Partners'/CCHN Tailored Plan
General Provider Information

Last updated 10/01/24

Submitting Authorizations Via Portal

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

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

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

Physical Health services are available for viewing on the Benefit Grids and PA Lookup Tool.

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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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Submitting Authorizations Manually

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

Authorization, Notification, and Determination Timeframes

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

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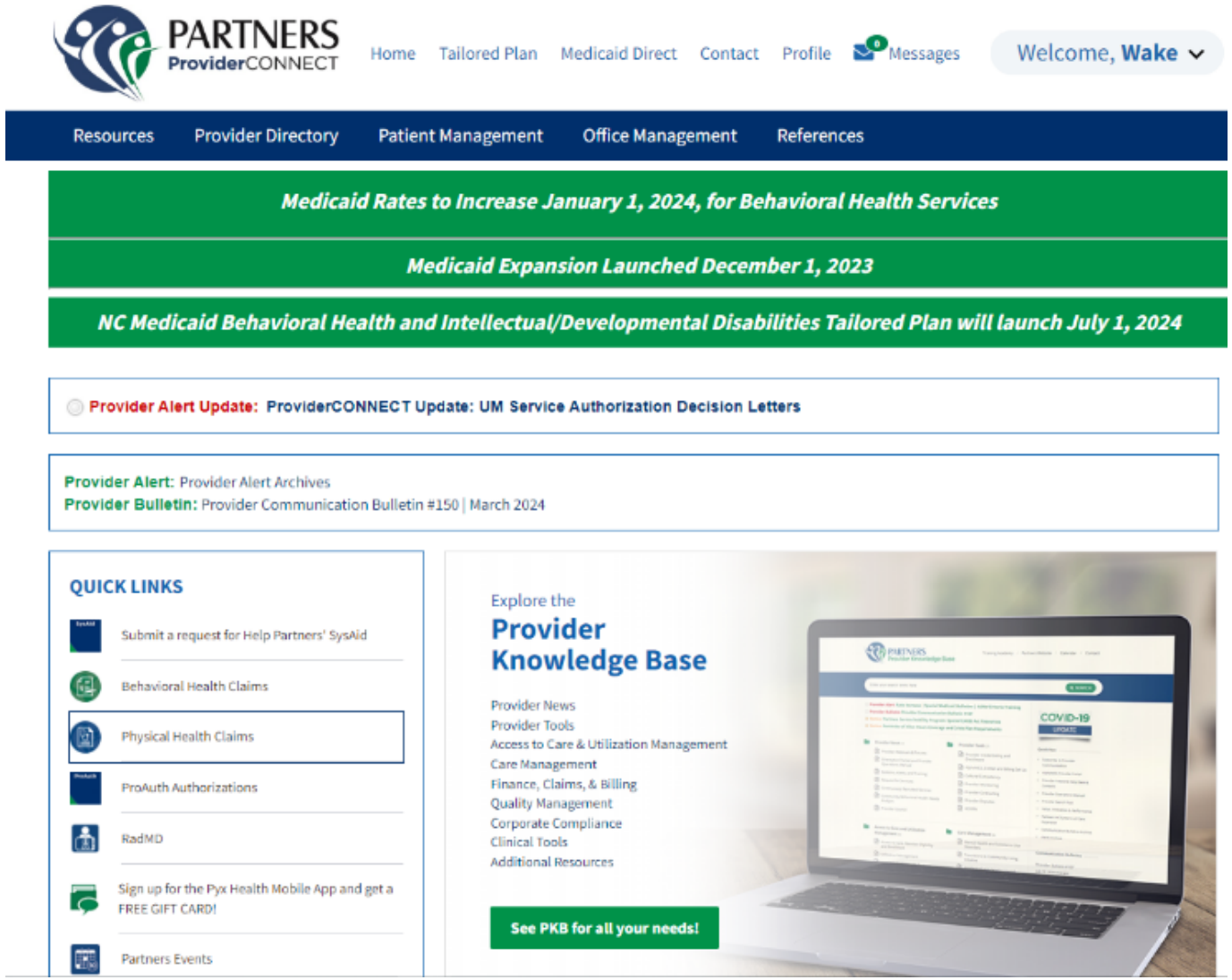
Submitting Claims

- 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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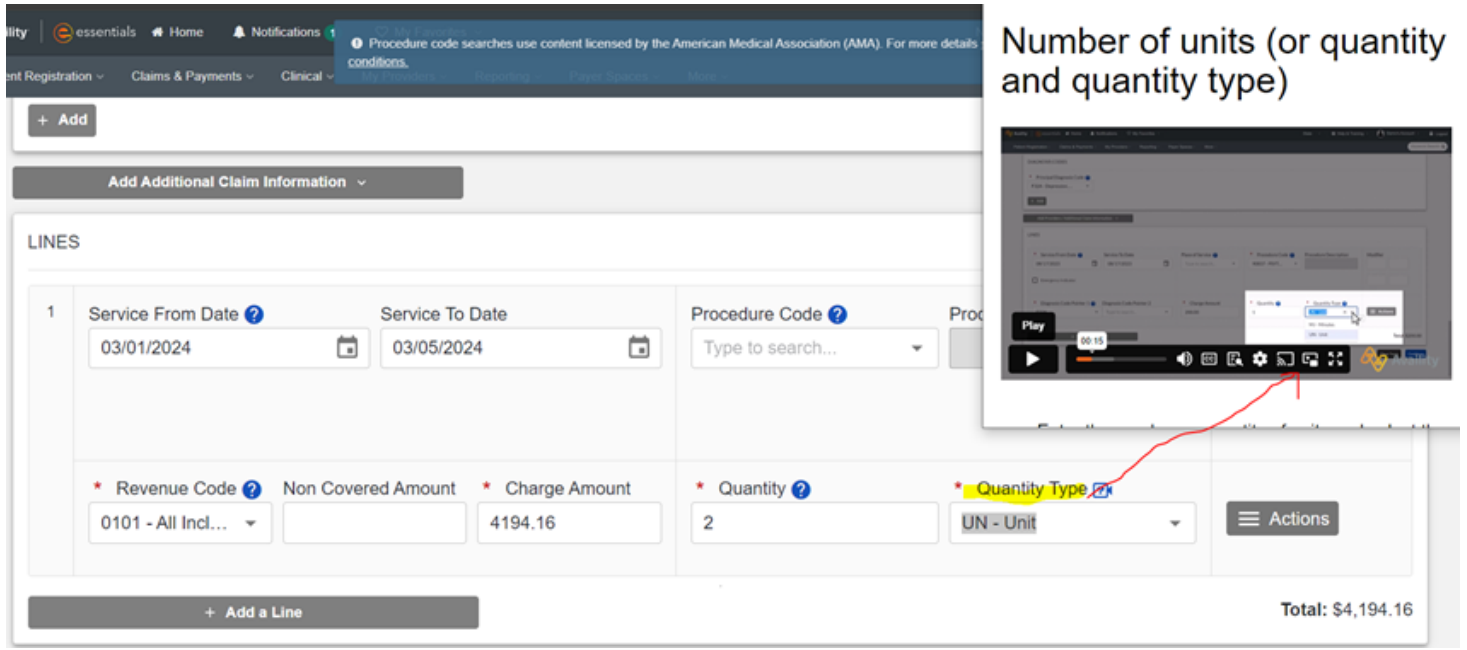
Claims Submission Tips

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

Availity Tips

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



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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Clearinghouse and Set Up of New Payers

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

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

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

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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 and Trillium. Payspan offers monthly training sessions for providers covering the following topics: How to Register with Payspan (New User) How to Add Additional Registration Codes to an Existing Payspan Account How to navigate through the Payspan web portal How to view a payment How to find a remit How to change bank account information How to add new users Registration information can be found through CCH: https://network.carolinacompletehealth.com/training

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:

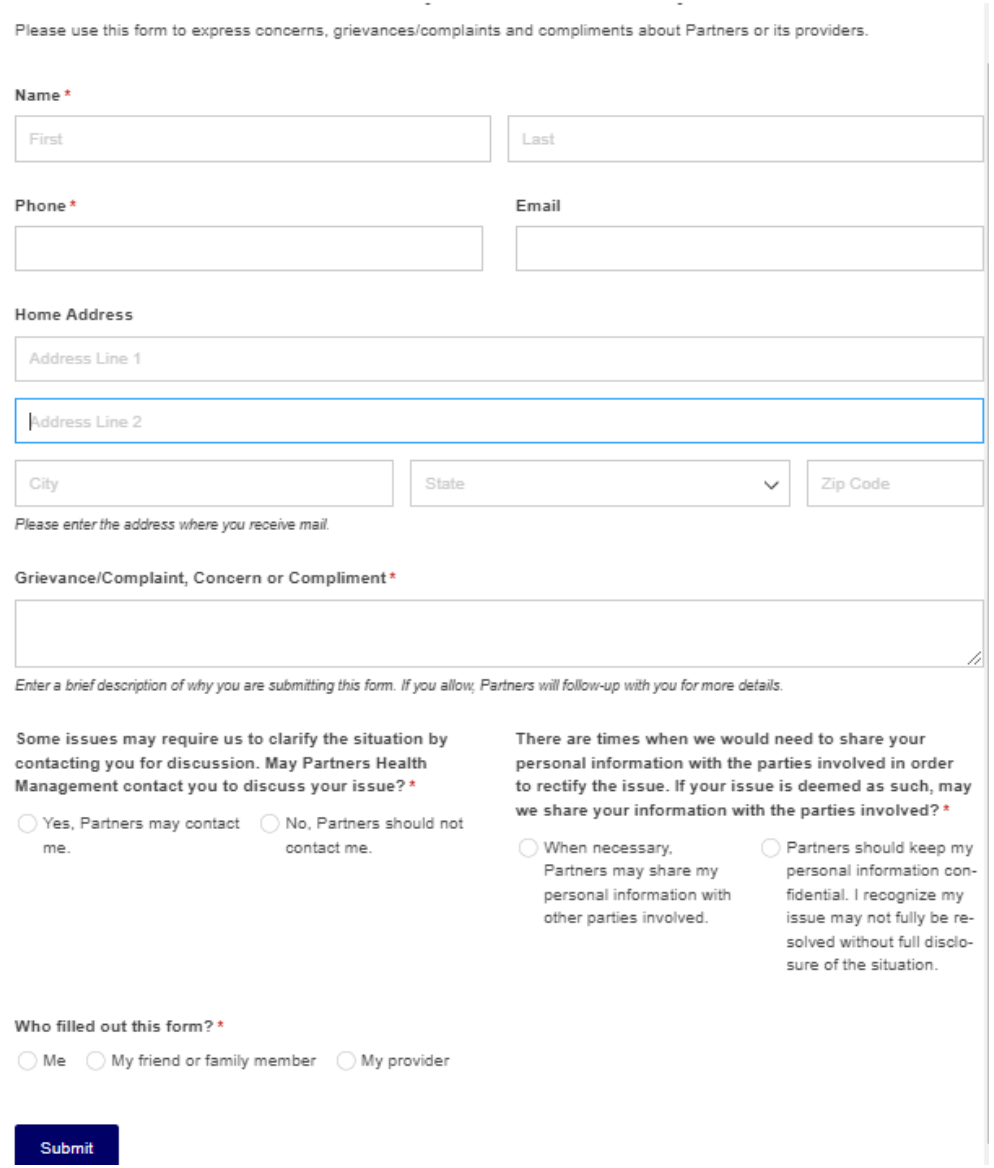
Partners Behavioral Health Management
c/o Grievances
901 South New Hope Road
Gastonia, NC 28054
**Include the grievance/complaint reference number located at the top of the Grievance Acknowledgement letter in the request.*

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.

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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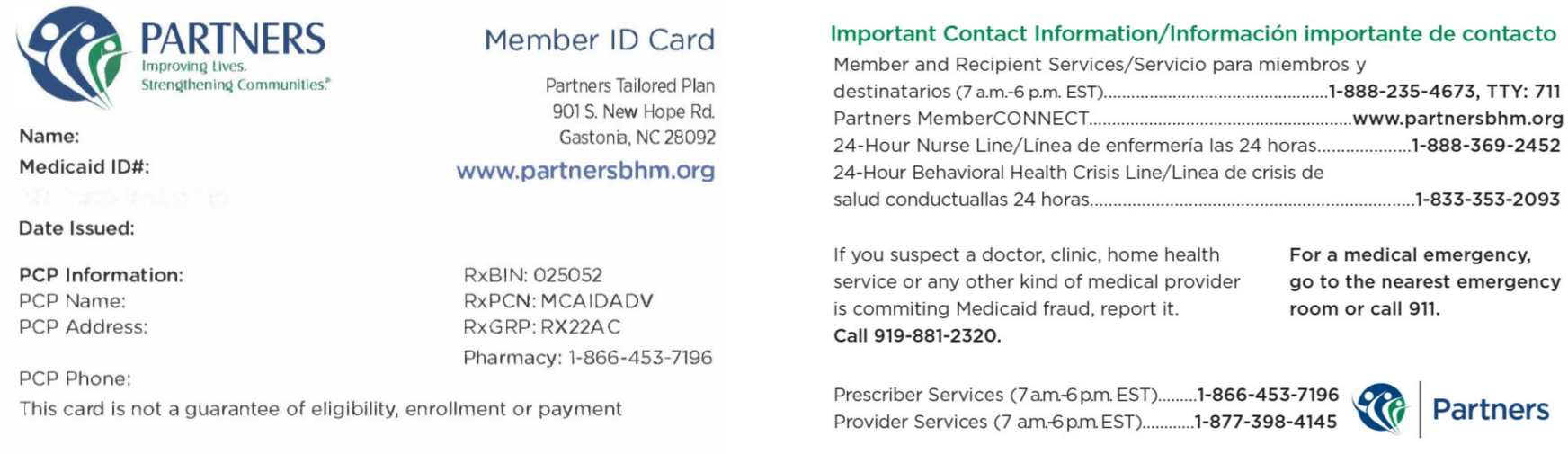
Partners Tailored Plan Member ID Cards



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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 via:
Secure web portal: https://providers.partnersbhm.org/category/providerconnect/
Provider Line: 1-877-398-4145.

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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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Partners Provider Communications

- CCHN Physical Health Provider Communications
- Partners Provider 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 Provider Resources

Inpatient Claims Submission Tips

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

Outpatient Claims Submission Examples

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

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

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

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

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

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How to File Claims as an OON Provider

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

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

Payment Expectations

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

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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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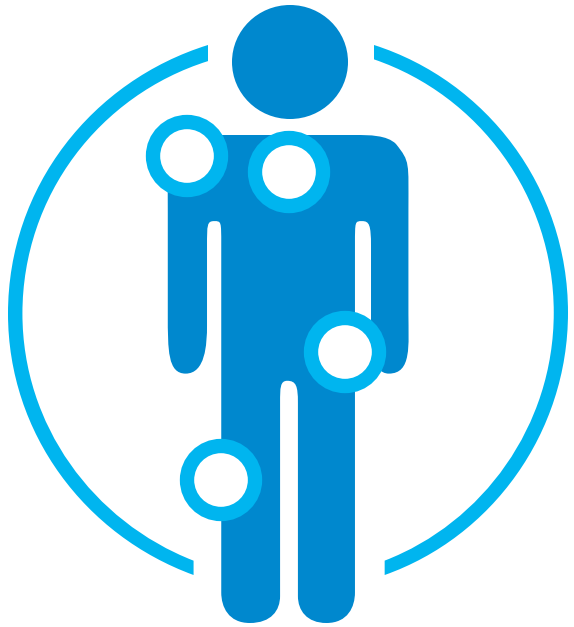
Evolent (Formerly National Imaging Associates, Inc.)

- 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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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

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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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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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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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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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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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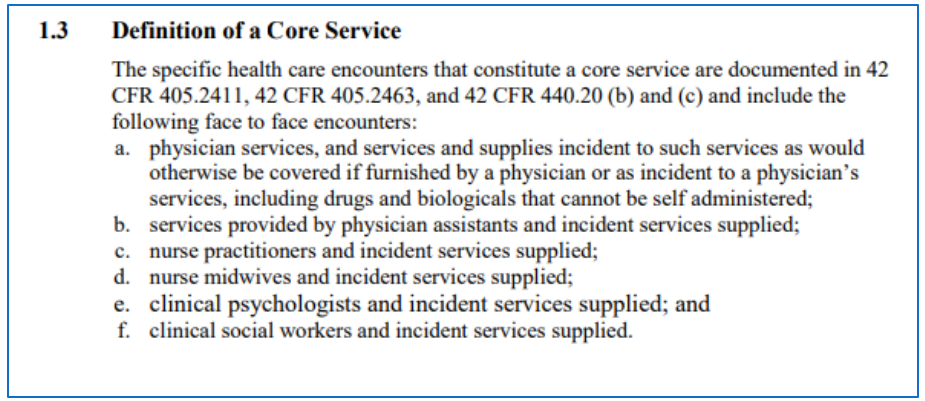
FQHC Billing Process

- FQHC Billing follows guidance provided in NC Clinical Policy 1D-4
- https://medicaid.ncdhhs.gov/documents/files/1d-4-2/open
- See “Attachment A” For Claims-Related Information
- BH Services provided through “Core Services” billed with T1015 and HI modifier.
- For DOS **beginning** 7/1/24, FQHC Core Service claims for Partners **Tailored Plan** members can be submitted using the physical health claim submission methods. These claims are processed by CCH.



1.3 Definition of a Core Service

The specific health care encounters that constitute a core service are documented in 42 CFR 405.2411, 42 CFR 405.2463, and 42 CFR 440.20 (b) and (c) and include the following face to face encounters:

a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician’s services, including drugs and biologicals that cannot be self administered;
b. services provided by physician assistants and incident services supplied;
c. nurse practitioners and incident services supplied;
d. nurse midwives and incident services supplied;
e. clinical psychologists and incident services supplied; and
f. clinical social workers and incident services supplied.

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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.