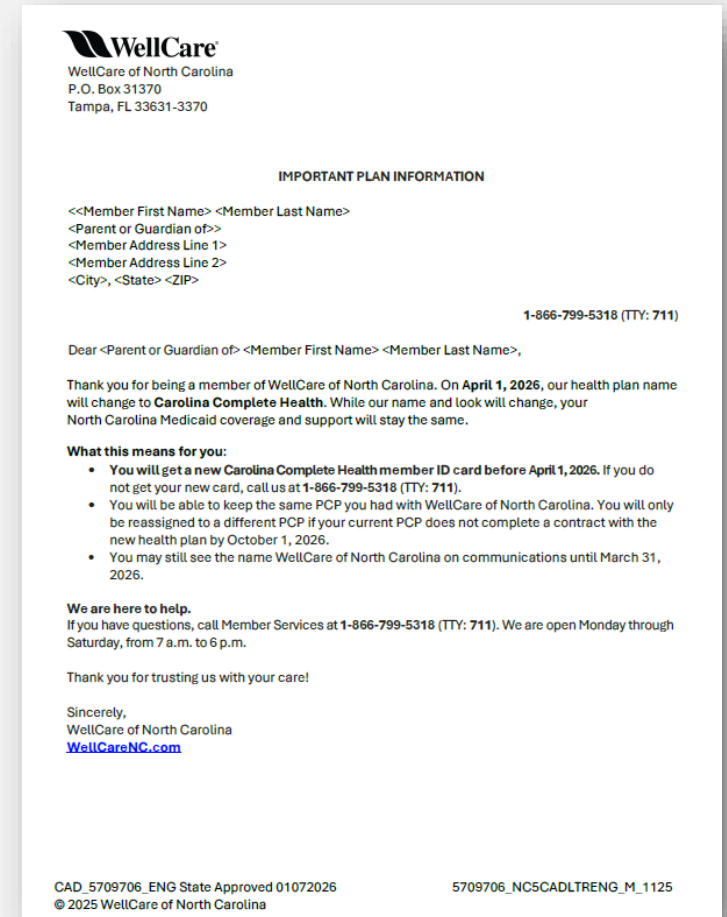


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Member Communications and Impact

- 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 were 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**.



Non-Emergency Medical Transportation

Beginning April 1, 2026, Carolina Complete Health will use Medical Transportation Management (MTM) as our transportation provider. (Please note: this is a vendor change for Carolina Complete Health members)

- Members may arrange transportation up to **30 days ahead**, with a minimum of **48 business hours' notice**.
- Urgent trips can be requested less than two business days.
- MTM reservation hours are Monday through Saturday, 7 a.m. to 6 p.m. EST. MTM is closed Sundays and national holidays (New Year's Day, Memorial Day, 4th of July, Labor Day). Scheduled trips are subject to member eligibility.



New Reservation Number:

MTM Member Reservation Number: 1-844-784-8931 (TTY: 711)

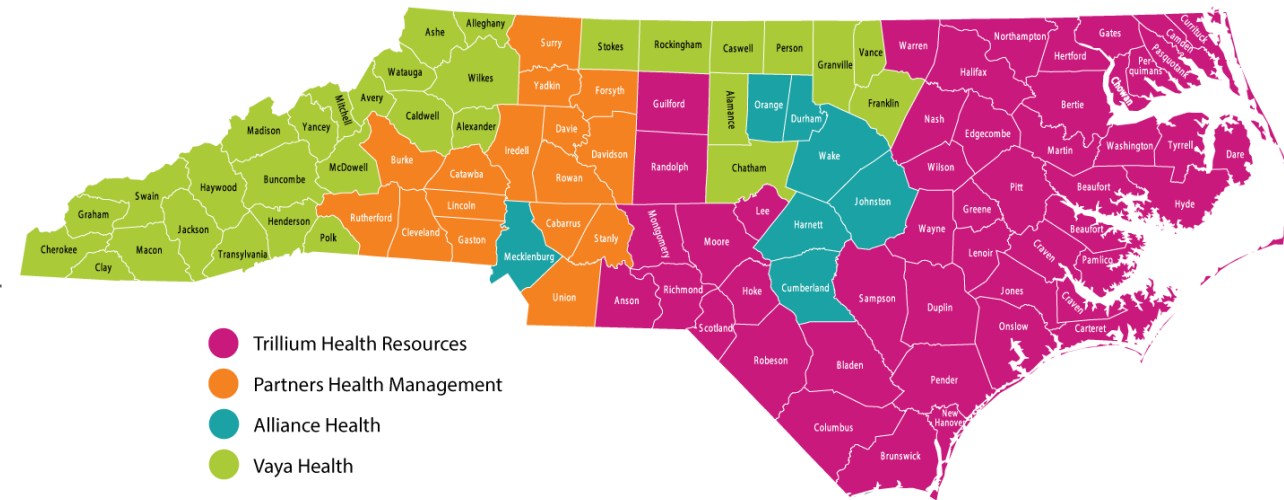
Value-Added Services

- In this merger, WellCare of North Carolina and Carolina Complete Health combined its value-added services (VAS)
- VAS details can be found at carolinacompletehealth.com/vas.

- \$75 My Health Pays Visa® Rewards Card
- \$150 Annual Household Food Allowance
- Active & Fit Gym Membership (Aged 18+)
- Doula and Breastfeeding Support Including Breast Pump
- \$150 New Parent's Package (Choice of car seat, portable crib, or stroller)
- 12 Hours of Tutoring for Members (Pre-K-12)
- \$50 Backpack with School Supplies (K-12)
- GED Prep and Exam Voucher
- \$175 Youth Program Voucher (Age 4-18)
- Up to \$150 Room to Breathe Asthma Supplies
- \$250 Housing/Utilities Allowance (per household)
- \$120 CVS® Over the Counter Allowance
- \$125 Vision Allowance for Members (Aged 21+)
- Weight Watchers Program (Aged 18+)
- Mental Health App through Teladoc
- Hearing Aids as an Extra Benefit (Aged 21+)
- \$175 Annual Expungement Certification Fee
- Transportation to VAS Service Locations
- \$100 on a Rewards Card for two (2) Tribal Talking Circles
- Cell Phone with Free Talk & Text
- Baby Bottles at Welcome Rooms
- Community Baby Showers for New or Expecting Parents
- Sensory and Alzheimer's/Dementia Kits
- Post-Hospitalization Home Delivered Meals

Tailored Plans

- Beginning April 1, 2026, Carolina Complete Health will be serving **all four Tailored Plans**: Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Health.
- Tailored Plans cover the same physical health services as Standard Plans plus specialized services for individuals with significant behavioral health conditions, intellectual/developmental disabilities (I/DDs), and traumatic brain injury (TBI), including Innovations and TBI waiver enrollees.
- Alliance and Vaya will continue managing their own provider networks. Carolina Complete Health will continue contracting for physical health providers for Trillium and Partners.
- For Alliance and Vaya, Carolina Complete Health will provide Nurse Advice Line services.
- For Trillium and Partners, Carolina Complete Health will continue to process physical health claims*, provide utilization management functions, serve in a secondary care management role for some members, provide Nurse Advice Line services, and some of the other same services and supports that have historically been provided.
*Trillium intends to pay its own physical health claims as early as 7/1/2026.



Portal Access for Third-Party Billers

Third-party billing entities supporting Carolina Complete Health providers should be granted access to the Secure Provider Portal by the practice's Portal Account Manager.

Access Steps:

1. Portal Account Manager sends an invitation to the third-party billers email address.
2. The biller receives an email link to the Carolina Complete Health Secure Provider Portal
3. The biller completes the account set-up by:
 - Creating an account
 - Verifying their email address
 - Entering the TIN, phone number and fax number (enter "0" if not available).
4. The biller contacts the Portal Account Manager to request account verification.
5. Once verified the biller can log in and submit claims and view claims.

For additional information please contact ProviderEngagement@cch-network.com and review the [Third-Party Biller Provider Portal Set-up \(PDF\)](#)

Registering for Payspan

To register for Payspan for the first time, you will need a registration code to get started. To begin registering, enter your PIN, TIN or EIN, and NPI. You can obtain your registration code in 1 of 3 ways:

1. Call 1-877-331-7154 to get your unique registration code (Monday thru Friday 8:00am to 8:00pm EST)
2. Send an email to Payspan at providersupport@payspanhealth.com and request a registration code. Be sure to include your Tax ID# (TIN), Health Plan name, and your contact information in your email.
3. Request a registration code on the [Payspan Health](#) website.

Once you have your registration code, you will visit the [Payspan Health](#) website, Click Start Registration and enter the requested information. Once complete, click Confirm.

Within a few business days, you will receive a deposit of less than \$1 from Payspan Health. Follow these steps to complete registration:

1. Log in to Payspan Health and click Payments.
2. Click the Account Verification link to the left side of the screen.
3. Enter the amount of deposit in this format: \$X.XX.

Quality Program



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Quality

Our commitment to quality outcomes and patient safety remains unchanged throughout the merger transition.

Quality Performance

- No disruption to care delivery: Continue current workflows, documentation, and evidence-based programs.
- Quality priorities and incentive measures are aligned with the Department's priorities for the combined entity.
- Providers will continue to have a single point of contact that manages relations and assigned Quality contact.

Care Gaps and Preventive Care

- Address open care gaps (e.g., screenings, immunizations, chronic conditions) without interruption. Members will continue to receive outreach and reminders from health plan.
- Carolina Complete Health's current incentive model will continue for the merged entity. Measures, targets for each year will be distributed through the Provider Engagement teams.

Data, Analytics & Reporting

- Quality and performance data remain accessible via provider portal and packets sent prior to meeting.
- Data validation and reconciliation underway for merged entity membership; analytics will continue to include actionable insights.
- Advance notice for any changes affecting reports or workflows.
- Supplemental Data set up process will remain the same and any adjustment will be communicated with impacted Practices.

Pay-for-Performance Program

Measures, Targets, Weights, & Incentives:

MY 2026 Pay for Performance Models for Practices with Pediatric and Mixed-age members

	Mixed Age Model			Pediatric Model		
	Target 1 50%	Target 2 100%	Weight	Target 1 50%	Target 2 100%	Weight
Adult Access To Preventive Visit (AAP)	65.02%	78.05%	6.00%	60.98%	78.05%	10.00%
Cervical Cancer Screening (CCS-E) - <i>Withhold</i>	49.83%	52.32%	8.75%			
Child & Adolescent Well-Care Visits (WCV) - - <i>Withhold</i>	57.72%	67.63%	8.75%	57.72%	67.63%	12.50%
Colorectal Cancer Screening (COL-E)	33.79%	41.39%	6.00%			
Chlamydia Screening in Women (CHL)	64.53%	70.67%	6.00%	62.73%	70.67%	10.00%
Glycemic Status Assessment for Patients With Diabetes <8.0% (GSD)	25.75%	60.58%	6.00%			
Controlling High Blood Pressure (CBP)	44.41%	67.88%	6.00%			
Immunizations for Adolescents (IMA Combo 2) - <i>Overall Rate - Withhold</i>	33.48%	36.48%	8.75%	33.48%	36.48%	12.50%
Immunizations for Adolescents (IMA Combo 2) - <i>Priority Pop.- Withhold</i>	30.48%	33.82%	8.75%	30.48%	33.82%	12.50%
Well Child Visits: 15-30 Months (W30) - <i>Overall Rate</i>				71.70%	82.12%	8.75%
Well Child Visits: 15-30 Months (W30) - <i>Priority Pop.- Withhold</i>	69.45%	76.29%	8.75%	69.45%	76.29%	12.50%
Well Child Visits: 0-15 Months (W30) - <i>Overall Rate</i>				70.81%	71.71%	8.75%
Well Child Visits: 0-15 Months (W30) - <i>Priority Pop.- Withhold</i>	65.33%	68.12%	8.75%	65.33%	68.12%	12.50%
Postpartum Care (PPC) - <i>Withhold</i>	74.07%	82.48%	8.75%			
Timeliness of Prenatal Care (PPC) - <i>Withhold</i>	64.13%	86.37%	8.75%			

**These measures and targets are for our standard incentive model available to our contracted Providers. These may vary for those participating in value-based arrangement. Refer to your specific agreement terms for more information.*

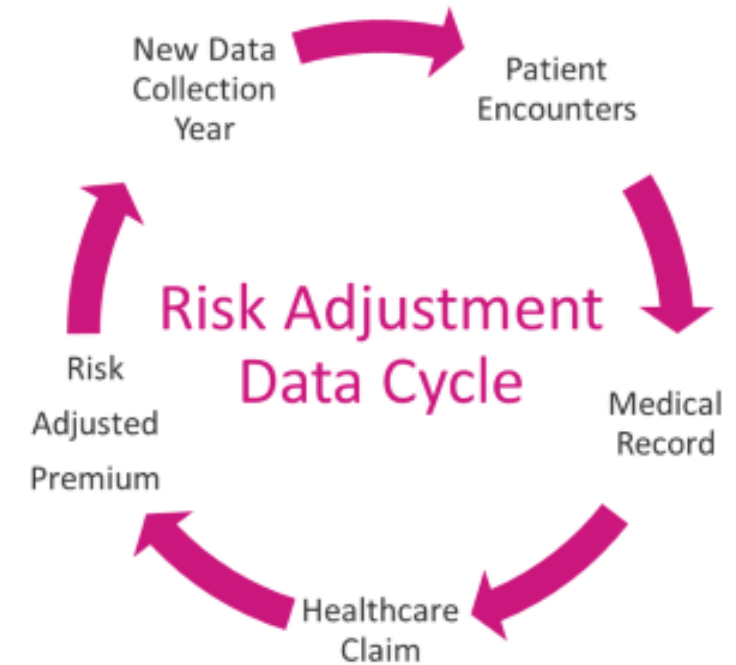
Continuity of Care Program



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Continuity of Care Program

- **Single Platform Post-Merger:** Carolina Complete Health and WellCare Medicaid members will be combined onto one platform.
- **CoC Program Rollout:** CoC will launch first for Carolina Complete Health Medicaid members, with future waves including WellCare Medicaid members.
- **Medicare Unchanged:** WellCare Medicare agendas will remain on the existing system used in prior years.
- **Provider Access & Submission:** Providers will continue to access CoC agendas through the Carolina Complete Health secure provider portal, with paper and fax submission options still available.
- [Risk Adjustment Provider Resources](#)



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+ <ul style="list-style-type: none"> • S9484 (1 unit = 1 hour) 	No authorization needed for first 7 calendar days (168 units) <ul style="list-style-type: none"> • Facility to notify health plan of admission within 72 hours 	As medically necessary
Facility Based Crisis Service for Children and Adolescents (Ages 6-17) <ul style="list-style-type: none"> • S9484 HA (1 unit = 1 hour) 	No authorization needed for first 72 hours (72 units) <ul style="list-style-type: none"> • Facility to notify health plan of admission within 72 hours 	

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
Partial Hospitalization <ul style="list-style-type: none"> H0035 (1 unit = 1 day) 	Up to 7 days <ul style="list-style-type: none"> This code should be used only for primary Mental Health conditions (not Substance Use Disorders) 	As medically necessary
Substance Abuse Intensive Outpatient Program (SAIOP) <ul style="list-style-type: none"> H0015 (1 unit = 1 day) 	No authorization required for the first 30 calendar days of treatment per member per State FY <ul style="list-style-type: none"> Subsequent authorizations up to 30 days 	
Substance Abuse Comprehensive Outpatient Treatment (SACOT) <ul style="list-style-type: none"> H2035 (1 unit = 1 hour) 	No authorization required for the first 30 calendar days of treatment per member per State FY <ul style="list-style-type: none"> Subsequent authorizations up to 30 days 	

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
<p>Mental Health Intensive Outpatient Program (In-Lieu of Service)</p> <ul style="list-style-type: none"> S9480 (1 unit = 1 day) 	<p>Up to 12 units (within 30 calendar days)</p> <ul style="list-style-type: none"> This code should be used only for primary Mental Health conditions (not Substance Use Disorders) 	<p>As medically necessary</p>
<p>Outpatient Behavioral Health Services: Psychotherapy</p> <ul style="list-style-type: none"> 90832, 90834, 90837, 90846, 90847, 90849, and 90853 	<p>No authorization needed for first 24 (unmanaged) units per member per State FY</p> <ul style="list-style-type: none"> 24 visits is any combination of codes 	<p>As medically necessary</p> <ul style="list-style-type: none"> Authorization requests can be for up to 6 months at a time

Outpatient Behavioral Health Services

Service & Code(s)	Initial Authorization	Continued Stay Authorization
<p>Psychological & Neurological Testing</p> <ul style="list-style-type: none"> 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96139, and 96146. 	<p>No authorization needed for first 16 units per member per State FY</p>	<p>As medically necessary</p>
<p>Research-Based Behavioral health Treatment (RB-BHT) For Autism Spectrum Disorder</p> <ul style="list-style-type: none"> 97151 – 97157 	<p>Authorization based on medical necessity, up to 6 months</p> <ul style="list-style-type: none"> 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 	<p>As medically necessary</p> <ul style="list-style-type: none"> 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)

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 (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

Electronic Visit Verification



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- Carolina Complete Health partners with HHAEExchange as the EVV Vendor.
- **Important Note:** HHAEExchange will link existing WellCare of NC connected agencies to the Carolina Complete Health Secure Provider Portal as part of the transition. A system review has been completed to identify providers who are new to Carolina Complete Health and most links will be established automatically before go-live.
- If you are not yet connected:
 - **Option 1** – Agencies currently without an EVV Solution: use the free EVV tools provided by HHAEExchange & Carolina Complete Health
 - **Option 2** – Agencies currently using another 3rd Party EVV Solution: you must integrate your existing EVV with HHAEExchange – HHA will route visit data to Carolina Complete Health
- The [HHAEExchange Provider Info Center](#) outlines necessary requirements to set up access to the HHAEExchange system. Complete [Provider Enrollment Form](#)
 - [North Carolina PHP Provider Information Center | HHAEExchange](#)
 - [North Carolina PHP HHAEExchange Provider Enrollment Form](#)

HHAEExchange Knowledge Base

Search for Key Words

Your search for "Diagnoses Codes" returned 28 result(s).

Billing Diagnosis Codes

There are two **Diagnosis Codes** categories: **Billing Dx Codes** and **Clinical Dx Codes**. **Billing Dx Codes** must be entered into the HHAEExchange system prior to generating an invoice. The system assigns a **Billing Dx Code** at the time of Invoice generation. The **Billing Dx Code** can be set in the sections ...

[Documentation/Billing/Bill-C-Diagnosis-Codes-S.htm](#)

How do I update a Billing Dx (diagnosis) Code for an internal member?

Billing Dx Codes must be available in the system when you generate an invoice so the system can assign a **Billing Dx Code** to the invoice based on the code's priority for the Agency and for the Member (Patient). If a generated invoice doesn't have a **Billing Dx Code**, or if the **Billing Dx Code** is ...

[Documentation/Patient/FAQ-Pat-C-Update-Bill-Dx-Code-Internal-S.htm](#)

Provider-Managed Billing Diagnosis Codes

This feature is activated by HHAEExchange System Administration. Contact HHAEExchange Support Team for details, setup, and guidance. **Billing Diagnosis Codes** are determined by the Payer and sent in the Authorization at the time of placement.

Providers servicing Linked Contracts receive Billing ...

[Documentation/Patient/Pat-C-Provider-Billing-Diagnosis-P.htm](#)

Auto-Placement by Service Code

This feature is enabled and managed by Payers (MCOs) and available to Members of a participating Payer network. To determine eligibility, the Member's Medicaid ID and/or the First Name, Last Name, and DOB must match the Payer system.

Contract Service Code – Allow Auto Placement The Auto-Placement by ...

[Documentation/Patient/Pat-B-Auto-Placement-Service-Code-S.htm](#)

How do I set billing DX codes?

Navigate Topics on Left-side Menu



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Billing

Refresh your skills and knowledge of HHAEExchange in the training videos and interactive demonstrations below:

Note: Some features may not be available in your portal. Features depend on role, permissions, and portal type.

Billing

Watch the Billing videos to learn more about the Billing process and how to correct claims after invoices are processed.

Learn to

- Generate paper invoices
- Process an invoice batch
- Search, review and delete invoices
- Perform changes in claims after processing invoices

Billing Review

10 min.

Generating Paper Invoices

9 min.

Process Invoice

10 min.

Search Review and

Claims & Payment



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Provider Managed Diagnosis Codes

- WellCare and Carolina Complete are both configured for provider managed diagnosis codes.
- Providers are responsible for adding and maintaining the member diagnosis codes directly within HHAeXchange
- For providers utilizing EDI, diagnosis codes must be included on the file sent by your 3rd party EVV vendor
- For step-by-step guidance, please refer to the HHAeXchange Knowledge Base <https://knowledge.hhaexchange.com/enterprise/Content/Documentation/Patient/Patient-N-Provider-Billing-Diagnosis-P.htm> External Link

Rate Management

- Current WellCare and Carolina Complete Health providers can manage their own rates in HHAx. There are not any default rates set, **providers must go into HHAx and set up rates prior to billing for the first time and anytime the fee schedule changes.**
- **Action required:** Any CCH-linked provider must set their rates. If you are NEW to being linked with Carolina Complete Health, then you need to do this prior to billing.
- EDI providers whose vendors *send rates on the visit file* do not need to take action.
- HHAx Knowledge Base: [How do I manage my contract rates?](#)

Billing Basics

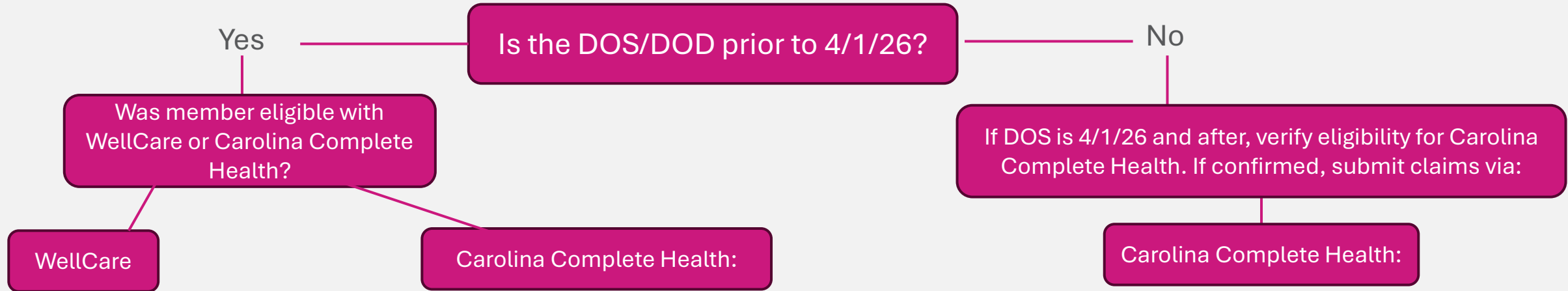
Personal Care Services

- EVV Required:
 - In-Home PCS services (taxonomy 253Z00000X, HA or HB modifier)
 - Claims must be submitted through HHAeXchange.
 - Claims submitted via any other source will be denied for EVV.
- Non-EVV:
 - Other PCS services (i.e Congregate Care settings) can be billed through the CCH Secure Provider Portal.
 - Claims can be submitted through the portal or Availity Essentials

Home Health Services

- Home Health Care Services may be billed directly to the health plan or submitted via EVV.
- For dates of service 4/1/26 and after, if billing directly:
 - [Availity Essentials](#)
 - [Carolina Complete Health Secure Portal](#)
 - Clearinghouse/EDI: Payer ID 68069
 - Mail: PO Box 8040 Farmington, MO 63640-8040
- **EVV visit data is required for HHCS and must be submitted**

EVV Claim Submission Decision Tree



- The visit and claim will need to be confirmed and billed against the WellCare NC contract
- If using HHAeXchange, select the member record associated with WellCare. Members previously covered by WellCare of North Carolina will show a “discharged” status in the HHAX portal under the WellCare NC record.
- If using third party EVV use HHAX Payer IDs:
 - WellCare PCS Payer ID: 23937
 - WellCare HHCS Payer ID: 57538

- The visit and claim will need to be confirmed and billed against the Carolina Complete Health contract with the Carolina Complete Health member record.
- If using third party EVV use HHAX Payer IDs:
 - Carolina Complete Health PCS Payer ID: 24075
 - Carolina Complete Health HHCS Payer ID: 57535

- For PCS subject to EVV billing:
 - Submit via HHAeXchange with the Carolina Complete Health member record
 - Or if using third party EVV, submit to Carolina Complete Health PCS Payer ID 24075
- For PCS in congregate care settings:
 - Submit per diem claims directly to Carolina Complete Health For Home Health Care Services
 - Submit via HHAeXchange with Carolina Complete Health member record or
 - If using third party EVV, submit with HHX Payer ID 57535 for Carolina Complete Health HHCS or
 - Submit claim to Carolina Complete Health directly

Claim Denials for Lacking EVV

Claims will DENY if they do not have matching EVV visit data.

To ensure your claims are not denied for EVV (EXev), you must :

- Submit billing through HHAX for Carolina Complete Health
- Or for Home Health Care Services, direct bill to CCH **AND** ensure your EVV visit data is successfully imported by HHAX prior to sending your claim to CCH. The CPT/HCPCS + Rev on HHAX visit and claim must match.
 - When the claim is billed directly to Carolina Complete Health without EVV data, it is placed on a 14-day hold to allow time for the EVV visit to be submitted via HHAExchange and matched with claims data received. If an EVV match is not found within the 14-day hold period, the claim will then be denied "EXev" unless otherwise denied immediately for a reason unrelated to EVV.

Billing Guidance

- Correcting claims denied for EVV (EXev)
 - If denied due to no EVV visit data in HHAX
 1. First submit data to HHAX and ensure it successfully imports
 2. Then submit a corrected claim to Carolina Complete Health
 - If denied due to mismatched CPT/HCPCS + Rev codes between HHAX visit data and claim
 - If HHAX data contains inaccurate procedure code, submit corrected visit data to HHAX. Then submit a corrected claim to Carolina Complete Health..
 - If claim contains inaccurate procedure code, then submit a corrected claim with the updated procedure code.
- [Corrected Claims Submission Guide](#)

Providers Using 3rd Party EVV Vendors

Health Plan EDI Payer ID ≠ HHAX Payer ID

Health Plan EDI Payer ID: used when submitting claims through a clearinghouse for Carolina Complete Health. More claims & billing information on [website](#).

HHAX Payer ID: used when sending visit data to HHAX

- Should align with the member's health plan eligibility for the date of service
- You will receive a "Patient not found" rejection from HHAX if this does not match the member's health plan.

WellCare PCS Payer ID: 23937

WellCare Home Health Payer ID: 57538

Carolina Complete Health Home Health: 57535

Carolina Complete Health PCS: 24075

- [HHAX Standard Plan EDI Code Table](#)

Billing in Congregate Care Settings

- Submit one line per date of service with 1 unit per service.
 - A claim line that spans multiple dates or includes a unit greater than one will deny.
- Providers should bill their usual and customary charge. No calculations are required by providers.
- Claims submitted will hit a pend code for pricing (DF: Pend: Manual Pricing Required)
- For additional details, see the following [Provider Bulletin](#)

Personal Care Services



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Requesting Initial PCS

- To request an independent assessment for a member, the MD caring for the member should complete Carolina Complete Health's 3051 Form. The completed form should be submitted via fax to 1-833-706-0238:
 - *The form must have the referring practitioner's signature. Signature stamps are not acceptable. The signature must be handwritten to be acceptable.*
- The member's medical provider should re-submit the 3051 form on an annual basis and as needed for a change in medical/functional condition which often occurs during a hospitalization or changes in support.
 - *All new referrals and medical change of status requests will require the referring entity to provide both the medical diagnosis description and diagnosis codes.*
- PCS Providers do not need to request re-authorization of PCS services. This is supported by LTSS Care Managers and the Utilization Management team directly.
 - *Medical Providers may receive a request to submit an updated 3051. Please respond promptly if requested to continue services.*

Member Needs PCS Services



Medical Provider faxes [3051 Form](#) to 1-833-706-0238



3051 Accepted

No



Returned For Corrections

Yes



3051 Submitted To Assessor For Processing



Face to Face Visit Scheduled With Member For Assessment



UM Conducts Review of PCS Request against the [NC Medicaid State Plan PCS Clinical Coverage Policy No: 3L](#)

Not Approved



Request is denied/Partially denied



PCS Plan Developed; Member Linked to PCS Provider. PCS provider receives a fax of the approved authorization.

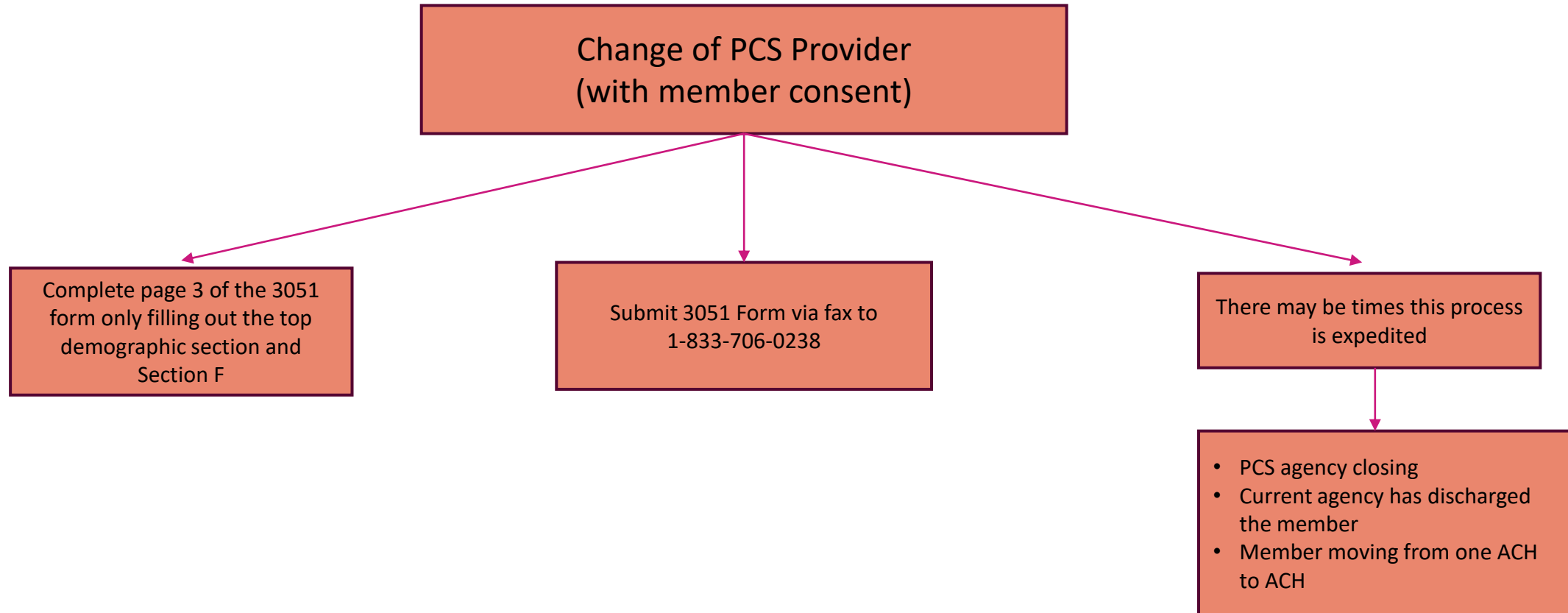
- If form is not complete (missing information, etc.) the 3051 is faxed back to the physician with an explanation of the missing information.
- Unable to Process – a request is considered “Unable to Process” when missing two or more of the identifying pieces of information

- The provider may request a P2P. Instructions will be found on the denial letter.
- If the provider wants to appeal the decision, the provider can call Carolina Complete Health
- A member can also request a State Fair Hearing



Reminder: To update your fax number, please update NCTracks

Changing PCS Providers



Requesting Additional PCS Hours

If the beneficiary is eligible for additional hours under Session Law 2013-306, the physician must complete the “optional attestation” section of the form to be considered for additional hours of PCS. Submit to via fax to Carolina Complete Health Care Management: 1-833-706-0238

1. Requires an increased level of supervision (observation resulting in an intervention) as assessed during an independent assessment conducted by NC Medicaid or a DHHS designated contractor;
2. Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills;
3. Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the beneficiary’s gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
4. Health record documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Beneficiary Name: _____ MID#: _____

Step 4 **OPTIONAL ATTESTATION: Practitioner should review the following and initial only if applicable:**

Beneficiary requires an increased level of supervision.	Initial: _____
Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary’s gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial: _____

Step 5 **SECTION C. PRACTITIONER INFORMATION**

Attesting Practitioner’s Name: _____ Practitioner NPI#: _____

Select one: Beneficiary’s Primary Care Practitioner Outpatient Specialty Practitioner Inpatient Practitioner

Practice Name: _____ NPI#: _____

Practice Contact Name: _____

Address: _____

Phone: _____ Fax: _____

Date of last visit to Practitioner: _____ ****Note: Must be < 90 days from Received Date**

Practitioner Signature AND Credentials: _____ **Date:** _____

Signature stamp not allowed

I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws.

Step 6 **SECTION D. CHANGE OF STATUS: MEDICAL** Complete for medical change of status request only.

Describe the specific medical change in condition and its impact on the beneficiary’s need for hands on assistance (Required):

Continuing PCS

- Providers do not need to request reauthorization of PCS.
- CCH LTSS Care Managers are responsible for reauthorizing personal care services through comprehensive face-to-face visits and assessments.
- Providers can access member health records, assessments and authorization status through the [Secure Provider Portal](#). For support in navigating the Secure Provider Portal, reach out to your [Provider Engagement Administrator](#).

Home Health



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Home Health Care Services

- All Home Health Care Services require a pre-authorization
- When submitting the PA, please attach the Plan of Care (POC) using the [CMS-485 Form](#)
- To reduce authorization denials and expedite review and approval, **please submit with the CMS-485 signed by the MD.**
- Clinical Policy: [Home Health Services, 3A \(PDF\)](#)

5.3.1.2 Documenting the Plan of Care

The physician shall authorize a POC by signing a completed Form CMS-485 submitted by the Home Health provider. The POC must be re-certified every 60 calendar days if the services continue to be medically necessary.

Claims Resources

- [Carolina Complete Health Electronic Claim Submission Methods](#)
- [Claims and Billing FAQ](#)
- [FQHC Billing Guidance](#)
- [Payspan Provider Guide](#)

Thank you!

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

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