



**Partners'/CCHN Tailored Plan Provider Office Hours**  
*Prenatal Programs available for Partners' Tailored Plan Members*  
**October 22, 2024**  
**12:00 PM – 12:30 PM**

# Agenda

- Hurricane Helene Policy Flexibilities
- Partners' Assistance to Providers
- Policy Flexibilities for Tailored Plan Launch
- Evolent
- Partners' Prior Auth Flexibilities
- Submitting Authorizations
- Reminders for your Members
- Partners' Pregnancy Program
- Partners' Tailored Plan Office Hours Topics
- Partners' Physical Health Communications
- Provider Support and Who to Contact
- Provider Resources
- Questions
- Additional Resources
  - How to Connect to ProviderConnect
  - Getting to ProAuth
  - Submitting Authorizations Manually
  - Authorization Notification and Determination Timeframes
  - Submitting Claims
  - Electronic Funds Transfer



# DHHS Hurricane Helene Flexibilities

## NC Medicaid Temporary Flexibilities Due to Hurricane Helene

- Provider guidance for reimbursement, enrollment and providing care for Medicaid beneficiaries

<https://medicaid.ncdhhs.gov/blog/2024/09/26/nc-medicaid-temporary-flexibilities-due-hurricane-helene>

- [Partners resource page:](#)

<https://www.partnersbhm.org/hurricane-helene/#1727901113823-bbb13dd4-b2e7>

<https://providers.partnersbhm.org/provider-alert-assistance-for-providers-experiencing-disruptions-due-to-hurricane-helene/>

- Backporch Chat – AHEC and DHHS – October 17, 2024

<https://public.3.basecamp.com/p/baX1ys45ZJXH2kgMXkNPUgZH>



# Partners' Assistance to Providers

- Partners Health Management is aware that some providers may be experiencing service disruptions due to the impact of Hurricane Helene. To assist these providers, Partners has created tools to report and track service and financial disruptions.
- Providers can notify Partners of service disruptions to members via the [Temporary Disruption to Service Delivery form](#). Financial reimbursement requests may be submitted via the [Disaster Expense Reimbursement form](#). Upon receipt of the forms, Partners will review and process them as quickly as possible.
- **What is happening?**
  - Partners has created tools to assist providers in reporting service or financial disruptions related to Hurricane Helene.
  - The [Temporary Disruption to Service Delivery form](#) allows providers to submit disruptions in services to members.
  - The [Disaster Expense Reimbursement form](#) allows providers to submit reimbursement requests for expenses incurred due to Hurricane Helene.
  - Please reach out if you are Physical Health Provider to [PHPAS@partnersbhm.org](mailto:PHPAS@partnersbhm.org)



# Policy Flexibilities for Tailored Plan Launch

- ▶ Tailored Plan goes live July 1, 2024. Below are policy flexibilities to help ease Member confusion and administrative burdens for providers.
- ▶ These Flexibilities have been extended, please see each item listed in the table detailed below.
- ▶ Additional information is available on Partners' Provider Knowledge base and linked here: [Provider Alert: Extension of Tailored Plan Launch Flexibilities - Partners Health Management - Provider Knowledge Base \(partnersbhm.org\)](https://partnersbhm.org/ProviderAlert/ExtensionofTailoredPlanLaunchFlexibilities-PartnersHealthManagement-ProviderKnowledgeBase)

Policy Flexibility	Duration	Time Frame
Relax Medical PA requirements	214 days	7/1/2024 – 1/31/2025
Relax Pharmacy PA requirements	214 days	7/1/2024 – 1/31/2025
Non-Par Providers paid at Par Rates	214 days	7/1/2024 – 1/31/2025
Non-Par Providers Follow In-Network Prior Authorization Rules	119 additional days	2/1/2025 – 5/31/2025
Ability to Switch PCP	214 days	7/1/2024 – 1/31/2025
Continuity of Care for Ongoing Course of Treatment	7 months	7/1/2024 – 1/31/2025

# Partners Prior Auth Flexibilities

- To alleviate provider administrative burden during the launch of Tailored Plans, Partners will initiate a No Prior Auth period for Medical Services rendered between 7/1/2024 and 1/31/2025.
- *\*This exception **does not apply** to reviews for inpatient hospitalizations, Electroconvulsive Therapy (ECT) for Inpatient and Outpatient Children only, Personal Care Services requiring Electronic Visit Verification, and initial ICF-IID or Innovations, which should still occur during this time period. Refer to [Partners Benefit Page](#) for more information regarding prior authorization requirements*
- For additional details, please review [Partners' Provider Alert dated September 25, 2024](#).
- You can also reach out to Partners:
  - Physical Health: [PHUMQuestions@partnersbhm.org](mailto:PHUMQuestions@partnersbhm.org) 1-877-398-4145
  - Behavioral Health: [UMQuestions@partnersbhm.org](mailto:UMQuestions@partnersbhm.org) 1-877-398-4145



# State Flexibilities and Transition of Care Flexibilities

- ▶ **If a provider is not in your Tailored Plan’s network**
  - Your providers need to accept your Tailored Plan to be covered. Providers that don’t accept Tailored Plans are considered “**out-of-network.**”
- ▶ **There are rules in place to help make this move easier for you.** The goal is to avoid disrupting your care as much as possible.
  1. You may keep seeing the **Medicaid providers you see now** until January 31, 2025 – even if they’re not listed on your health plan ID card. (If you see a new provider for the first time, they must accept your Tailored Plan.)
  2. Your coverage for the **medicine** you take also stays the same until January 31, 2025.
  3. You can keep seeing the **dental** providers you see now. Your dental coverage will not change.
  4. You can change your **primary care provider (PCP)** for any reason until January 31, 2025.
- ▶ **If you would like to continue to see an out-of-network provider after January 31, 2025, talk to your Tailored Plan:**
  - **Alliance Health**, 1-800-510-9132, TTY: 711 or 1-800-735-2962
  - **Partners Health Management**, 1-888-235-4673, TTY/English: 1-800-735-2962, TTY/Spanish: 1-888-825-6570
  - **Trillium Health Resources**, 1-877-685-2415, TTY: 711
  - **Vaya Total Care**, 1-800-962-9003, TTY: 711

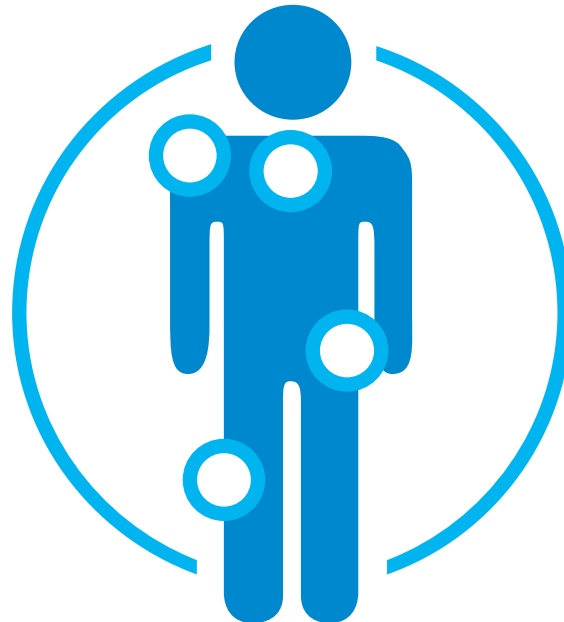
<https://providers.partnersbhm.org/wp-content/uploads/partners-physical-health-oon-provider-guidance.pdf>



# Evolut (Formerly National Imaging Associates, Inc.)

- Partners, through its partnership with Carolina Complete Health, will use Evolut (formerly National Imaging Associates, Inc.) to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services**.
- Any services rendered on and after February 1, 2025 will require authorization. Only non-emergent procedures performed in an outpatient setting require authorization with Evolut.
- Providers may submit prior authorization requests to Evolut now, however they are not required during the flexibility period.

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- MUGA Scan
- Myocardial Perfusion Imaging
- Stress Echocardiography
- Echocardiography



## Excluded from the Program Procedures Performed in the following Settings:

- Hospital Inpatient
- Observation
- Emergency Room



# Evolut (Formerly National Imaging Associates, Inc.)

Item	Key Point(s)
RadMD Access & Features	<ul style="list-style-type: none"><li>▪ <b>Prior authorization requests can be made online at: <a href="http://www1.RadMD.com">www1.RadMD.com</a></b></li><li>▪ RadMD Website – Available 24/7 (except during maintenance)</li><li>▪ Request authorization (ordering providers only) and view authorization status</li><li>▪ Upload clinical information</li><li>▪ View Evolut’s Clinical Guidelines ▪ Frequently Asked Questions ▪ Quick Reference Guides ▪ Checklist ▪ RadMD Quick Start Guide ▪ Claims/Utilization Matrices</li><li>▪ View and manage Authorization Requests with other users (Shared Access) ▪ Requests for additional Information and Determination Letters ▪ Clinical Guidelines ▪ Other Educational Documents</li></ul> <p>To sign up for RadMD Go to: <a href="http://www1.RadMD.com">www1.RadMD.com</a> Click the New User button and set up a unique username/account ID and password for each individual user in your office. NIA-Carolina Complete Health educational documents: <a href="http://www1.RadMD.com">www1.RadMD.com</a></p>


Resource: [Evolut Resource Page for Partners Providers](#)

# Reminders for your Members

- Influenza, COVID-19 and respiratory syncytial virus (RSV) are expected to increase over the coming weeks.
- Vaccinations are the best way to prevent serious illness, hospitalization and death from these infections.
- Vaccinations are especially important for those at higher risk of severe viral respiratory disease, including people 65 years and older, children younger than 5, pregnant women, those with a weakened immune system and those with certain medical conditions such as asthma, diabetes, heart disease and obesity.



# Partners Tailored Plan Member ID Cards



**Member ID Card**

Partners Tailored Plan  
901 S. New Hope Rd.  
Gastonia, NC 28092

[www.partnersbhm.org](http://www.partnersbhm.org)

**Name:**  
**Medicaid ID#:**  
**NC Health Choice ID#:**

**PCP Information:**  
PCP Name:  
PCP Address:  
  
PCP Phone:

RxBIN: 025052  
RxPCN: MCAIDADV  
RxGRP: RX22AC  
Pharmacy: 1-866-453-7196


**Important Contact Information/Información importante de contacto**

Member and Recipient Services/Servicio para miembros y destinatarios (7 a.m.-6 p.m. EST).....1-888-235-4673, TTY: 711  
Partners MemberCONNECT.....[www.partnersbhm.org](http://www.partnersbhm.org)  
24-Hour Nurse Line/Línea de enfermería las 24 horas.....1-888-369-2452  
24-Hour Behavioral Health Crisis Line/Línea de crisis de salud conductuallas 24 horas.....1-833-353-2093

If you suspect a doctor, clinic, home health service or any other kind of medical provider is committing Medicaid fraud, report it.  
**Call 919-881-2320.**

**For a medical emergency, go to the nearest emergency room or call 911.**

Prescriber Services (7 am-6 pm. EST).....1-866-453-7196  
Provider Services (7 am-6 pm. EST).....1-877-398-4145



**Partners**

Possession of an ID card does not guarantee eligibility.

Check member eligibility via:

Secure web portal: <https://providers.partnersbhm.org/category/providerconnect/>

Provider Line: 1-877-398-4145.

**Please do not turn members away if their card has not yet been updated.**



**PARTNERS**  
Improving Lives. Strengthening Communities.®

# Pregnancy Program

- Partners' Pregnancy Program
- Pregnancy Management Program
- Care Management for High-Risk Pregnancy (CMHRP) Program
- Partners Care Management resources and supports



# Partners' Pregnancy Program

- Partners is committed to supporting our members at every stage of life.
- Our pregnancy program offers help to members who are pregnant.
- People who identify their pregnancies early and receive appropriate health care are less likely to have serious complications and healthier outcomes.
- Through care management and support, this program ensures expecting members receive the best possible care.



# Partners' Pregnancy Program

- Who is eligible for the Pregnancy Program?
- Any member of Partners who is pregnant may participate in at least part of the program. Care managers can help them learn more.
- The Partners' Pregnancy Program has multiple parts:
  - Pregnancy Management Program
  - Care Management for High-Risk Pregnancy (CMHRP)
  - Resources and support from the Partners Care Management Team



# Partners' Pregnancy Program

## Pregnancy Management Program

- Provides a coordinated set of high-quality clinical maternity services to all members who are pregnant and are enrolled in Tailored Plan managed care.
- Includes a screening to identify members who may be at-risk for adverse birth outcomes.
- If a person is pregnant or thinks they might be pregnant, it is important to see a healthcare provider as soon as possible.
- Care managers can help schedule an appointment with a provider.





# Partners' Pregnancy Program

## CMHRP

- CMHRP is a program available through Local Health Departments for people with high-risk pregnancy.
- High risk pregnancy is when a person who is pregnant and their fetus have a higher chance of experiencing problems than normal.
- Members may be referred by their doctor, community agencies (e.g., WIC, DSS), or care manager.
- Members can also refer themselves by contacting their Local Health Department.



# Partners' Pregnancy Program

## Partners Care Management

- Support for pregnancy-related decision-making
- Referrals through NCCARE360 and/or HOP
- Resources to manage mental health conditions, substance use disorders, or I/DD while pregnant
- Resources to learn positive coping skills
- Nurse-supported medication education
- Pyx Health App
- Pregnancy education materials



# Partners' Pregnancy Program

- How to join the Partners' Pregnancy Program:
  - Providers, care managers or caregivers can refer members to the program.
  - Members may also self-refer.
  - You can also email referrals or questions about the program to:  
[PopulationHealthPrograms@PartnersBHM.org](mailto:PopulationHealthPrograms@PartnersBHM.org)
- Providers can support Partners' Pregnancy Program by:
  - Educating Partners pregnant members at PCP and specialty doctor visits on the resources offered.
  - Referring members to CMHRP.
  - Encouraging members to reach out to their Care Managers for more information.



# In Conclusion...

- Partners wants to help our members have healthy pregnancies.
- Care managers can connect members who are pregnant with programs and supports.
- If you know a member who is pregnant or are trying to become pregnant, encourage them to call or message their care manager.



# Partners' Tailored Plan Office Hours Topics

Partners and Carolina Complete Health will host office hours for Partners Tailored Plan physical health providers. We will use the time to share pertinent updates related to the topics and specialty areas below as well as hear from you and answer any questions you may have.

Office Hours sessions will be held every three weeks on Tuesdays at 12PM. Please register for the sessions that you would like to attend. **If you would like to register for more than one session, you must register separately.**

- **9/10:** Personal Care Services focus. Intended audience: Any provider billing for PCS, including adult care homes and in-home PCS. View [slides](#) and [recording](#).
- **10/01:** Utilization Management focus with tips and best practices for submitting authorizations. Intended audience: all physical health Partners providers.
- **10/22:** Prenatal Programs available for Partners members. Intended audience: Advanced Medical Homes, FQHCs, and Health Departments.
- **11/12:** Home Health Provider topics. Intended audience: All Home Health Care Services Providers.
- **12/3:** Hot Topics/General Education and Q&A Intended audience: all physical health Partners providers.

[https://centene.zoom.us/webinar/register/WN\\_44IO68UTRfGCcZSt2koKug#/registration](https://centene.zoom.us/webinar/register/WN_44IO68UTRfGCcZSt2koKug#/registration)



# Partners Provider Communications

- CCHN Physical Health Provider Communications
- Partners Provider Alerts



# Provider Support and Who to Contact

Who	What	How
Partners Customer Service	<ul style="list-style-type: none"> <li>• Claims questions</li> <li>• Prior Auth questions</li> <li>• Grievances and Appeals</li> <li>• Portal (ProviderConnect)</li> <li>• Member assignment</li> </ul>	1-877-398-4145; 7 a.m. to 6 p.m. Monday-Saturday
Carolina Complete Health Network Provider Relations	<ul style="list-style-type: none"> <li>• Tailored Plan Physical Health Contracting</li> </ul>	NetworkRelations@cch-network.com
Carolina Complete Health Provider Engagement	<ul style="list-style-type: none"> <li>• Payspan</li> <li>• Panel Status</li> <li>• Education</li> </ul>	<u>CCHN Provider Engagement Team</u>

# Provider Resources

- Partners Provider Services Line: [1-877-398-4145](tel:1-877-398-4145)
- Partners Member & Recipient Services: [1-888-235-HOPE](tel:1-888-235-HOPE)
- Partners Behavioral Health Crisis: [1-833-353-2093](tel:1-833-353-2093)
- Carolina Complete Health Network [Provider Engagement Team](#)
- [Tailored Plan Information for Partners Providers External Link](#)
- [Partners Provider Trainings External Link](#)
- [Partners Out-of-Network \(OON\) Provider Guide \(PDF\)](#)
- [Partners Durable Medical Equipment Provider Guide](#)
  - This document and process does not apply to the NC Innovations Waiver service T2029 Assistive Technology Equipment & Supplies (ATES). For questions on ATES, please contact the member's Partners Health Management Care Manager.





# Questions?





# Additional Provider Resources

# Submitting Authorizations Via Partners' Portal

- ProAuth is Partners platform for authorization submission through our secure provider portal, ProviderCONNECT.
- Providers will be given instructions to access ProAuth when they join the network and access ProviderCONNECT.
- **ProAuth is the preferred method for service authorization request submission.**
- **Phone:**
  - 1-877-398-4145
- **Physical Health Fax Numbers:**
  - Inpatient Requests 336-527-3208
  - Outpatient Requests 704-884-2613
  - Transplant Requests 866-753-5659
  - Pharmacy PADP Requests 704-772-4300
- **UM Physical Health Email Addresses:**
  - For Service Requests: PHManualAuthorizations@partnersbhm.org
  - For Questions: PHUMQuestions@partnersbhm.org

How can providers determine which services require prior authorization for a health plan?

Partners Benefit Grids and Service Pre-Authorization Lookup Tool can be located at:  
<https://providers.partnersbhm.org/benefits/>

# How to Connect to ProviderConnect to Access ProAuth

## ➤ Partners ProviderCONNECT Portal Setup

- To access ProviderCONNECT, in-network contracted providers must identify one individual who will serve as their Local Administrator and will be responsible for managing all other users who access Partners' ProviderCONNECT for that provider organization.

## ➤ Action needed

- Designated portal administrators must complete Partners Health Management ProviderCONNECT set-up form: <https://www.surveymonkey.com/r/MBXQSBF>
- Once you complete the survey, you will receive an email from Partners in 1-2 business days with next steps.
- For questions about this form please contact [credentialingteam@partnersbhm.org](mailto:credentialingteam@partnersbhm.org).
- **If you are unsure if your organization has a Local Administrator, you can see the organizations already connected and their Local Administrator at this link on Partners' Provider Knowledge Base <https://providers.partnersbhm.org/identifying-a-local-administrator/>**

# ProviderConnect

- View additional information on ProviderConnect using the following links:
  - <https://providers.partnersbhm.org/category/providerconnect/>
  - <https://providers.partnersbhm.org/providerconnect-local-administrator-instructions/>
  - <https://providers.partnersbhm.org/provider-alert-local-administrators-can-now-set-up-users-in-providerconnect/>

# Logging into ProviderConnect

- All Authorization Requests must be submitted through ProAuth
- ProAuth can only be accessed vis the ProviderConnect portal
- Log into ProAuth through ProviderConnect portal
  - Chrome is the recommended browser
- ProviderConnect Login – <https://id.partnersbhm.org/>
- Logins and passwords are obtained from your organizations' Local Administrator
- Local Administrators may inquire about login issues/questions via email at: [providerconnectsupport@partnersbhm.org](mailto:providerconnectsupport@partnersbhm.org)

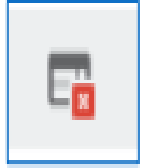
# Getting to ProAuth

- From the ProviderConnect homepage, use the Quick Links on the left to access ProAuth Authorizations:

The screenshot displays the PARTNERS ProviderCONNECT homepage. At the top left is the logo for PARTNERS ProviderCONNECT. To its right is a navigation menu with links for Home, Medicaid Direct, Tailored Plan, Contact, Profile, and Messages. A 'Welcome,' button is also visible. Below the navigation is a dark blue bar with links for Provider Directory, Resources, Patient Management, Office Management, and References. A green banner announces 'Partners NC Medicaid Direct Health Plan Effective April 1'. Below this, another green banner states 'ProAuth Authorizations directly accessed under the Quick Links Now!'. A red notice icon indicates 'Notice: Providers must now use ProAuth for prior authorizations'. Further down, there are sections for 'Provider Alert: Local Administrators Must Set Up General Users in ProviderCONNECT. To View Previous Alerts: Provider Alert Archives' and 'Provider Bulletin: Provider Communication Bulletin #140 | May 2023'. The 'QUICK LINKS' section on the left contains two items: 'Behavioral Health Claims' and 'ProAuth Authorizations', with the latter highlighted by a red rectangular box. To the right of the quick links is a section titled 'Explore the Provider Knowledge Base' with a sub-header 'Provider News, Provider Tools,' and a background image of a laptop displaying the website.

# Getting to ProAuth (cont)

- If the link goes to a page with no information or an error message, you may need to turn off the pop-up blocker and change the setting to Always Allow
- This may need to be done twice, but once pop-ups are allowed, you won't have to fix it again.



The screenshot shows a web browser window with the URL `pbhmbeta.healthtrioconnect.com/app/iso/outbound/CasenetProAuthStage/redirect.page/?zsesschk=b7d3ba5ac1c84e32ad2095df8714017b`. The browser's address bar and toolbar are highlighted with a red box. The website header features the Partners ProviderCONNECT logo and navigation links: Home, Tailored Plan, Medicaid Direct, Contact, Profile, and Messages. A user greeting 'Welcome, Laura' is displayed. The footer contains links for News, Subscribe, Feedback, Fraud and Abuse, and Protecting Privacy, along with social media icons for Twitter, Facebook, LinkedIn, and Instagram.



# Welcome to ProAuth – Authorization Requests Portal

- ProAuth opens to the Dashboard where you can:
  - Search members
  - Create authorizations
  - View authorizations

**PARTNERS** Partners BHM STAGE ProAuth PROVIDER FILTER (0/08) Laura Reisinger Help About

Dashboard

Member Search

Dashboard

CREATE INPATIENT AUTHORIZATION | CREATE SERVICE/PROCEDURE AUTHORIZATION

Filter By ?

Member ID:

Authorization Number:

Diagnosis Type: All

Date of Service From Date: 01/19/2024

Date of Service To Date:

Include Closed

Requested By Me

FILTER RESET

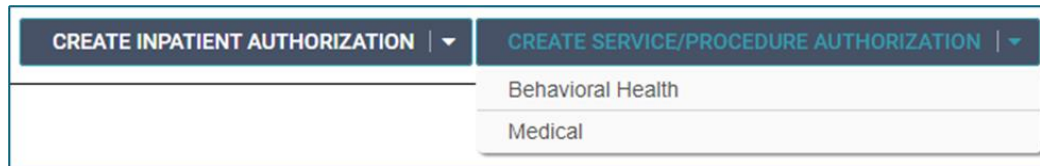
Inpatient Authorizations Summary

EXTEND VIEW AUTH DETAILS

Member Name	Authorization #	Determination Sta...	From Date	To Date	Servicing Facility	Diagnosis Code	State
No records found							

# Submitting an Authorization Request

- ▶ From the Dashboard:
  - At the top right of the screen click either:
    - Create Inpatient Authorization or
    - Create Service/Procedure Authorization



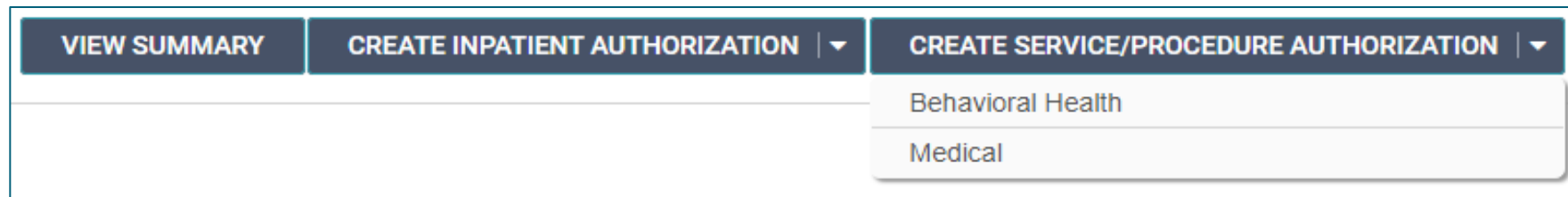
- **Inpatient services** must be submitted as an Inpatient Authorization
  - **NOTE:** Inpatient level of care is provided by hospitals
  - **ICF-IID** is not considered Inpatient
- **Outpatient services** must be submitted as a Service/Procedure Authorization

**For either option, you must select Behavioral Health or Medical**

- Behavioral Health includes mental health, substance use and intellectual and developmental disabilities
- Medical is physical health services only

# Submitting an Authorization Request

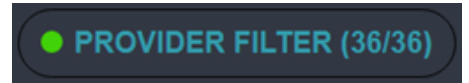
- From the Member Search screen, the options to Create an Authorization are the same but at the bottom of the screen.



A screenshot of a web interface showing a horizontal menu with three main buttons: "VIEW SUMMARY", "CREATE INPATIENT AUTHORIZATION | ▾", and "CREATE SERVICE/PROCEDURE AUTHORIZATION | ▾". The "CREATE SERVICE/PROCEDURE AUTHORIZATION" button is expanded, showing a dropdown menu with two options: "Behavioral Health" and "Medical".

# Reviewing Authorization Status on Dashboard

## ➤ On the Dashboard



- Make sure your Provider Filter in the top right corner is green
  - You will only be able to see the authorizations submitted for the selected site location(s) and authorizations you submitted for other providers (care managers).
- It is best not to fill in every filter option but to use as few filters as possible to find the Authorization(s) you are looking for.
- Make sure “Date of Service From Date” is on or before the Authorization start date.

A screenshot of a web dashboard's filter section. At the top, there are two buttons: "CREATE INPATIENT AUTHORIZATION" and "CREATE SERVICE/PROCEDURE AUTHORIZATION". Below them is a "Filter By" section with a question mark icon. The filter options include: Member ID (text input), Authorization Number (text input), Diagnosis Type (dropdown menu), Date of Service From Date (calendar icon, text input with "01/18/2024" and "MM/DD/YYYY" below), Date of Service To Date (calendar icon, text input with "MM/DD/YYYY" below), Inpatient Service Types (dropdown menu), and Service/Procedure Service Types (dropdown menu). There are also two checkboxes: "Include Closed" and "Requested By Me". At the bottom are "FILTER" and "RESET" buttons.

Dashboard

CREATE INPATIENT AUTHORIZATION | CREATE SERVICE/PROCEDURE AUTHORIZATION

Filter By ?

Member ID: [text input]

Authorization Number: [text input]

Diagnosis Type: [dropdown menu]

Date of Service From Date: [calendar icon] 01/18/2024 [MM/DD/YYYY]

Date of Service To Date: [calendar icon] [text input] [MM/DD/YYYY]

Inpatient Service Types: [dropdown menu]

Service/Procedure Service Types: [dropdown menu]

Include Closed  Requested By Me

FILTER RESET

# Reviewing Authorization Status on Dashboard

- After filtering, you will see a list of search results including member name(s), Authorization numbers, Determination Status, Start Date, End Date and State
- Inpatient Authorizations and Service/Procedures Authorizations have separate tables

Dashboard CREATE INPATIENT AUTHORIZATION CREATE SERVICE/PROCEDURE AUTHORIZATION

+ Filter By ? Include Closed: No | From Date: 01/22/2024 | To Date: 01/29/2024 | Member ID: 734143 | Diagnosis Type: All

- Inpatient Authorizations Summary

EXTEND VIEW AUTH DETAILS VIEW CORRESPONDENCE

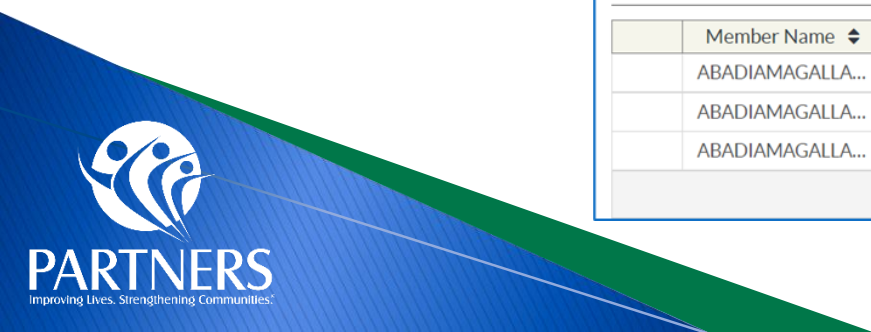
Member Nam...	Authorization...	Determinatio...	From Date	To Date	Servicing Faci...	Diagnosis Co...	State
No records found							

- Service / Procedure Authorizations Summary

ADD/EXTEND SERVICE VIEW AUTH DETAILS VIEW CORRESPONDENCE

Member Name	Authorization #	Determination Stat...	Start Date	End Date	State
ABADIAMAGALLA...	OP0005112402	Approved	04/01/2023	02/29/2024	Open
ABADIAMAGALLA...	OP0000047045	Partially Approved	03/01/2023	02/29/2024	Open
ABADIAMAGALLA...	OP0010613970	Pending	01/25/2024	01/27/2024	Open

Navigation: 1 / 10



# Extending an Authorization

- **Extending an Authorization only applies to Inpatient Concurrent requests and Physical Health service requests.**
  - Select Approved Authorization.
  - Click ADD/EXTEND SERVICE.
  - Complete required details to extend auth period as required by service code and benefit plan.
  - Complete required documentation on authorization screens and Submit.

<b>ADD/EXTEND SERVICE</b>		<b>VIEW AUTH DETAILS</b>
	End Date ▾	State ▾
	01/07/2023	Open
	01/04/2023	Open



# ProviderConnect and ProAuth Trainings

- For a Comprehensive Training regarding the features and submission of authorizations via ProAuth, please visit Partners' Provider Knowledgebase

<https://www.partnerstraining.org/>

## ProviderCONNECT Trainings

**ProAuth Demonstration Video April 2024**

On Demand 45:00 ([Register](#))

[Supporting Documentation and Q&A](#)

**ProviderCONNECT User Navigation Guide Video**

On Demand 7:37 ([Register](#))

[Supporting Documentation](#)

**ProviderCONNECT LA Non-Utilizer Report Video**

On Demand 6:11 ([Register](#))

[Supporting Documentation](#)

**ProviderCONNECT Secure Messages Video**

On Demand 9:49 ([Register](#))

[Supporting Documentation](#)

**ProviderCONNECT Document Manager Video**

On Demand 8:30 ([Register](#))

[Supporting Documentation](#)

**Provider SysAid2 Service Ticket Overview Video**

On Demand 7:30 ([Register](#))

[Supporting Documentation](#)



# Submitting Authorizations Manually

- Providers can find the Partners Manual Authorization Request Form here:  
<https://providers.partnersbhm.org/utilization-management/>
- This form is to be used for the following situations:
  - The ProAuth/TruCare system is not available and is not expected to be available for an extended period. For example; 4 hours or more; this information will be communicated via the Partners website.
  - The Provider is an out-of-network and/or non-participating provider who is serving a Partners member who either requires specialty treatment not available in the network, is out of the catchment area when a crisis occurs or lives in another catchment area, but Medicaid is not expected to change. For example, members living in residential situations outside of the Partners catchment area but continue to have Medicaid from one of Partners counties.
  - A service is being requested that is not in the Partners Benefit Plan and is not an available drop-down option for services in the ProAuth/TruCare system. For example, an EPSDT Medicaid request for a service not included in the Partners Medicaid Benefit Plan.



# Authorization, Notification, and Determination Timeframes

Authorization Type	Timeframe for Provider	Timeframe for Determination
Standard Service Request (Inpatient)	All non-emergency inpatient admissions require prior authorization. Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.	72 hours
Standard Service Request (Outpatient)	Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.	14 days
Urgent Service Request (Inpatient)	Emergency admissions will require notification via authorization submission within one (1) business day, following the date of admission.	72 hours
Urgent Service Request (Outpatient)	Prior authorization should be requested as soon as need for service is identified, prior to service being performed.	72 hours
Retrospective Review	Retrospective review is an initial review of services provided to a beneficiary, but for which authorization and/or timely notification was not obtained due to extenuating circumstances. Providers may request a retrospective review up to 90 days after the date of service (DOS) or date of admission (DOA) in the case of an inpatient request.	30 days

# Submitting Claims

- You can submit your Physical Health Claims through ProviderConnect

The screenshot shows the PARTNERS ProviderCONNECT website. At the top, there is a navigation bar with the logo and links for Home, Tailored Plan, Medicaid Direct, Contact, Profile, and Messages. A user is logged in as 'Welcome, Wake'. Below this is a secondary navigation bar with links for Resources, Provider Directory, Patient Management, Office Management, and References. The main content area features three green banners with news: 'Medicaid Rates to Increase January 1, 2024, for Behavioral Health Services', 'Medicaid Expansion Launched December 1, 2023', and 'NC Medicaid Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan will launch July 1, 2024'. Below the banners are two alert boxes: one for a 'Provider Alert Update' regarding UM Service Authorization Decision Letters, and another for 'Provider Alert: Provider Alert Archives' and 'Provider Bulletin: Provider Communication Bulletin #150 | March 2024'. On the left, a 'QUICK LINKS' section lists various services, with 'Physical Health Claims' highlighted. On the right, a 'Provider Knowledge Base' section lists various resources like Provider News, Provider Tools, and Care Management, with a 'See PKB for all your needs!' button. The background of the right side shows a laptop displaying the website interface.

# Submitting Claims

Method	Physical Health Claims Submission	Behavioral Health Claims Submission
Electronic	ProviderConnect, <a href="https://id.partnersbhm.org/">https://id.partnersbhm.org/</a> then choose <b>Physical</b> Health Claims to submit <b>Physical</b> Health Claims, this brings you to Availity.	ProviderConnect, <a href="https://id.partnersbhm.org/">https://id.partnersbhm.org/</a> then choose <b>Behavioral</b> Health Claims to submit <b>Behavioral</b> Health Claims, this brings you to Alpha+.
Paper	Partners Health Management Attn: Claims PO Box 8002 Farmington, MO 63640-8002	901 S. New Hope Road, Gastonia, NC 28054
Clearinghouse/SFTP	Provider's Clearinghouse connection to Availity, then the claim can be passed for processing.	Behavioral Health Claims will be submitted to Alpha+
Payor ID	68069	13141

# Claims Submission Tips

- For dates of service beginning 7/1/24, instead of submitting physical health claims to NC Tracks for Partners Tailored Plan members, providers should submit to Carolina Complete Health using one of the physical health methods outlined in this training.
- **Frequently used provider Guides:**
  - Rendering and Billing Taxonomy placement on claims: [Provider Guide](#)
  - NPI and TIN should align with NCTracks provider data: [Provider Guide](#)
  - The National Drug Code (NDC) must be submitted on a claim along with any PADP drugs and the CPT vaccine product codes: [Provider Guide](#)
  - Pediatric modifier placement follows the [Health Check Billing Guide](#)
  - If the claim contains CLIA-certified or CLIA-waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims: [Provider Guide](#)

# Availity Questions

- Providers should see an updated number of units dropdown.
- Availity also added a video detailing to new unit's process.

The screenshot displays the Availity web interface for a claim line. The main interface shows a table with the following data:

Service From Date	Service To Date	Procedure Code	Revenue Code	Non Covered Amount	Charge Amount	Quantity	Quantity Type
03/01/2024	03/05/2024	Type to search...	0101 - All Incl...		4194.16	2	UN - Unit

A video player overlay is positioned in the top right corner, showing a video titled "Number of units (or quantity and quantity type)". A red arrow points from the video player to the "Quantity Type" dropdown menu in the main interface, which is currently set to "UN - Unit".

# EDI Questions

- EDI claims can be submitted to Payer ID 68069
- Choose “Partners Health Management Physical Health 68069”
- As long as the providers clearinghouse has a connection to Availity, the claim will pass through to be processed by CCH.
- Medicaid claims should be submitted within 365 days from date of service.
- ProviderCONNECT to submit claims in Availity for Medicaid Tailored Plan
- Physical Health claims
  - Mail physical health claims to: Partners Health Management Claims, PO Box 8002, Farmington, MO 63640-8002
- Questions:
  - Phone: 704-842-6486
  - Fax: 704-854-4203

# Clearinghouse and Set Up of New Payers

- Partners Health Management has partnered with Availity®, an independent company, to operate and service our electronic data interchange (EDI) and portal transactions.
- Physical Health Claims can be submitted through Availity beginning with Dates of Service July 1, 2024.
- **Noted Impacts:** For any Provider using a clearinghouse or vendor to submit transactions to Partners Health Management today, Partners Health Management and Availity are working with your trading partner to update the connections.
- For Questions regarding set up or additional information please refer to Partners' Provider Knowledge Base, <https://providers.partnersbhm.org/alphamcs-zixmail-sign/>
- Providers with questions regarding Availity can contact the Availity Help Desk by calling 1.800.AVAILITY (282.4548). The help desk is available Monday – Friday, 8 a.m. – 7 p.m. Eastern Standard Time.

# Clearinghouse and Set Up of New Payers

## Existing Availity Trading Partners

If you are currently sending EDI Transactions for other Health Plans via a secure FTP account with Availity, follow your standard business process to work with Partners Health Management. If you need assistance, please refer to the resources in this [EDI Quick Start Guide for Availity](#).

## New to Availity?

If you do not already have an Availity Account, please register with the links below:

1. Go to [www.availity.com](http://www.availity.com)
2. Click **Register** and complete the process. For registration guidance or tips, we recommend you refer to the following resource prior to starting your registration application:
  - [Register and Get Started with Availity Portal microsite](#)
  - [EDI Quick Start Guide for Availity](#)
  - [Submitting a Claim on Availity Essentials](#)



# Claims rejections for dates of service prior to 7/1/2024

- Physical health claims for dates of service prior to 7/1/2024 should be processed as Medicaid Direct claims and submitted to Medicaid Direct via NCTracks.
- For DOS **beginning** 7/1/24, physical health claims for Partners **Tailored Plan** members can be submitted using the physical health claim submission methods. These claims are processed by CCH.



# Electronic Funds Transfer for Claims

## Behavioral Health Claims

### Partners EFT process:

Please contact Partners Vendor Group for EFT and banking information set: [vendorsetup@partnersbhm.org](mailto:vendorsetup@partnersbhm.org)

## Physical Health Claims

### Payspan: A Faster, Easier Way to Get Paid (PDF)

To contact Payspan: Call 1-877-331-7154, Option 1 or email [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)  
Monday thru Friday 8:00 am to 8:00 pm est.

Providers must register with each line of business (LOB): there will be registration codes specific for Partners and Trillium.

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

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

Registration information can be found through CCH:

<https://network.carolinacompletehealth.com/training>



# Durable Medical Equipment

- Tailored Plans offer the same physical health services as Standard Plans and Medicaid Direct.
- For a Partners Tailored Plan member, you can request authorization for DME using the ProAuth tool in ProviderCONNECT.
- DME billed on a medical claim must be submitted to Partners using the physical health submission methods. CCH will process the claims. This includes CPT codes on applicable DME [Fee Schedules](#).
- DME billed at Pharmacy Point-of-sale, i.e. Diabetic Supplies [on the PDL](#), are managed through Partner's Pharmacy PBM, CVS Caremark®.
- When submitting a claim for manually priced DME items, an invoice must be attached to the claim for reimbursement review.
- Providers must use the correct modifier for DME services as applicable for the services rendered.
- Relevant DME clinical coverage policies include:
  - [Physical Rehabilitation Equipment and Supplies, 5A-1 \(PDF\)](#)
    - For guidance in reference non-invasive osteogenic stimulation, please refer to policy titled [Osteogenic Stimulation, NC.CP.MP.194 \(PDF\)](#)
  - [Respiratory Equipment and Supplies, 5A-2 \(PDF\)](#)
    - Prior approval is required prior to the initiation of oxygen therapy and for continuation of active oxygen therapy on at least an annual basis.
  - [Nursing Equipment and Supplies, 5A-3 \(PDF\)](#)
  - [Orthotics and Prosthetics, 5B \(PDF\)](#)

Resource: [Partners Physical Health DME Provider Guide](#)



# Provider Resources

NC Medicaid Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan will launch July 1, 2024.

If you are experiencing a behavioral health crisis, call Partners new Behavioral Health Crisis Line: 833-353-2093.

The Tailored Plan Primary Care Provider Choice Period ends May 15. Call 1-888-235-4673 to select your Primary Care Provider or fill out the Choose or Change Your PCP form.

1-877-864-1454 ▶ Training Resource and Collaborative ▶ Provider Knowledge Base ▶ Find a Provider ▶ ProviderCONNECT ▶ MemberCONNECT



Tailored Plan Home Members Recipients Pharmacy Providers Contact

### Partners Tailored Plan

Partners Tailored Plan covers services for mental health, substance use disorders, intellectual & developmental disabilities, physical health and pharmacy. If you have questions or want more information, contact Member and Recipient Services at 1-888-235-4673.

If you are a provider in the Partners network, or are interested in joining our network, please call our dedicated Provider Line at 1-877-398-4145.

Members	Recipients	Pharmacy	Provider
If you have Medicaid, we have a lot of information to help you get or use services. You can select a topic from the Members tab at the top of the page. If you need to talk to someone, you can call our Member and Recipient Services Line at 1-888-235-4673. We want to help you get the most out of your benefits plan.	If you do not have Medicaid, are uninsured or under insured, you may get services using state funds. The Recipients tab at the top of the page will give you information on many topics. You may also call Member and Recipient Services for more information. That number is 1-888-235-4673.	Partners Tailored Plan works with CVS Health to ensure your pharmacy needs are met. You can find information on the pharmacy program by selecting a topic from the Pharmacy tab located at the top of the page, including a link to the NC Medicaid Preferred Drug List.	Providers may use the Provider tab to find information on joining the Partners Tailored Plan network, manuals and forms, how to access ProviderCONNECT, our secure provider portal and how to access online training materials. We truly see our providers as partners and are here to help you succeed.
<a href="#">▶ Learn More</a>	<a href="#">▶ Learn More</a>	<a href="#">▶ Learn More</a>	<a href="#">▶ Learn More</a>

## Learn More About Partners Health Management

- <https://www.partnersbhm.org/tailoredplan/>
- <https://www.partnersbhm.org/tailoredplan/providers/manuals-forms-and-policies/>
- <https://www.partnersbhm.org/wp-content/uploads/partners-quick-reference-guide.pdf>
- <https://www.partnersbhm.org/tailoredplan/pharmacy/>
- <https://www.partnersbhm.org/tailoredplan/providers/provider-training-materials/>
- <https://providers.partnersbhm.org/claims-information/>
- [NC DHHS Tailored Plan Toolkit](#)

# Checking Eligibility in NCTracks

- Providers may verify member eligibility in NCTracks
- A TP Member will show benefit plan “TPMC – Tailored Plan Medicaid Managed Care”
- Seeing a “Tailored Care Management” provider does not indicate TP eligibility. Medicaid Direct members are also eligible for Tailored Care Management



# Medicaid Direct Example

Health Plan: Medicaid							
Benefit Plan	Category of Eligibility	Dates of Enrollment	Managing Entity	Address	Residential County Code	Daytime Phone	After Hours Phone
MEDICAID	IASCN- IASCN	07/01/2024 - 07/31/2024					

Service Types And Copay									
AMB SERVIC : \$0.00	ANESTHESIA : \$0.00	BRAND NAME : \$0.00	CARDIAC RE : \$0.00	CHEMOTHERA : \$0.00					
CHIROPRACT : \$0.00	DENTAL : \$0.00	DIAG LAB : \$0.00	DIAG MEDI : \$0.00	DIAG X-RAY : \$0.00					
DIALYSIS : \$0.00	DME PURCHA : \$0.00	DME RENTAL : \$0.00	EMERGENCY : \$0.00	FAMILY PLA : \$0.00					
GENERIC PR : \$0.00	HLTH BNFT : \$0.00	HME HLTHCR : \$0.00	HOSP A SUR : \$0.00	HOSP ER AC : \$0.00					
HOSP ER MD : \$0.00	HOSP INPAT : \$0.00	HOSP OTPAT : \$0.00	HOSPICE : \$0.00	HOSPITAL : \$0.00					
IMMUNIZATI : \$0.00	LONG TERM : \$0.00	MEDI CARE : \$0.00	MNTL HLTH : \$0.00	MRI CAT SC : \$0.00					
NEWBORN CA : \$0.00	OCCP THRPY : \$0.00	ORAL SURGE : \$0.00	PEDIATRIC : \$0.00	PHARMACY : \$0.00					
PHYSICAL M : \$0.00	PODIATRY : \$0.00	PRF OF VS : \$0.00	PRF VSHME : \$0.00	PRF VSINPT : \$0.00					
PRF VSOUT : \$0.00	PSYCH INPT : \$0.00	PSYCH OTPT : \$0.00	PSYCHOTHER : \$0.00	RADI THERA : \$0.00					

Benefit Plan	Category of Eligibility	Dates of Enrollment	Managing Entity	Address	Residential County Code	Daytime Phone	After Hours Phone
ROUTINE PH : \$0.00	SECOND SUR : \$0.00	SKILL NUR : \$0.00	SPEECH THE : \$0.00	SUBSTANCE : \$0.00			
SURGICAL : \$0.00	SURGICAL A : \$0.00	URGENT CAR : \$0.00	VISION OP : \$0.00	WELL BABY : \$0.00			
MANAGED CARE FOR BEHAVIORAL HEALTH SERVICES	ASCN- ASCN	07/01/2024 - 07/31/2024	LME/MCO Name	LME/MCO Address		LME/MCO Phone	

Service Types And Copay									
MNTL HLTH : \$0.00									

**Tailored Care Manager**

Tailored Care Manager:  Daytime Phone:

Medicaid Direct members have managed care for BH services only through the LME/MCO

Tailored Care Manager listed is not an indication they are a TP member. Medicaid Direct members may also be eligible for TCM



# TP Member Example

Tailored Plan Medicaid Managed Care indicator



Health Plan: Medicaid																																																																			
Benefit Plan	Category of Eligibility	Dates of Enrollment	Managing Entity	Address	Residential County Code	Daytime Phone	After Hours Phone																																																												
MC-MEDICAID CARVE-OUT PLAN	MADCY-MADCY	07/01/2024 - 07/31/2024																																																																	
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# Inpatient Claims Submission Tips

## ➤ Physical Health Claims

- Physical Health claims uses the primary diagnosis on inpatient claims to determine the claim is physical health vs. behavioral health and processes the claim accordingly.
- If an inpatient claim has a primary diagnosis for physical health but the member also received behavioral health services during the stay, the claim will be processed using the appropriate DRG for the full stay.

## ➤ Behavioral Health Claims

- Behavioral Health claims uses the primary diagnosis on inpatient claims to determine if the claim is behavioral health vs. physical health. If an inpatient claim has a behavioral health primary diagnosis, the claim will be processed at the per diem rate for the room and board revenue code.



# Outpatient Claims Submission Examples

- Child presents for an EPSDT Well Child Check and the PCP also manages ADHD diagnoses

Service Line CPT Code	Service Line Primary Diagnoses Code
99393	Z00129
99401	F909
99213	F909
92551	Z00129

- Adult member sees their PCP for ADHD management and has a cough. The PCP runs a COVID test during the visit

Service Line CPT Code	Service Line Primary Diagnoses Code
99214	F909
87636	R051

- Today, these claim scenarios today are billed to Medicaid Direct, and July 1, 2024, they will be processed by Carolina Complete Health for Partners' Tailored Plan providers.
- Please use the physical health claim submission steps outlined on Slide 13.

# Claims Reconsideration Process

- Partners works diligently with Providers to resolve their issues; however, there are times when a Provider is dissatisfied with a Claims Processing outcome.
- If dissatisfied with the Claims Processing outcome, Providers can complete the **Reconsideration Form** listed below.
- Claims Analysts will review claims submitted on the form for accuracy and provide the research outcome.
- If dissatisfied with the outcome of the Claims Reconsideration, Providers have the option to **File a Grievance/Complaint**.

Email claims reconsideration review form to [claimsdepartment@partnersbhm.org](mailto:claimsdepartment@partnersbhm.org).  
The form is located at <https://providers.partnersbhm.org/claims-information/>.  
A grievance can be submitted if provider is unsatisfied with the outcome of the claim review. <https://providers.partnersbhm.org/grievance-incident-reporting/>.

# Ways Providers Can File a Grievance

- Intake Points: Any Partners staff may receive provider grievances via the following methods:
  - Telephone – Call 1-888-235-HOPE (4673)
  - Mail – Partners Health Management, c/o Grievance/Complaint, 901 South New Hope Road, Gastonia, NC 28054
  - Email – [Grievances@partnersbhm.org](mailto:Grievances@partnersbhm.org)
  - Online – Feedback form <https://www.partnersbhm.org/feedback/>
  - In person – Every employee at Partners is able to receive your grievance or complaint.
  - ProviderCONNECT (Provider Portal)



Providers Members Services Be Involved About Us Medicaid Transformation Tailored Plan

## Feedback

You're always welcome to tell us your thoughts. Use the form below to leave a compliment or grievance/complaint about Partners or our Providers. All feedback is important to us. Some concerns and complaints will require a formal process when we look into them. These are considered grievances/complaints. Although your feedback is confidential, there are times when it is helpful for us to contact you.

You can file a grievance/complaint by:

- ▶ Telephone - Call 1-888-235-HOPE (4673)
- ▶ Mail - Partners Health Management, C/o Grievances/Complaints, 901 South New Hope Road, Gastonia, NC 28054
- ▶ Email - [Grievances@partnersbhm.org](mailto:Grievances@partnersbhm.org)
- ▶ Online - Use our [feedback form](#) >
- ▶ Or in person - Every employee at Partners is able to take your grievance/complaint.

### Concerns, Grievances/Complaints, and Compliments

Please use this form to express concerns, grievances/complaints and compliments about Partners or its providers.

**Name \***

First  Last

**Phone \***

**Email**

**Home Address**

Address Line 1

Address Line 2

City  State  Zip Code

Please enter the address where you receive mail.

**Grievance/Complaint, Concern or Compliment \***

Enter a brief description of why you are submitting this form. If you allow, Partners will followup with you for more details.

Some issues may require us to clarify the situation by contacting you for discussion. May Partners Health Management contact you to discuss your issue? \*

Yes, Partners may contact me.  No, Partners should not contact me.

There are times when we would need to share your personal information with the parties involved in order to rectify the issue. If your issue is deemed as such, may we share your information with the parties involved? \*

When necessary, Partners may share my personal information with other parties involved.  Partners should keep my personal information confidential. I recognize my issue may not fully be resolved without full disclosure of the situation.

**Who filled out this form? \***

Me  My friend or family member  My provider

*Partners will provide providers any reasonable assistance in completing forms and other procedural steps.*



# ProviderCONNECT

## File a Grievance/Complaint

Additional Resources / File a Grievance/Complaint

Grievances (also called concerns or complaints) are defined as “an expression of dissatisfaction about matters involving the MCO or MCO Provider Network.” Grievances/complaints are expressions of dissatisfaction about any matters other than an “action” (summarized as Utilization Management Department decisions to deny, reduce, suspend or terminate any requested services).

Anyone at Partners can receive a grievance/complaint. Grievances/complaints may be submitted via telephone, mail, email, Partners’ website, or in person.

The Legal Department is responsible for assigning grievances/complaints to appropriate staff or departments for resolution. The Legal Department also tracks, monitors, and ensures that the grievance/complaint is resolved. Timelines regarding resolution are available in the [Provider Operations Manual](#).

If the person filing the grievance/complaint is a member or recipient, or is someone acting by or on behalf of a member or recipient, and would like to request an extension to the resolution of the grievance/complaint, the request\* should be submitted either in person, by calling 1-877-864-1454, or in writing to the following address:

### Partners Behavioral Health Management

c/o Grievances  
901 South New Hope Road  
Gastonia, NC 28054

\*Include the grievance/complaint reference number located at the top of the Grievance Acknowledgement letter in the request.

Please remember that:

- Any person or organization has the right and ability to bring a grievance/complaint.
- Upon enrollment and upon request, the grievance/complaint process must be shared with all enrollees and families of enrollees accordingly.
- Additionally, Providers must inform enrollees and families that they may contact Partners directly about any grievance/complaint.
- Providers must publish and make available the toll-free Partners’ Customer Services number for enrollees and family members, along with the telephone number for the Disability Rights of North Carolina.
- Partners has a standardized appeal process for grievances/complaints that is outlined in the [Provider Operations Manual](#).
- Providers must keep documentation on all grievances/complaints received, including dates received, the issues included in the grievances/complaints, and resolution information.
- Any unresolved grievances/complaints should be referred to Partners.

If you have questions regarding this process, please call 1-877-864-1454 or email [Grievances@PartnersBHM.org](mailto:Grievances@PartnersBHM.org)

Grievance/Complaint Online Form

Grievance/Complaint Online Form

Please use this form to express concerns, grievances/complaints and compliments about Partners or its providers.

Name \*

First

Last

Phone \*

Email

Home Address

Address Line 1

Address Line 2

City

State

Zip Code

Please enter the address where you receive mail.

Grievance/Complaint, Concern or Compliment \*

Enter a brief description of why you are submitting this form. If you allow, Partners will follow-up with you for more details.

Some issues may require us to clarify the situation by contacting you for discussion. May Partners Health Management contact you to discuss your issue? \*

- Yes, Partners may contact me.  No, Partners should not contact me.

There are times when we would need to share your personal information with the parties involved in order to rectify the issue. If your issue is deemed as such, may we share your information with the parties involved? \*

- When necessary, Partners may share my personal information with other parties involved.  Partners should keep my personal information confidential. I recognize my issue may not fully be resolved without full disclosure of the situation.

Who filled out this form? \*

- Me  My friend or family member  My provider

Submit

# How to File Claims as an OON Provider

- OON Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty (180) calendar days after the date of the member's discharge from the facility. See page two for OON Provider Claim Submission guidance.
- Providers should use the appropriate paper claim form type (CMS 1500 or UB 04) and submit to:
  - Partners Health Management
  - PO Box 8002
  - Farmington, MO 63640-8002
- OON Providers who have an EDI/Clearinghouse claim submission process, may submit physical health claims to Payer ID 68069.

**Note for Home Health and Community Based Personal Care Services:** OON Providers subject to EVV requirements, must submit claims through Electronic Visit Verification (EVV). Partners utilized HHAeXchange as the EVV vendor. Please view the Partners EVV Welcome Letter for additional details on connecting with the HHA portal.

<https://providers.partnersbhm.org/wp-content/uploads/partners-physical-health-oon-provider-guidance.pdf>



# Payment Expectations

- Providers can expect the first checkwrite by July 9, 2024.
- This checkwrite will include dates of service July 1, 2024, forward.
- Partners will include interest and penalties as part of claims processing according to the contractual agreement.
- The payment will be reflected on the Remittance Advice/Explanation of Payment using Claim Adjustment Reason Code (CARC) 225 – Penalty or Interest Payment by Payer.

# Tailored Plan Transportation Services

**Non-Emergency Medical Transportation (NEMT)**  
**Non-Emergency Medical Transportation (NEMT)** is the new name for your transportation benefits under the Tailored Plan.

Members and/or their guardian will need to use **Modivcare**, Partners' transportation vendor, to access this service.

**Tailored Plan Members:** Call Member Services at **1-888-235-4673** and choose the "Transportation" option starting May 16, 2024, to schedule rides that will begin July 1, 2024.

## What appointments are covered?

- Medical, dental and vision
- Behavioral health
- Prescription pick-up following Primary Care Provider (PCP) appointments
- Women Infants Children (WIC)
- Non-medical appointments such as educational classes and weight-control classes, including Weight Watchers

<https://www.partnersbhm.org/tailoredplan/members/tailored-plan-transportation-services/>



# Contracting with Partners Tailored Plan

- Physical Health Providers may enter a contract with Partners Tailored Plan through our physical health partner, Carolina Complete Health
- Please initiate your contract with the [Contract Request Form](#)
- You may also reach out to the Carolina Complete Health Network team via email at: [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com)

**Note:** Prior to contracting, providers must be credentialed with NC Medicaid. NCTracks is the system of record for provider enrollment data.





# Personal Care Services Referral Process

The steps for submitting a new referral for PCS includes the following:

1. Partners DHB-3051 form should be completed by the member's primary care provider or physician.
2. Fax the completed form to Partners at **704-457-5261**.
3. Once this form is completed, a member of our team will contact you within 30 days to schedule a face-to-face meeting to complete your assessment.
4. After the assessment has been completed and the start date has been determined, an authorization will be created/submitted by Carolina Complete Health (CCH) and will be shared with the Provider agency. Providers will receive notification of authorization via ProviderCONNECT.

