Partners'/CCHN Tailored Plan
General Information Session Office Hours
July 1st, 2025
12:00PM

Last updated 6/3/25

Agenda

General Information and Policy Flexibility Notifications

- Who We Are: Partners and Carolina Complete Health
- Personal Care Services Overview
- Known Issues

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
- Tobacco Free Campus Guidance and Implementation
- Project Echo – Webinars
- Provider Support and Who to Contact
- Provider Resources
- Questions

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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.

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Hot Topics

Known Issues Tracker

Status	Health Plan	Date Issue Identified	Category	Provider Type	Est. Fix Date	Issue Description	Resolution
Open	Tailored Plans - Partners	5/20/2025	Claims; Configuration	All	6/12/2025	Identified issue with member enrollment file causing claims to deny 'L6: Please submit to Primary Insurer' incorrectly and eP: Requires Primary EOB; Auth Req'd for EPDST Consideration.	System configuration logic is being updated. Claims impacted will be identified and will be reprocessed once the system fix is completed. No further action needed from providers at this time.
Open	Tailored Plans - Partners	5/1/2025	Claims; Configuration	All	6/6/2025	Identified process workflows that are causing incorrect denials related to authorizations (EX Codes: A1,Hn) when an authorization has been obtained by the provider and billed appropriately to match the authorization. "A1: No Authorization on File', 'Hn: No Authorization on File Matches"	Processes are being updated. Claims impacted will be identified and will be reprocessed once completed. If a claim remains denied once the updates are complete, please review the claim submission for billing errors and submit a corrected claim.

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Known Issues Tracker (continued)

Status	Health Plan	Date Issue Identified	Category	Provider Type	Est. Fix Date	Issue Description	Resolution
Open	Tailored Plans - Partners	4/16/2025	Configuration	PCS - Facilities	5/29/2025	Issue identified with manual pricing for Congregate Care PCS claims according to the per diem rate effective 04/01/2025.	A manual process is in place to ensure accurate pricing. All impacted claims will be reprocessed. No further action needed from providers at this time.
Open	Tailored Plans - Partners	1/27/2025	Claims; Configuration	Behavioral Health; Physical Health	6/26/2025	Identified gaps within the hierarchy logic associated with Behavioral Health/Physical Health Claims routing that caused Partners Claims to inappropriate pay lines when they should have been rejected to submit to Partners for behavioral Health Processing. Additional updates to hierarchy logic required due to revised guidance from NC DHHS received 05/01/25, to ensure that Partners Behavioral Health Claims appropriately reject with message to submit to Partners for behavioral Health Processing.	System configuration logic is being updated. Claims impacted will be identified and will be reprocessed once the system fix is completed. Providers should continue to submit future Physical Health claims for continued processing.

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Personal Care Services [PCS]

Clinical Coverage Policy[CCP] 3L

Definition of PCS as per Clinical Coverage Policy [CCP-3L]

- Personal care services (PCS) is a benefit for the elderly, people with disabilities, and people with chronic or temporary conditions.

- It assists them with activities of daily living and helps members remain in their homes and communities.

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Care Locations for PCS

- Personal Care Services (PCS) provides direct care services to individuals residing in several settings:

- Private living arrangement (Beneficiaries under 18 years of age approved for PCS under EPSDT may receive services in the home, school, or other approved community settings)

- Residential facility licensed by North Carolina as an adult care home

- Combination home as defined in G.S. 131E-101(1a)

- Group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G.5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability or substance abuse dependency

Qualifying for PCS

To qualify for PCS, a member must have a medical condition, disability or cognitive impairment, and demonstrate unmet needs for:

- Three of the five ADLs with limited hands-on assistance
- Two ADLs, one of which requires extensive assistance
- Two ADLs, one of which requires assistance at the full dependence level
- PCS program eligibility is determined by an independent assessment conducted by a Care Manager and is provided according to an individualized service plan, based on medical necessity.

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PCS Prior Approval Requirements

CCP-3L - prior approval is required before rendering Personal Care Services in In-Home and alternate settings.

The amount of prior approved service is based on an independent assessment conducted by a Care Manager, to determine the members' ability to perform Activities of Daily Living (ADLs).

The five qualifying ADLs for the purposes of this program are bathing, dressing, mobility, toileting, and eating. Member performance is rated as:

- a. totally independent;
- b. requiring cueing or supervision;
- c. requiring limited hands-on assistance;
- d. requiring extensive hands-on assistance; or
- e. totally dependent.

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PCS Prior Approval Requirements cont.

Members must:

- a. Obtain a Physician Referral; and attestation, prior to start of service
- b. Receive an independent assessment from a TCM
- c. Meet minimum PCS eligibility requirements;
- d. Obtain a service authorization for a specified number of PCS hours per month; and
- e. Obtain an approved service plan from the provider.

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PCS Monthly Service Hour Limits

Per CCP-3L:

The following hour limits apply to members who meets PCS eligibility requirements and coverage criteria in this policy:

- 1. A member under 18 years of age may be authorized to receive up to 60 hours of service **per month**; and
- 2. A member age 18 years and older may be authorized to receive up to 80 hours of service **per month.**

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Additional PCS Service Hours

Maybe approved for members 18+ years of age who meet the eligibility criteria, and **ALL the criteria provided below,** is eligible for **up to 50 additional hours** of PCS per month.

1. Requires an increased level of supervision, based on the in-home assessment.
2. Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills.

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Additional PCS Service Hours cont.

1. Regardless of setting, requires a physical environment that addresses safety and safeguards the member because of the member's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and

2. Health record documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

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PCS Assessments, Expedited Assessments, Reassessments, Change of Status Reviews, Service Authorizations

1. PCS assessments, expedited assessments, reassessments, and change of status reviews for determining eligibility and authorizing services must be conducted by a Care Manager.
2. In-home care provider organizations are not authorized to perform PCS assessments for authorizing Medicaid services.
3. The assessment shall determine the effective date and issue prior authorization for a member approved for services.
4. The assessment determines the qualifying ADLs, the level of assistance required for each, and the amount and scope of PCS to be provided.
5. The assessment determines the end date for approval of services and the date of the next reassessment that shall be no later than 365 calendar days from the approval date.

Requirement for Physician Referral for PCS

- The member must be referred to PCS by his or her primary care practitioner or attending physician utilizing the Physician Referral form.
- The Physician Referral approved by NC Medicaid is the NC Medicaid-3051 PCS Request for Independent Assessment for Personal Care Services Attestation for Medical Need.
- Members, family, or legally responsible person are responsible for contacting their primary care or attending physician and requesting a referral for Medicaid PCS.
- Members must be seen by their physician/practitioner during the preceding 90 calendar days. If not, they must schedule an office visit to request a referral for a Medicaid PCS eligibility assessment.
- Once a referral is made by the member's physician/practitioner, the PCS assessment should be performed and is required prior to approval/authorization of services.

Requirements for PCS Eligibility Assessments

- All PCS assessments must be performed by Independent Assessors/TCM.
- All assessments for new admissions to PCS shall be face-to-face and conducted in the beneficiary's primary private residence.
- In-home assessments must contain an assessment of the beneficiary's home environment to identify any health or safety risks to the beneficiary or to the PCS aides who will provide the services.

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Requirements for PCS Reassessments

- Annual reassessments to occur on or before the end of the current services authorization date.
- PCS providers shall report discharges within seven business days of the member's discharge from PCS.
- Reassessments must be conducted face-to-face.
- Determine members eligibility for PCS.
- Determine and authorize hours of service and level of care for new PCS Referrals.
- Determine and authorize hours of service and level of care for continuation of PCS for each subsequent authorization period.
- Determine and authorize hours of services and level of care resulting from significant changes in the member’s ability to perform their ADLs.
- Provide the basis for service plan development.

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When is PCS Not Covered CCP-3L

Per CCP-3L PCS IS NOT COVERED when:

a. the initial independent assessment has not been completed;

b. the PCS is not documented as completed in accordance with this clinical coverage policy;

c. a reassessment has not been completed within 30 calendar days of the end date of the previous prior authorization period because the beneficiary refused assessment, could not be reached to schedule the assessment, or did not attend the scheduled assessment;

When is PCS not Covered cont.

d. the PCS is provided at a location other than the beneficiary's primary private residence, except when EPSDT requirements are met as listed in Subsection 2.2;
e. the PCS exceeds the amount approved by the Independent Assessment
f. the PCS is not completed on the date the service is billed;
g. the PCS is provided prior to the effective date or after the end date of the prior authorized service period;
h. the PCS is provided by an individual whose primary private residence is the same as the beneficiary's primary private residence;
i. the PCS is performed by an individual who is the beneficiary's legally responsible person, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary;

Note:
Spouses are expected to provide care for each other unless medical documentation, work verification, or other information indicates otherwise.

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When is PCS not Covered cont.

In addition to the specific criteria not covered in Subsection 4.2.1 of CCP-3L:

PCS is not covered when rendered concurrently with another substantially equivalent Federal or State funded service. Services equivalent to PCS.

a. When home health aide services and in-home aide services in the Community Alternatives Programs (CAP/Children, CAP/Choice, CAP/Disabled Adults) are rendered;

And PCS is not covered when member is receiving;

b. Private Duty Nursing (PDN)

PCS and Electronic Visit Verification- EVV

Provider(s) subject to the EVV requirements – in Home Care Providers [care rendered in the members home]:

- Must capture and verify seven (7) core in-home visit components, required under the 21st Century Cures Act to complete real-time electronic verification, tracking, and documentation.

These core components are:

1. Date of Service;
2. Location of service delivery;
3. Individual providing service;
4. Type of services performed;
5. Individual receiving service;
6. Time service begins; and
7. Time service ends.

- The qualifying services to be validated are as follows:
  - **CPT Code 99509 Modifier(s):**
    - Any member **Under 21 Years regardless of setting HA**;
    - **In-Home Care Agencies**, members **21 Years and Older HB**.

** Note: Adult Care Home Providers are not subject to the EVV requirement. Authorization is required but not visit verification.

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PCS Care at Home Modifiers

PCS care at Home modifiers:

- 99509 HA
- 99509 HB

PCS claims requiring Electronic Visit Verification (EVV): Claims for PCS using CPT code 99509 with an HA or HB modifier are subject to EVV requirements and must be submitted through HHAeXchange.

Must be built as per how the provider is contracted to operate.

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Congregate Settings

Adult Care Home Personal Care Services (ACH/PCS) claims in NC: For services on and after April 1, 2025, providers billing Adult Care Home PCS using procedure code 99509 must use modifiers SC, HC, TT, HQ, HH, or HI to indicate a single service date per line.

- Adult Care Homes – 99509-HC
- Combination Homes – 99509-TT
- Special Care Home – 99509-SC
- Family Care Homes – 99509-HQ
- Supervised Living Facilities for adults with MI/SA – 99509-HH
- Supervised Living Facilities for adults with I/DD 99509-HI

* Modifier is important but will not impact claims payment. However, it must be correct for care rendered at home, not in congregate settings.

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New Changes for 2025

Per diem (per day) pricing

• New Rules Effective April 1, 2025 (Delayed from January 1, 2025):

For claims with dates of service on or after this date, including billing for

99509 HC, SC, HQ, HH, HI, and TT:

– Each claim line must include one date of service and one unit representing one calendar day

– A claim line that spans multiple dates or include a unit greater than

one, will deny

• Daily rate will be calculated using PA information at time of adjudication

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Reimbursement Calculation [example]

Prior authorization (PA) Details:

- – Effective Date: 2025-01-01
- – Expiration Date: 2025-01-31
- – CPT/Modifier 99509-HC
- – Approved Units: 360

- Steps for Reimbursement Calculation:
  - – Determine the PA days for the effective date through expiration date = 31 days
  - – Determine daily unit by dividing the approved units (360) by the PA days (31) =
  - 11.61units/day.
  - – Calculate the reimbursable amount: daily authorized units X effective rate (11.61 X
  - $5.96 = $69.20 per day).

Service Lines

	* Date(s) of Service	* Procedure	Modifiers	* Pointers	* Amount	* Quantity	* Quantity Type	Line Item Control Number
1.	01/01/2025-01/01/2025	99509	HC	1	200.00	1.00	UN-UNITS	

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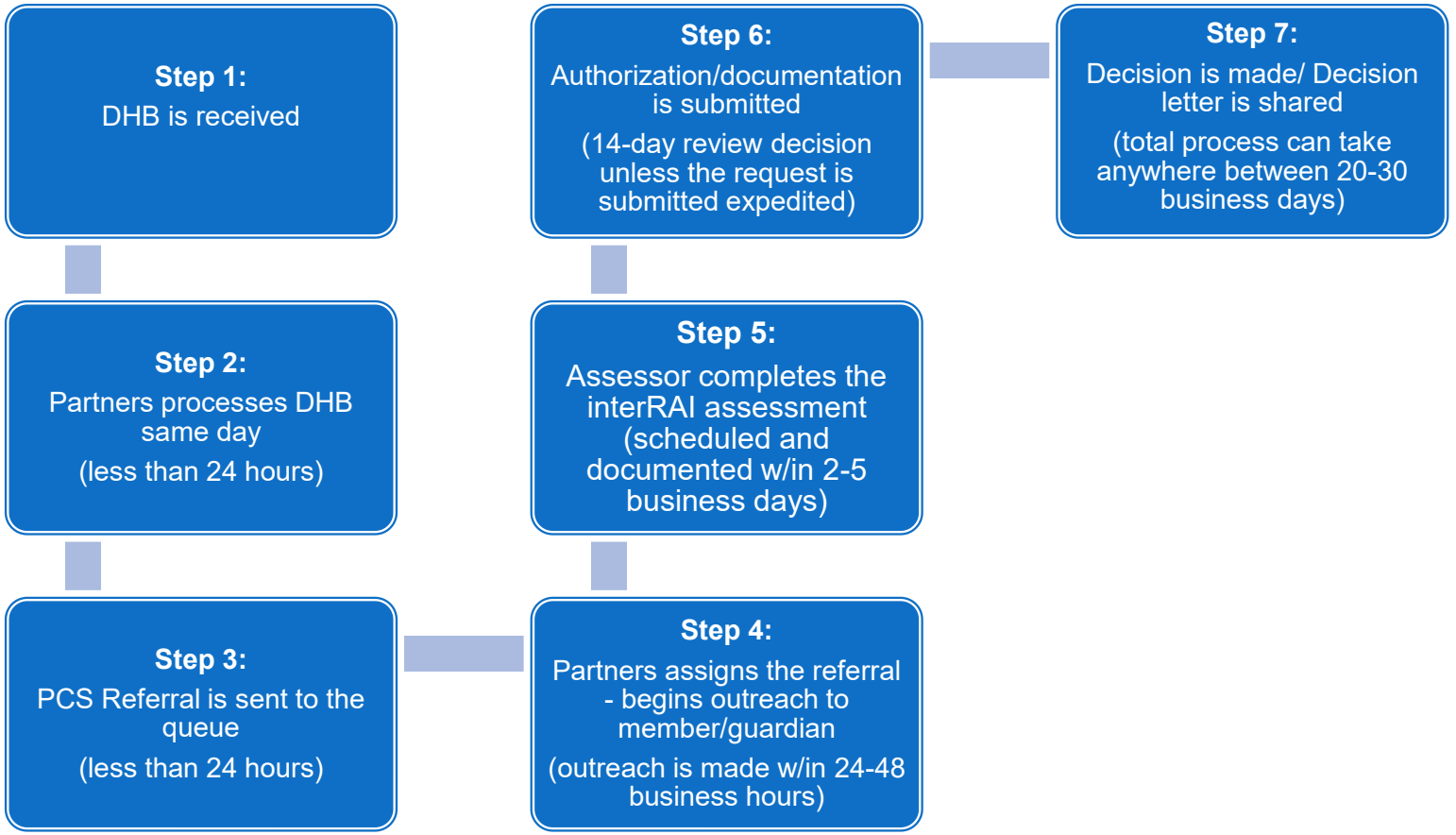
PCS Request Timeline



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Referral Workflow

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.

View the **Personal Care Services Clinical Coverage Policy**.

If you have questions related to PCS, please submit them to **Partners_PCSInquiry@PartnersBHM.org**

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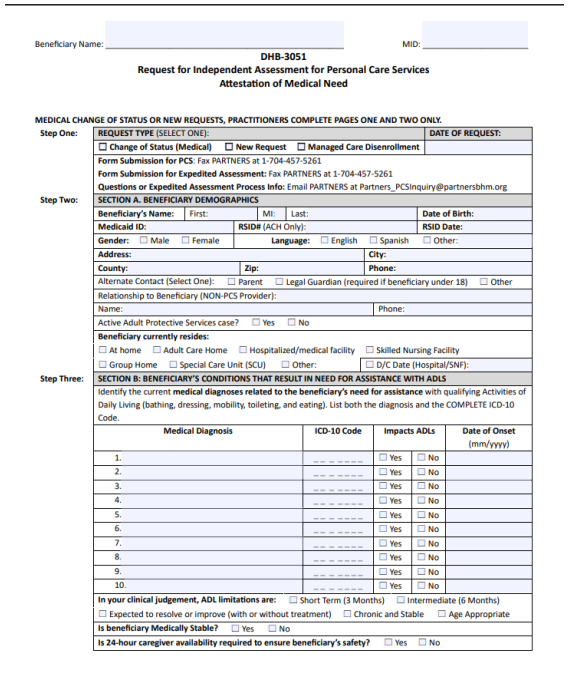
How Can I Request PCS?
DHB 3051



Beneficiary Name: _____ MID: _____

DHB-3051

Request for Independent Assessment for Personal Care Services
Attestation of Medical Need

MEDICAL CHANGE OF STATUS OR NEW REQUESTS, PRACTITIONERS COMPLETE PAGES ONE AND TWO ONLY.

Step One:

REQUEST TYPE (SELECT ONE):	**DATE OF REQUEST:**
☐ **Change of Status (Medical)** ☐ **New Request** ☐ **Managed Care Disenrollment**	
Form Submission for PCS: Fax PARTNERS at 1-704-457-5261	
Form Submission for Expedited Assessment: Fax PARTNERS at 1-704-457-5261	
Questions or Expedited Assessment Process Info: Email PARTNERS at Partners_PCSInquiry@partnersbhm.org	

Step Two:

SECTION A. BENEFICIARY DEMOGRAPHICS				
Beneficiary's Name:	First:	MI:	Last:	**Date of Birth:**
Medicaid ID:	**RSID#** (ACH Only):			**RSID Date:**
Gender: ☐ Male ☐ Female	**Language:** ☐ English ☐ Spanish ☐ Other:			
Address:			**City:**	
County:	**Zip:**		**Phone:**	
Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary under 18) ☐ Other				
Relationship to Beneficiary (NON-PCS Provider):				
Name:			Phone:	
Active Adult Protective Services case? ☐ Yes ☐ No				
Beneficiary currently resides:				
☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility				
☐ Group Home ☐ Special Care Unit (SCU) ☐ Other:			☐ D/C Date (Hospital/SNF):	

Step Three:

SECTION B: BENEFICIARY'S CONDITIONS THAT RESULT IN NEED FOR ASSISTANCE WITH ADLS

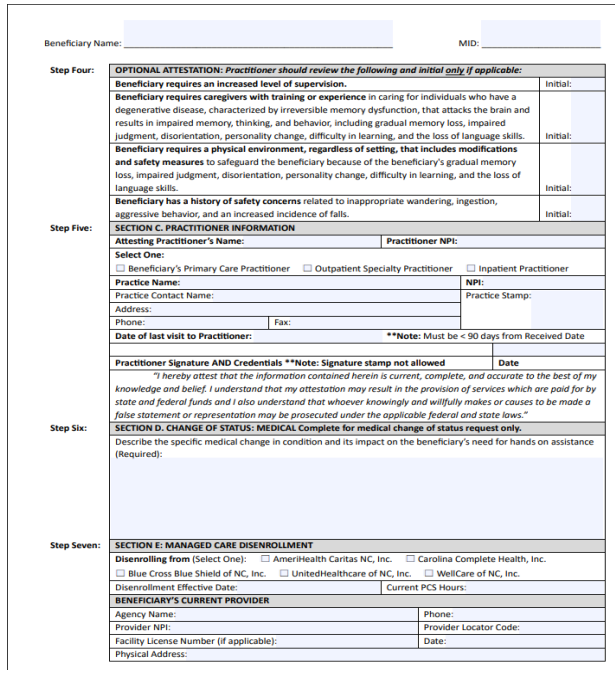
Identify the current **medical diagnoses related to the beneficiary's need for assistance** with qualifying Activities of Daily Living (bathing, dressing, mobility, toileting, and eating). List both the diagnosis and the COMPLETE ICD-10 Code.

	Medical Diagnosis	ICD-10 Code	Impacts ADLs		Date of Onset (mm/yyyy)
1.		_ _ _ _ _ _ _	☐ Yes	☐ No	
2.		_ _ _ _ _ _ _	☐ Yes	☐ No	
3.		_ _ _ _ _ _ _	☐ Yes	☐ No	
4.		_ _ _ _ _ _ _	☐ Yes	☐ No	
5.		_ _ _ _ _ _ _	☐ Yes	☐ No	
6.		_ _ _ _ _ _ _	☐ Yes	☐ No	
7.		_ _ _ _ _ _ _	☐ Yes	☐ No	
8.		_ _ _ _ _ _ _	☐ Yes	☐ No	
9.		_ _ _ _ _ _ _	☐ Yes	☐ No	
10.		_ _ _ _ _ _ _	☐ Yes	☐ No	

In your clinical judgement, ADL limitations are: ☐ Short Term (3 Months) ☐ Intermediate (6 Months)
☐ Expected to resolve or improve (with or without treatment) ☐ Chronic and Stable ☐ Age Appropriate

Is beneficiary Medically Stable? ☐ Yes ☐ No

Is 24-hour caregiver availability required to ensure beneficiary's safety? ☐ Yes ☐ No



Beneficiary Name: _____ MID: _____

Step Four:

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

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

Step Five:

SECTION C. PRACTITIONER INFORMATION	
Attesting Practitioner's Name:	**Practitioner NPI:**
Select One:	
☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner	
Practice Name:	**NPI:**
Practice Contact Name:	Practice Stamp:
Address:	
Phone: Fax:	
Date of last visit to Practitioner:	****Note:** Must be < 90 days from Received Date
Practitioner Signature AND Credentials ****Note: Signature stamp not allowed	**Date**

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

Step Six:

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

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

Step Seven:

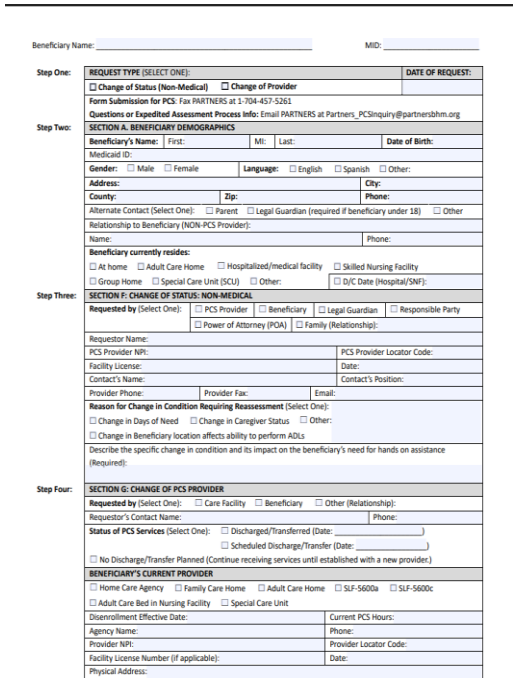
SECTION E: MANAGED CARE DISENROLLMENT

Disenrolling from (Select One): ☐ AmeriHealth Caritas NC, Inc. ☐ Carolina Complete Health, Inc.
☐ Blue Cross Blue Shield of NC, Inc. ☐ UnitedHealthcare of NC, Inc. ☐ WellCare of NC, Inc.

Disenrollment Effective Date:	Current PCS Hours:

BENEFICIARY'S CURRENT PROVIDER

Agency Name:	Phone:
Provider NPI:	Provider Locator Code:
Facility License Number (if applicable):	Date:
Physical Address:	



Beneficiary Name: _____ MID: _____

Step One:

REQUEST TYPE (SELECT ONE):	**DATE OF REQUEST:**
☐ **Change of Status (Non-Medical)** ☐ **Change of Provider**	
Form Submission for PCS: Fax PARTNERS at 1-704-457-5261	
Questions or Expedited Assessment Process Info: Email PARTNERS at Partners_PCSInquiry@partnersbhm.org	

Step Two:

SECTION A. BENEFICIARY DEMOGRAPHICS				
Beneficiary's Name:	First:	MI:	Last:	**Date of Birth:**
Medicaid ID:				
Gender: ☐ Male ☐ Female	**Language:** ☐ English ☐ Spanish ☐ Other:			
Address:			**City:**	
County:	**Zip:**		**Phone:**	
Alternate Contact (Select One): ☐ Parent ☐ Legal Guardian (required if beneficiary under 18) ☐ Other				
Relationship to Beneficiary (NON-PCS Provider):				
Name:			Phone:	
Beneficiary currently resides:				
☐ At home ☐ Adult Care Home ☐ Hospitalized/medical facility ☐ Skilled Nursing Facility				
☐ Group Home ☐ Special Care Unit (SCU) ☐ Other:			☐ D/C Date (Hospital/SNF):	

Step Three:

SECTION F: CHANGE OF STATUS: NON-MEDICAL

Requested by (Select One): ☐ PCS Provider ☐ Beneficiary ☐ Legal Guardian ☐ Responsible Party
☐ Power of Attorney (POA) ☐ Family (Relationship):

Requestor Name:		
PCS Provider NPI:		PCS Provider Locator Code:
Facility License:		Date:
Contact's Name:		Contact's Position:
Provider Phone:	Provider Fax:	Email:

Reason for Change in Condition Requiring Reassessment (Select One):
☐ Change in Days of Need ☐ Change in Caregiver Status ☐ Other:
☐ Change in Beneficiary location affects ability to perform ADLs

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

Step Four:

SECTION G: CHANGE OF PCS PROVIDER

Requested by (Select One): ☐ Care Facility ☐ Beneficiary ☐ Other (Relationship):

Requestor's Contact Name:	Phone:

Status of PCS Services (Select One): ☐ Discharged/Transferred (Date: _____)
☐ Scheduled Discharge/Transfer (Date: _____)
☐ No Discharge/Transfer Planned (Continue receiving services until established with a new provider.)

BENEFICIARY'S CURRENT PROVIDER

☐ Home Care Agency ☐ Family Care Home ☐ Adult Care Home ☐ SLF-5600a ☐ SLF-5600c
☐ Adult Care Bed in Nursing Facility ☐ Special Care Unit

Disenrollment Effective Date:	Current PCS Hours:
Agency Name:	Phone:
Provider NPI:	Provider Locator Code:
Facility License Number (if applicable):	Date:
Physical Address:	

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PCS FAQs

- **Who does the PCS assessments?**

The PCS assessments can only be conducted by a Registered Nurse. These assessments must also be conducted face to face.

- **What if the PCS request needs to be submitted as expedited?**

If the request needs to be submitted as an expedited request, this should be indicated on the DHB-3051. The BH Logistics Team will escalate this request to the assessors for review and the assessor will make telephone outreach to conduct a telephonic assessment.

- **What if my member is Medicaid Direct and not a Tailored Plan member?**

If the member is a Medicaid Direct member, the DHB form should be sent to NCLIFTSS (NCLIFTSS@acentra.com)– this request will not be processed via Partners.

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PCS FAQs

- **What if the member hasn't seen a doctor in the last 90 days?**

The member will need to schedule an appointment with their PCP to begin the process

- **What if I want to request a change in provider or request an increase in hours?**

An updated DHB form will need to be updated to begin the process

- **What if my PCS hours are reduced or denied?**

The CM and/or CSS will receive notification of this reduction/denial. If the member would like to appeal this decision, the information and steps for this process will be sent to the member in the Notice of Adverse Benefit Decision letter that is sent from the Appeals Department.

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PCS FAQs

- **How does a provider view an PCS Assessment at Partners Health Management?**

For PCS assessment reviews this can be accessed by contacting our PCS Inquires Team at Partners_PCSInquiry@PartnersBHM.org . Currently assessments are not available to be viewed in ProAuth but are being reviewed for an enhanced feature in the future.

- **Is a care plan needed for PCS services? If so, what should be listed on the Care Plan?**

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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** 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

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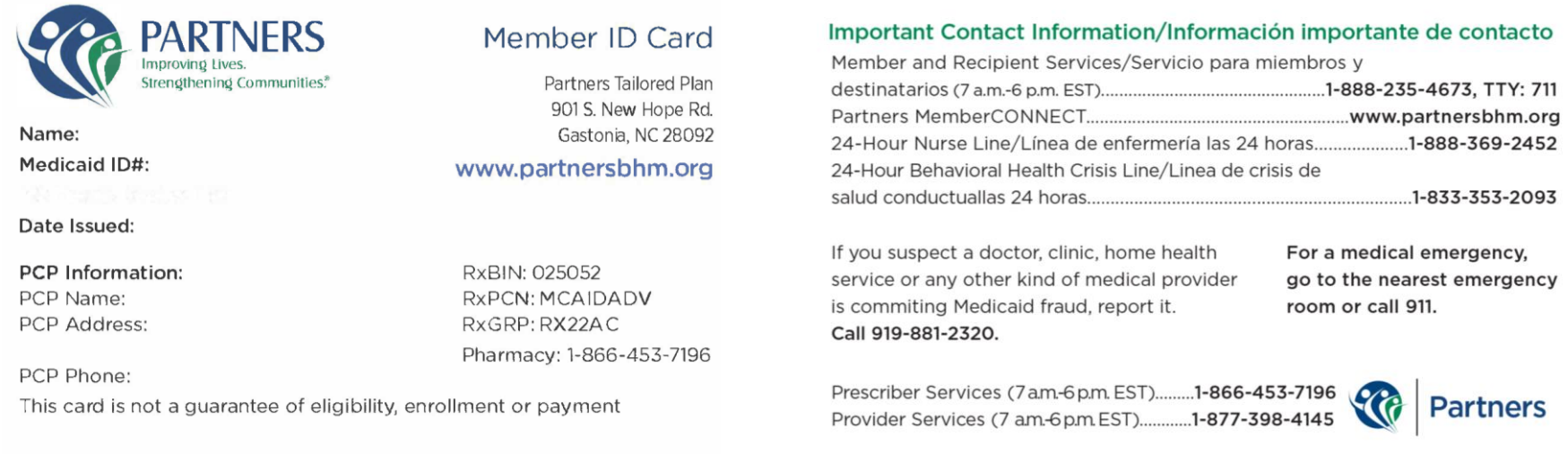
Partners Tailored Plan Member ID Cards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Member ID Card

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

Name:
Medicaid ID#:
Date Issued:

PCP Information:
PCP Name:
PCP Address:

PCP Phone:

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

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

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
24-Hour Nurse Line/Línea de enfermería las 24 horas.....1-888-369-2452
24-Hour Behavioral Health Crisis Line/Linea 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 commiting Medicaid fraud, report it. **Call 919-881-2320.**

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

Prescriber Services (7 a.m.-6 p.m. EST).....1-866-453-7196
Provider Services (7 a.m.-6 p.m. EST).....1-877-398-4145

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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.

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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

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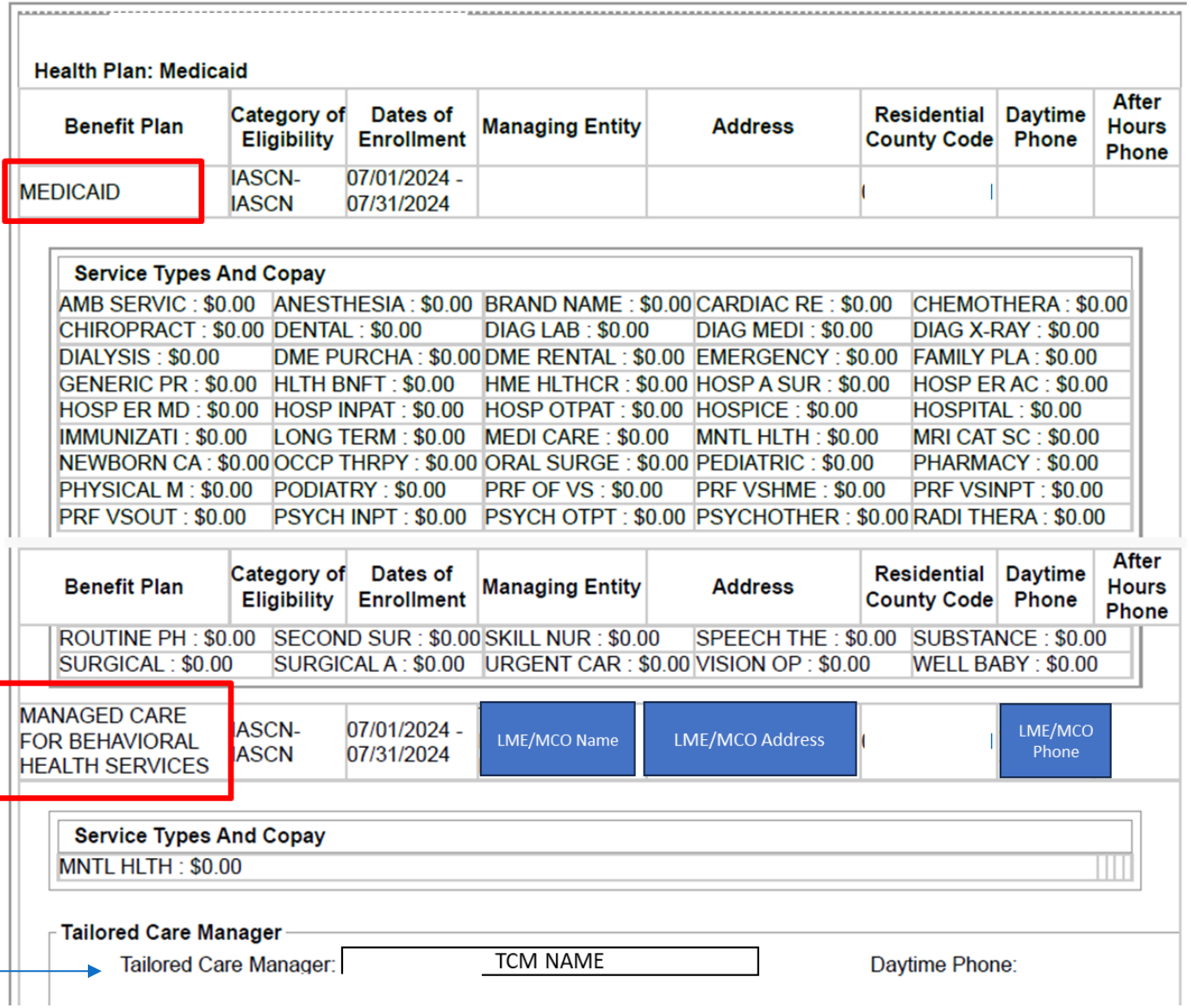
Medicaid Direct Example



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	IASCN-IASCN	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: TCM NAME 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

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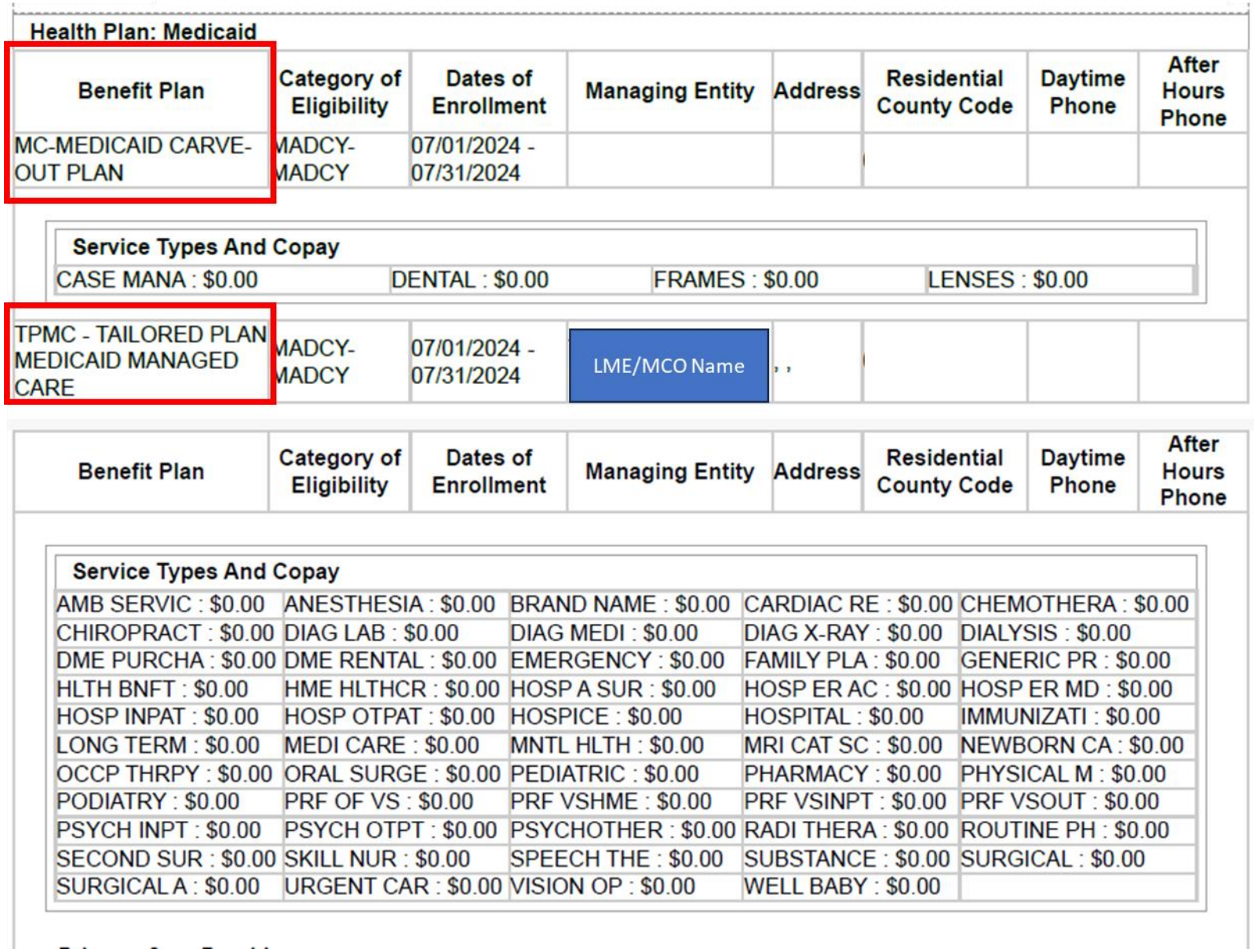
TP Member Example

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					

Service Types And Copay			
CASE MANA : $0.00	DENTAL : $0.00	FRAMES : $0.00	LENSES : $0.00

Benefit Plan	Category of Eligibility	Dates of Enrollment	Managing Entity	Address	Residential County Code	Daytime Phone	After Hours Phone
TPMC - TAILORED PLAN MEDICAID MANAGED CARE	MADCY-MADCY	07/01/2024 - 07/31/2024	LME/MCO Name	, ,			

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	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	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	

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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.
- **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/**

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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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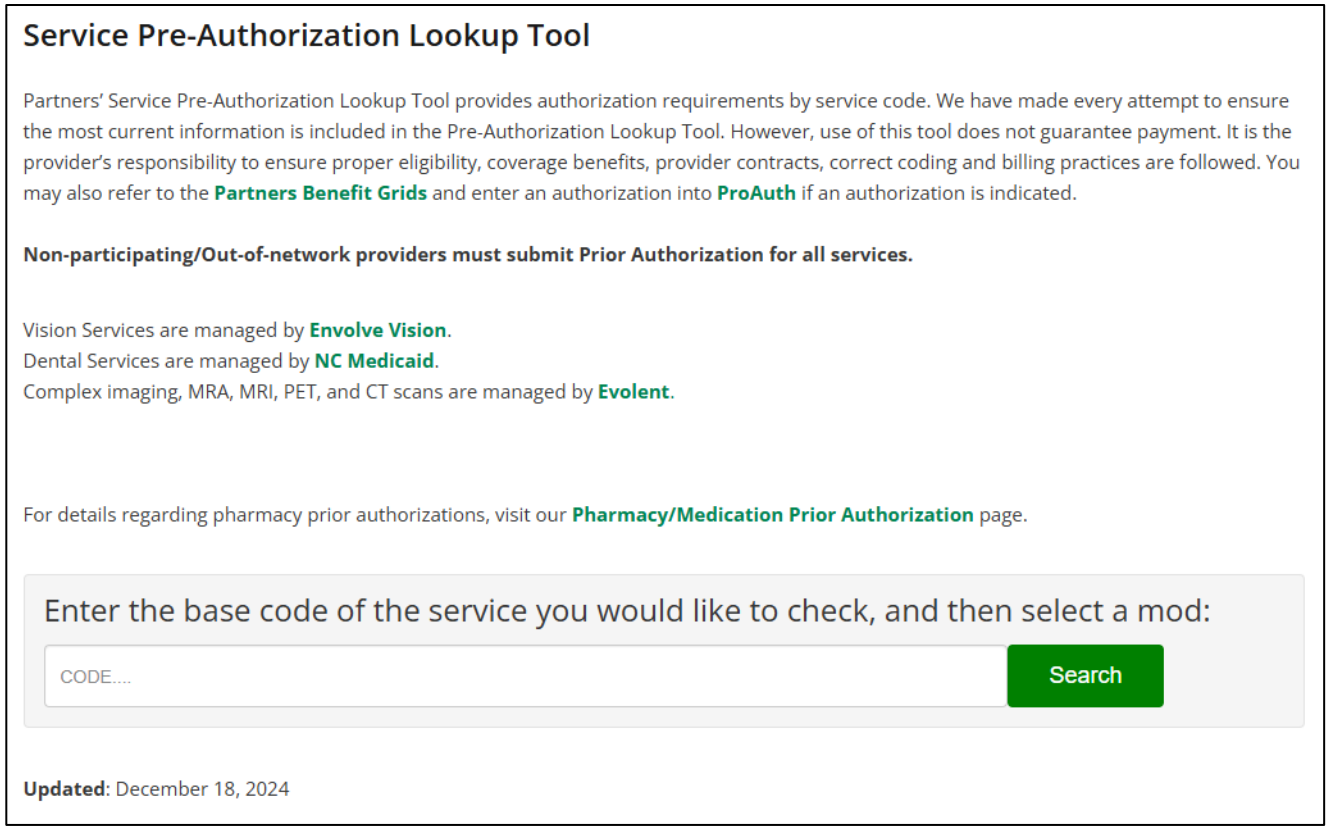
Physical Health Authorizations

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:

CODE.... Search

Updated: December 18, 2024

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Submitting Authorizations

Electronic Submission (Preferred)	Manual Submission
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.**	**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 For Questions that are GENERAL and without Protected Health Information (PHI): PHUMQuestions@partnersbhm.org

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Logging into ProAuth

- 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

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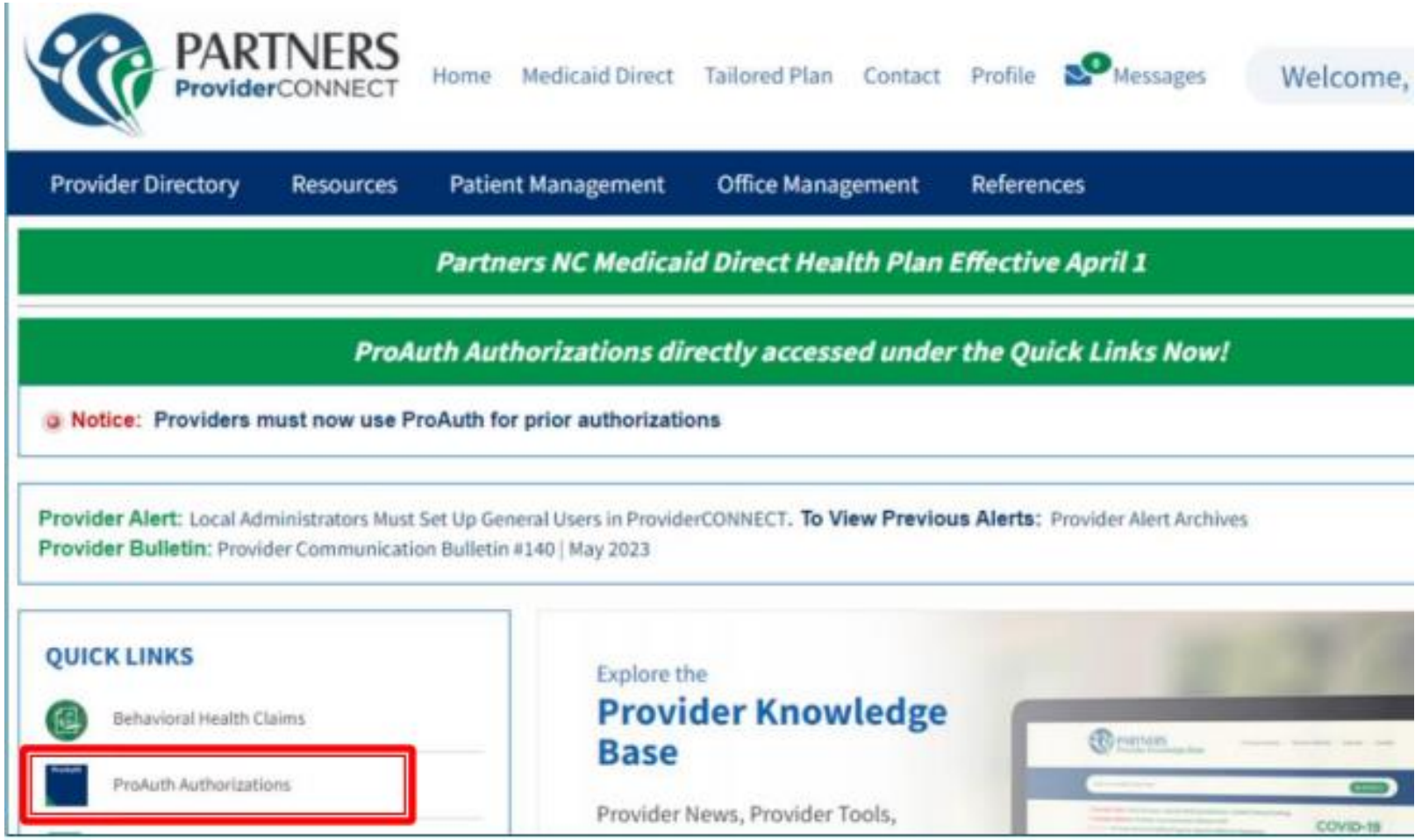
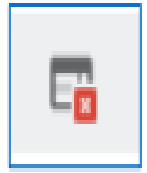
Getting to ProAuth

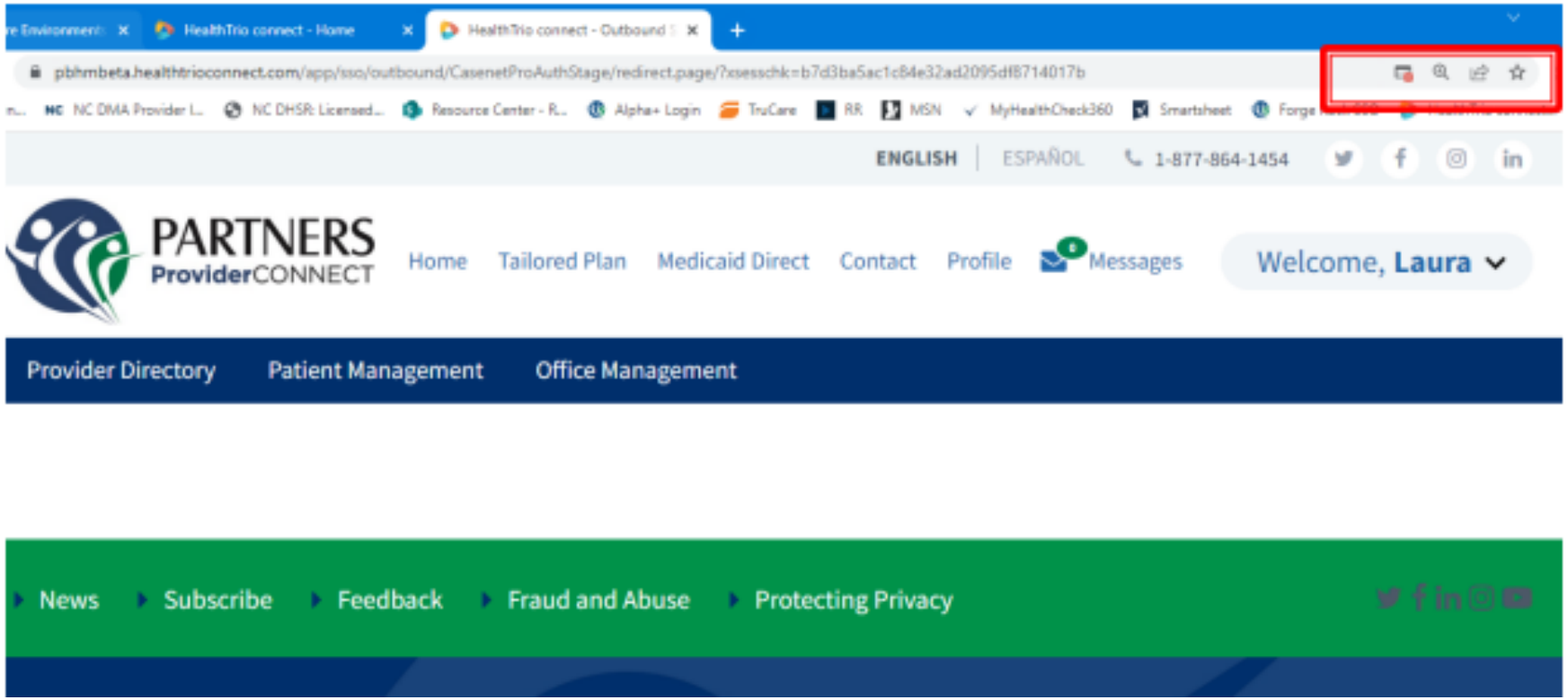
- From the ProviderConnect homepage, use the Quick Links on the left to access ProAuth Authorizations:



Getting to ProAuth (cont)

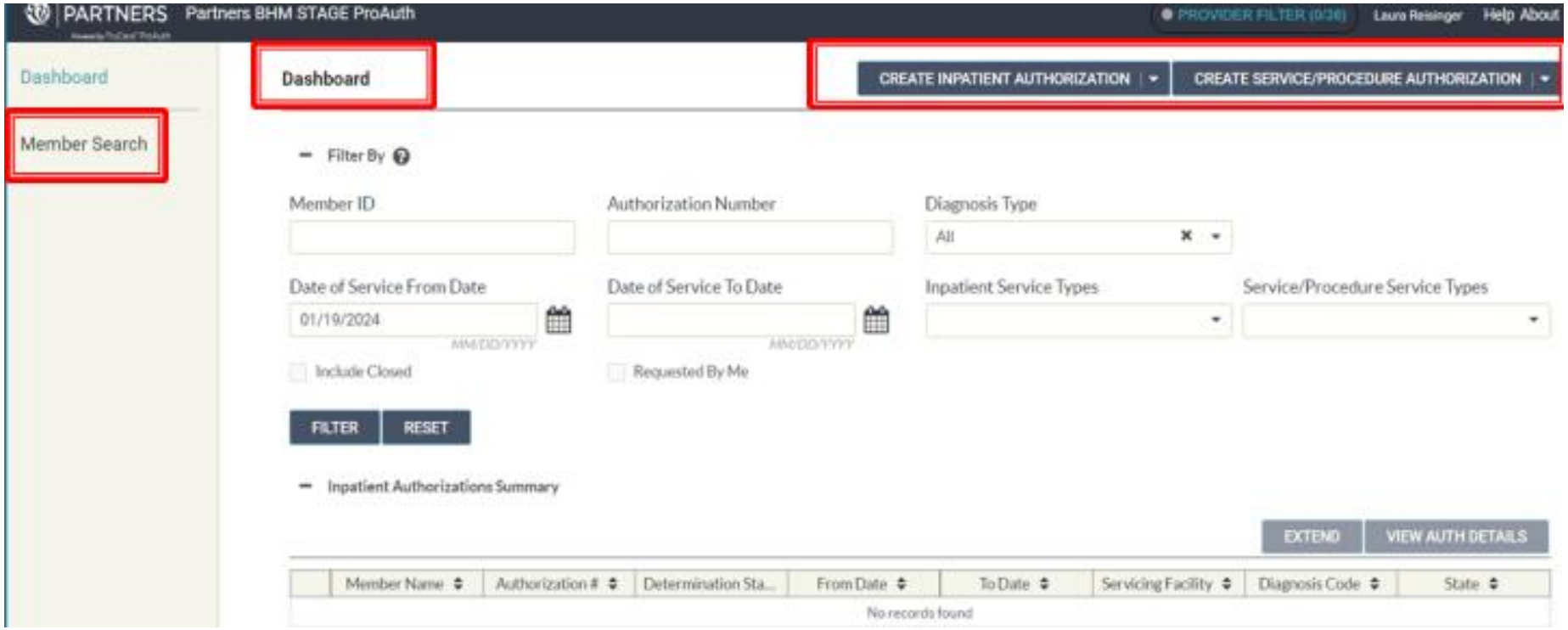
- If the link goes to a page with no information or an error message, you may need to turn off the pop-up blocker and change the setting to Always Allow
- This may need to be done twice, but once pop-ups are allowed, you won't have to fix it again.





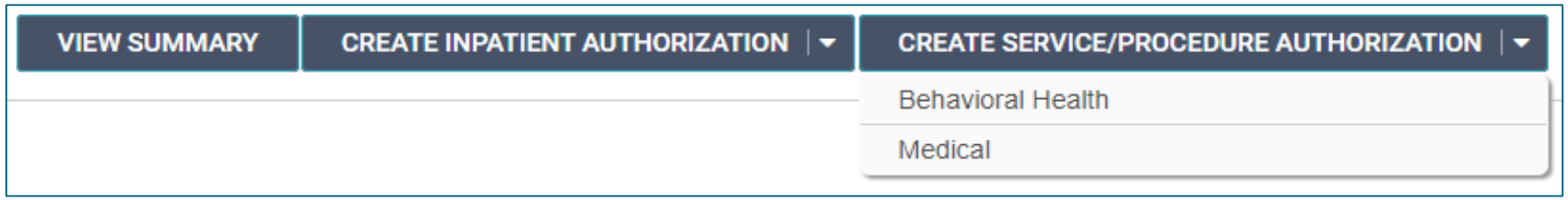
Welcome to ProAuth – Authorization Requests Portal

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



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.



Additional ProAuth Training

- https://www.partnerstraining.org/
- On-demand webinar: Register and view instant playback
- **Supporting Documentation and Q&A**

For questions related to ProAuth please contact proauth@partnersbhm.org for assistance.

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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

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Additional Provider Resources

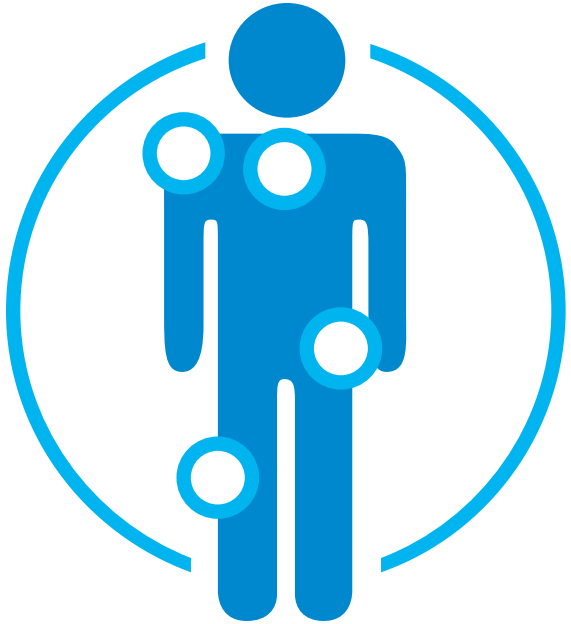
Evolent Utilization Management Program

(Non-emergent, advance, outpatient imaging services)

Evolent (Formerly National Imaging Associates, Inc.)

- Partners, through its partnership with Carolina Complete Health, will use Evolent (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 Evolent.
- Providers may submit prior authorization requests to Evolent 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

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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

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Evolent (Formerly National Imaging Associates, Inc.)

Item	Key Point(s)
RadMD Access & Features	▪ **Prior authorization requests can be made online at: www1.RadMD.com** ▪ RadMD Website – Available 24/7 (except during maintenance) ▪ Request authorization (ordering providers only) and view authorization status ▪ Upload clinical information ▪ View Evolent'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**

Resource: Evolent Resource Page for Partners Providers

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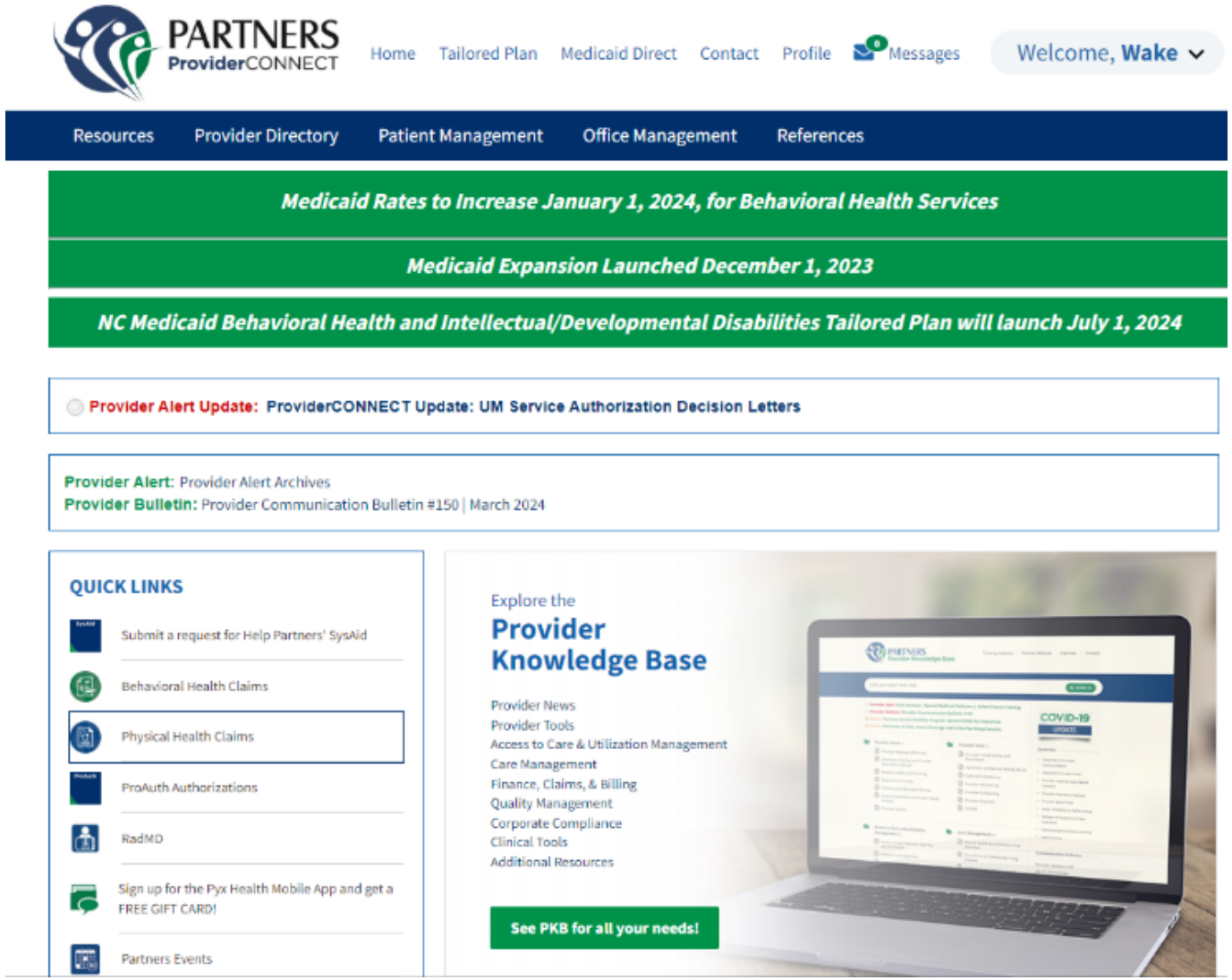
Claims and Payments

Submitting Claims

- You can submit your Physical Health Claims through ProviderConnect



Submitting Claims

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

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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

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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#/

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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
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

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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	https://medicaid.ncdhhs.gov/health-plan-billing-guidance Updated billing guidance from NC Medicaid includes logic for behavioral health vs physical health claims. *Please also see the 1/30/25 KIT as there may be erroneous denials for 96110 and 96127 assessments.
DENY-BILL NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATES	Provider data on the claim must match what is in NCTracks. 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: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf
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	

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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

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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 5/2/25
  - View this page for latest versions: 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)

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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.

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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

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Electronic Funds Transfer for Claims

Behavioral Health Claims	Physical Health Claims
Partners EFT process: Please contact Partners Vendor Group for EFT and banking information set: vendorsetup@partnersbhm.org	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 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

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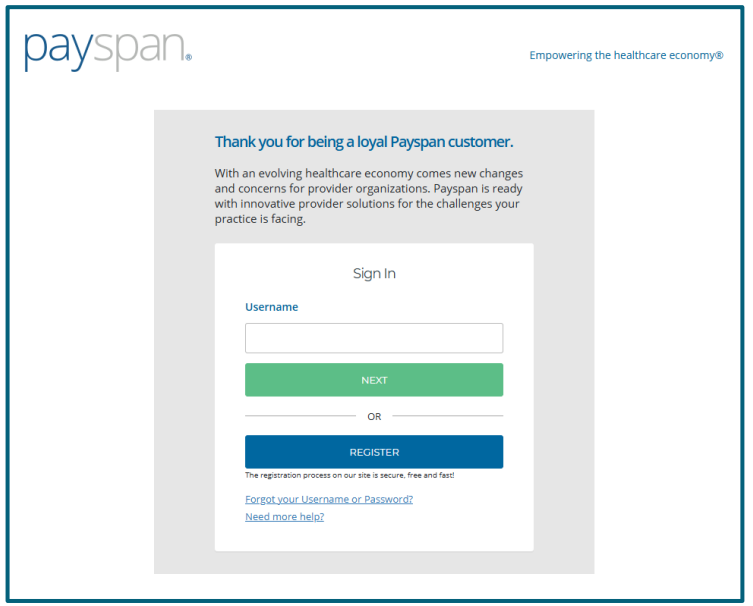
Electronic Funds Transfer

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:

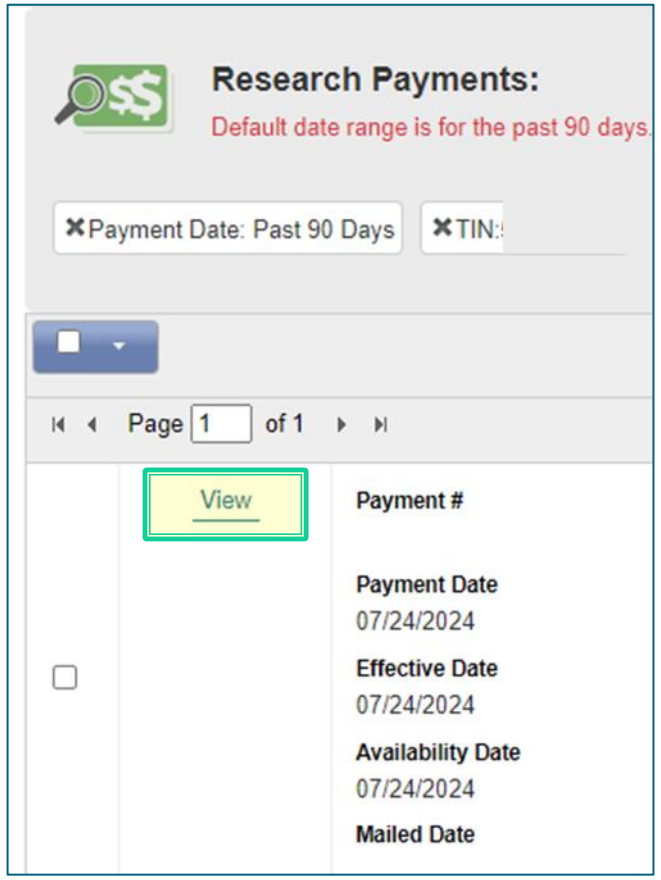
- How to register with Payspan (New User)
- How to add additional registration codes to an existing Payspan account
- How to navigate through the Payspan web portal
- How to view a payment
- How to find a remit
- How to change bank account information
- How to add new users

For training links visit our website under Education and Training



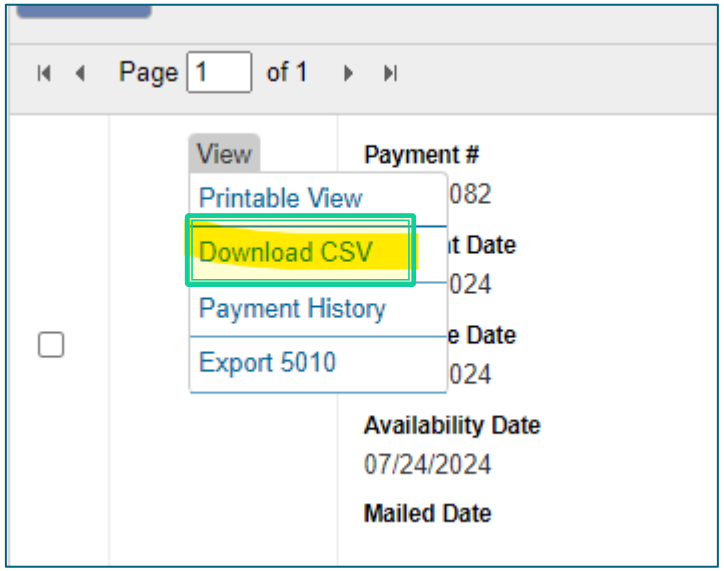
Access ERA in Payspan

1



Scroll down and click ‘View all EOP’

2



Download CSV

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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?	1st 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.

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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.
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/.

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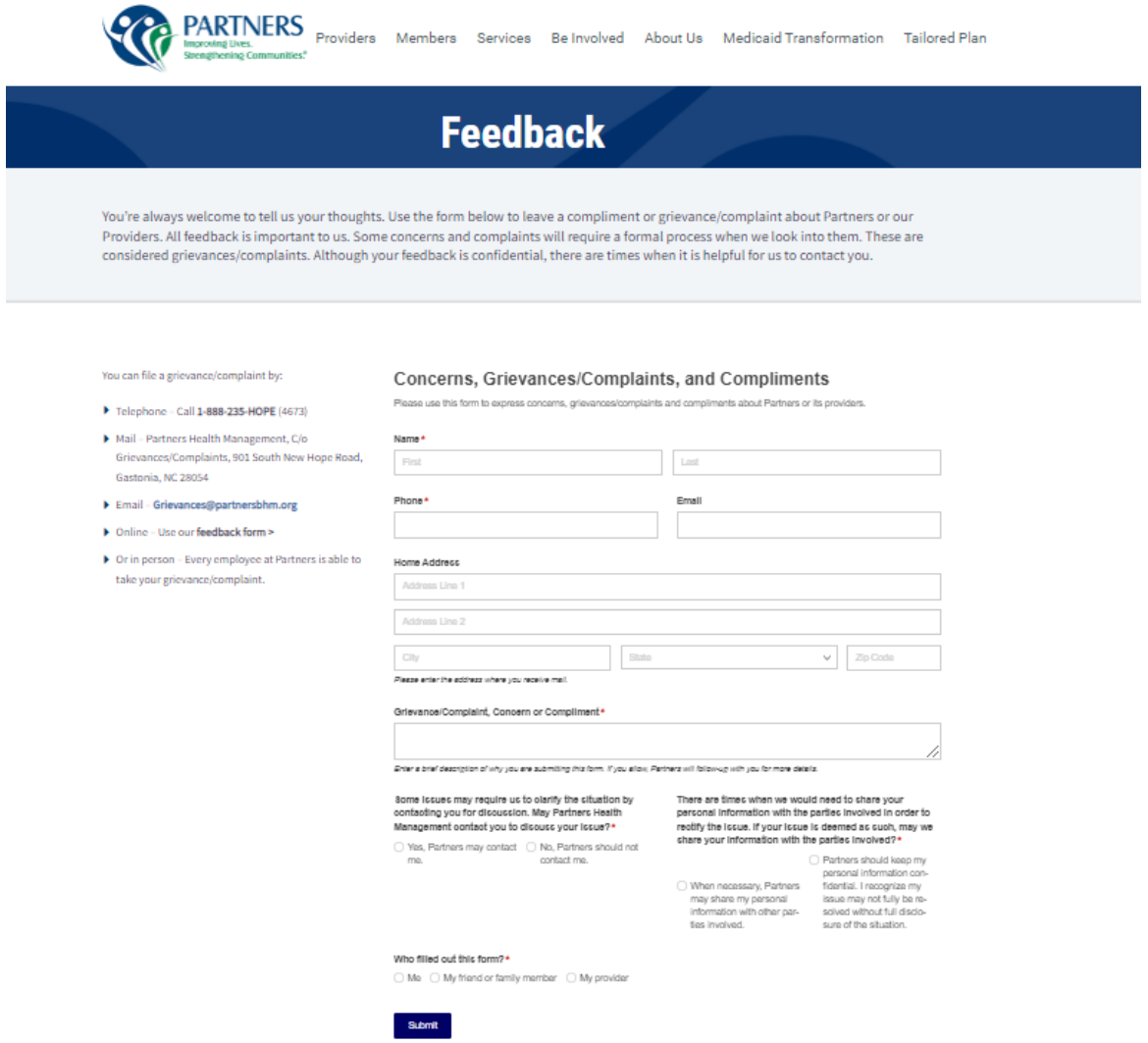
Ways Providers Can File a Grievance

- 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
  - 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)



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

ProviderCONNECT

File a Grievance/Complaint

/ Additional Resources / File a Grievance/Complaint

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

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

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

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

Partners Behavioral Health Management
c/o Grievances
901 South New Hope Road
Gastonia, NC 28054
**Include the grievance/complaint reference number located at the top of the Grievance Acknowledgement letter in the request.*

Please remember that:

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

If you have questions regarding this process, please call 1-877-864-1454 or email **Grievances@PartnersBHM.org**

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.

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Partners Provider Communications

- Physical Health Provider Communications

This Link will take you to the Communications page for Physical Health Communications

- Provider Alerts

This Link will take you to the Partners Provider Knowledge Base where you will see Partners Provider Communications and Alerts.

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Provider Support and Who to Contact

Who	What	How
Partners Customer Service	• Claims questions • Prior Auth questions • Grievances and Appeals • Portal (ProviderConnect) • Member assignment	1-877-398-4145; 7 a.m. to 6 p.m. Monday-Saturday
Carolina Complete Health Network Provider Relations	• Tailored Plan Physical Health Contracting	NetworkRelations@cch-network.com
Carolina Complete Health Provider Engagement	• Payspan • Panel Status • Education	CCHN Provider Engagement Team

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Questions?

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Additional Resources

- Pro Auth Additional Resources
- Claims/Payments Additional Resources
- Personal Care Services Additional Resources
- Skilled Nursing Facilities Additional Resources
- General Provider Resources

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Pro Auth Additional Resources

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

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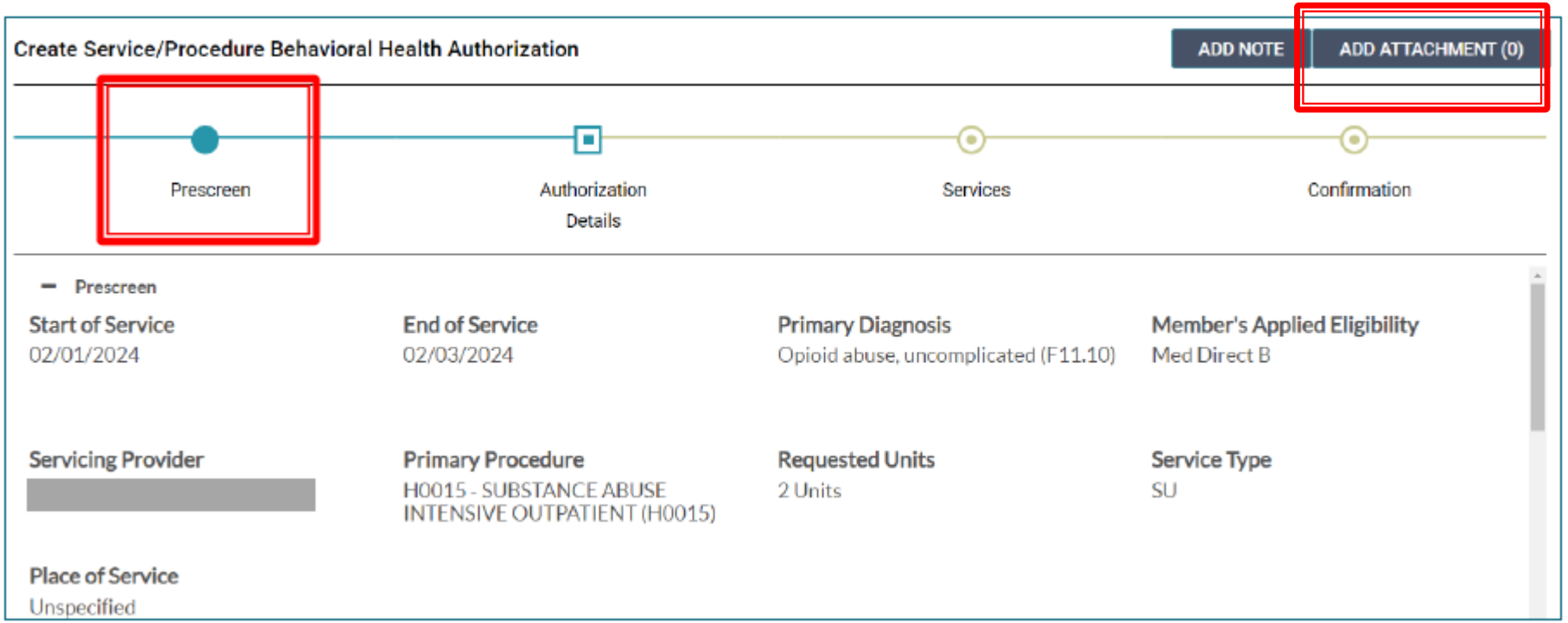
Uploading Documentation in ProAuth

- 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.



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.

Claims/ Payments Additional Resources

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.

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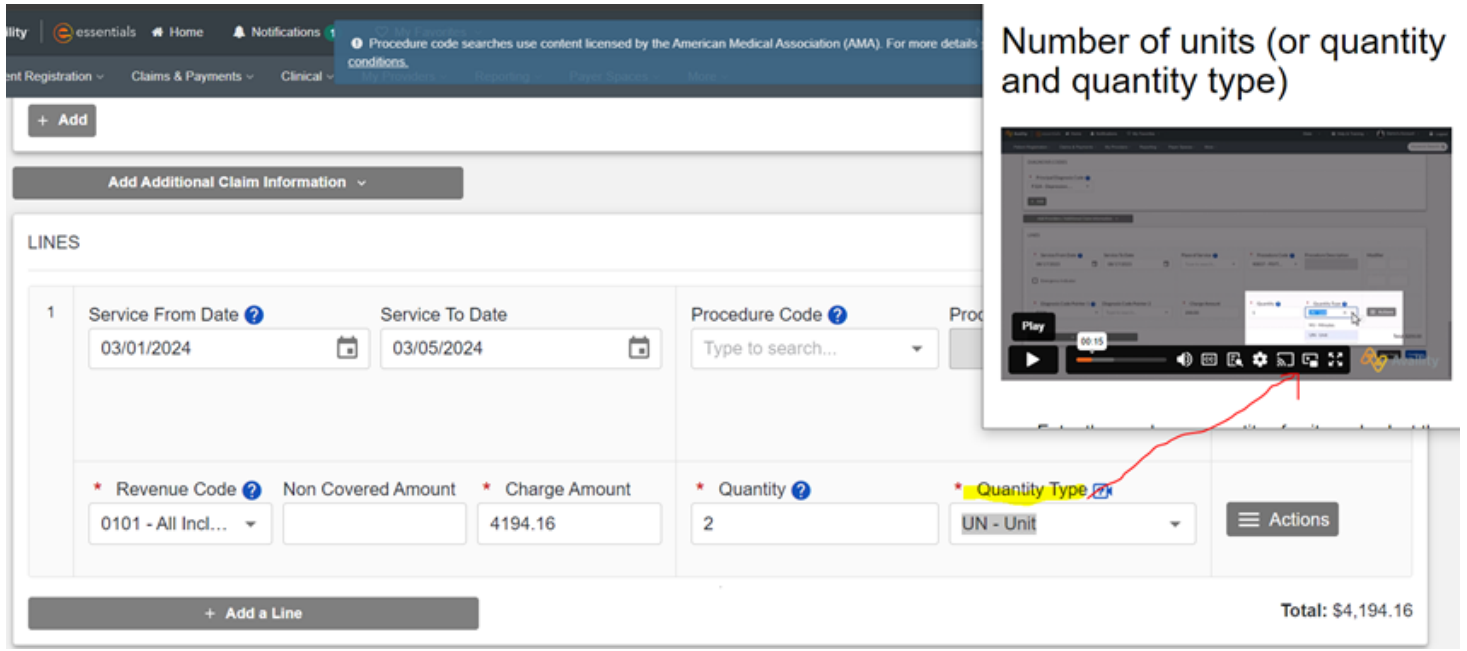
Availity Tips

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



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**.

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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.

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Inpatient Claims Submission Tips

- Physical Health Claims
  - Physical Health claims uses the primary diagnosis on inpatient claims to determine the claim is physical health vs. behavioral health and processes the claim accordingly.
  - If an inpatient claim has a primary diagnosis for physical health but the member also received behavioral health services during the stay, the claim will be processed using the appropriate DRG for the full stay.
- Behavioral Health Claims
  - Behavioral Health claims uses the primary diagnosis on inpatient claims to determine if the claim is behavioral health vs. physical health. If an inpatient claim has a behavioral health primary diagnosis, the claim will be processed at the per diem rate for the room and board revenue code.

Outpatient Claims Submission Examples

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

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

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

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

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

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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.

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

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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?** 1st 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**. 20th 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.

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Personal Care Services Provider Resources

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.

If you have questions related to PCS forms, please submit them to **Partners_PCSInquiry@PartnersBHM.org**

Important Reminder: 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 20th 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.

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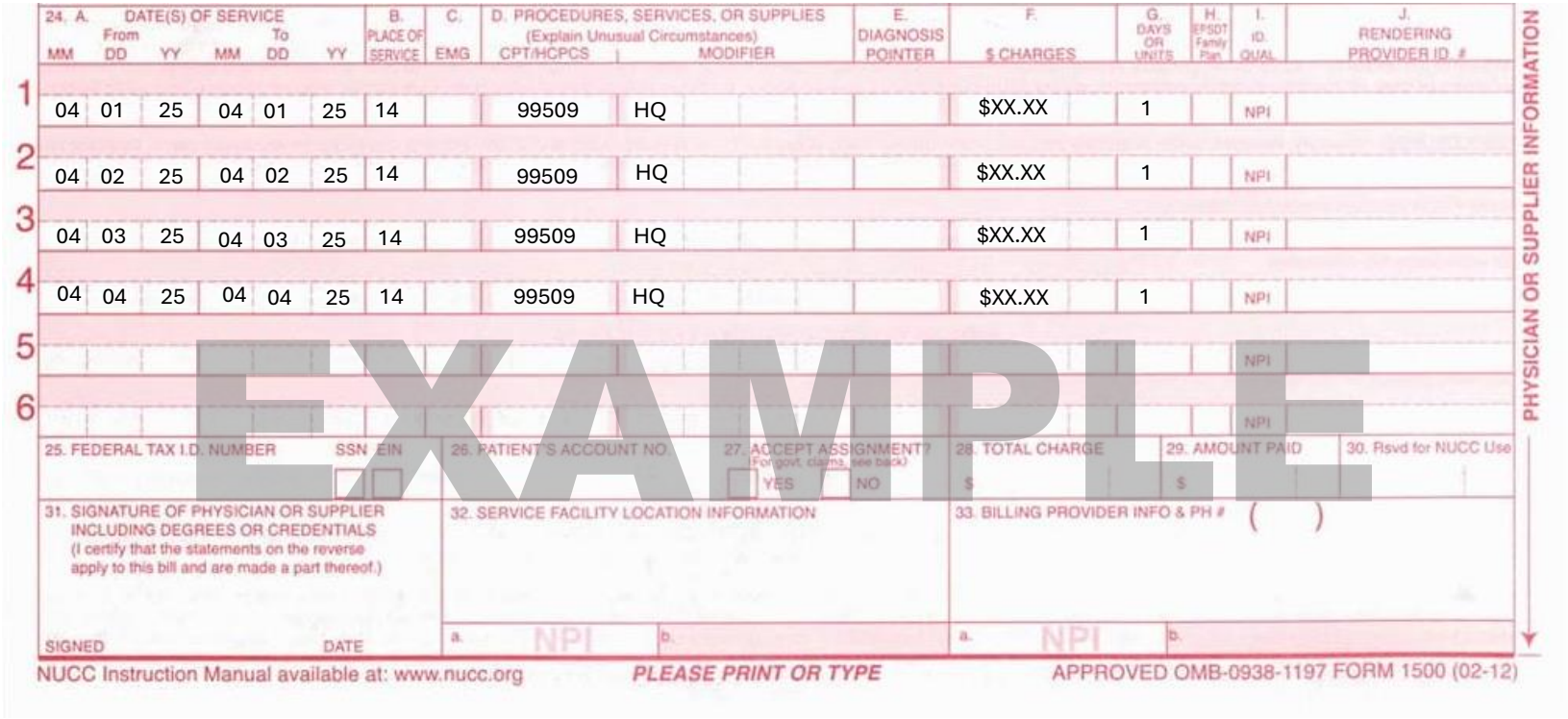
SAMPLE Per Diem Claim



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 04	01	25	04	01	25	14		99509	HQ		$XX.XX	1		NPI	
2 04	02	25	04	02	25	14		99509	HQ		$XX.XX	1		NPI	
3 04	03	25	04	03	25	14		99509	HQ		$XX.XX	1		NPI	
4 04	04	25	04	04	25	14		99509	HQ		$XX.XX	1		NPI	
5														NPI	
6														NPI	

EXAMPLE

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

- Representation of how to bill the service line(s) on the claim.
- Providers should enter appropriate diagnoses code(s) and all other required claim fields.

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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

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Personal Care Services (continued)

- **If your organization provides Personal Care Services to Medicaid Direct Members, please see below opportunities from NC Medicaid:**
  - NC Medicaid provided virtual office hours January through March to address any questions about the daily rate reimbursement process.
  - NC Medicaid met with providers during office hours and reviewed with them previously paid claims and walk them through how to submit claims that align with the daily per diem methodology
  - PowerPoint Presentation PCS Rate Methodology Changes

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PCS Reminder

- **EVV**: PCS billed by taxonomy 253Z00000X with CPT 99509 and an HA or HB modifier are subject to EVV requirements and claims must be submitted through HHAeXchange.
  - All providers are expected to be fully compliant with EVV requirements.
  - EVV data must be validated prior to claims adjudication.
  - Claims without the required EVV criteria will deny.
  - Partners works with HHAeXchange as its EVV partner.
- **Non-EVV:** Other physical health PCS services (i.e Congregate Care settings) can be billed through Availity via the Partners' Portal: ProviderCONNECT.

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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

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

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Skilled Nursing Facilities (SNF) Additional Resources

Skilled Nursing Facility Referral Process

1. Partner's Utilization Management (UM) team (including Carolina Complete Health) collaborates with hospital discharge planners to identify members transitioning from acute care to SNF.
2. SNF submits a request for admission to Partners; medical necessity is reviewed by UM.
3. Upon approval, Partners sends authorization and SNF submits DHB-2039 form to DSS to initiate financial eligibility review.
4. PASRR Level 1 screening is required; if positive, a Level 2 evaluation ensures appropriate placement for individuals with SMI, ID/D

Additional Information can be found on slide 90

For questions, please contact CTT Referrals:
CTT_inpatientED_Referrals@partnersbhm.org

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Skilled Nursing Facility FAQ's

Q: What is the Skilled Nursing Facility (SNF) admission process under Partners Tailored Plan?

A: Partners' Utilization Management (UM) team works with hospital discharge planners to identify eligible members. SNFs submit admission requests to Partners Intake. After UM reviews for medical necessity, approval is sent, and SNFs submit the DHB-2039 form to DSS to begin financial eligibility review.

Q: When is a PASRR evaluation required?

A: All admissions require a PASRR Level 1 Screening. If positive for SMI, ID/DD, or related conditions, a Level 2 Evaluation is conducted to assess placement needs and specialized services.

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Skilled Nursing Facility FAQ's

Q: Who coordinates services once a member is admitted to a SNF?

A: The Care Transitions Team (CTT) enrolls the member in TruCare, coordinates with SNFs on discharge plans, and ensures tracking and support through weekly Clinical Huddles. If the member is a Level 2 on the PASRR, they will have a Tailored Care Manager (TCM) assigned to coordinate care.

Q: What happens if a member is discharged within 90 days?

A: The CTT creates a 90-day Transition Plan and facilitates post-discharge services, including transportation, home support and outpatient appointments. A warm handoff is made to the TCM.

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Skilled Nursing Facility FAQ's

Q: How is Medicaid disenrollment handled for members in SNFs?

A: If a member remains in a SNF for 90 consecutive days, they are disenrolled from the Tailored Plan and moved to NC Medicaid Direct on the first day of the following month. CTT submits the LTSS Disenrollment Form and notifies the TCM and SNF of the change.

Partners will not be doing Physical Health but will be coordinating care for Behavioral Health/IDD.

Q: Who can hospital staff contact for help?

A: CTT Referrals: CTT_inpatientED_Referrals@partnersbhm.org

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Skilled Nursing Facility Medicaid Disenrollment

Medicaid Disenrollment

- If member remains in SNF for 90 consecutive days, they are disenrolled from the Tailored Plan and transferred to NC Medicaid Direct on the first of the following month.
- If discharge results in admission to CAP/C, CAP/DA or PACE, CTT will also complete the LTSS Disenrollment Form.
- CTT submits the LTSS Disenrollment Form to the state and notifies involved parties (UM, TCM, SNF).
- CTT will support the Provider and Network team during this process by submitting the LTSS Disenrollment form.
- CTT will facilitate a warm hand-off by communicating discharge plans directly to the member's assigned Tailored Care Manager (TCM) via email or phone call after notification of the discharge. CTT will document warm hand-off in TruCare notes.

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Specialized Therapies Modifier Reminder

- Specialized Therapy billing requires either modifiers GN, GO, or GP are submitted with outpatient specialized therapy (OST) services.
- Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services.
- They should never be used with codes that are not on the list of applicable therapy services.
- Reference:
  https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2019downloads/r4440cp.pdf

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Hot Topics

Known Issues Tracker

Status	Health Plan	Date Issue Identified	Category	Provider Type	Est. Fix Date	Issue Description	Resolution
Open	Tailored Plans - Partners	5/20/2025	Claims; Configuration	All	6/12/2025	Identified issue with member enrollment file causing claims to deny 'L6: Please submit to Primary Insurer' incorrectly and eP: Requires Primary EOB; Auth Req'd for EPDST Consideration.	System configuration logic is being updated. Claims impacted will be identified and will be reprocessed once the system fix is completed. No further action needed from providers at this time.
Open	Tailored Plans - Partners	5/1/2025	Claims; Configuration	All	6/6/2025	Identified process workflows that are causing incorrect denials related to authorizations (EX Codes: A1,Hn) when an authorization has been obtained by the provider and billed appropriately to match the authorization. "A1: No Authorization on File', 'Hn: No Authorization on File Matches"	Processes are being updated. Claims impacted will be identified and will be reprocessed once completed. If a claim remains denied once the updates are complete, please review the claim submission for billing errors and submit a corrected claim.

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Known Issues Tracker (continued)

Status	Health Plan	Date Issue Identified	Category	Provider Type	Est. Fix Date	Issue Description	Resolution
Open	Tailored Plans - Partners	4/16/2025	Configuration	PCS - Facilities	5/29/2025	Issue identified with manual pricing for Congregate Care PCS claims according to the per diem rate effective 04/01/2025.	A manual process is in place to ensure accurate pricing. All impacted claims will be reprocessed. No further action needed from providers at this time.
Open	Tailored Plans - Partners	1/27/2025	Claims; Configuration	Behavioral Health; Physical Health	6/26/2025	Identified gaps within the hierarchy logic associated with Behavioral Health/Physical Health Claims routing that caused Partners Claims to inappropriate pay lines when they should have been rejected to submit to Partners for behavioral Health Processing. Additional updates to hierarchy logic required due to revised guidance from NC DHHS received 05/01/25, to ensure that Partners Behavioral Health Claims appropriately reject with message to submit to Partners for behavioral Health Processing.	System configuration logic is being updated. Claims impacted will be identified and will be reprocessed once the system fix is completed. Providers should continue to submit future Physical Health claims for continued processing.

Statewide Credentialing Committee Stakeholder Engagement

- **Topic:**

A Credentialing Committee will be established and will be responsible for reviewing NC Medicaid practitioner files that contain flagged items for disposition of their enrollment, reenrollment, and recredentialing applications as well as issues discovered through ongoing monitoring.

- **Who is Impacted:**

This will apply to all providers contracted with NC Medicaid, Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS), Division of Public Health (DPH), Office of Rural Health (ORH) and all NC Medicaid Managed Care health plans. The tentative launch date for the Credentialing Committee is Fall 2025.

- **Questions:**

Any related questions can be sent to Medicaid.credcommittee.stakeholders@dhhs.nc.gov.

- https://medicaid.ncdhhs.gov/providers/provider-enrollment/provider-credentialing/credentialing-committee#AdditionalResources-4617

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General Provider Resources

Provider Resources

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

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TP Care management Communications with PCP Practices – Contact Information

Tailored Care Management (TCM) Assignment Questions:

- NCTracks is the source of truth for TCM assignment
- If questions remain after checking NCTracks, please reach out to the Care Connections team through a single email group distribution:
- screeningandreferral@partnersbhm.org
- Member Services Line: If you have any questions or need more information on anything, please call Member and Recipient Services Monday-Saturday, 7 a.m. – 6 p.m., **1-888-235-4673**, or Relay NC 711 or TTY **1-800-735-2962** (English) and **1-888-825-6570** (Spanish). We are here for you.

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How to Make a Referral for Partners' Tailored Care Management?

Tailored Care Management Referral Questions:

- You can email Partners a referral for Tailored Care Management through screeningandreferral@partnersbhm.org
- Please include the Member Medicaid Number on the email
- The Screening and Referral Team at Partners will verify the members' eligibility for Tailored Care Management
- They will see if they are already connected to Tailored Care Management
- The team will then follow up with the Primary Care Practice who made the referral to close the loop.
- The turn around time is typically the same business day or next business day for follow up

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Provider Department Communications

- **Corrections to 2025 CPT Code Update Bulletin Effective Jan. 1, 2025**
- This corrects the end-date for code G9920 in the December 2024 bulletin.
- This bulletin applies to NC Medicaid Direct and NC Medicaid Managed Care
- https://medicaid.ncdhhs.gov/blog/2025/03/27/corrections-2025-cpt-code-update-bulletin-effective-jan-1-2025

- **Quarterly Provider Update – Spring 2025**
- Information on Provider Ombudsman, CFSP, and Upcoming Credentialing Changes.
- https://medicaid.ncdhhs.gov/blog/2025/03/27/quarterly-provider-update-spring-2025

- **Updates on Electronic Visit Verification for Home Health Care Services and Direct Billing**
- NC Medicaid's Electronic Visit Verification (EVV) system for Home Health ensures compliance with federal requirements
- This bulletin applies to NC Medicaid Managed Care.
- https://medicaid.ncdhhs.gov/blog/2025/03/27/updates-electronic-visit-verification-home-health-care-services-and-direct-billing

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Provider Department Communications (Cont.)

- **Permission Matrix Updates – NC Tracks**
- The following changes to the Provider Permission Matrix were made to align the taxonomy's assigned categorical risk level, additional screening requirements and federal fee. These changes will take effect on June 1, 2025.
  - Home Health Agencies (251E00000X) have a high categorical risk level, requiring a site visit. Providers will be prompted to respond to questions regarding any previous site visit, or be contacted to schedule a site visit, in their future NCTracks applications.
  - Community Based Residential Treatment Facility; Mental Illness (320800000X) has a limited categorical risk level and will no longer require payment of the federal fee. In-Home Supportive Care (253Z00000X) providers have a high categorical risk level and must be assessed for payment of a federal fee. Providers will be prompted to respond to questions regarding payment of the federal fee in their future NCTracks applications. This change is applicable to all enrollment types.

- The Provider Permission Matrix, Instructions job aid and a list of Federal Fees & NC Enrollment Fees by Year are available on the NCTracks Provider Enrollment webpage.

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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/

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Thank you for joining us today for this informational session

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