carolina complete health™

New Provider Orientation

Updated February 2025

Agenda

General Overview

- About NC Medicaid
- Who We Are – North Carolina's First and Only Provider Led Entity
- Tailored Plans
- Provider Experience Team

Operational Information

- Serving our Members
- Website, Secure Portal & Tools
- Benefit Explanation
- Care Management & Care Coordination
- Specialty Referrals &Prior Authorizations
- Claims
- Grievances and Appeals
- Clinical Policy
- Compliance Training
- Cultural Competency Resources

About NC Medicaid

What is NC Medicaid Managed Care?

NC Medicaid Managed Care is the way most Medicaid beneficiaries and consumers get their health care and services.

Beneficiaries enroll in a health plan that contracts with the NC Department of Health and Human Services (NCDHHS). Doctors, nurses, hospitals and other providers join a health plan's network. Beneficiaries visit their primary care provider and specialists in the health plan's network. All health plans offer the same basic Medicaid benefits and services. Some health plans may offer additional services.

What is NC Medicaid Direct?

NC Medicaid Direct is the way some NC Medicaid beneficiaries get their health care coverage and services. Beneficiaries can visit any doctor, nurse, hospital or other provider who accepts NC Medicaid patients.

What is Medicaid expansion?

North Carolina has expanded health care coverage to more people.

With Medicaid expansion, more people can get NC Medicaid. Adults ages 19 through 64 with higher incomes may be eligible for Medicaid even if they did not qualify before. NC Medicaid pays for doctor visits, yearly check-ups, emergency care, dental care, mental health and more – at little or no cost to beneficiaries.

Individuals eligible for Medicaid expansion may be enrolled in a NC Medicaid Managed Care plan or in NC Medicaid Direct.

About Carolina Complete Health

Carolina Complete Health Network is a subsidiary of the North Carolina Medical Society and co-owned by the North Carolina Community Health Center Association. Through a joint venture with Centene Corporation, we established the first and only Provider-Led Entity (PLE) in North Carolina; Carolina Complete Health (CCH). CCH is a Medicaid health plan and together as the PLE we seek out physician and clinician expertise in medical policy and aim to give providers a voice in how to best to care for their patients while reducing administrative burden.

Centene Corporation	• **Fortune 25** company with over 30 years of Medicaid experience • **#1 in Medicaid and #1 in Marketplace** in the U.S., operating in **50** states • Insure over **26 million** members
NC Medical Society	• **8,000+** members including doctors and physician assistants • Lead health policy in North Carolina • Engaged in practice transformation and provider recruitment strategies • Advocate for medically underserved and rural populations
NC Community Health Center Association	• **39** health center grantees and look-alike organizations • Serving over **500,000** underinsured and uninsured • **270** clinical sites across 100 counties in North Carolina

North Carolina's Only Physician-Led Medicaid Plan

Medical Policy

In partnership with providers, Carolina Complete Health is helping to lead the way on medical policy and initiatives that can innovate and improve care for Medicaid members.

Enhanced Engagement

Dedicated Provider Engagement and Network Support teams to provide one-on-one support to Providers with elevated customer service.

Innovation

We partner with providers and stakeholders to launch innovative pilots aimed to improve health outcomes and health equity.

Transparency

Leveraging multiple communications channels to keep providers informed of known issues and resolutions; staying responsive and closing the loop.

Proactivity

Fostering relationships with Provider Associations, Societies, and Clinically Integrated Networks to better address provider needs; using a data-driven approach to develop education strategies.

Our Goals

Why we're in business — **OUR PURPOSE**

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

What we do — **OUR MISSION**

Better health outcomes at lower costs

What we represent — **OUR PILLARS**


Focus on the Individual

+


Whole Health

+


Active Local Involvement

What drives our activity — **OUR BELIEFS**

We believe healthier individuals create more vibrant families and communities.

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

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

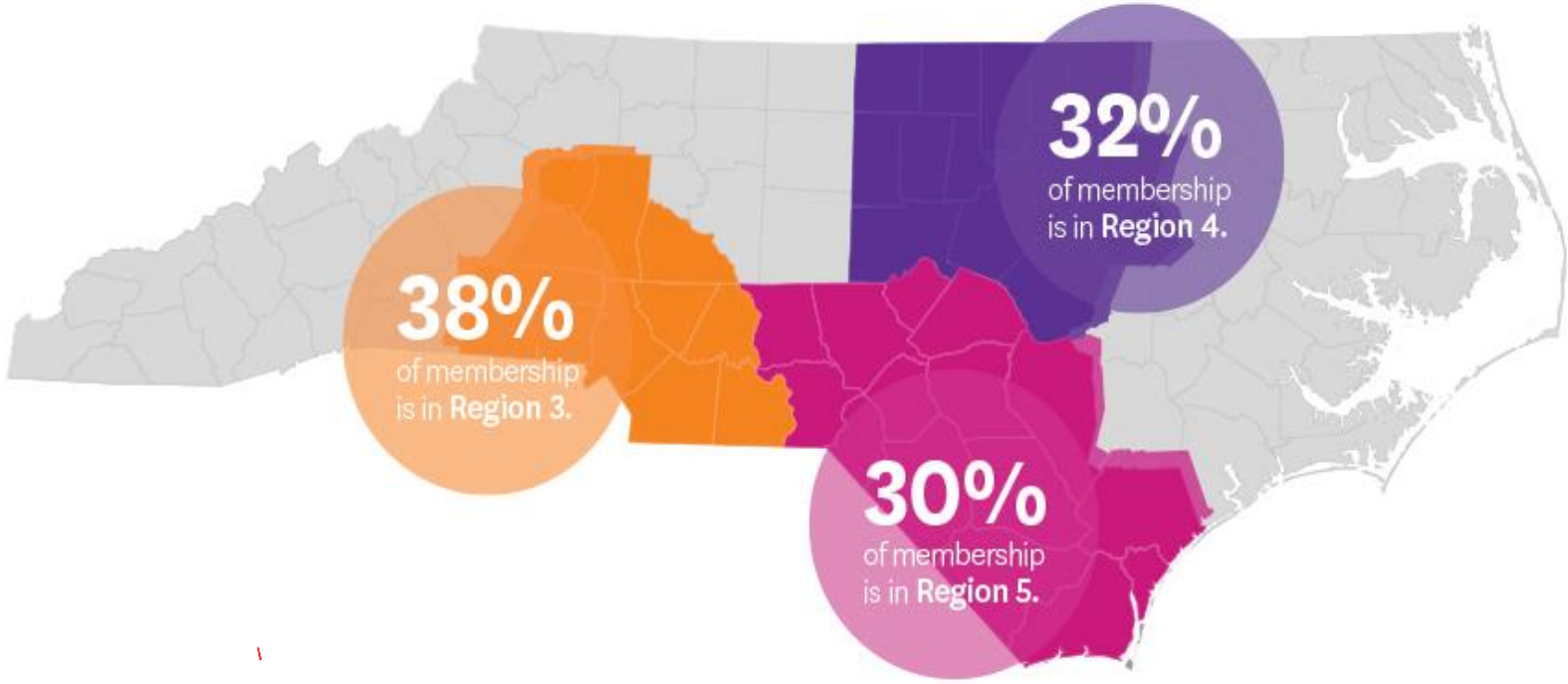
We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Our Commitment to North Carolina

Carolina Complete Health

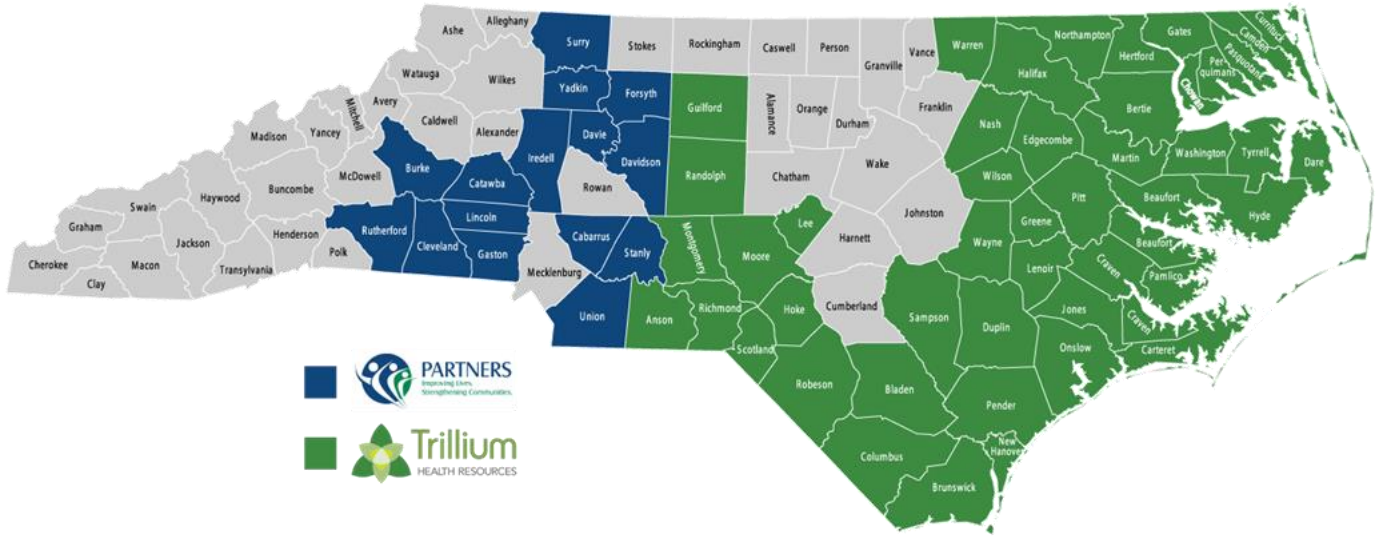
- Provides Medicaid in 41 counties
- Over 270,000 members
- 152,000+ babies and children
- 830 Long-Term Service and Support (LTSS) members
- 350+ employees
- Offices located in Charlotte and Durham



Tailored Plans

CCH Tailored Plans Partners

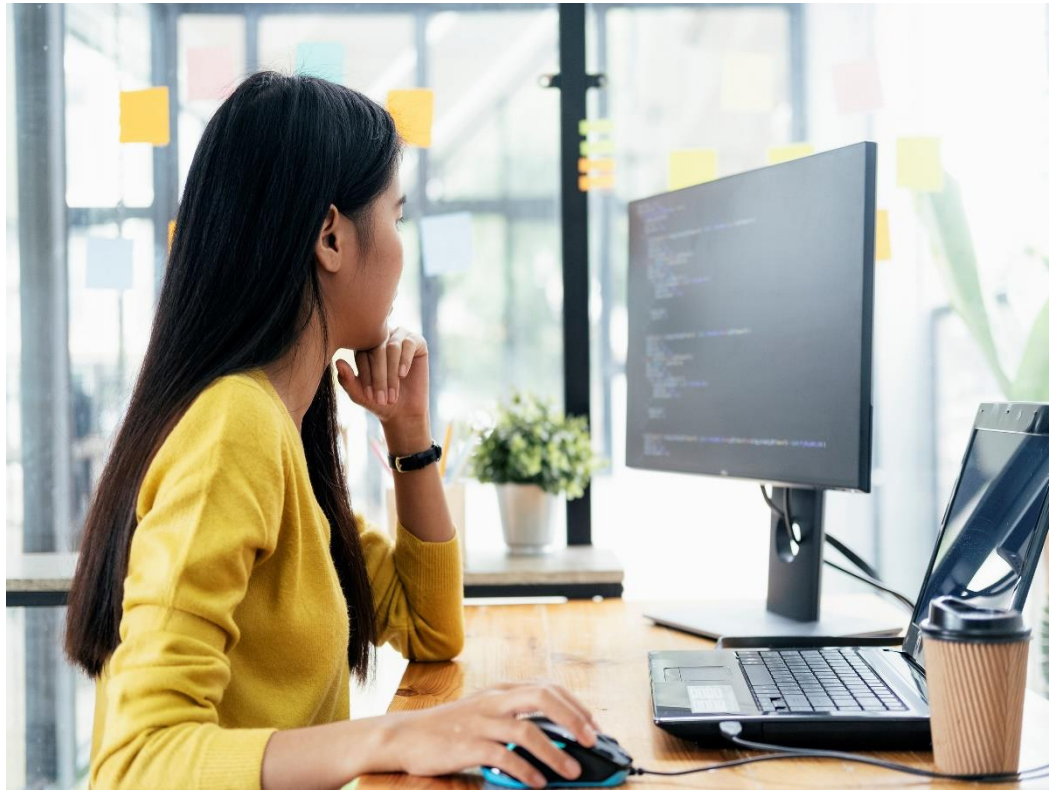
- North Carolina launched the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans on July 1, 2024. This is an integrated health plan for individuals with behavioral health needs and intellectual/developmental disabilities (I/DDs).
- Carolina Complete Health is working with Tailored Plans – Partners Health Management and Trillium Health Resources.
- Physical Health Tailored Plan providers should review specific training and materials specific to their Tailored Plan using these links Tailored Plans page and Education and Training



Getting Acquainted

Provider Relations

- Credentialing/Network status
- Contract Questions
- Claims questions
- Inquiries related to administrative policies, procedures, and operational issues
- Provider Services: 1-833-552-3876 or NetworkRelations@cch-network.com



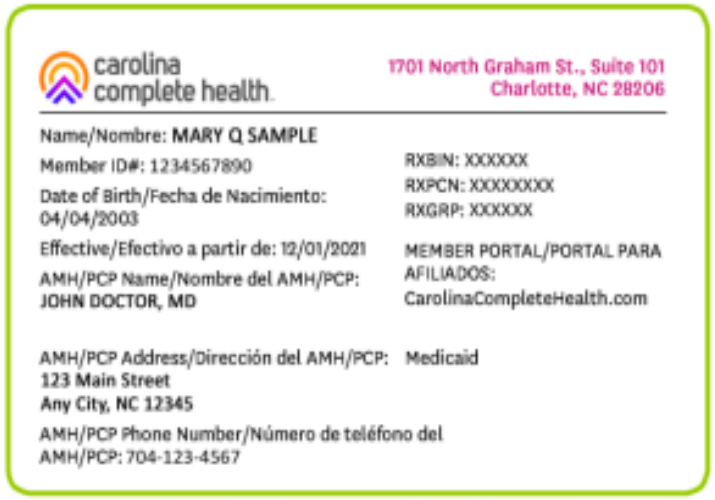
Provider Engagement Team

- Provider education and orientation
- Payspan Support for EFT/ERA
- HEDIS/care gap reviews
- Financial analysis on P4P or CoC Risk Adjustment Programs
- Innovation and Transformation
- AMH oversight in partnership with CCH
- EHR utilization
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Provider Portal Training

Contact: providerengagement@cch-network.com

Serving Our Members

Member ID Card


carolina complete health

1701 North Graham St., Suite 101
Charlotte, NC 28206

Name/Nombre: **MARY Q SAMPLE**

Member ID#: 1234567890

Date of Birth/Fecha de Nacimiento: 04/04/2003

Effective/Efectivo a partir de: 12/01/2021

AMH/PCP Name/Nombre del AMH/PCP: **JOHN DOCTOR, MD**

RXBIN: XXXXXX
RXPCN: XXXXXXXX
RXGRP: XXXXXX

MEMBER PORTAL/PORTAL PARA AFILIADOS:
CarolinaCompleteHealth.com

AMH/PCP Address/Dirección del AMH/PCP:
123 Main Street
Any City, NC 12345

Medicaid

AMH/PCP Phone Number/Número de teléfono del AMH/PCP: 704-123-4567


IMPORTANT CONTACT INFORMATION / INFORMACIÓN IMPORTANTE DE CONTACTO
Members/Afiliados:
Call **1-833-552-3876** (TTY: 711) for **Member Services** / Servicios para afiliados and **24/7 Nurse Advice Line** / Línea de consejo de enfermería que atiende 24/7
Call **1-855-798-7093** for **Behavioral Health Crisis Line** / Línea de crisis de salud mental

Providers: Call **1-833-552-3876 for**
Provider Service Line · Prescriber Service Line · Prior Authorization
Pharmacy Help Desk: XXX-XXX-XXXX **Pharmacy Prior Authorization:** 1-833-585-4309
Pharmacy Paper Claims: P.O. Box 989000, West Sacramento CA 95798
All Medical Claims: Carolina Complete Health, PO Box 8040, Farmington, MO 63640-8040

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.** Some services are carved out. A full list of benefits can be found in the Member Handbook at **CarolinaCompleteHealth.com.**

Si sospecha que un médico, clínica, hospital, servicio de atención médica en el hogar o cualquier otro tipo de proveedor médico está cometiendo fraude contra Medicaid, infórmelo. Llame al 1-919-881-2320. Algunos servicios están excluidos. Puede encontrar una lista completa de beneficios en el Manual para afiliados de **CarolinaCompleteHealth.com.**

Note If a member has an ID card, it does not automatically mean they are covered.

*to verify eligibility, use NC Tracks https://www.nctracks.nc.gov/

log on to CCH portal https://provider.carolinacompletehealth.com or Call 1-833-552-3876.

Interactive Voice Response (IVR) System

**From any touch tone phone and follow the appropriate menu options to reach our automated beneficiary eligibility-verification system twenty-four (24) hours a day*

Beneficiary Functionality

- Verify PCP demographic information
- Obtain benefit information such as office, emergency, inpatient and outpatient co-payments
- Check claims status

Provider Functionality

- Verify beneficiary demographic information
- Check claim status
- Obtain benefit information such as office, emergency room, inpatient and outpatient coverage, long-term care, and community services
- Obtain co-payment information when checking beneficiary eligibility
- Connect to care coordinators and referral specialist
- Connect with our vendors who supply medically necessary covered services

PCP Information

Key Points:

If a member needs to update their PCP:

Option 1: Call Member Services at **833-552-3876**.
Option 2: Use the PCP Change Request Form.
Primary Care Provider (PCP) Change Fax Form (PDF)

For PCP-Initiated Changes:
Send member reassignments to:
PEmemberreassignment@cch-network.com

Changes are effective the 1st of the following month.

Access and Accountability

After Hours – All Providers

After Hours (Passing Standards)

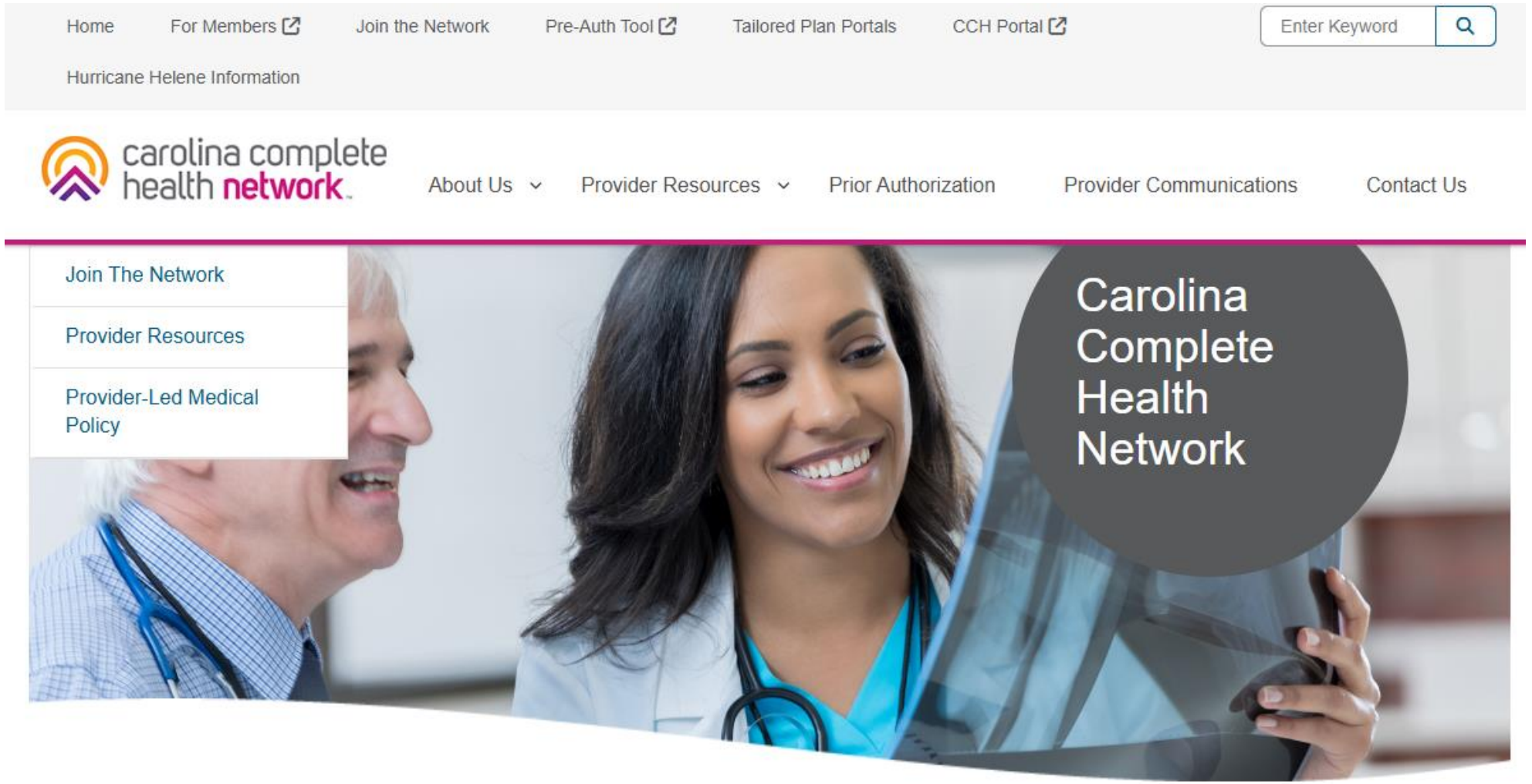
- Answering service or system that will page physician
- Answering system with option to page physician

Appointment Access and Availability Standards

PRIMARY CARE & PEDIATRIC	SPECIALIST	PRENATAL	BEHAVIORAL HEALTH
➢ **Urgent Care:** Within 24 hours of member's call ➢ **Routine**: Within 30 calendar days of request	➢ **Urgent Care:** Within 24 hours ➢ **Routine:** Within 30 calendar days	➢ **Initial Appointment – 1st or 2nd Trimester: Urgent Care:** Within 14 calendar days. ➢ **Initial Appointment – high risk pregnancy or 3rd Trimester:** Within 5 calendar business days	➢ **Emergency Services:** Immediately 24/365 ➢ **Mobile Crisis Management**: Within two hours ➢ **Urgent:** Within 24 hours ➢ **Routine Services for Mental Health:** Within 14 calendar days ➢ **Routine Services for SUD's:** Within 48 hours

Website, Secure Portal, and Tools

Provider Website (Public)
www.carolinacompletehealth.com



Web-Based Tools

- Web-Based Tools : Pre-Auth Tool
- Provider information for medical services
  - Prior Authorization tool
  - Forms
  - CCH's plan news
  - Clinical guidelines
  - Provider bulletins
  - Contract request forms
  - Provider Engagement contact information

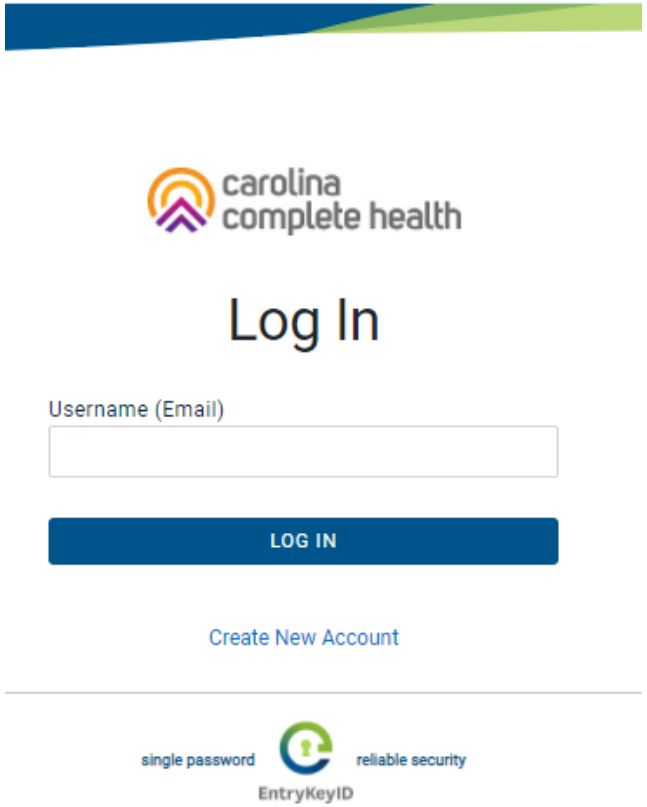
- **Carolina Complete Health is committed to enhancing our web-based tools and technology, provider suggestions are welcome!**
  - https://www.surveymonkey.com/r/CCHWEBSITE

Provider and Billing Manuals

- The Manuals includes a wide array of important information relevant to providers including, but not limited to:
  - Network information
  - Billing guidelines
  - Claims information
  - Regulatory information
  - Key contact list
  - Quality initiatives
  - And much more!
- Both can be found in the Manuals and Forms section of Provider Resources on the CCHN Website: https://network.carolinacompletehealth.com/resources.html
- You will be notified of updates via notices posted on our website and/or in the monthly Provider Pulse newsletter.

CCH Standard Secure Portal

- For Carolina Complete Health Standard Plan
- 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:
  - Recording
  - Slides (PDF)



Tailored Plan Secure Portals

Partners: ProviderCONNECT

Effective July 1, 2024, providers who are contracted with Partners for Tailored Plan will submit Physical Health claims or authorization inquiries through Partners ProviderCONNECT Portal.

https://www.partnersbhm.org/tailoredplan/providers/providerconnect/

Partners ProviderCONNECT set up:

- Designated portal administrators must complete Partners Health Management ProviderCONNECT set-up form.
- For questions about this form please contact credentialingteam@partnersbhm.org.
- View additional information on ProviderConnect through Partners provider website.

Trillium: Physical Health Portal

Effective July 1, 2024, providers who are contracted with Trillium for Tailored Plan will submit Physical Health claims or authorization inquiries through the Trillium Physical Health Portal.

https://provider.trilliumhealthresources.org/

Trillium Physical Health Portal Setup:

- To access the Trillium Physical Health Portal, contracted providers must identify an individual who will serve as the Portal Account Manager.
- The Account Manager should follow the prompts using the portal link to create an account, validate their email, and register the Tax ID Number (TIN)
- After registering, email your assigned Provider Engagement Administrator or ProviderEngagement@cch-network.com to request verification.

Availity

Carolina Complete Health has chosen Availity Essentials as its new, secure provider portal. Starting 10/21/24

Register and Get Started with Availity Essentials

Providers Can:

- Verify Eligibility and Benefits
- Submit Claims
- Check Claim Status
- Submit Authorizations
- Upcoming* Remittance Tracking & Claims Disputes and Appeals

Benefit Explanation

- Value Added Services
- Non-Emergent Medical Transportation
- Language Assistance

Value-Added Services

- School Supplies
- Math and Reading Tutoring
- Youth Programs
- New Parents Package
- Community Baby Showers
- OTC Pharmacy Allowance
- My Healthy Balance
- Cell Phone
- Weight Watchers
- YMCA Pre-Diabetes Prevention
- YMCA BPSM Support Program
- Room to Breathe Asthma Program
- Tribal Talking Circles
- GED Vouchers
- Quit For Life

https://www.carolinacompletehealth.com/vas

For questions or to learn how to get these services, please contact Member Services at 1-833-552-3876

Non-Emergency Medical Transportation (NEMT)

- Carolina Complete Health can arrange and pay for member transportation to and from appointments for Medicaid-covered services.
- Call **ModivCare**, Carolina Complete Health's transportation provider, up to 30 days before the appointment to arrange for round-trip transportation. There is no limit to the number of trips during the year between medical appointments, healthcare facilities, or pharmacies.
- **ModivCare Member Reservations Number:** 855-397-3601
- For more information: Carolina Complete Health Transportation Services
- For PHP NEMT Information: NC DHHS NEMT Fact Sheet

Language Assistance

Carolina Complete Health provides free language assistance to all members in person and telephonically/virtually

Telephonically/virtually

- Language Line: Toll Free 1-866-998-0338
- Account Number 13982
- Medicaid PIN #6329

In-person via Language Services Associates (LSA)

- Contact vendor by phone: 866-827-7028
- Enter Account Number #47716855
- Speak with representative on the details of language needed for appointment or home visit.

Care Management and Care Coordination

Care Management

Carolina Complete Health is committed to supporting the success of the local care management model


Carolina Complete Health
Care Management Department
1-833-552-3876

Care Management & Care Coordination

- Carolina Complete Health's Care Coordination model is designed to help beneficiaries obtain needed services from our array of covered service or from the community services at the right time and the right place.
- It is a multi-disciplinary care management team inclusive of **CCH and Advanced Medical Home (AMH) and LHD (Local Health Department) providers,** focused on:
  - A holistic approach to yield better outcomes
  - Promoting continuity of care
  - Increase positive medical outcomes—highest levels of wellness, functioning, and quality of life
  - **Ensuring that each beneficiary receives quality, comprehensive care services within the community**
  - Discharge planning and personalized treatment plans

LTSS Care Management

- **Care Managers (CM) will work collaboratively with AMH providers and/or co-lead the creation of the Comprehensive Care Plan (CCP) depending on AMH capability for complex Beneficiaries receiving LTSS services**
- CM will coordinate support AMHs to coordinate and assist beneficiaries in gaining access to needed services—covered, non-covered, medical, social, housing, educational, and other services and supports
- If CCH is leading Care Management, then the CM with support the beneficiary to identify strengths, goals, development of CCP, evaluations, reassessments, and leveling of care. Service Plans are reviewed with beneficiaries during regularly scheduled face-to-face meetings
- The CM will further support the AMH in providing referrals to community resources if the beneficiary is no longer Medicaid eligible

Care Management

- CCH will ensure that Care plans will incorporate both covered and non-covered services to reflect the range of health, behavioral health (BH), functional, social, and other needs that are within the scope of BH population covered (not TBI or severe BH)
- Work with delegated AMHs on holistic care of eligible beneficiaries
- Pay careful attention both to compliance with prescribed medications as well as potential impact of each medication on all **PH and BH conditions**
- Rapid and thorough identification and assessment of program participants, especially beneficiaries with special health care needs

Specialty Referrals and Prior Authorizations

Specialty Referrals

When a member need to visit a specialist know that:

- ***Referrals are not required for members to seek care with in-network specialists***
- Carolina Complete Health educates them to seek care or consultation with their Primary Care Provider (PCP) first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers
- Specialists are required to report to Carolina Complete Health limitations on the number of referrals accepted. The Specialist must notify Carolina Complete Health when the Specialist reaches eighty-five (85) percent capacity

Prior Authorizations

Use the Prior-authorization needed tool on the network.carolinacompletehealth.com

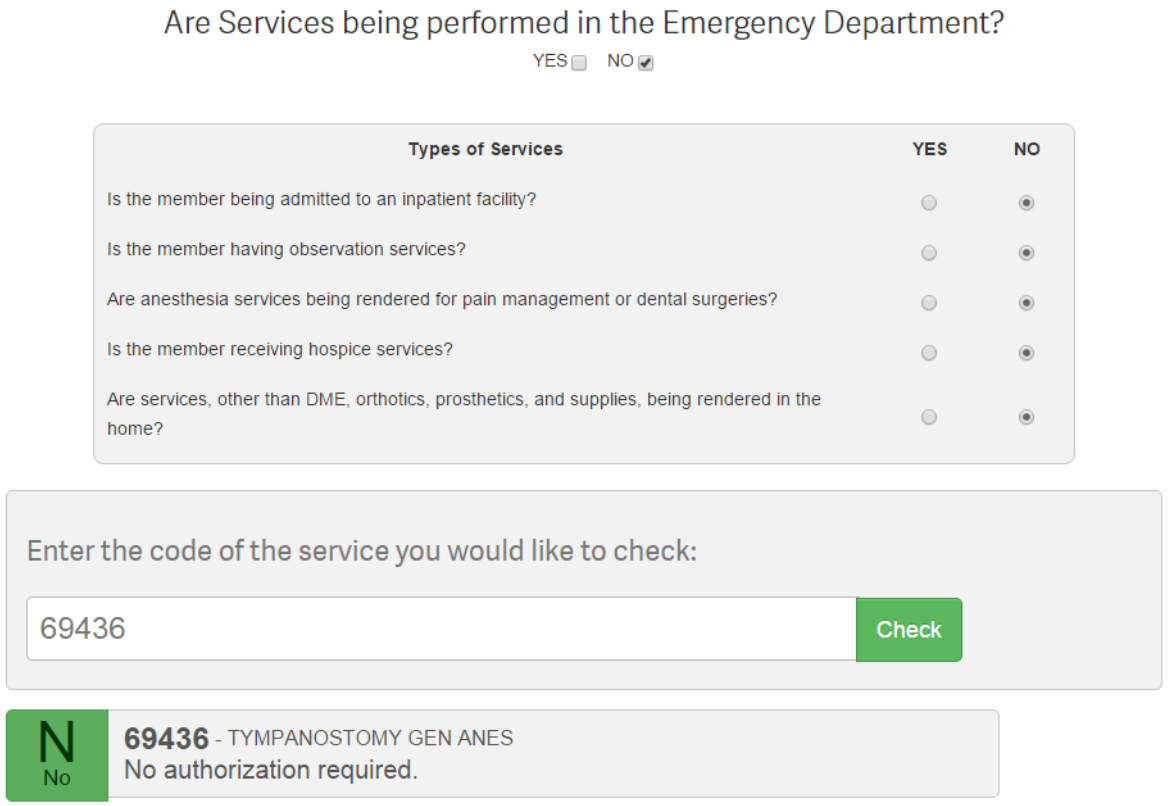
Need a Prior Authorization? It can be requested in the following three ways

1. Secure Web Portal:
   This is the preferred and fastest method network.carolinacompletehealth.com
   Login in the upper right-hand corner
2. Availity: https://www.availity.com/providers/
3. Phone: 1-833-552-3876
4. Fax*
   Medical PA Fax: **1-833-238-7694**
   BH Inpatient Fax: **1-833-596-2768**
   BH Outpatient Fax: **1-833-596-2769**
   Pharmacy PA Fax: **1-866-399-0929**

*There is a specific standardize fax form available online: Prior Authorization Fax Form (PDF)

Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Will be available on the provider section of the Carolina Complete Health website
- **https://network.carolinacompletehealth.com/resources/prior-authorization.html**



Services That Require Prior Authorizations

All out-of-network (non-par) services and providers require prior authorization, *excluding emergency services, family planning, post stabilization services, and table top x-rays*

Ancillary Services

- Air Ambulance Transport (non-emergent fixed wing airplane)
- DME purchases costing $500 or more or rental of $250 or more
- Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
- Orthotics/Prosthetics billed with an "L" code costing $500 or more or rental of $250 or more
- Hearing Aid devices including cochlear implants
- Genetic Testing

Inpatient Services

- All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn
- All services performed in out of network facility
- Hospice care
- Rehabilitation facilities
- Skilled nursing facility
- Transplant related support services including pre-surgery assessment and post-transplant follow up care
- Notification for all Urgent/Emergent Admissions:
- Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes

Procedures/Services

- All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)
- Potentially Cosmetic including but not limited to:
    - bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures
- Experimental or investigational
- High Tech Imaging (i.e. CT, MRI, PET)
- Hysterectomy
- Oral Surgery
- Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PA, Notification, and Determination Timeframes

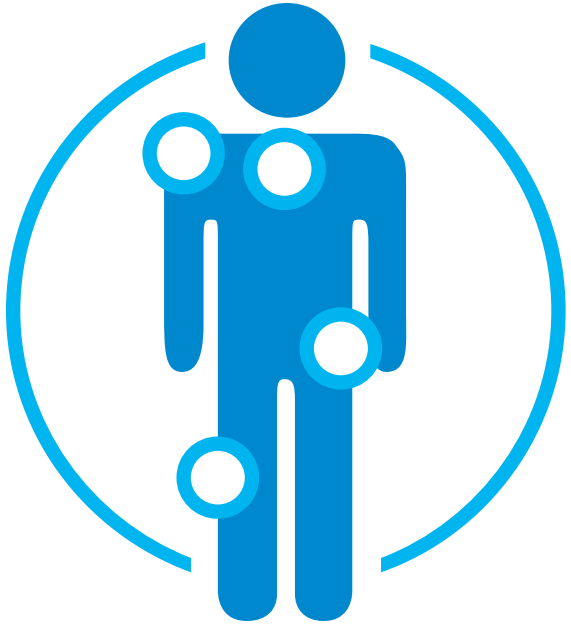
Authorization Type	Timeframe for Provider to Notify CCH	Timeframe for Determination by CCH upon receipt of medical necessary medical information.
Standard Service Auth (inpatient)	Prior Authorization required at least fourteen (14) business days prior to the scheduled admission date	Within fourteen (14) business days from receipt of necessary medical information.
Standard Service Auth (outpatient)	Prior Authorization required at least fourteen (14) business days prior as soon as the need for service is identified	Within fourteen (14) business days from receipt of necessary medical information.
Emergent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Urgent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Retrospective Review	If the request is received within 90 days from the date of service (DOS) or the date of admission (DOA) and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity	The health plan will have 30 calendar days to review and finalize a decision. If the request lacks clinical information, Carolina Complete Health may extend the retrospective review time frame for up to 15 calendar days (total 45 calendar days for review).

High Tech Radiology Utilization Management Program

Carolina Complete Health will use Evolent, formerly National Imaging Associates, Inc. (NIA), to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services.**

Effective July 1, 2021: Any services rendered on and after July 1, 2021 will require authorization. Only non-emergent procedures performed in an outpatient setting require authorization with Evolent.

- 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

High Tech Radiology Utilization Management Program

Item	Key Point(s)
RadMD Access & Features	▪ **Prior authorization requests can be made online at: www1.RadMD.com** ❖ **Required for CT/CTA, MRI/MRA, and PET Scan** ▪ RadMD Website – Available 24/7 (except during maintenance) ▪ Request authorization (ordering providers only) and view authorization status ▪ Upload clinical information ▪ View NIA's Clinical Guidelines ▪ Frequently Asked Questions ▪ Quick Reference Guides ▪ Checklist ▪ RadMD Quick Start Guide ▪ Claims/Utilization Matrices ▪ View and manage Authorization Requests with other users (Shared Access) ▪ Requests for additional Information and Determination Letters ▪ Clinical Guidelines ▪ Other Educational Documents To sign up for RadMD Go to: **www1.RadMD.com** 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: **www1.RadMD.com**

Medical Management

- Carolina Complete Health Med Mgmt department hours are Monday through Friday 8AM-5PM

Medical Management

Phone: 1-833-552-3876

Fax: 1-833-238-7689

Claims

Claims Definition

Clean Claim

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

Exceptions

If a claim meets the definition above, but either of the following circumstances apply, it will not be considered a clean claim

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

Ways to Submit Claims

Claims may be submitted in four ways:

1. The secure provider portal: https://provider.carolinacompletehealth.com
2. Availity: https://www.availity.com/providers/
3. Electronic Clearinghouse
   Carolina Complete Health Payer ID: 68069
4. Mail
   Carolina Complete Health
   Attn: Claims
   PO Box 8040
   Farmington, MO 63640-8040

Common Causes of Claims Processing Delays and Denial

- Incorrect Form Type
- Diagnosis Code Missing Digits
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Enrollee ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third-Party Liability Information

Timely Filing Guidelines

Initial Filing (Contracted and HOP Providers)	**365 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Initial Filing (Non-contracted providers)	**180 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Coordination of Benefits (Carolina Complete Health as secondary)	365 calendar days from the primary payer's determination
Claims Corrections	365 calendar days from the date of service to file a timely corrected claim
Claims Reconsideration (Level I)	365 calendar days from the date of the EOP or ERA
Claims Grievance (Level II)	30 calendar days from the date of the EOP or ERA

Electronic Visit Verification

- The 21st Century Cures Act requires NC Medicaid to begin using an Electronic Visit Verification (EVV) system for Home Health Care Services (HHCS) and Personal Care Services (PCS).
- To ensure that the provider community complies with the Cures Act mandate requirements, Carolina Complete Health partners with HHAeXchange as its EVV solution.
- **Claims for PCS services billed with CPT 99509 with HA and HB modifier must also be submitted through HHAeXchange.**
- Home Health Care Services are billed through the CCH Secure Portal.
- For additional PCS and HH information visit: network.carolinacompletehealth.com/resources/home-health-and-personal-care-services.html

Provider Payments

- Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim
- Nursing facility and hospice clean claims will be resolved (finalized paid or denied) within 30 days, following receipt of the claim.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- CCH Medical Claims are paid weekly on Monday and Thursday
- For more information, view our Billing Manual.

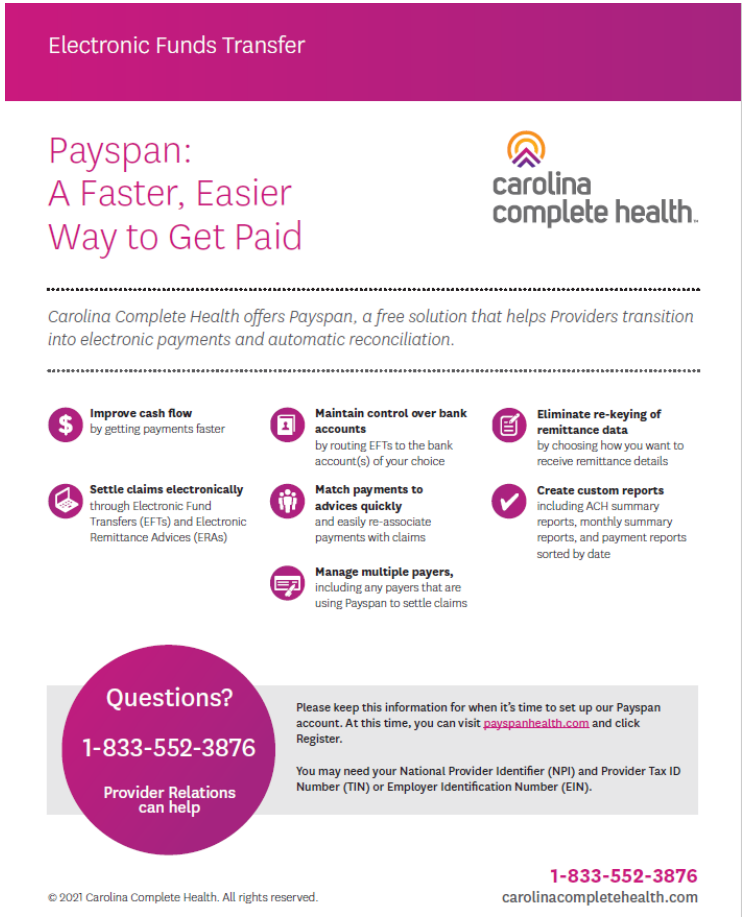
Electronic Funds Transfer

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

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

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

For training links visit our website under Education and Training



Electronic Funds Transfer

Payspan:
A Faster, Easier
Way to Get Paid

carolina complete health

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

Improve cash flow by getting payments faster

Maintain control over bank accounts by routing EFTs to the bank account(s) of your choice

Eliminate re-keying of remittance data by choosing how you want to receive remittance details

Settle claims electronically through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)

Match payments to advices quickly and easily re-associate payments with claims

Create custom reports including ACH summary reports, monthly summary reports, and payment reports sorted by date

Manage multiple payers, including any payers that are using Payspan to settle claims

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

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

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

1-833-552-3876
carolinacompletehealth.com

Provider Claim Reconsideration (Level I)

A Claim Reconsideration is a formal expression by a Provider, which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service.

- Contracted providers must submit requests for claim reconsideration within 365 calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).
- Non-Contracted providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA. Providers must complete a claim reconsideration prior to submitting a claim grievance.

Claim reconsiderations may be submitted via provider secure web portal or to the address below.

Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms

Provider Claim Grievance (Level II)

A Claim Grievance is the mechanism following the exhaustion of the claim reconsideration process that allows providers the right to express dissatisfaction regarding the amount reimbursed or the denial of a particular service. All claim grievances must be submitted from the provider within thirty (30) calendar days from the date of the EOP or ERA.

- Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process.

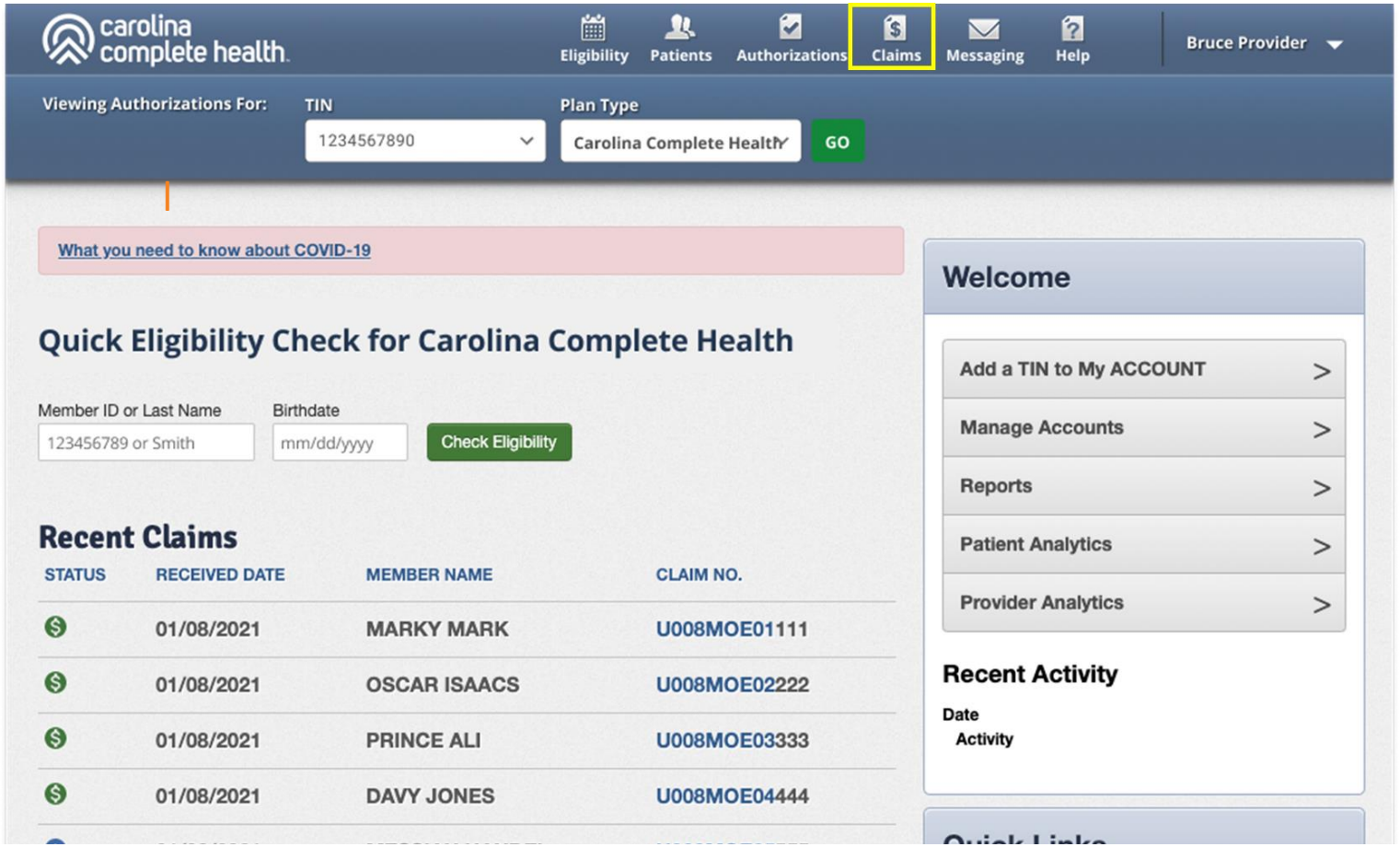
Please submit eligible claim grievances via provider secure web portal or to the address below:

Claim Grievances
Carolina Complete Health
P.O. Box 8040
Farmington, MO 63640-8040

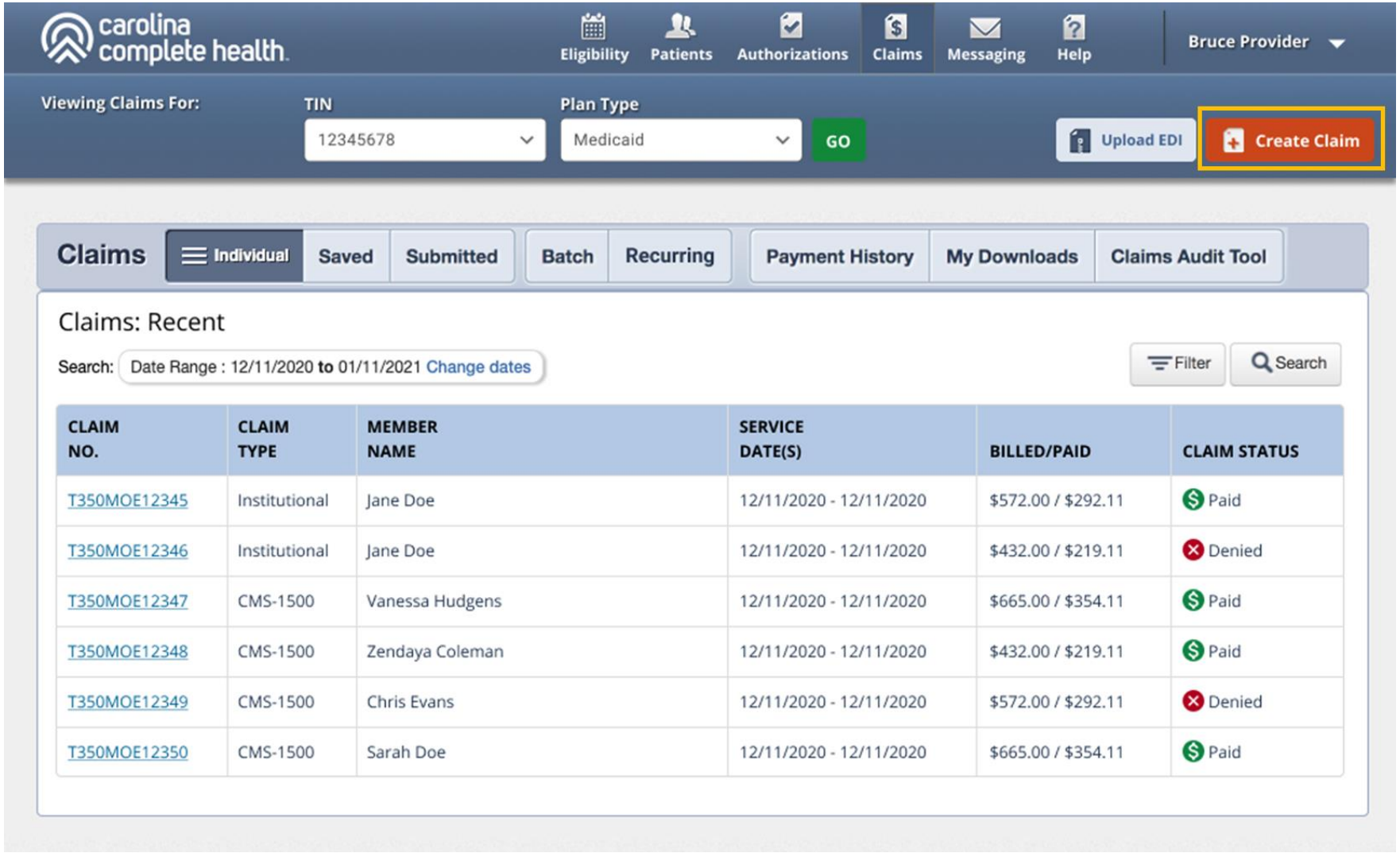
NOTE: If submitting a claim reconsideration or grievance through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms.

A decision will be made, and appropriate notification of the decision must be received by the Provider within 30 calendar days of Carolina Complete Health's receipt of the request.

Claims Submission on the Portal

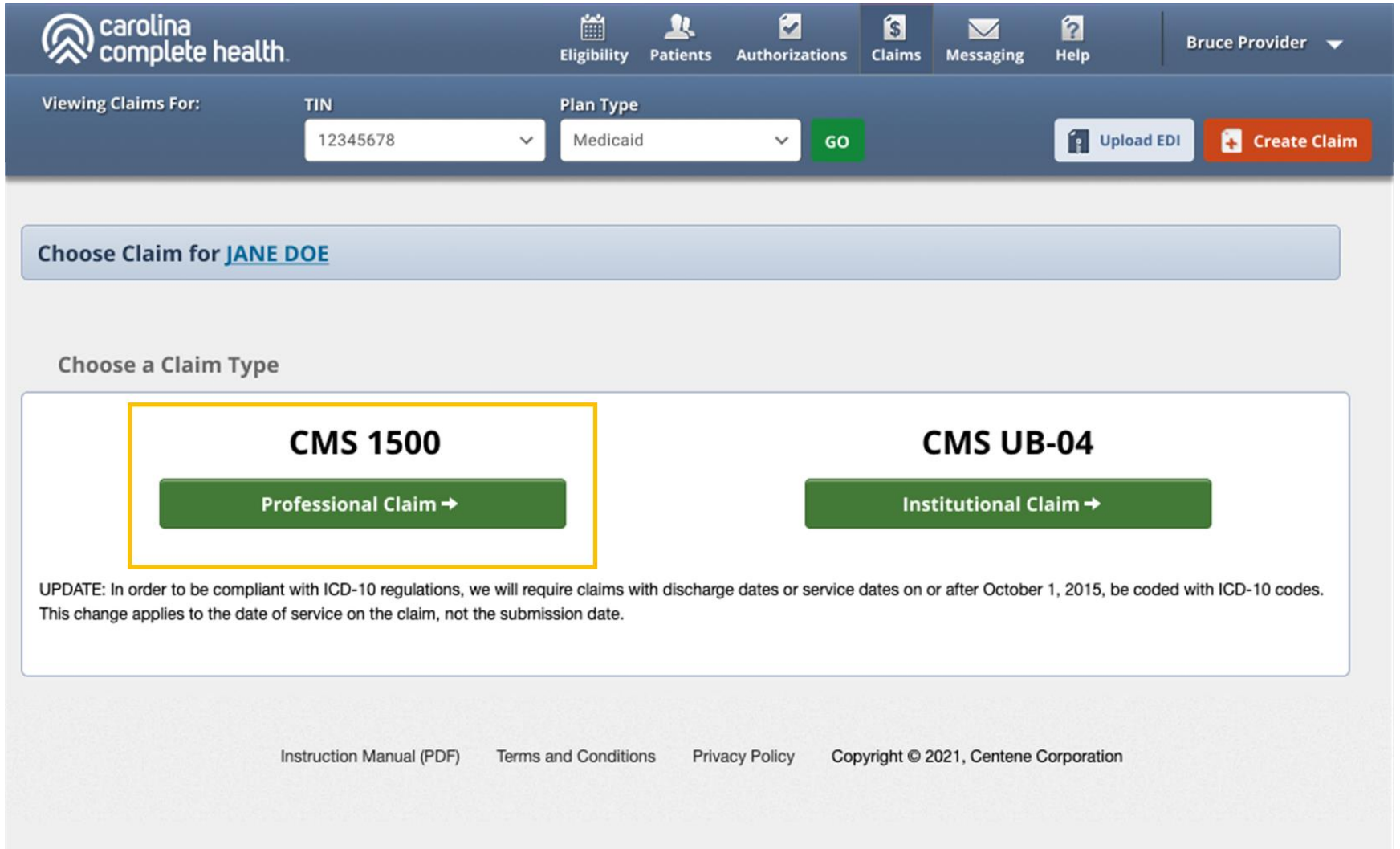


Claims Submission on the Portal

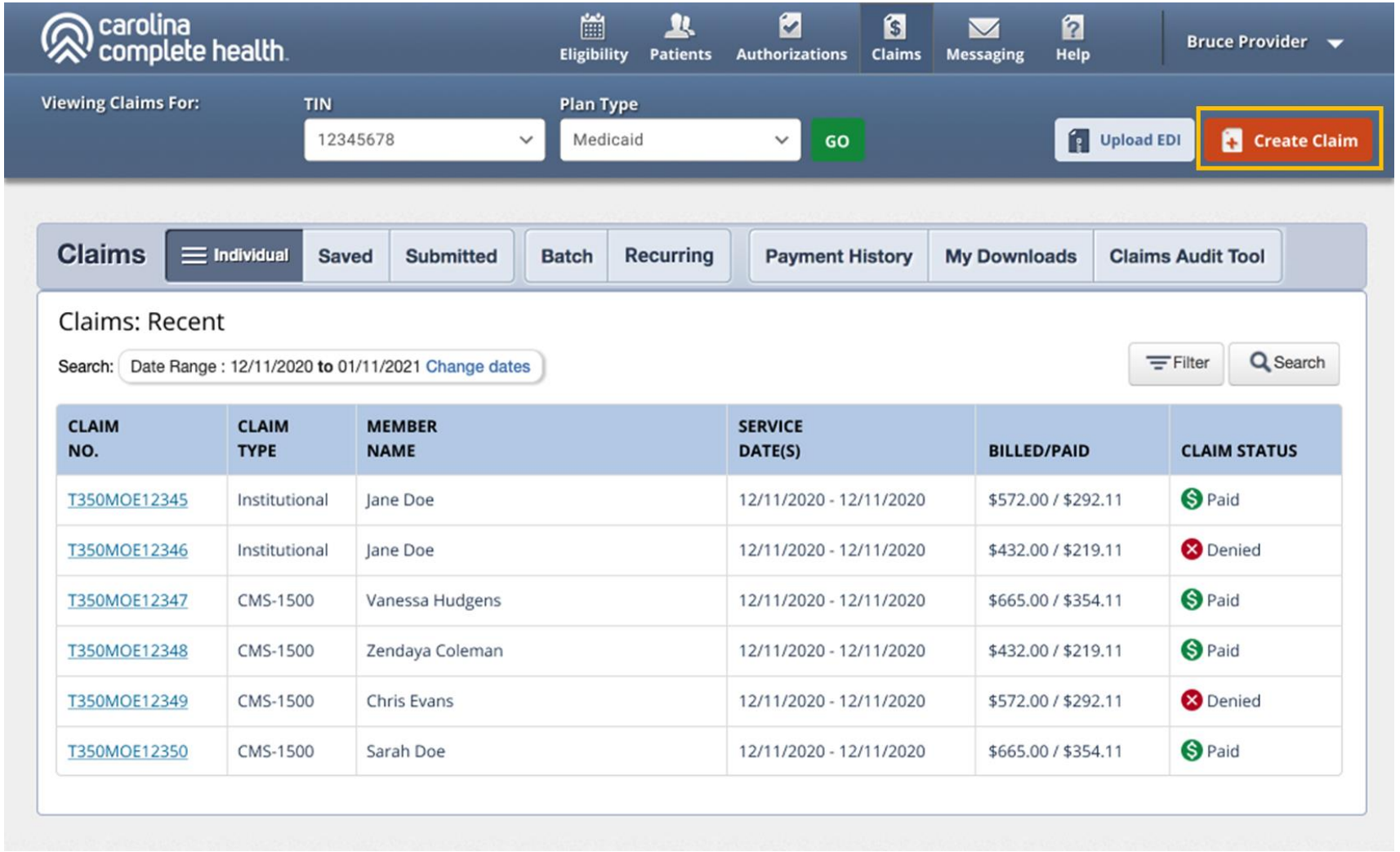


CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
T350MOE12345	Institutional	Jane Doe	12/11/2020 - 12/11/2020	$572.00 / $292.11	Paid
T350MOE12346	Institutional	Jane Doe	12/11/2020 - 12/11/2020	$432.00 / $219.11	Denied
T350MOE12347	CMS-1500	Vanessa Hudgens	12/11/2020 - 12/11/2020	$665.00 / $354.11	Paid
T350MOE12348	CMS-1500	Zendaya Coleman	12/11/2020 - 12/11/2020	$432.00 / $219.11	Paid
T350MOE12349	CMS-1500	Chris Evans	12/11/2020 - 12/11/2020	$572.00 / $292.11	Denied
T350MOE12350	CMS-1500	Sarah Doe	12/11/2020 - 12/11/2020	$665.00 / $354.11	Paid

Claims Submission- Professional

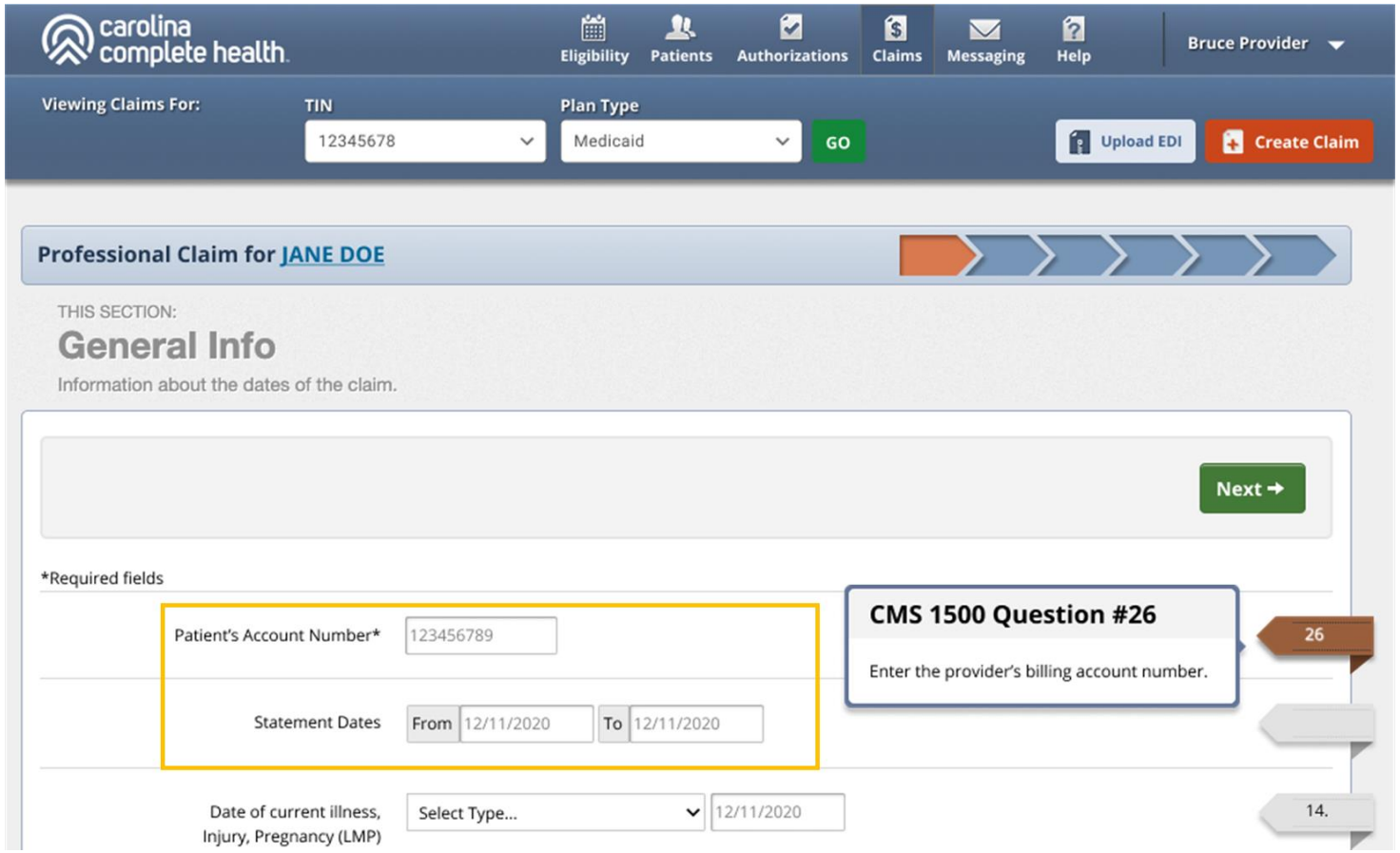


Claims Submission- Professional



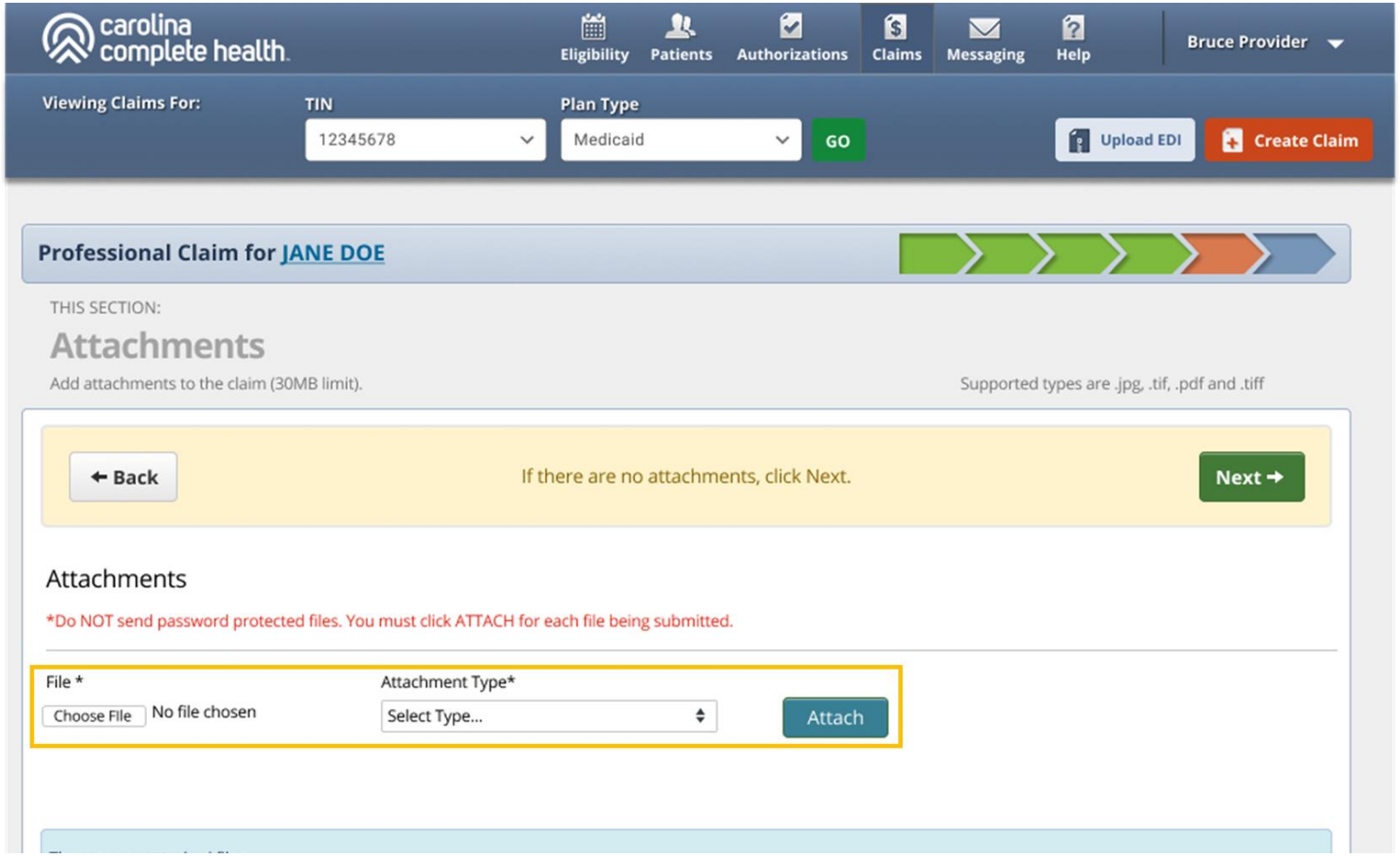
Claims Submission- Professional

In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields. Then click Next, and follow the prompts to add diagnosis codes, coordination of benefits information, and other required information.



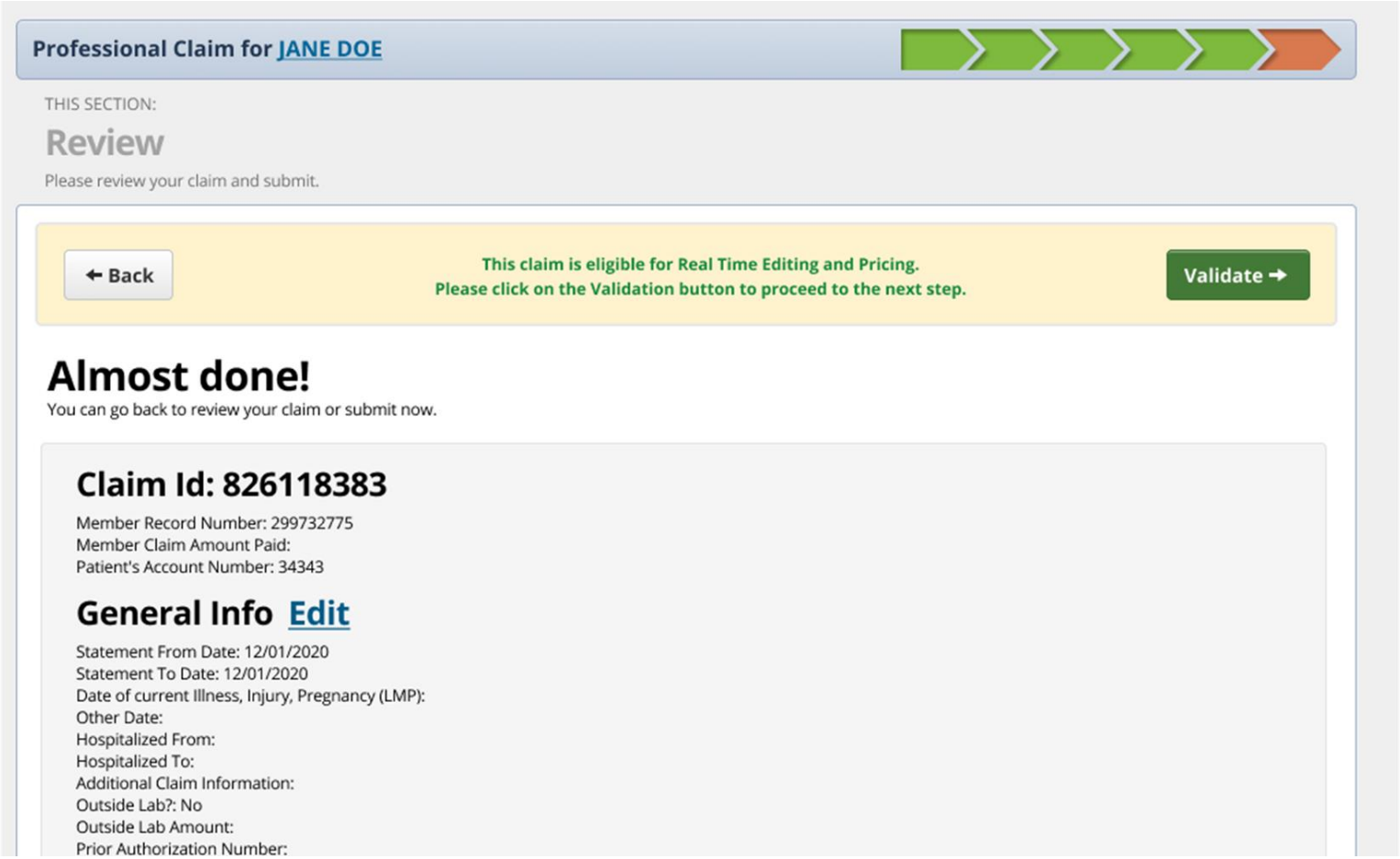
Claims Submission- Professional

If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.

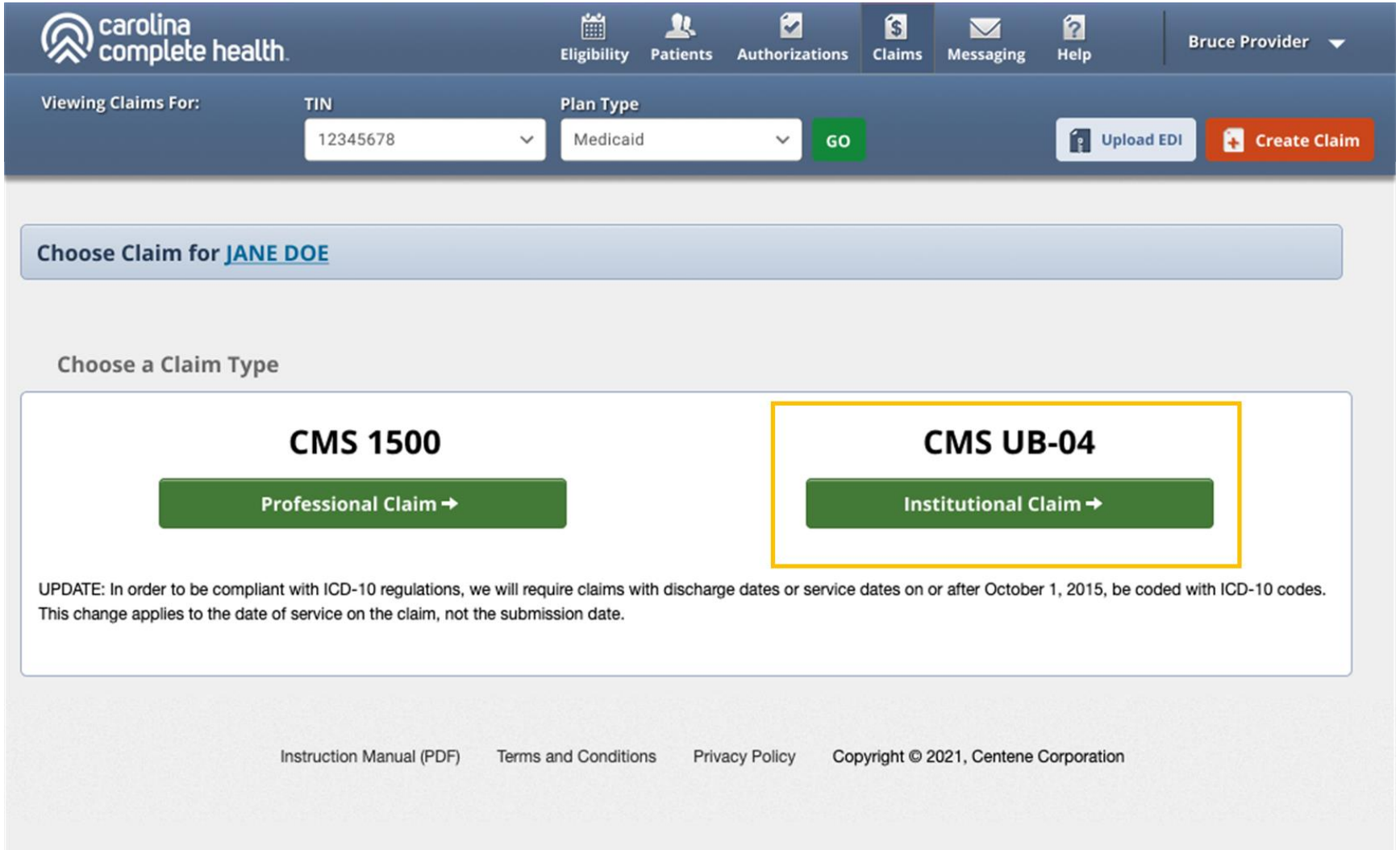


Claims Submission- Professional

Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Validate button, then Submit button

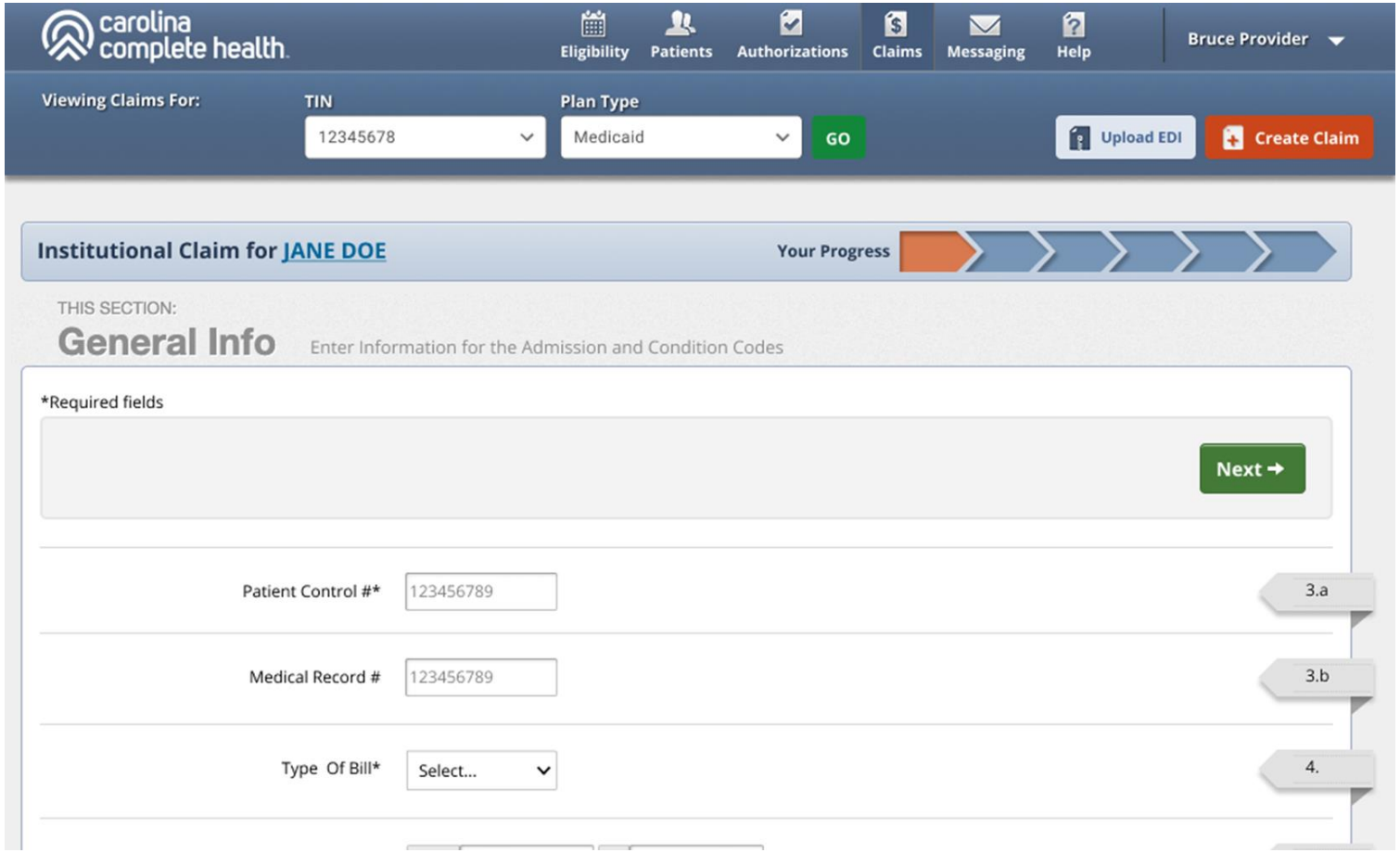


Claims Submission- Institutional



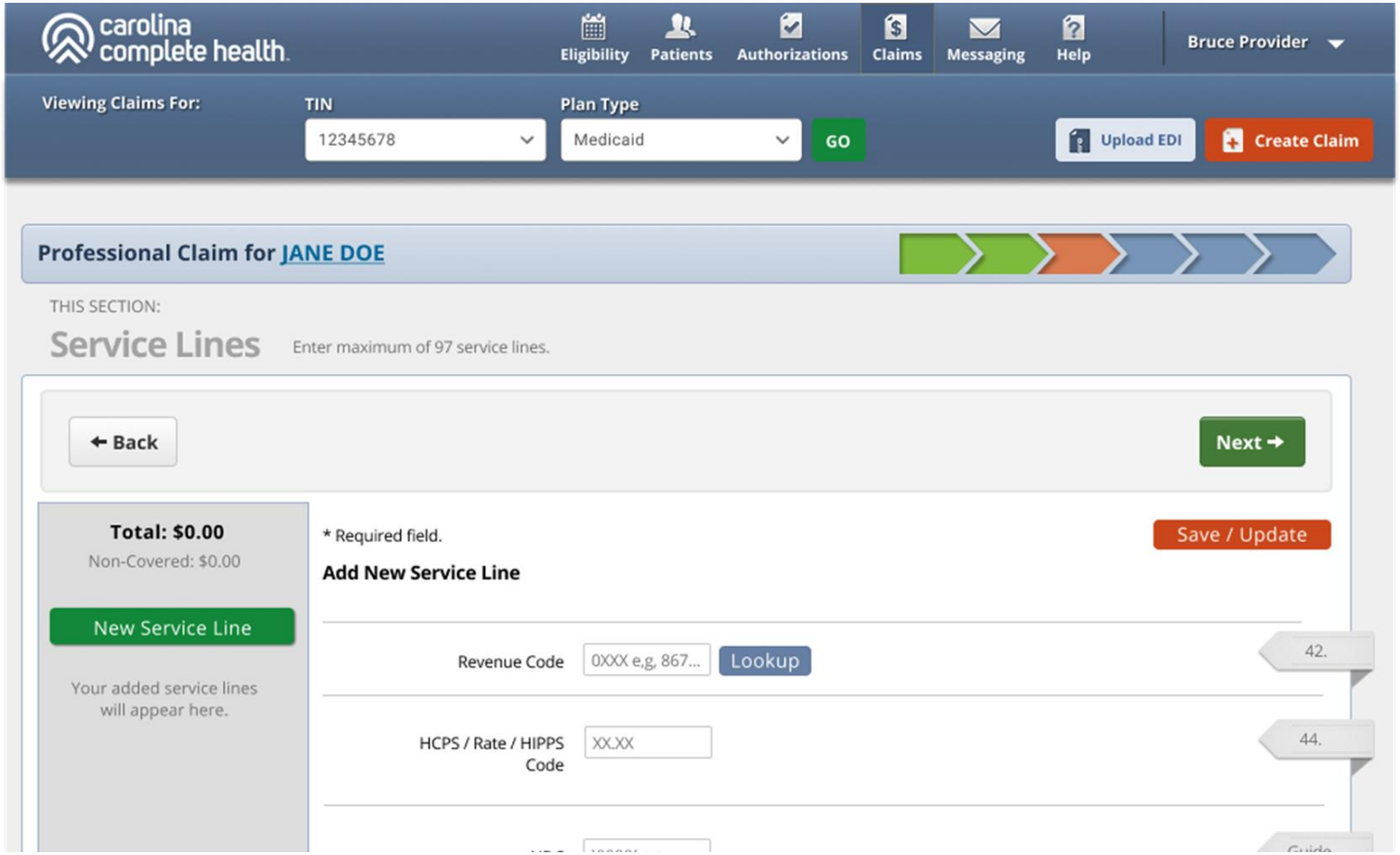
Claims Submission- Institutional

In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form. Then click Next, and follow the prompts to reflect the Billing Provider, Pay-to Provider, and Attending Provider, etc, and then click Next.



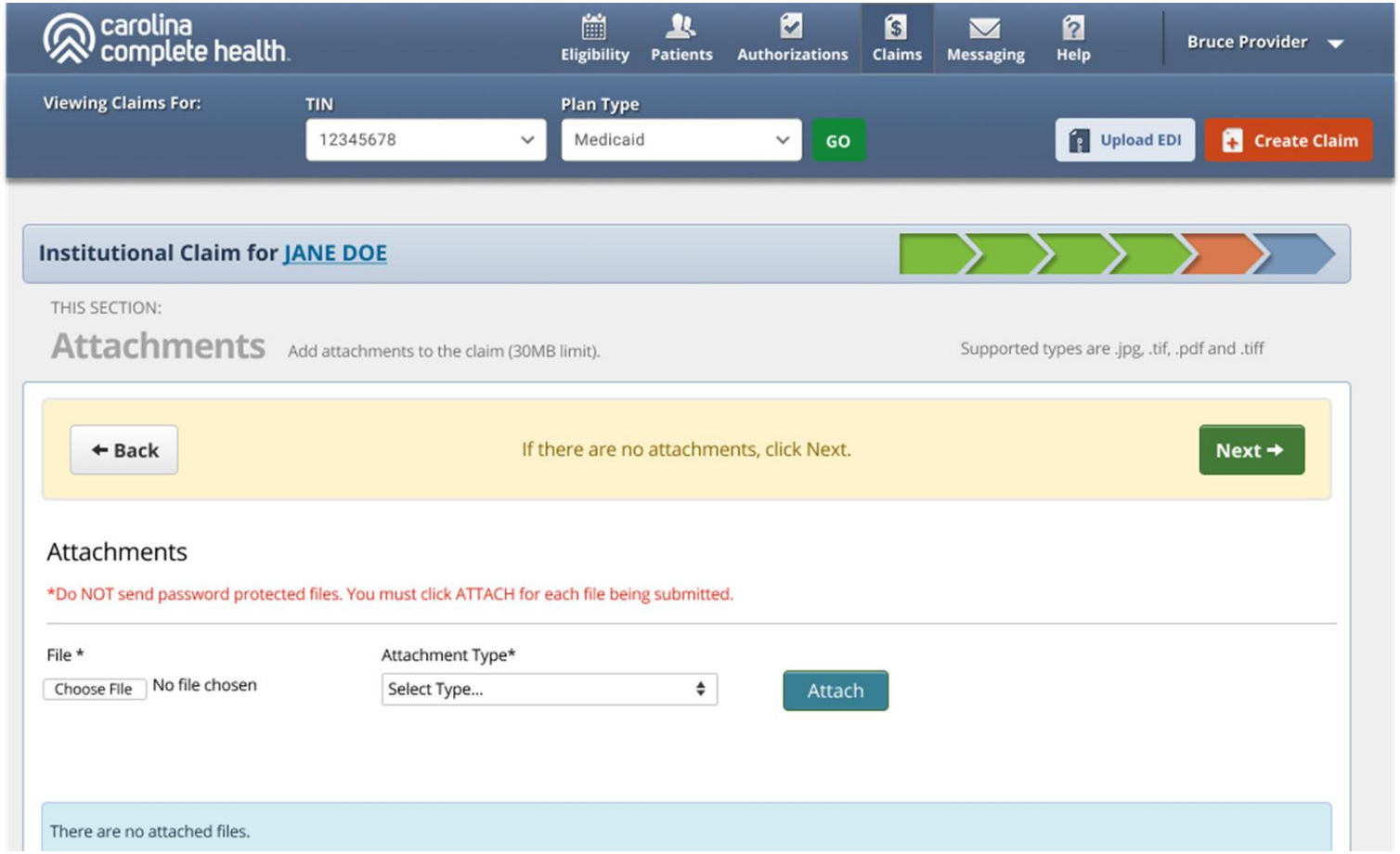
Claims Submission- Institutional

- In the Service Lines section, enter the information about the services provided.
- Click **Save/Update**, and to add a new service line click the **+ New Service Line** button on the left to add additional service lines.
- Click the **Next** button.



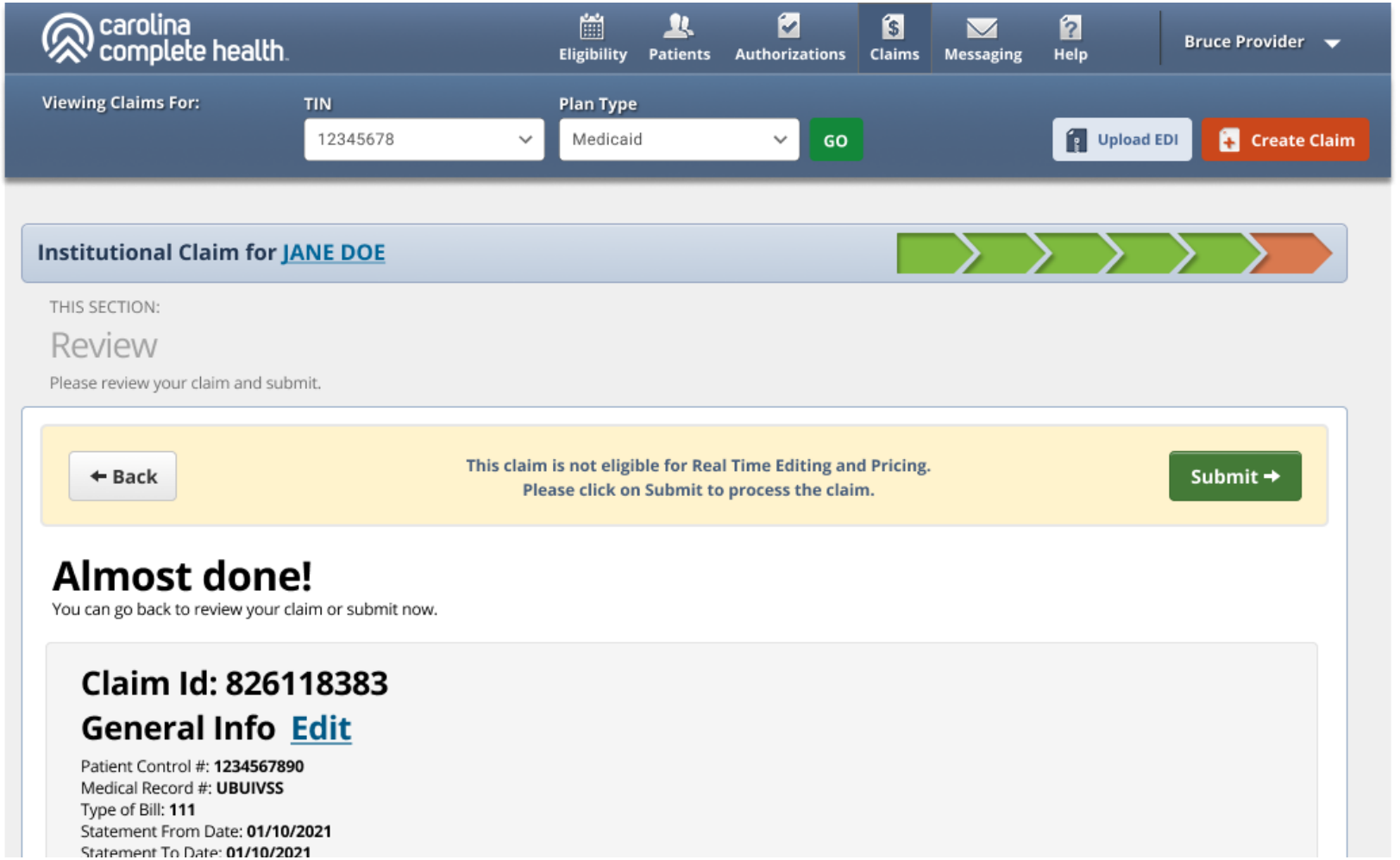
Claims Submission- Institutional

- If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.



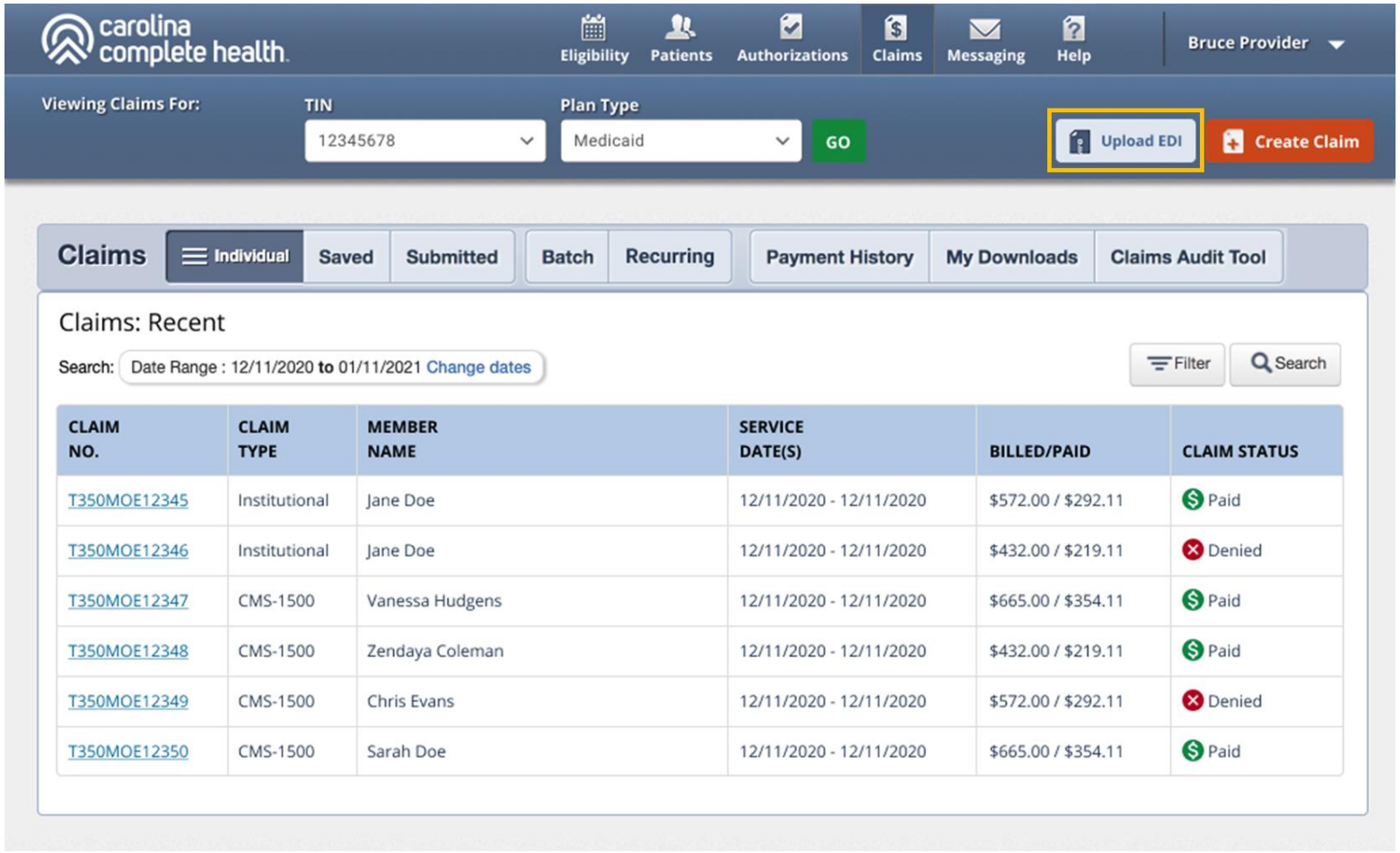
Claims Submission- Institutional

Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Submit button



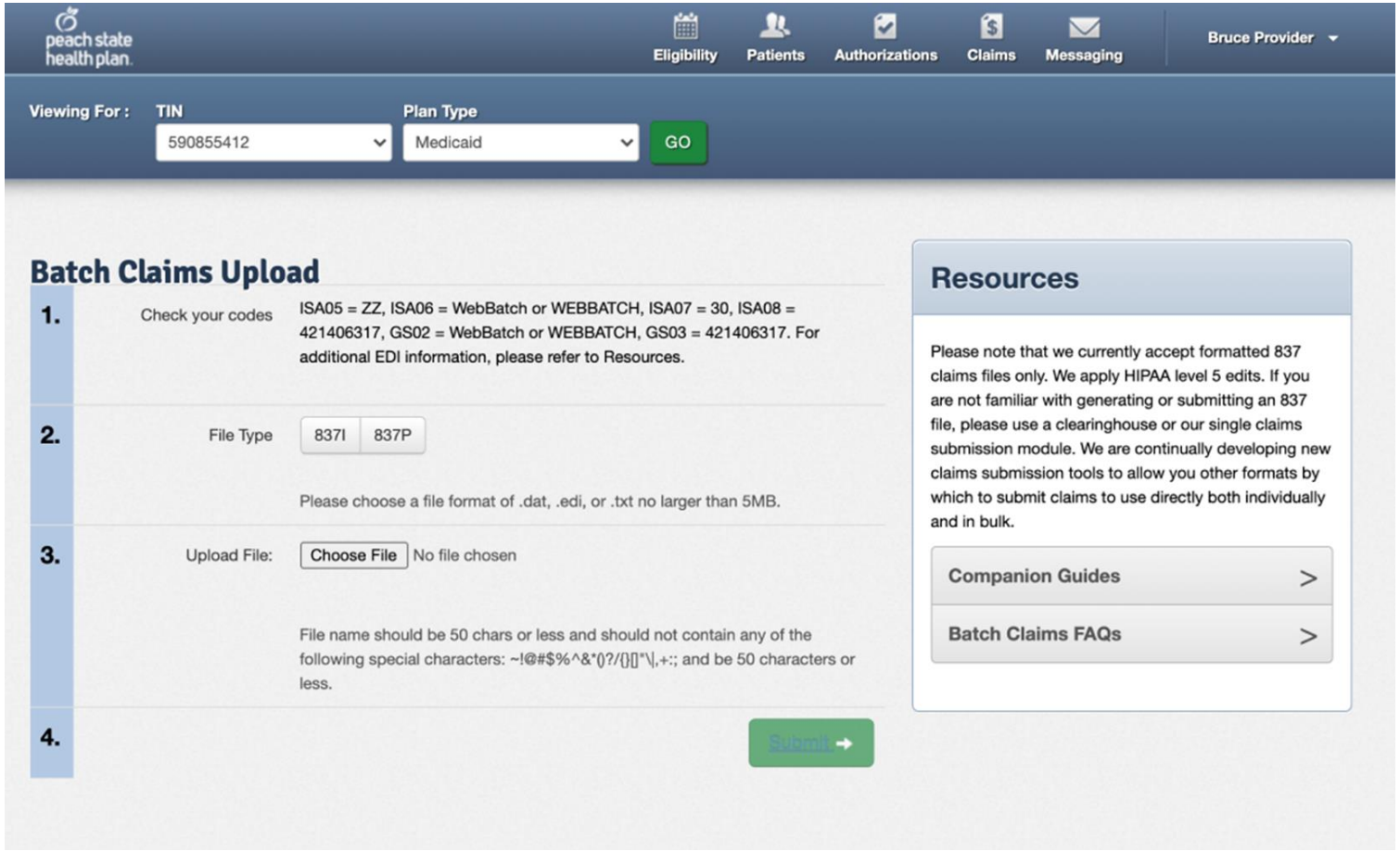
Claims Submission- Institutional

- Batch claims can be submitted through the portal by selecting the **Claims** tab at the top of the home page.
- On the claims landing page, select **Upload EDI**.



Claims Submission- Batch Claims

Once on the Batch Claims Upload screen, follow the instructions. There is a Companion Guide and FAQ included if you have any questions.



Secure Portal Additional Trainings

- Secure portal slide guide (PDF)
- Secure portal slide guide (PDF)
- Checking member eligibility and health record (PDF)
- Submitting a claim (PDF)
- Registering and Logging In (PDF)

Grievances and Appeals

Provider G&A Process

- A **Grievance** is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, claims, or any aspect of Carolina Complete Health functions.
  - After the complete review of grievances, **not** related to claims, Carolina Complete Health shall open communication with the provider to review the status of the grievance. If the grievance cannot be resolved in fifteen (15) days, the Plan will provide a status update at that time and will fully resolve all grievances within thirty (30) calendar days from the date the grievance was received.

- Complaints may be submitted in writing via mail or fax, or orally by contacting provider services.
  Filing a Provider Grievance & Appeal (Non-Claim):
  1. Online through the provider portal provider.carolinacompletehealth.com
  2. Talking to your Provider Engagement or Relations Team Member or email to CCHGrievancesAppeals@carolinacompletehealth.com
  3. Calling our Provider Services: 833-552-3876
  4. Mailing
     Carolina Complete Health
     Attn: Appeals and Grievances
     P.O. Box 8040 Farmington, MO 63640-8040

- **Providers may also submit a complaint to Managed Care Provider Ombudsman Program by phone 1-866-304-7062 or by email: Medicaid.ProviderOmbudsman@dhhs.nc.gov**

Member G&A Process

- A beneficiary's authorized representative, or beneficiary's provider (with written consent from the beneficiary) may file an appeal or grievance.
- Beneficiary **Grievances** include but are not limited to quality of care; personal behavior of provider or employee; failure to respect a beneficiary's rights; harmful administrative process or operation.
- Carolina Complete Health will send a letter to acknowledge the grievance within 5 days of receipt of the grievance and to notify of our decision within 30 days of receipt of the grievance.
  - Exception- If a 14-day extension is requested by the party that submitted the grievance or Carolina Complete Health required additional information.
  - External review of second level grievances may also occur.
- Beneficiary Appeals and grievances can be filed several ways:
  - Call Beneficiary Services: 1-833-552-3876
  - Electronically by fax: 1-833-318-7256
  - Email to: CCHGrievancesAppeals@carolinacompletehealth.com
  - In person or by mail at:
    Carolina Complete Health
    Appeals and Grievances
    1701 North Graham St, Suite 101, Charlotte, NC 28206
  - If a Beneficiary needs support or education about their rights and responsibilities under NC Medicaid they can contact the NC Medicaid Ombudsman by email at: ncmedicalidombudsman.org or by Phone: 1-877-201-3750
- In addition to the two levels of appeals, there is a **State Fair Hearing** process.
  - Beneficiaries will be notified of their rights to a State Fair Hearing, if applicable, in writing upon resolution of their appeal.

Clinical Policy

Clinical Policies

- Providers contracted with Carolina Complete Health are responsible for upholding CCH clinical policies.
- Providers with questions about any clinical policy should contact their provider relations representative for additional information or ask to be connected with the plan's medical management team.
- Clinical policies are posted to the Provider website https://network.carolinacompletehealth.com/resources/clinical-policies.html

Medical Management

Phone: 1-833-552-3876

Fax: 1-833-238-7689

CCHN Clinical Policy Workgroup

Medical policy work is currently focused on five target groups:

- Primary Care
- Pediatrics
- Behavioral Health
- Emergency Medicine
- OB/GYN

Roles/Responsibilities for Medical Policy Workgroup participation include, but are not limited to:

- Participate in parliamentary style run of all workgroup meetings
- Support ongoing efforts to identify, develop and maintain necessary medical policies and clinical care guidelines
- Email CCHNMedicalPolicy@cch-network.com with interest and/or feedback.

Provider are encouraged to provide feedback on clinical policies, particularly if providers notice any barriers to treatment due to a clinical policy.

- Feedback will be shared with CCHN clinical policy workgroups

Compliance Training

Compliance Training

- As a Carolina Complete Health medical provider, you are provided annual awareness training about the following topics:
  - Privacy and Confidentiality
  - General Compliance and Business Ethics
  - Fraud, Waste, and Abuse
  - Administrative Firewalls
  - Conflict of Interest
  - Gifts, the Workplace, and You
- Please review General Compliance and Fraud, Waste and Abuse Training for Medical Providers Training
  - Available on our Education and Training site
  - Attestation: https://www.surveymonkey.com/r/CCHNPO

Cultural Competency

Cultural Competency

- **Cultural Competency and CLAS Tribal training available on Education and Training page**
- Complimentary Interpretation Services
  - As a CCH provider, you have access to interpretation services:
  - **Language Line:**
    Toll Free 1-866-998-0338
    Account Number 13982
    Medicaid PIN #6329
- All customer service phone lines will be TTY and TDD capable for different languages and the deaf
- CCH material is available minimally in English and Spanish
- For assistance with cultural competency issues and/or educational sessions, please contact provider services at the number above or discuss with you provider engagement specialist

Wrap Up

Evaluation

- We value your feedback!
  - Please take the time to evaluate this course and add any comments you may have.
  - We will tabulate responses and comments. These summaries will be used in the formation of future courses on any specific topic that our participating providers find beneficial.
  - Future courses may be held regionally, face-to-face, or via webinars. Our intent is to keep all of you informed as much as possible.
  - https://www.surveymonkey.com/r/YYZH2KB

Additional Onboarding Trainings

View the PHP Streamlined Orientation

- Recording
- Slides

On-demand CCH Orientation

- Recordings

Additional onboarding trainings: Education & Training

1. Cultural Competency
2. EPSDT
3. Provider Compliance

Attestation and Feedback:

- https://www.surveymonkey.com/r/YYZH2KB

Connect with Us!!

- Contact us!
  - Phone Number:
    1-833-552-3876
    TDD/TTY: 1-800-735-2962
  - Email: networkrelations@cch-network.com
- To get a copy of training and educational materials:
  - https://network.carolinacompletehealth.com/resources/education-and-training.html

Questions?