Partners'/CCHN Tailored Plan
Home Health Care Services Session Office Hours
Sept 2, 2025
12:00PM

Last updated 8/29/2025

Agenda

General Information

- Who We Are: Partners and Carolina Complete Health
- General Reminders and Communication
- Home Health Care Services EVV and NON EVV
- HHA Exchange Portal
- Home Health Code Crosswalks

Operational Information

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

Provider Resources

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

Carolina Complete Health and Partners

- **Partners Health Management** and **Carolina Complete Health** bring a shared vision for true partnerships with all providers across the system of care, which is reflected in our network management model.
- As the only Provider-led Entity (PLE), **CCH** seeks out physician and clinician expertise in medical policy and aim to give providers a voice in how to best to care for their patients while reducing administrative burden.
- Since **Partners'** inception as a managed care organization, **Partners** has executed a strategy of collaboration with providers.
- Our mutual goals is to aid provider success as they offer accessible, robust and effective services for members.

General Reminders and Communication

- Important Information on the Payment Schedule
- Due to the upcoming Labor Day holiday, the payment schedule for claims will be adjusted to minimize interruptions of payments to Partners Tailored Plan Physical Health providers.
- There will be a slight change to the schedule for the Monday September 1, 2025, check run. We will be scheduling a check run on Tuesday, September 2, 2025, and payments will process to providers on Wednesday, September 3rd, 2025.
- For details regarding the remaining changes to the 2025 Holiday Check Run schedule, please visit the following webpage: https://network.carolinacompletehealth.com/resources/claims-and-billing/holiday-check-run-schedules.html

General Reminders and Communication

- **Statewide Credentialing Committee**
- **Please join the North Carolina Department of Health and Human Services (NCDHHS), Division of Health Benefits (DHB), on Sept. 24, 2025 from 2-3 p.m. to continue the discussion of a new initiative led in tandem with General Dynamics Information Technology (GDIT).** This initiative will establish a Credentialing Committee aimed at maintaining a high-quality, ethical, and competent provider network to support NC Medicaid beneficiaries.
  - This session will offer stakeholders:
  - A collaborative forum to discuss the committee's future role in the provider enrollment and credentialing process to determine compliance of regulatory requirements by NC Medicaid provider applicants.
  - Committee member recruitment and onboarding.
  - Status of committee bylaws.
  - Review of frequently asked questions and answers pertaining to the development of this project.
  - High level project timeline.
  - **The sessions are intended to be interactive as the Department values input from partnering stakeholders, and will occur monthly, as follows, until the project implementation:**
  - **September 24, 2025**
- **You are encouraged to submit your related questions and comments for targeted open discussion at the meetings to Medicaid.credcommittee.stakeholders@dhhs.nc.gov.**

General Reminders and Communication

- Statewide Credentialing Committee
- https://medicaid.ncdhhs.gov/providers/provider-enrollment/provider-credentialing/credentialing-committee#AdditionalResources-4617
- **If you are participating on the Statewide Credentialing Committee, there are several dates of interest:**
  - **Week of Sept. 15 or 22, 2025**: Voting member onboarding and training (via webinar)
  - **Week of Oct. 6, 2025**: Committee members begin reviewing cases and attend the first Committee meeting
- Applications for **non-voting, volunteer peer review members** of the Credentialing Committee are now being accepted by General Dynamics Information Technology (GDIT). Eligibility requirements, provider types considered, participation expectations, and information about how to apply, can be found in the NCTracks announcement Now Accepting Applications for NCDHHS Credentialing Committee Peer Reviewers.
- **Additional resources, including official Committee bylaws, a fact sheet, webinar information and frequently asked questions are available on the Credentialing Committee webpage.**

General Reminders and Communication

- *A Message from NCTracks on Behalf of NC Medicaid*
- NC Medicaid is streamlining the nursing facility payment process to support timely provider reimbursement and reduce administrative delays.
- **Key Updates:**
- **MAGI Members**: Providers can bill immediately upon admission. No DSS action or PML determination is required.
- **All Members**: Payment is no longer delayed by the transfer of assets evaluation. Claims can be paid once PML is determined (for non-MAGI members).
- **Sanctions** from asset evaluations will apply starting the date listed on the DSS-8110 notice, always ending on the last day of the month.
- For more information, read the full bulletin: NF Payments Bulletin

General Reminders and Communication

- **New Attestation Requirements for Individual Providers**
- Effective Sept. 28, 2025, NCTracks is implementing a new attestation process for Individual and Atypical Individual providers as part of initial enrollment, re-enrollment and reverification applications submitted through the secured provider portal of NCTracks.
- This change aligns with the National Committee for Quality Assurance (NCQA) standards.

New Attestation Requirements for Individual Providers

- For initial and re-enrollment applications, the Individual practitioner will be required to complete an attestation before the application can be submitted for processing through NCTracks.
- The Office Administrator (OA), after completing the application, will be prompted to “Request Provider Attestation” which will generate a notification to the Individual provider via a secure link to the Individual provider’s email address listed on the application.
- To complete the attestation, the provider must confirm their identity by entering their National Provider Identifier (NPI)/Atypical number, date of birth, and the last four digits of their Social Security Number (SSN), then review the application and “Approve” or “Reject.”
- If the Office Administrator (OA) and Individual Provider are the same person (based on SSN), the provider can complete and submit the application directly.
- An email notification is sent to the OA when the attestation is completed, whether the Individual provider approves or rejects the application, allowing the OA to either correct and resend the application to the Individual provider for attestation, or submit the application.
- If the Individual provider attestation is not completed within 45 calendar days, the application will automatically abandon.
- **Important Notes**
  - Draft applications in the system at the time of implementation will be deleted.
  - Providers should submit draft applications before Sept. 28, 2025, to prevent loss of data.
  - For questions, please contact the NCTracks Contact Center at **1-800-688-6696.**

Home Health Care Services

- Home Health services are provided to beneficiaries who reside in private residences. Medically necessary services include:
  - Home health aide services
  - Skilled nursing services
  - Medical supplies
  - Specialized therapies
    - physical therapy
    - speech-language pathology
    - occupational therapy
    - Skilled nursing, specialized therapies and medical supplies can be provided if the beneficiary resides in an adult care home (such as a rest home or family care home).

Intended for Home Health Therapy, Skilled Nursing, Aide providers (251E00000X)

Home Health Referral Process

- 1. Physician Referral & Prescription:
  - A physician needs to prescribe the home health services based on the member's medical needs and goals.
- 2. Provider Coordination:
  - The home health agency or provider should coordinate with Partners/CCH to arrange for the service.
- 3. Prior Authorization (PA):
  - The provider must request Prior Authorization (PA) from Partners/CCH to get approval for services being rendered.
- 4. Documentation:
  - The provider needs to submit health records supporting the medical necessity of the service and ensure the provider is in the network.

For specific questions regarding Home Health Referrals please contact our CTT team at Ctt_inpatientEd_referrals@partnersbhm.org .

Home Health Electronic Visit Verification (EVV) Checklist

Provider Readiness Checklist

1. Ensure your EVV vendor is sending visit data to HHAX today for Partners Tailored Plan members!
2. Ensure your EVV vendor is aligned with HHAX Visit File Specifications

   E.g., field formatting, required fields, accurate HHAX payer ID values in alignment with member's eligibility Visit Import Guide v5
3. Ensure your practice and EVV vendor are aligned with the Procedure Code Crosswalks
   - Auth request → HHAX Visit File data → Claim
4. Partners Code Crosswalk- Code Cross Walk

   (EVV HHCS Code Crosswalk on Provider Knowledge Base page)
5. Ensure your practice is educated on monitoring HHAX EDI Rejected Visits
6. Ensure your practice is reviewing claims with informational edit "R9" during soft launch to identify adjustments required to prevent claims denials in hard launch
7. Submit a ticket to HHAX to disable E-billing if your practice will Direct Bill
8. Reach out to our EVV Support Team at Evvsupport@partnersbhm.org with any questions or issues

PARTNERS

Improving Lives. Strengthening Communities.®

Physical Health Authorizations

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.

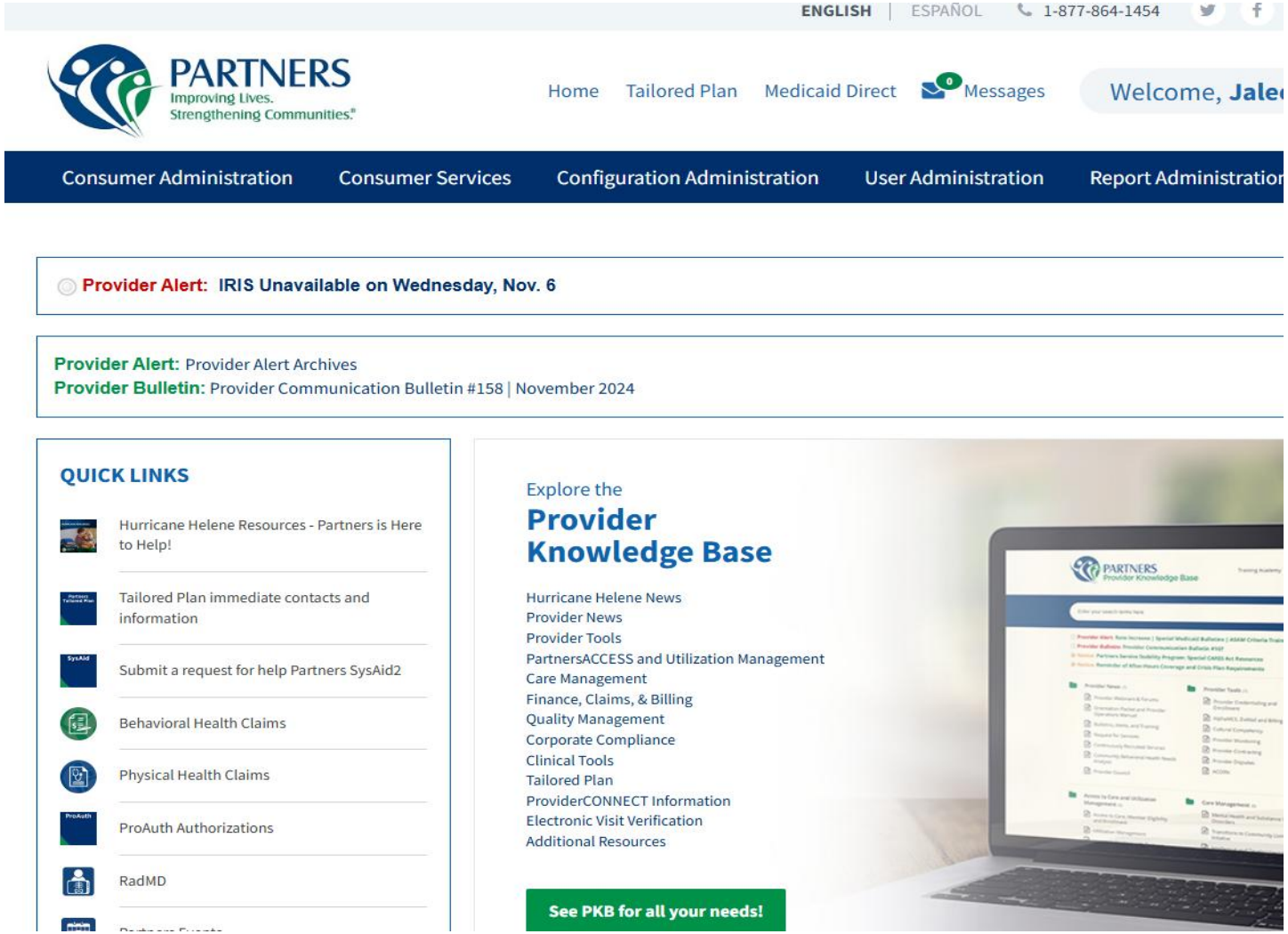
- **Action needed**
  - Designated portal administrators must complete Partners Health Management ProviderCONNECT set-up form: **https://www.surveymonkey.com/r/MBXQSBF**
  - Once you complete the survey, you will receive an email from Partners in 1-2 business days with next steps.
  - For questions about 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/**

Logging into ProviderConnect

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

Getting to ProAuth

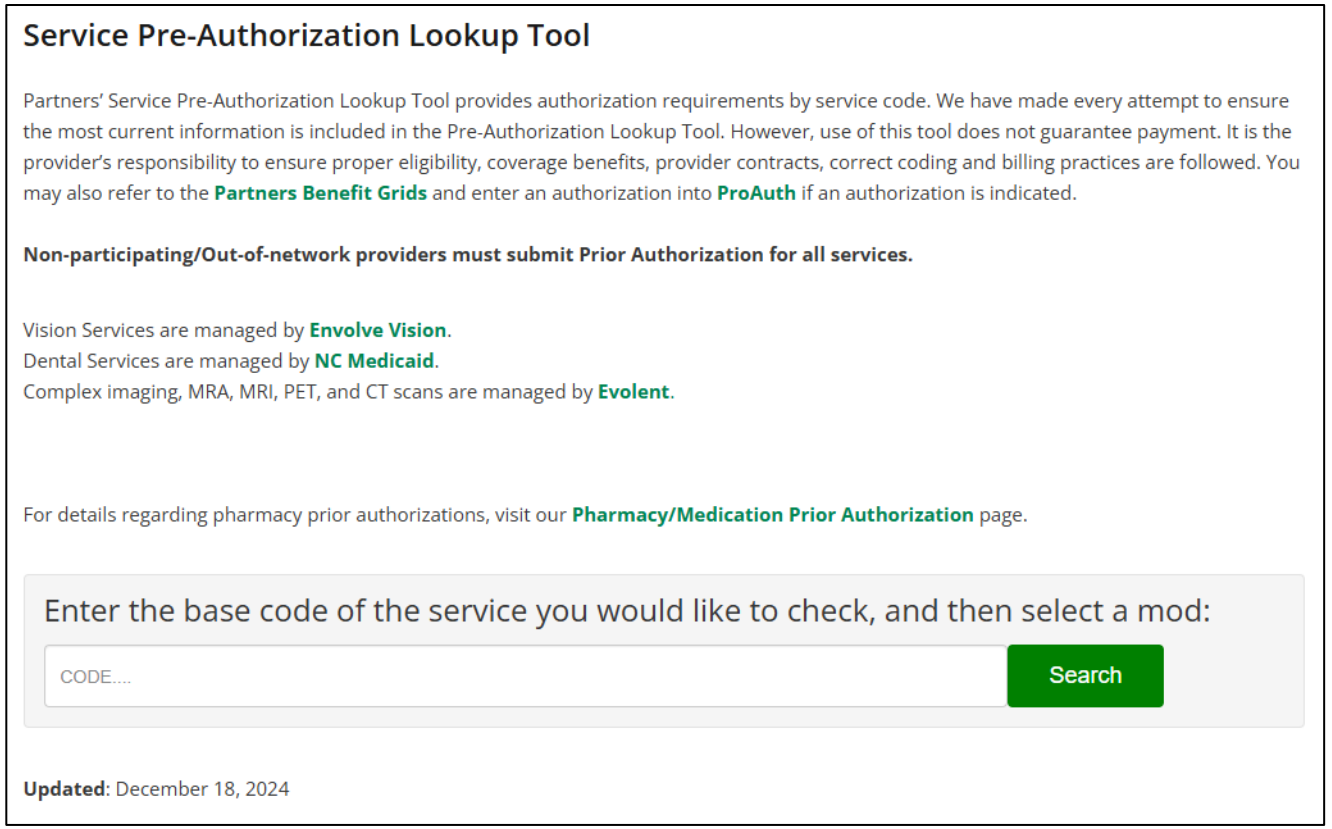
- From the ProviderConnect homepage, use the Quick Links on the left to access ProAuth Authorizations:



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

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health.

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

Authorization, Notification, and Determination Timeframes

Authorization Type	Timeframe for Provider to Notify Partners	Timeframe for Determination by Partners upon receipt of medical necessary medical information.
Standard Service Auth	Prior Authorization required at least fourteen (14) business days prior to the scheduled admission date or as soon as the need for service is identified	Current: Within fourteen (14) calendar days from receipt of necessary medical information. **Effective January 1, 2026: Within seven (7) calendar days from the receipt of necessary medical information. If the request lacks clinical information, Partners may extend the review time frame for up to 7 calendar days (max 14 calendar days for review).**
Emergent/Urgent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning or as soon as the need for service is identified.	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request. If the request lacks clinical information, Partners may extend the review time frame for up to 14 calendar days (max 17 calendar days for review). **Effective January 1, 2026: If the request lacks clinical information, Partners may extend the review time frame for up to 11 calendar days (max 14 calendar days for review).**
Concurrent Review	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning.	For concurrent review requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request. If the request lacks clinical information, Partners may extend the review time frame for up to 14 calendar days (max 17 calendar days for review). **Effective January 1, 2026: If the request lacks clinical information, Partners may extend the review time frame for up to 11 calendar days (max 14 calendar days for review).**
Retrospective Review	If the request is received within 90 days from the date of service (DOS) or the date of admission (DOA) and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity .	The health plan will have 30 calendar days to review and finalize a decision. If the request lacks clinical information, Partners may extend the retrospective review time frame for up to 15 calendar days (max 45 calendar days for review).

Home Health Care Services EVV

The 21st Century Cures Act requires NC Medicaid to begin using an Electronic Visit Verification (EVV) system for Home Health Care Services (HHCS) and Personal Care Services (PCS) for both physical and behavioral health services.

To ensure that the provider community complies with the Cures Act mandate requirements, Partners Health Management, alongside Carolina Complete Health, has partnered with HHAeXchange as its EVV solution.

Learn more about electronic visit verification and review the NC Medicaid EVV FAQ.

Partners Health Management uses HHAeXchange as our EVV Vendor.

Not Connected to HHAeXchange

The HHAeXchange provider information center outlines necessary requirements to set up access to the HHAeXchange system. If your agency does not have a portal with HHAeXchange, please complete the Provider Portal survey.

HHAeXchange offers EVV solutions at no cost to providers and data integration options for providers who already have EVV software. Based on your provider set up, below are the options available with HHAeXchange:

Option 1: Agencies currently without an EVV Solution: use the free EVV tools provided by HHAeXchange Partners and Carolina Complete Health.

Option 2: Agencies currently using another third party EVV Solution: use your existing EVV system and import visit data into HHAeXchange.

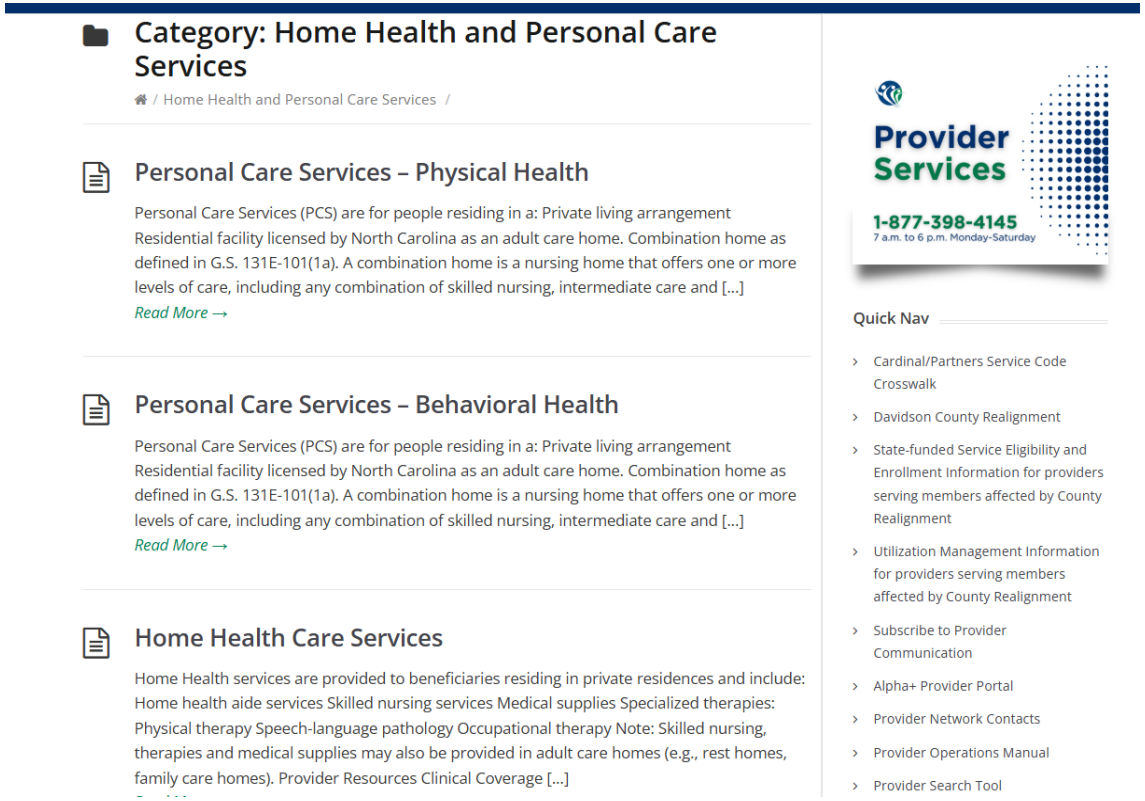
- **HHA will route visit data to Partners and Carolina Complete Health.**

Please complete the Provider Portal survey.

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

Home Health Resources



Category: Home Health and Personal Care Services

Home Health and Personal Care Services /

Personal Care Services – Physical Health

Personal Care Services (PCS) are for people residing in a: Private living arrangement Residential facility licensed by North Carolina as an adult care home. Combination home as defined in G.S. 131E-101(1a). A combination home is a nursing home that offers one or more levels of care, including any combination of skilled nursing, intermediate care and [...]

Read More →

Personal Care Services – Behavioral Health

Personal Care Services (PCS) are for people residing in a: Private living arrangement Residential facility licensed by North Carolina as an adult care home. Combination home as defined in G.S. 131E-101(1a). A combination home is a nursing home that offers one or more levels of care, including any combination of skilled nursing, intermediate care and [...]

Read More →

Home Health Care Services

Home Health services are provided to beneficiaries residing in private residences and include: Home health aide services Skilled nursing services Medical supplies Specialized therapies: Physical therapy Speech-language pathology Occupational therapy Note: Skilled nursing, therapies and medical supplies may also be provided in adult care homes (e.g., rest homes, family care homes). Provider Resources Clinical Coverage [...]

Provider Services

1-877-398-4145

7 a.m. to 6 p.m. Monday-Saturday

Quick Nav

- Cardinal/Partners Service Code Crosswalk
- Davidson County Realignment
- State-funded Service Eligibility and Enrollment Information for providers serving members affected by County Realignment
- Utilization Management Information for providers serving members affected by County Realignment
- Subscribe to Provider Communication
- Alpha+ Provider Portal
- Provider Network Contacts
- Provider Operations Manual
- Provider Search Tool

Partners Health Management Home Health Page
https://providers.partnersbhm.org/

Home Health Clinical Coverage Policy NC DHSS: https://medicaid.ncdhhs.gov/node/859

NC DHHS Home Health Resources:
https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/home-health-services

Home Health Care Services Billing Guide:
https://providers.partnersbhm.org/wp-content/uploads/partners-home-health-provider-guide.pdf

Partners operates a dedicated EVV help desk for general inquiries, troubleshooting or contracted provider resolution. We also work in collaboration with our EVV vendor, HHAeXchange. If you have any questions or need assistance, please email EVVSupport@PartnersBHM.org.

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

Additional ProAuth Training

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

Member Eligibility

Submitting X12 Transactions (EX: 270/271)

Method	Physical Health X12 Submission Payer ID: 68069	Behavioral Health X12 Submission Payer ID: 13141
PARTNERS Provider Knowledge Base	Please refer to Partners' Provider Knowledge Base and then proceed to **Availity – Physical Health Transactions Setup.** https://providers.partnersbhm.org/alphamcs-zixmail-sign/	Please refer to Partners' Provider Knowledge Base and then proceed to **Alpha+ Provider Set Up.** https://providers.partnersbhm.org/alphamcs-zixmail-sign/
Clearinghouse (Availity)/ Alpha+ (Partners)	Physical Health transactions can be submitted through Availity with ***Dates of Service*** beginning July 1, 2024. Availity Quick Start Guide	Behavioral Health transactions, e.g., 270/271 can be submitted to Partners by contacting Partners IT Service Desk at servicedesk@partnersbhm.org or follow the step-by-step process at
Electronic Data Interchange (EDI)	Provider's Clearinghouse connection to Availity for submitting EDI X12 files (e.g., 837, 270, 276) can be processed with Response. EDI Quick Start Guide for Availity	For information on submitting Behavioral Health 270/271 Eligibility Benefit Inquiry and Response, Click here: https://providers.partnersbhm.org/wp-content/uploads/Submitting-270_271-EDI-X12-File-to-Partners_-20240610.pdf

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

Claims and Payments

Billing HHCS Reminders EVV

- Service Codes sent in Visit Files to HHAX must match the EXACT value in the CCH code crosswalk or HHAX EDI Code Table Guide (ie, spacing, no hyphens, etc)

Partner Health Code Crosswalk (HHCS): https://providers.partnersbhm.org/home-health-care-service-hhcs-code-crosswalk-xlsx/

- CPT/HCPCS code sent to HHAX should align with your prior authorization (if applicable)

- Home Health Care Services Billing Guide: https://providers.partnersbhm.org/wp-content/uploads/partners-home-health-provider-guide.pdf

Billing HHCS Example EVV

- CPT/HCPCS and Revenue Code used on your claim should align with the data sent to HHAX.

Partners Health Management

Claims and Billing Guidance for Home Health EVV - REV/HCPC/CPT Codes

					Codes in green require prior authorization		EVV Visit Data	Claims Fields	
Program	Service Type	REV Code	Service Description	Prior Auth Required?	Use These Codes for PA requests and claims	Do NOT use these Codes	Use These Code Combos for EVV Visit Data	Box 42 (Rev Code):	Box 44 (HCPCS/CPT):
Home Health	Therapies	RC420	Physical Therapy	Yes	97110 97116 G0151 G0157 G0283 G2168 S9131	G0159	97110 RC420 97116 RC420 G0151 RC420 G0157 RC420 G0283 RC420 G2168 RC420 S9131 RC420	0420	97110 97116 G0151 G0157 G0283 G2168 S9131

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

Billing Home Health Care Services EVV

- Visit the new HHAeXchange Knowledge Base:
  - No login required
  - Access training videos, FAQs, job aids, and more

Providers using HHAX as your EVV vendor:
https://knowledge.hhaexchange.com/provider/Content/Home/Home-C.htm

3rd party vendor (EDI) providers - NEW!:
https://knowledge.hhaexchange.com/edi/Content/Home/Home-C.htm

Billing Home Health Care Services EVV

- Partners Health Management encourages providers to submit some visit data every week to HHAX during soft launch, and monitor if visits successfully import or reject at HHAX.

This ensures we can:

– Identify any HHAX configuration that may need further review

– Identify if your 3rd party EVV vendor configurations are working as intended

Please ensure your vendor has the current file specifications in the previous slide. Your vendor should be aligned or working to align with these specs and code crosswalk ahead of a new hard launch date.

You may still bill Partners Health Management/CCH directly during soft launch if your visits do not successfully import to HHAX.

New hard launch date 10/1/25

Direct Billing For EVV Home Health Services

Partners Health Managment will support a “Direct Billing” solution for Home Health Providers

- Allows claims to be submitted to Partners Health via any of our accepted claims submission paths.
- Visit data must still be sent AND successfully imported to HHAX

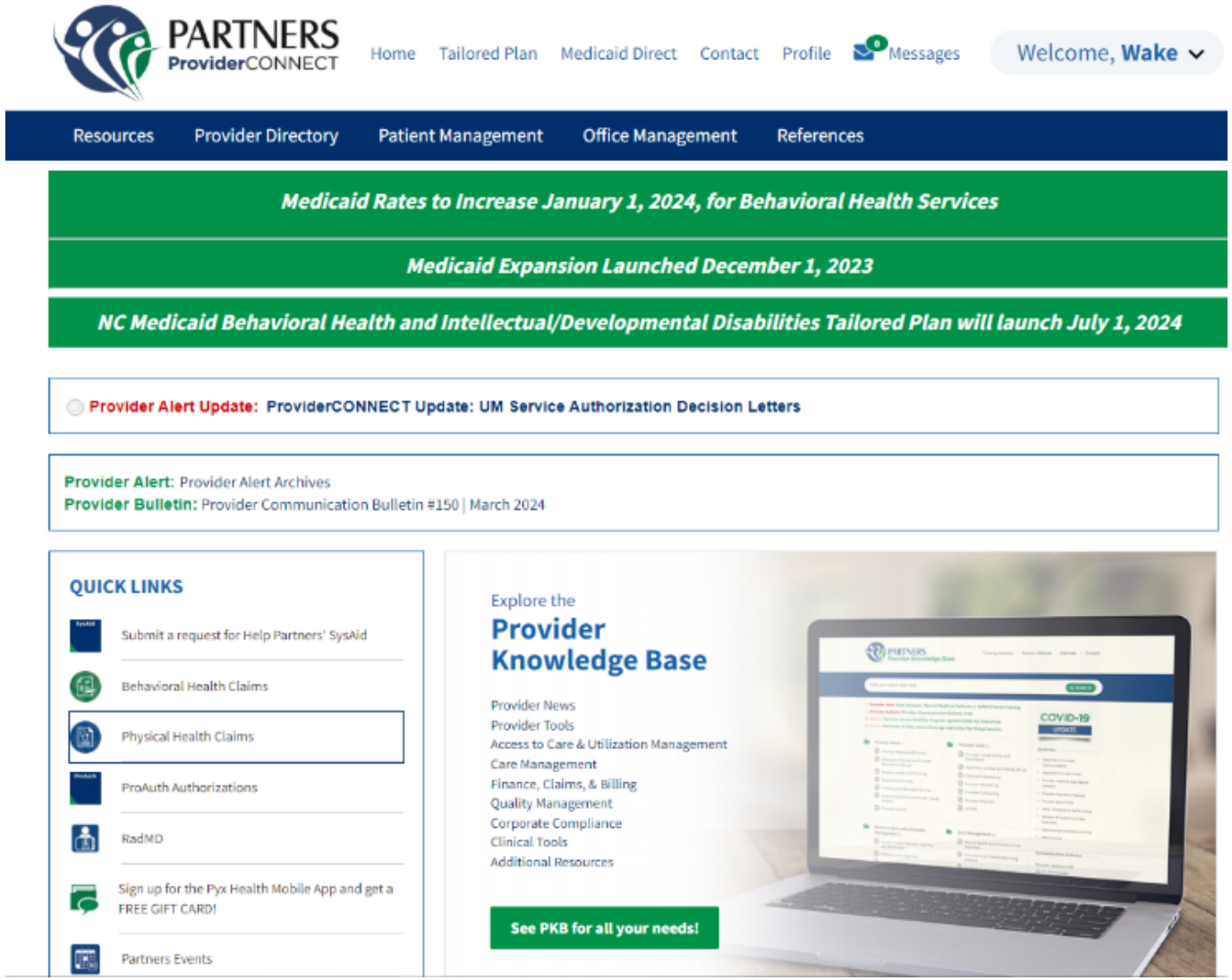
In soft launch, visit data is not required for claims adjudication but strongly recommended
In hard launch, visit data will be required for claims adjudication
› Visit data, claims data, and authorization data (where applicable) must match

Home Health Care Billing Surveys have been sent out to HHCS providers.

This does not apply to Personal Care Services (PCS) providers

Submitting Claims

- You can submit your Physical Health Claims through ProviderConnect



Submitting Claims NON EVV

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

EDI Questions

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

Clearinghouse and Set Up of New Payers

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

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#/

Additional Claim Tips

SERVICE OR SERVICE/MODIFIER COMBO NOT FOUND ON FEE SCHEDULE

- Partners adheres to the NC Medicaid Fee Schedule for physical health claim processing. See State website for fee schedules, covered services, and appropriate modifiers: https://ncdhhs.servicenowservices.com/fee_schedules

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. Please use the Partners provider portal to verify member eligibility and other health insurance.

Home Health Provider Claim Denial Trends

Claim Denial Reason	Guidance
ATTENDING PROV TAXONOMY REQUIRED	On Institutional claims (ASC X12 837-I) the billing provider taxonomy should be included in EDI loop 2000A and the attending provider taxonomy, when applicable, should be included in EDI loop 2310A. Taxonomy must also match NCTracks provider data. Note: Billing and rendering taxonomy is also required. See our Claims Submission Reminder Guide (PDF) for information on where to place taxonomy number on your claim
DENY-ATTEND NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATE	All provider data on the claim, including NPI and Taxonomy, must match what is in NCTracks. NCTracks is the "system of record" for provider enrollment data, which is then shared with health plans to inform contracting and provider directories. Claims information is also validated against provider enrollment data. Provider Enrollment and Data (PDF)
DENY: DUPLICATE CLAIM SERVICE	The claim adjudication process will evaluate billed claims to determine if there is a previously submitted claim for the same enrollee and provider in history that is a duplicate to the billed claim. The claims will be reviewed across different providers to determine if another provider was paid for the same procedure, for the same enrollee on the same date of service. If you need to make a correction to your original submission, please submit a corrected claim instead of an additional first-time claim.
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. Please verify member eligibility with other health insurance through the Partners portal ProviderCONNECT.
DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED	Authorizations are granted at the CPT code level. Providers can submit authorizations via web submission through ProviderCONNECT using ProAuth. For a demonstration, visit the Partners Knowledge Base. To determine if a pre-auth is needed, utilize the Partners' Service Pre-Authorization Lookup Tool

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

Provider Payments

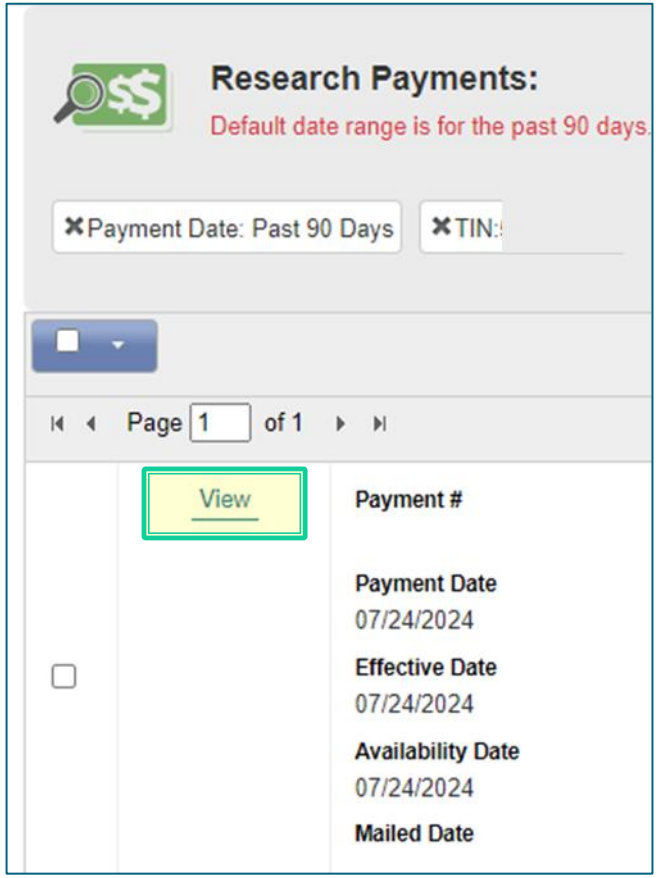
- **Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days** and 99% within 30 calendar days following receipt of the claim.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- Partners check run scheduled is weekly on Mondays, with payment issued to providers on Tuesdays.
- Remittance Advice, also referred to as an 835 or Explanation of Payment (EOP), are issued with payment and can be accessed several ways:
  - Payspan: https://www.payspanhealth.com/
  - Physical copy if you receive paper check

Electronic Funds Transfer 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

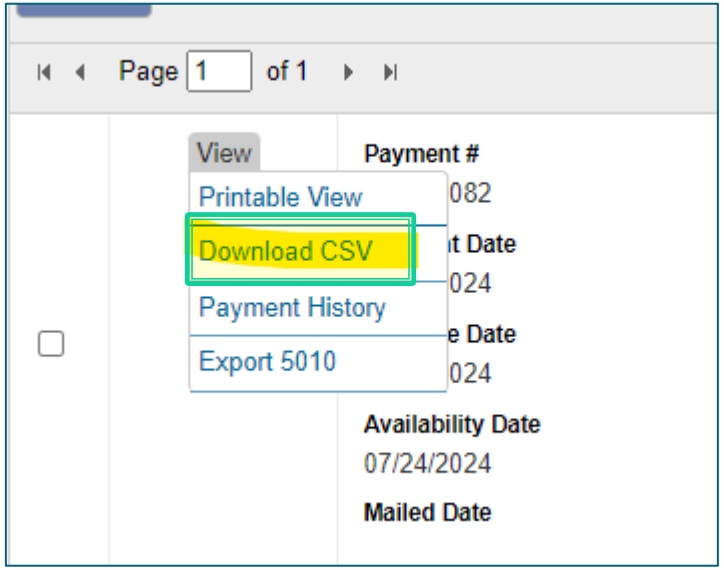
Access ERA in Payspan

1



Scroll down and click ‘View all EOP’

2



Download CSV

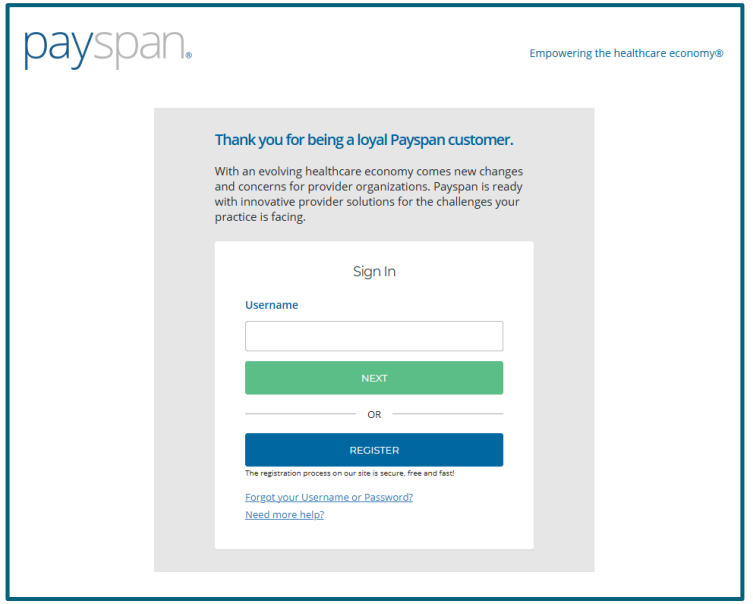
Electronic Funds Transfer

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



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**.

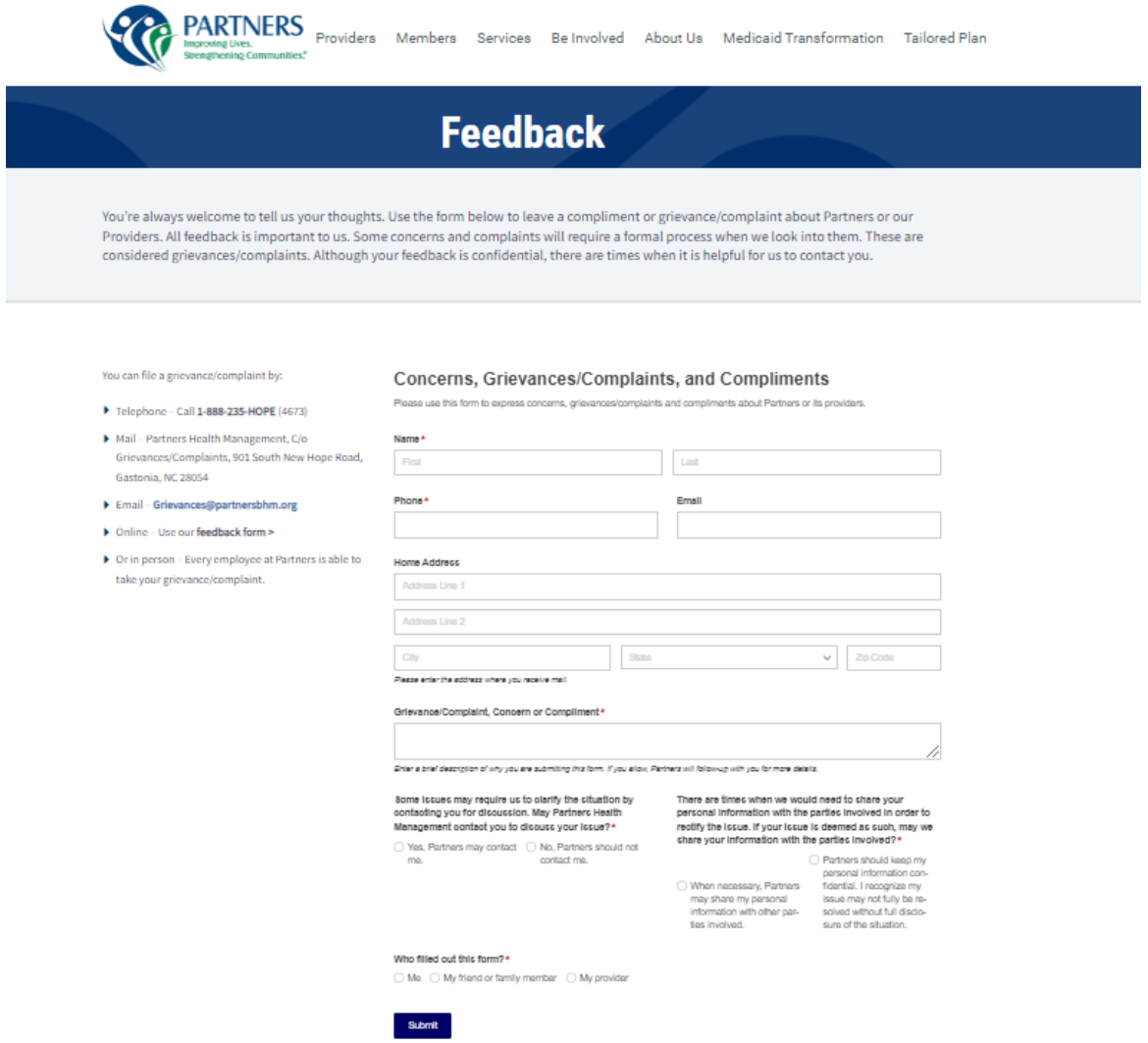
Email claims reconsideration review form to claimsdepartment@partnersbhm.org.
The form is located at https://providers.partnersbhm.org/claims-information/.
A grievance can be submitted if provider is unsatisfied with the outcome of the claim review. https://providers.partnersbhm.org/grievance- incident-reporting/.

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

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.

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

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.

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

- **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

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

Questions?

PARTNERS
Improving Lives. Strengthening Communities.®

Additional Provider 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.

Frequent Asked Questions

- **Are referrals to specialists required?** No. Members can seek in-network specialist care without a referral. Members are encouraged to seek consultation first from their primary care provider. PCPs are encouraged to coordinate care to specialists. Prior Authorization rules may apply.
- **What are the copay rules?** Copays are established by NC Medicaid and are consistent across all Medicaid plans. Read more here.
- **How do I know which CPT code and modifier to use and if it is covered?** Partners adheres to the NC Medicaid Fee schedule and covered for physical health services. Utilize the NC DHHS Service Now Page

PARTNERS
Improving Lives. Strengthening Communities.

Durable Medical Equipment

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

Resource: Partners Physical Health DME Provider Guide

Provider Resources

Learn More About Partners Health Management

- https://www.partnersbhm.org/tailoredplan/
- https://www.partnersbhm.org/tailoredplan/providers/manuals-forms-and-policies/
- https://www.partnersbhm.org/wp-content/uploads/partners-quick-reference-guide.pdf
- https://www.partnersbhm.org/tailoredplan/pharmacy/
- https://www.partnersbhm.org/tailoredplan/providers/provider-training-materials/
- https://providers.partnersbhm.org/claims-information/

- NC DHHS Tailored Plan Toolkit

Tailored Plan Transportation Services

Non-Emergency Medical Transportation (NEMT)

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

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

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

What appointments are covered?

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

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

PARTNERS
Improving Lives. Strengthening Communities.

carolina complete health

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.