



**Partners'/CCHN Tailored Plan  
General Information Session Office Hours  
February 4, 2025  
12:00PM**

# Agenda

## **General Information and Policy Flexibility Notifications**

- ▶ Who We Are: Partners and Carolina Complete Health
- ▶ Hurricane Helene Policy Flexibilities
- ▶ Policy Flexibilities for Tailored Plan Launch
- ▶ NC DHHS News

## **Operational Information**

- ▶ Verifying Member Eligibility
- ▶ Provider Portal: ProviderConnect
- ▶ Prior Authorization (Submission, Timeframes, Evolent)
- ▶ Claims, Billing, and Payment (Submission, EFT)

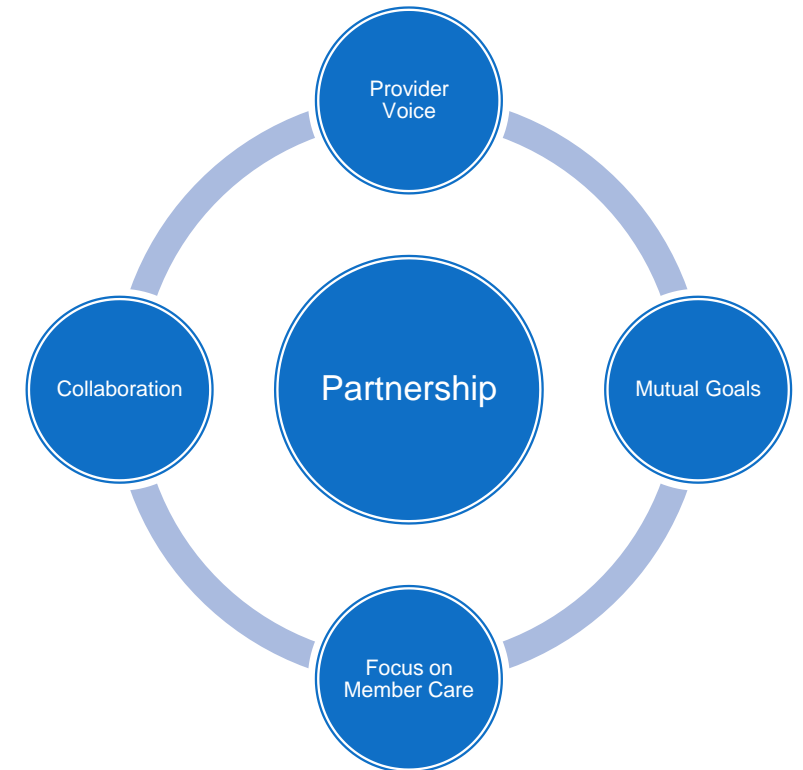
## **Provider Resources**

- ▶ Partners' Physical Health Communications
- ▶ Provider Support and Who to Contact
- ▶ Provider Resources
- ▶ Questions



# Carolina Complete Health and Partners

- **Partners Health Management** and **Carolina Complete Health** bring a shared vision for true partnerships with all providers across the system of care, which is reflected in our network management model.
- As the only Provider-led Entity (PLE), **CCH** seeks 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.
- Since **Partners'** inception as a managed care organization, **Partners** has executed a strategy of collaboration with providers.
- Our mutual goals is to aid provider success as they offer accessible, robust and effective services for members.



# DHHS Hurricane Helene Flexibilities

## NC Medicaid Temporary Flexibilities Due to Hurricane Helene

- ▶ Now, all NC Medicaid Hurricane Helene flexibilities will be effective from Sept. 26, 2024, through Feb. 28, 2025.
- ▶ Provider guidance for reimbursement, enrollment and providing care for Medicaid beneficiaries
- ▶ <https://medicaid.ncdhhs.gov/blog/2024/12/12/hurricane-helene-policy-flexibilities-support-providers-and-members-dec-12-2024>



# 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://providers.partnersbhm.org/clarification-of-clinical-coverage-policy-and-hurricane-helene-flexibilities/)
- ▶ <https://providers.partnersbhm.org/clarification-of-clinical-coverage-policy-and-hurricane-helene-flexibilities/>

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: [PHManualAuthorizations@partnersbhm.org](mailto:PHManualAuthorizations@partnersbhm.org) 1-877-398-4145 – Please use this for questions that contain specific questions regarding an authorization for a Tailored Plan Member.



# No Prior Auth (PA) Flexibility Carve Outs

*\*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*

*PA should still be requested for these services during this time period.*

*Refer to [Partners Benefit Page](#) for more information regarding prior authorization requirements*



# Expiring Transitions of Care PA Flexibilities

- ▶ **Expiring Transitions of Care PA Flexibilities**
- ▶ Transitions of Care PA Flexibilities introduced during the Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan launch ended on **Jan. 31, 2025**. After this date, members will need new prior authorizations (PAs) as their current ones expire.
- ▶ Full details on these flexibilities and pharmacy PA tips are in Partners' [Provider Communication Bulletin #158](#).





# Preferred Drug List (PDL) and Pharmacy Prior Authorization (PA) Requests

## ▶ PDL and Pharmacy Prior Authorization (PA) Requests

- The Partners Pharmacy team offers strategies to help providers reduce prescription claim denials and prior authorization (PA) rejections, improving medication access and minimizing provider frustration. These tips focus on:
- Reducing PA denials caused by incomplete information.
- Selecting clinically appropriate medications from the preferred drug list (PDL).
- Preventing costly delays, duplicative reviews and appeals.

## ▶ Preferred Drug List (PDL) Guidance

- Before prescribing, check the NC Medicaid [PDL](#) to select preferred medications that do not require PA. Non-preferred alternatives are often more costly without proven clinical benefits. Categories with red headings indicate additional clinical criteria, which must be documented on the correct PA form.

## ▶ Brand vs. Generic Medications

- For PDL classes where a preferred brand is available over a non-preferred generic, providers requesting PA for the non-preferred generic must give a clinical rationale. Preferred brands typically bypass PA requirements. A complete list of these medications is available in the [NC Medicaid Pharmacy Newsletter](#).



# PDL and Pharmacy Prior Authorization (PA) Requests

## ▶ Submitting a PA Request:

- Read and complete all sections of the PA form, including any attestation statements.
- Attach required clinical documentation.
- Forms are available on [Partners' website](#).
- For assistance, contact 1-877-817-2184.

## ▶ Submission Options:

- **Electronic:** Use an EPA platform like “Cover My Meds” (fastest method).
- **Fax:** Specialty PA: **833-896-0652** | Non-Specialty PA: **866-255-7569**.
- **Phone:** Call CVS at **1-877-817-2184**.

## ▶ Requests for Additional Information:

- If CVS requests additional information, submit the requested documentation to CVS within **24 hours** to avoid administrative denials.



# PDL and Pharmacy Prior Authorization (PA) Requests

## ▶ Clinical Category Tips:

- **Anti-epileptic agents:** For seizure disorders, include the diagnosis on the prescription to access both preferred and non-preferred medications.
- **A+KIDS:** Submit safety documentation using the A+KIDS PA form for antipsychotics prescribed to children under 18.
- **Adult antipsychotic use:** For adults with specific severe and persistent mental illness (SPMI) diagnoses, include “Meets PA Criteria” handwritten on the prescription or in e-prescription comments to bypass PA for preferred antipsychotics. Requests for non-preferred agents require a PA. **The qualifying diagnoses include:**
  - Schizophrenia
  - Schizophreniform disorder
  - Schizoaffective disorder
  - Delusional disorder
  - Brief psychotic disorder
  - Shared psychotic disorder
  - Psychotic disorder Not Otherwise Specified (NOS)
  - Bipolar disorder
  - Major depressive disorder with psychotic features
  - Treatment resistant depression (antipsychotic use for TRD is adjunctive only)
  - Tourette syndrome
  - Other psychoses
- **Hepatitis C:** PA is not required for **Mavyret®** or generic for **Eplusa®**
- **Opioid partial agonist Medications for Opioid Use Disorder (MOUD):** Preferred agents not requiring PA include:
  - Brixadi™, buprenorphine-naloxone SL tablet (Suboxone®), Suboxone® SL Film, Sublocade® syringe.



# 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-on-provider-guidance.pdf>



# Vaccine for Children Program

## ▶ Update on the Vaccine for Children Program for Displaced NC Medicaid Beneficiaries

- Children with NC Medicaid temporarily living in another state can get a free Vaccine for Children (VFC) vaccine from any VFC provider in that state.
- <https://medicaid.ncdhhs.gov/blog/2024/12/20/update-vaccine-children-program-displaced-nc-medicaid-beneficiaries>

## ▶ This bulletin applies to NC Medicaid Direct and NC Medicaid Managed Care.

- Children with NC Medicaid temporarily living in another state can get a free Vaccine for Children (VFC) vaccine from any VFC provider in that state. The VFC program is a federal program that gives free vaccines to children ages 18 and under.
- VFC providers can include local health departments, Federally Qualified Health Centers (FQHCs) and pediatrician offices. A pharmacy may be a VFC provider, depending on the state.
- Parents of children eligible for VFC can visit the Center for Disease Control's website to find a list of [local health departments by cities and counties](#) in their area. If parents need help, they may contact the [VFC Program Manager](#) in each state. A list of managers is available to help parents find the VFC program manager in each state. The list can be found at [VFC Program Manager](#).
- For more information, please visit [Vaccines for Children \(VFC\) Program: Information for Parents](#) webpage.

## ▶ Contact NCTracks Call Center, 1-800-688-6696

# Important Information: Personal Care Services

- ▶ The rate methodology for providers rendering Personal Care Services (PCS) in congregate setting was originally planned to change effective Jan. 1, 2025. To provide additional support, the rate methodology changes will be delayed until **April 1, 2025**.
- ▶ **Impacted Providers: Personal Care Services for Beneficiaries in Congregate Settings**
  - Special Care Home – 99509-SC
  - Adult Care Homes – 99509-HC
  - Combination Homes – 99509-TT
  - Supervised Living Facilities for adults with MI/SA – 99509-HH
  - Supervised Living Facilities for adults with I/DD- 99509-HI
  - Family Care Homes – 99509-HQ
- ▶ **Impacted Procedure Codes:** Only procedure code 99509 and modifiers SC, HC, TT, HH, HI, HQ will be impacted by the change.
- ▶ For additional details, review the information in the December 20<sup>th</sup> Medicaid Bulletin: [“Personal Care Services Rate Reimbursement Methodology for Individuals Living in Congregate Settings”](#)
- **Impacted CPT Code:** Only procedure code **99509 and modifiers SC, HC, TT, HH, HI, HQ** will be impacted by the change.
- Reimbursement will no longer be based on the actual time spent delivering the service on a specific day. Instead, reimbursement will be based on a calculated per diem (daily) rate.
- Per diem rates will be based on the number of total units prior-approved for PCS services to each specific beneficiary for an authorized period.



# PCS Per Diem Rate Change: Provider Tips

- Provider should bill their usual and customary charge. Continue using the same claim form type.
- When billing per diem, each day of care should be listed on a separate line.
- **A claim line that spans multiple dates or includes a unit greater than one, will deny.**
- Claims lines submitted for dates of service on or after the effective date must be billed for a single date of service and bill 1 unit.
- Claims created in advance under the current guidelines of 1 unit = 15 minutes will not be compatible with the new billing guidelines of 1 unit per day.



# PCS Per Diem Rate Change: Q&A

- Q: Can multiple claims be billed at one time?
  - A: Yes, 1 claim line = 1 date of service, and a full month of claim lines (28, 29, 30 or 31 lines) can be on a claim.
- Q: Can a claim be submitted weekly?
  - A: Yes
- Q: Should the calculated daily rate be included in the claim when filing?
  - A: No, the provider should bill 1 unit per day and Carolina Complete Health's billing system will calculate the daily rate.
- Q: With this new change, does billing have to be completed monthly, only?
  - A: No, billing can be completed at the same cadence as before; however, 1 unit must be billed per day.
- Q: Will the last day of the month be automatically cutback to the lower percentage if the approved PCS hours are runs out before the end of the month?
  - A: Yes





# Personal Care Services (continued)

- ▶ **If your organization provides Personal Care Services to Medicaid Direct Members, please see below opportunities from NC Medicaid:**
  - NC Medicaid will invite providers to virtual office hours January through March to address any questions about the daily rate reimbursement process.
  - NC Medicaid will meet with providers during office hours and review with them previously paid claims and walk them through how to submit claims that align with the daily per diem methodology
  - Dates, times, and registration links are available via the [NC Medicaid Bulletin](#).



# New Clinical Coverage Policy for Cell and Gene Therapies

## ▶ New Clinical Coverage Policy for Cell & Gene Therapies

Effective Jan. 1, 2025, NC Medicaid will cover U.S. Food & Drug Administration approved cell and gene therapies:

<https://medicaid.ncdhhs.gov/blog/2024/12/20/new-clinical-coverage-policy-cell-gene-therapies>

- ▶ This bulletin article applies to NC Medicaid Direct and NC Medicaid Managed Care.
- ▶ A new clinical coverage policy (CCP) will provide coverage for U.S. Food & Drug Administration (FDA) approved cell and gene therapies **effective Jan. 1, 2025**. Please consult CCP 1S-13 located on the [NC Medicaid Program Specific Clinical Coverage webpage](#) for detailed information regarding this new policy.
- ▶ For beneficiaries enrolled in a managed care plan, providers should contact the appropriate health plan for that beneficiary.
- ▶ **Contact** NCTracks Call Center: 800-688-6696 or [NC Managed Care health plans](#)

# 2025 CPT Code Update

- ▶ **2025 CPT Code Update related to Medicaid Direct**

Effective with date of service Jan. 1, 2025, new CPT codes have been added, some end-dated, and descriptions of some existing codes have been updated

- <https://medicaid.ncdhhs.gov/blog/2024/12/20/2025-cpt-code-update>



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Improving Lives. Strengthening Communities.®

# Member ID Card and Eligibility Check

# PCP Member Choice Update

- ▶ Partners is committed to providing members with the best possible Primary Care Provider (PCP) choices. However, members may sometimes be unable to select their preferred PCP due to panel limits.
- ▶ A “panel limit” refers to the maximum number of members a physician can manage in their practice. This limit is determined by factors such as the physician’s available time, the complexity of members’ needs and the practice’s capacity to ensure quality care. Maintaining an appropriate panel size is essential to provide adequate attention, prevent burnout and improve care quality.
- ▶ If a provider’s panel limit is reached and we cannot confirm the member’s established relationship with that provider, documentation is required to assign the member to the PCP. Providers must submit a letter on office letterhead, including the member’s name, date of birth, Medicaid ID and confirmation of either an established relationship or acceptance of the member. Alternatively, we can accept claims history showing at least six months of primary care treatment.
- ▶ Documentation should be sent by email to [PCP@PartnersBHM.org](mailto:PCP@PartnersBHM.org) or by fax to **704-884-2736** (Attention: Member PCP Choice).
- ▶ For questions, contact Renee Jenkins, Member Engagement Support Specialist, at **704-842-6488**

<https://providers.partnersbhm.org/provider-communication-bulletin-159/#5>



# Partners Tailored Plan Member ID Cards



Name:

Medicaid ID#:

Date Issued:

PCP Information:

PCP Name:

PCP Address:

PCP Phone:

This card is not a guarantee of eligibility, enrollment or payment

## Member ID Card

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

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

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



Partners

*Possession of an ID card does not guarantee eligibility.*

Check member eligibility through one of the methods below:

1. NCTracks
2. Secure web portal: <https://providers.partnersbhm.org/category/providerconnect/>
3. Provider Line: 1-877-398-4145.



# 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

Benefit Plan may list Medicaid or MC-Medicaid Carve Out Plan



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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LONG TERM : \$0.00	MEDI CARE : \$0.00	MNTL HLTH : \$0.00	MRI CAT SC : \$0.00	NEWBORN CA : \$0.00																																																															
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# Secure Provider Portal

# ProviderConnect

## ▶ 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/>



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# Physical Health Authorizations

# Pre-Authorization Lookup Tool

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/>

## Service Pre-Authorization Lookup Tool

Partners' Service Pre-Authorization Lookup Tool provides authorization requirements by service code. We have made every attempt to ensure the most current information is included in the Pre-Authorization Lookup Tool. However, use of this tool does not guarantee payment. It is the provider's responsibility to ensure proper eligibility, coverage benefits, provider contracts, correct coding and billing practices are followed. You may also refer to the [Partners Benefit Grids](#) and enter an authorization into [ProAuth](#) if an authorization is indicated.

**Non-participating/Out-of-network providers must submit Prior Authorization for all services.**

Vision Services are managed by [Envolve Vision](#).

Dental Services are managed by [NC Medicaid](#).

Complex imaging, MRA, MRI, PET, and CT scans are managed by [Evolent](#).

For details regarding pharmacy prior authorizations, visit our [Pharmacy/Medication Prior Authorization](#) page.

Enter the base code of the service you would like to check, and then select a mod:

**Updated:** December 18, 2024



# Submitting Authorizations

## Electronic Submission (Preferred)

ProAUTH via ProviderCONNECT Secure Provider Portal:

- <https://id.partnersbhm.org/>
- 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.**

## Manual Submission

**Phone:**

- 1-877-398-4145

**Fax or Email with the [Manual Authorization Request Form](#)**

• **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](mailto:PHManualAuthorizations@partnersbhm.org)

For Questions that are GENERAL and without Protected Health Information (PHI):

[PHUMQuestions@partnersbhm.org](mailto:PHUMQuestions@partnersbhm.org)

# 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)



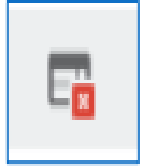
# Getting to ProAuth

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

The screenshot shows the PARTNERS ProviderCONNECT homepage. At the top left is the logo. The navigation bar includes links for Home, Medicaid Direct, Tailored Plan, Contact, Profile, and Messages. A 'Welcome,' message is visible on the right. Below the navigation bar is a dark blue menu 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 that, 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' and 'Provider Bulletin'. 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.



A screenshot of a web browser displaying the HealthTrio connect website. The browser's address bar shows the URL: pbhmbeta.healthtrioconnect.com/app/iso/outbound/CasenetProAuthStage/redirect.page/?zsesschk=b7d3ba5ac1c84e32ad2095df8714017b. A red box highlights the browser's address bar and navigation icons. The website header includes the PARTNERS ProviderCONNECT logo, navigation links (Home, Tailored Plan, Medicaid Direct, Contact, Profile, Messages), and a user greeting (Welcome, Laura). Below the header is a dark blue navigation bar with links for Provider Directory, Patient Management, and Office Management. At the bottom, a green footer bar contains links for News, Subscribe, Feedback, Fraud and Abuse, and Protecting Privacy, along with social media icons.

# 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

Date of Service From Date Date of Service To Date Inpatient Service Types Service/Procedure Service Types

01/19/2024 All

MM/DD/YYYY MM/DD/YYYY

Include Closed  Requested By Me

FILTER RESET

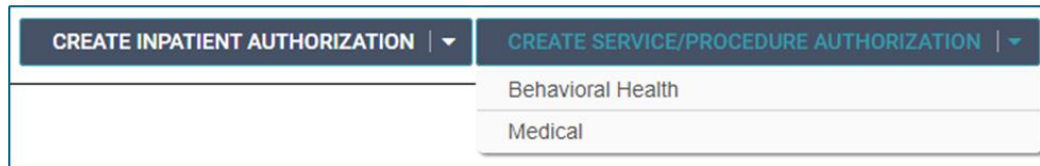
Inpatient Authorizations Summary

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



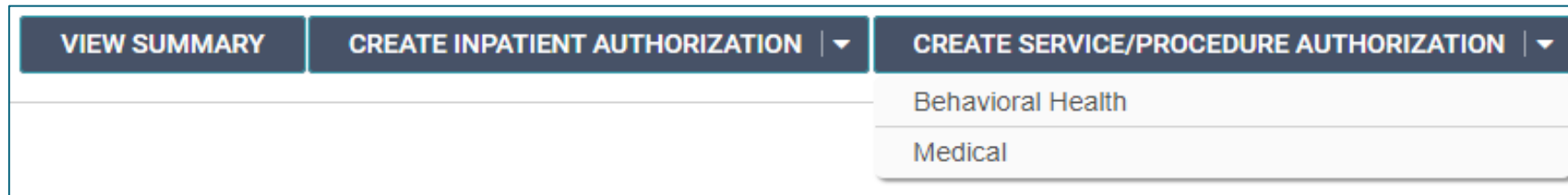
- **Inpatient services** must be submitted as an Inpatient Authorization
  - **NOTE:** Inpatient level of care is provided by hospitals
  - **ICF-IID** is not considered Inpatient
- **Outpatient services** must be submitted as a Service/Procedure Authorization

**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 row of three buttons: "VIEW SUMMARY", "CREATE INPATIENT AUTHORIZATION", and "CREATE SERVICE/PROCEDURE AUTHORIZATION". The "CREATE SERVICE/PROCEDURE AUTHORIZATION" button is expanded to show a dropdown menu with two options: "Behavioral Health" and "Medical".

# Uploading Documentation in ProAuth

- ▶ In the Prescreen section, there will be a button to “ADD ATTACHMENT” in the upper right-hand corner.
- ▶ Tip: Minimize the zoom on the browser screen if you are not seeing the buttons.

Create Service/Procedure Behavioral Health Authorization

ADD NOTE ADD ATTACHMENT (0)

Prescreen Authorization Details Services Confirmation

Prescreen

Start of Service 02/01/2024	End of Service 02/03/2024	Primary Diagnosis Opioid abuse, uncomplicated (F11.10)	Member's Applied Eligibility Med Direct B
Servicing Provider [Redacted]	Primary Procedure H0015 - SUBSTANCE ABUSE INTENSIVE OUTPATIENT (H0015)	Requested Units 2 Units	Service Type SU
Place of Service Unspecified			



# Additional ProAuth Training

- ▶ <https://www.partnerstraining.org/>
- ▶ On-demand webinar: [Register and view instant playback](#)
- ▶ [Supporting Documentation and Q&A](#)

## ProviderCONNECT Trainings

ProAuth Demonstration Video April 2024

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

[Supporting Documentation and Q&A](#)



# 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 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.

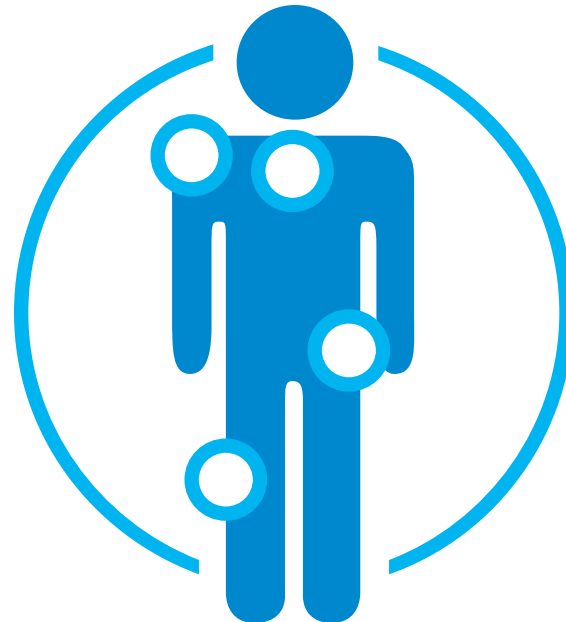


# **Evolent Utilization Management Program** **(Non-emergent, advance, outpatient imaging services)**

# 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)
<b>RadMD Access &amp; Features</b>	<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](#)



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# Claims and Payments

# 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 dark blue menu 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 white boxes for alerts: 'Provider Alert Update: ProviderCONNECT Update: UM Service Authorization Decision Letters' and 'Provider Alert: Provider Alert Archives' and 'Provider Bulletin: Provider Communication Bulletin #150 | March 2024'. On the left, a 'QUICK LINKS' section lists: 'Submit a request for Help Partners' SysAid', 'Behavioral Health Claims', 'Physical Health Claims' (highlighted with a blue border), 'ProAuth Authorizations', 'RadMD', 'Sign up for the Pyx Health Mobile App and get a FREE GIFT CARD!', and 'Partners Events'. On the right, a 'Provider Knowledge Base' section is displayed over a laptop image, listing: 'Provider News', 'Provider Tools', 'Access to Care & Utilization Management', 'Care Management', 'Finance, Claims, & Billing', 'Quality Management', 'Corporate Compliance', 'Clinical Tools', and 'Additional Resources'. A green button at the bottom of this section says 'See PKB for all your needs!'.

# Submitting Claims

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

# Claims Trends/Data

DENY: BILL PRIMARY INSURER 1STRESUBMIT WITH EOB	Prior to submitting claim, verify member’s eligibility to determine if there is a primary payer. Federal regulations require Medicaid to be the “payer of last resort,” meaning that all third-party insurance carriers must pay before Medicaid processes the claim.
DENY: PLEASE SUBMIT TO PARTNERS FOR BEHAVIORAL HEALTH PROCESSING	<p><a href="https://medicaid.ncdhhs.gov/health-plan-billing-guidance">https://medicaid.ncdhhs.gov/health-plan-billing-guidance</a></p> <p>Updated billing guidance from NC Medicaid includes logic for behavioral health vs physical health claims.</p> <p>*Please also see the 1/30/25 KIT as there may be erroneous denials for 96110 and 96127 assessments.</p>
DENY-BILL NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATES	<p>Provider data on the claim must match what is in NCTracks.</p> <p>Missing rendering and/or missing billing taxonomy is a common cause of claim processing delays and denials. Taxonomy numbers must also align with your provider data in NCTracks. Please also advise your Clearinghouse to make sure the changes made to taxonomy placement are permanent on your account going forward. Provider Guide:</p> <p><a href="https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf">https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf</a></p>
BILLING NPI NOT ON MEDICAID FILE/NOT ACTIVE ON SVC DATE	Provider data on the claim must match what is in NCTracks.
DENY: PER STATE GUIDELINES- PROCEDURE NOT SEPARATELY REIMBURSABLE	



# Known Issues Tracker

- ▶ Both Partners and CCH maintain a Known Issues Tracker. Physical Health Tailored Plan providers may reference this weekly for issues related to claims and other operational areas.
- ▶ Partners: <https://providers.partnersbhm.org/claims-information/>
- ▶ CCH: [https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH\\_Known\\_Issues\\_Tracker\\_Current.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH_Known_Issues_Tracker_Current.pdf)



# Physical Health vs. BH Billing

- ▶ On 11/25/24, NC Medicaid released updated health plan billing guidance effective 10/01 that outlined BH vs PH claim guidance.
- ▶ Health Plan Billing Guidance was since updated on 1/10/25
  - View this page for latest versions: [medicaid.ncdhhs.gov/health-plan-billing-guidance](https://medicaid.ncdhhs.gov/health-plan-billing-guidance)
- ▶ “Claims with a primary care billing or rendering provider taxonomy will be considered Physical Health” (Level 5, Primary Care Physicians)
- ▶ **KNOWN ISSUE: 96110 and 96127 denials (details on next slide)**



# Known Issues Tracker 1/30/25

- ▶ **Description:** DHHS issued guidance on "Behavioral Health – Physical Health Claim Definition to Health Plans" effective 10/01/24, initially stating that procedure codes 96110, 96105 (developmental screening) 96121, 96127 (behavioral screening) and 96146 (psychological screening) were exclusive to behavioral health. As a result, these codes were being denied because they were processed as behavioral health services under the Tailored Plan, rather than as standard screenings in pediatric primary care. However, after further review and inquiries to DHHS, updated guidance clarified that these procedure codes are shared between physical and behavioral health and can be reimbursed under either benefit.
- ▶ **Resolution:** The affected codes were removed from the BH exclusive list in accordance with NCDHHS TP BH vs PH Definition logic. System configuration to reflect this change is currently in progress. The impacted claims have been identified and will be processed once the configuration is complete.
- ▶ **Estimated Fix date:** 3/24/2025. This is the estimated date for claims that were incorrectly denied to be reprocessed and paid accordingly.
- ▶ **Providers do not need to take action at this time and should continue billing 96110 and 96127 on the physical health primary care claims.**



# Known Issues Tracker

- ▶ **Status:** CLOSED
- ▶ **Date Identified:** 12/19/2024
- ▶ **Description:** CCH has identified an issue with FQHC/RHC claims which is causing claims billed with procedure code T1015 and a HI modifier to be rejected for " Please submit to Partners/Trillium for behavioral health processing"
- ▶ **Resolution:** System configuration logic is being updated. Impacted claims have been identified for reprocessing. No further action from providers is needed at this time.



# 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.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- Partners check run scheduled is weekly on Mondays, with payment issued to providers on Tuesdays.
- Remittance Advice, also referred to as an 835 or Explanation of Payment (EOP), are issued with payment and can be accessed several ways:
  - Payspan: <https://www.payspanhealth.com/>
  - Physical copy if you receive paper check

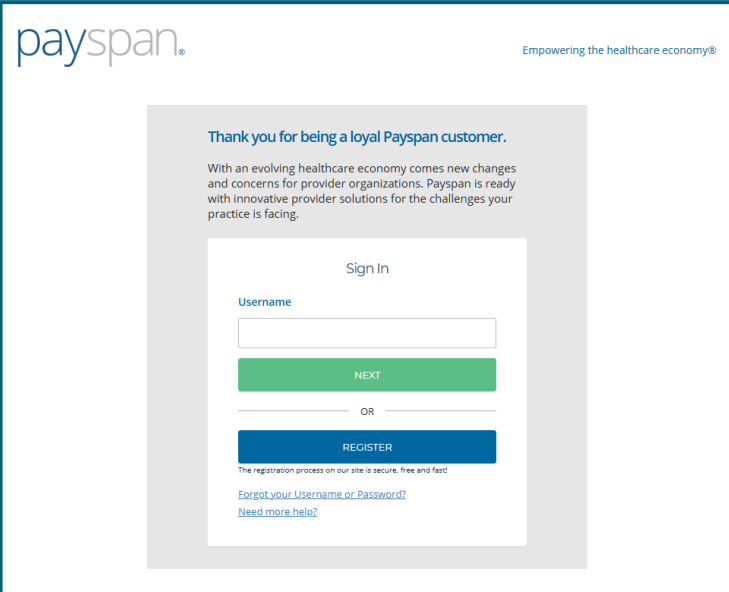
# Electronic Funds Transfer

**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](#)



The screenshot shows the Payspan web portal login page. At the top left is the Payspan logo with the tagline "Empowering the healthcare economy®". Below the logo is a message: "Thank you for being a loyal Payspan customer. With an evolving healthcare economy comes new changes and concerns for provider organizations. Payspan is ready with innovative provider solutions for the challenges your practice is facing." The main content area is titled "Sign In" and contains a "Username" input field, a green "NEXT" button, and an "OR" separator. Below the separator is a blue "REGISTER" button. At the bottom of the sign-in area, there is a small note: "The registration process on our site is secure, free and fast!" followed by two links: "Forgot your Username or Password?" and "Need more help?".

# Access ERA in Payspan

1

**Research Payments:**  
Default date range is for the past 90 days.

Payment Date: Past 90 Days    TIN:

View

Payment #
082

Payment Date: 07/24/2024  
Effective Date: 07/24/2024  
Availability Date: 07/24/2024  
Mailed Date:

Scroll down and click 'View all EOP'

2

Page 1 of 1

View

- Printable View
- Download CSV
- Payment History
- Export 5010

Payment #	Payment Date	Effective Date	Availability Date	Mailed Date
082	07/24/2024	07/24/2024	07/24/2024	

Download CSV



# Medical Home Payment and Reporting

**Where can practices find their Medical Home fee Capitation Reports?**

Via Payspanhealth.com. For providers not yet enrolled, visit <https://www.payspanhealth.com/> and click register or contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00am to 8:00pm EST. Also see attached guide. [Using Payspan to Access Medical Home Payments \(PDF\)](#)

**What section of that portal should they be directed to?**

In Payspan, under Payment details, click View, then Download CSV. Open the excel document and save a copy for your records.

**What system or portal do they need access to, to obtain said reporting? On what date of the month is the enrollment count for the Medical Home PMPM payment captured?**

1<sup>st</sup> of the month

**When does your plan project that these payments will be made to practices each month?**

20th of each month. First couple of months may be close to end of the month.





# 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



# Availity and Clearinghouse 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.
- [https://qa-essentials.availity.com/availity/Demos/REC\\_AP\\_Onboarding/index.html#/](https://qa-essentials.availity.com/availity/Demos/REC_AP_Onboarding/index.html#/)

# 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](#)

# Availity Tips

- ▶ Providers should be able to see an updated number of units dropdown.
- ▶ Availity has included a video detailing to new unit's process.

The screenshot displays the Availity web interface for adding claim information. The main form includes fields for Service From Date (03/01/2024), Service To Date (03/05/2024), Procedure Code (with a search dropdown), Revenue Code (0101 - All Incl...), Non Covered Amount, Charge Amount (4194.16), Quantity (2), and Quantity Type (UN - Unit). A video player is overlaid on the right side of the form, 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 form. The total amount for the line is \$4,194.16.

Number of units (or quantity and quantity type)

# Availity Tips

- ▶ For Additional Training, Log Into Availity
- ▶ Select **Get Trained** under **Help & Training** (Essentials) or **Help & Resources** (Essentials Pro).
- ▶ For Availity customer support for Availity products and applications, call 1-800-282-4548.
- ▶ For information about Availity product training, view [ALC FAQ](#) and [ALC User Guide](#).



# 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 to Partners 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)

<https://www.payspanhealth.com/nps>

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.

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>



# Claims Reconsideration Process

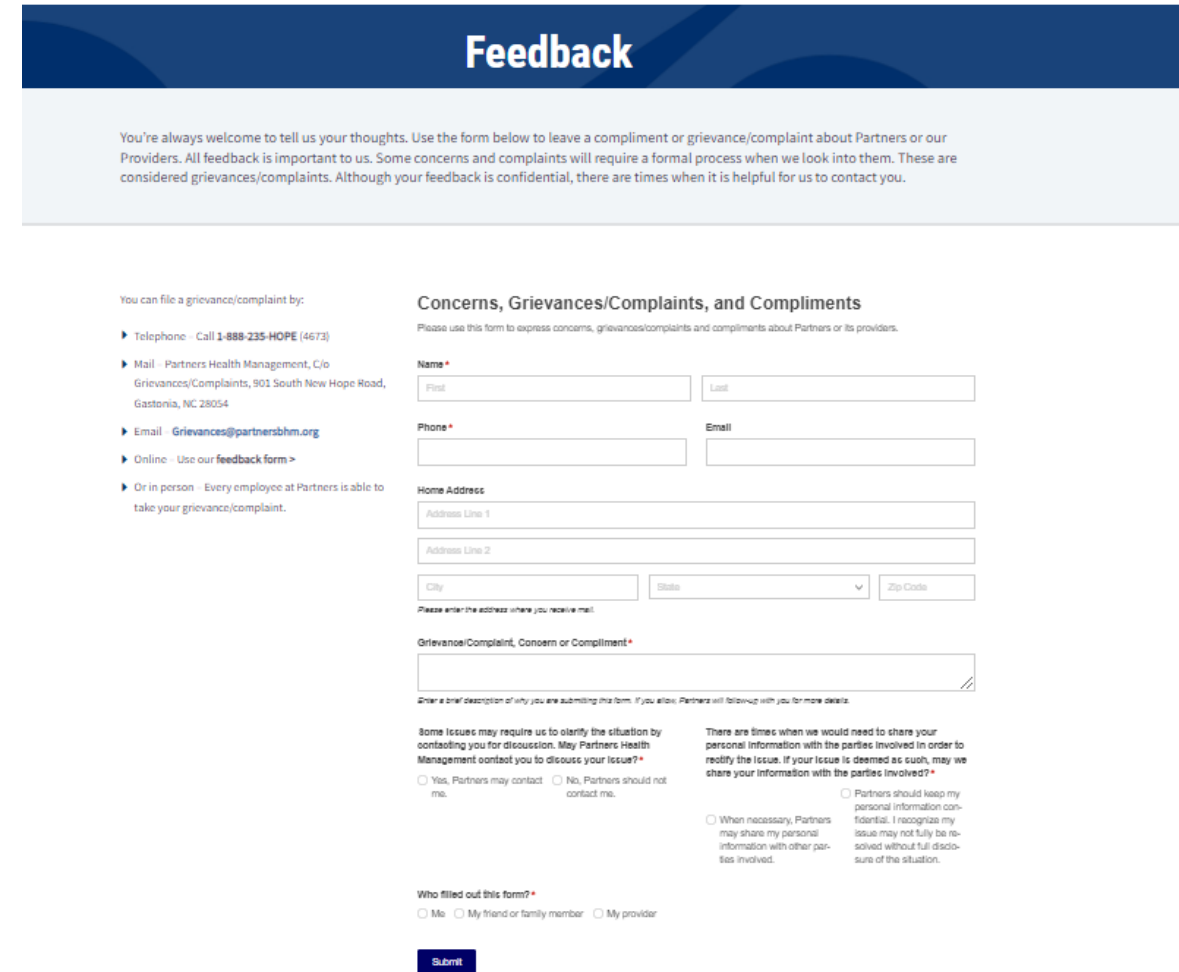
- Partners works diligently with Providers to resolve their issues; however, there are times when a Provider is dissatisfied with a Claims Processing outcome.
- If dissatisfied with the Claims Processing outcome, Providers can complete the [Reconsideration Form](#) listed below.
- Claims Analysts will 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)



**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

Home / 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](#)

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

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

# 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>

# Questions?





# Additional Provider Resources

# 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.



# 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.

# 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.

# 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](#)

# 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.



# Medical Home Fees and Common Questions

- **Where can practices find their Medical Home fee Capitation Reports?** Payspan portal. Providers are receiving training on how to navigate reports available on Payspan by CCHN, our provider team. Via Payspanhealth.com. For providers not yet enrolled, visit <https://www.payspanhealth.com/nps> and click register or contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00am to 8:00pm EST. Also see attached guide. [Using Payspan to Access Medical Home Payments \(PDF\)](#)
- **What system or portal do they need access to, to obtain said reporting? What section of that portal should they be directed to?** In Payspan, under Payment details, click View, then Download CSV. Open the excel document and save a copy for your records.
- **On what date of the month is the enrollment count for the Medical Home PMPM payment captured?** 1<sup>st</sup> of the month
- **When does your plan project that these payments will be made to practices each month? i.e., 15th of each month, by the first of the month, etc.** 20<sup>th</sup> of each month. First couple of months may be close to end of the month.
- **What type of monthly reporting is provided with each payment? Can practices download copies of these reports for their records?** Payspan reports are available for practices to review payments.
  - What details are provided in this report to assist practices with balancing their finances? See next slide.

# Medical Home Fees and Common Questions

Report Details  
Available in  
Payspan

PayerName
PaymentNumber
PaymentDate
TotalPaymentAmount
PayeeName
PayeeTIN
LOB
PCPName
PCPNPI
MemberProduct
MemberName
MemberID1
MemberID2
MemberCOVDate
MemberMonths
CAPPaymentAmount



# 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.

