# Partners and Carolina Complete Health Frequently Asked Questions

## Authorizations

- **Question:** Will authorizations for OT/PT/ST services for pediatrics go through Carolina Complete Health for Tailored Plan members w/ Partners? Will the claims and billing will go through them as well?
    - **Answer:** Authorizations will come through Partners ProviderCONNECT - our portal. We will review and process those TP member authorization requests for services and then you can submit your claims through this portal as well. https://providers.partnersbhm.org/category/providerconnect/

- **Question:** Can you touch on how prior authorizations and claims will be routed for Physical Health benefits for Tailored Plan members once we go live? I.e., Will physical health prior authorizations and claims go to Carolina Complete Health, or will they go to Partners Health?
    - **Answer:** 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. https://providers.partnersbhm.org/category/providerconnect/

- **Question:** Authorizations will have to submitted on the Partners portal correct for physical health providers?
    - **Answer:** 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. https://providers.partnersbhm.org/category/providerconnect/

- **Question:** Will ABA Authorizations be sent to the same UM team/on the same portals, or will these authorizations go somewhere new?
    - **Answer:** Same team and portal as you currently use for Medicaid Direct members.

- **Question:** Will pediatric speech therapy require prior authorization?
    - **Answer:** Partners follows NC Clinical Coverage Policies regarding prior authorization requirements. Per Clinical Coverage Policy No: 10A Outpatient Specialized Therapies:

      5.1 Prior Approval
      Medicaid shall require prior approval for all Outpatient Specialized Therapies treatments. The provider shall obtain prior approval before rendering Outpatient Specialized Therapies treatments. In order to obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.

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- **Question:** Will the prior authorization process for outpatient therapy services be the same as CCHN?
    - **Answer:** Providers can submit prior authorization requests, review progress and access adverse decision letters via ProviderCONNECT. The preferred method of prior authorization submission is through ProAuth, which can be accessed through ProviderCONNNECT. Partners Utilization Management department can also accept prior authorization requests sent via fax or email or requested via telephone. https://www.partnersbhm.org/tailoredplan/providers/prior-authorization-submissions/
    - Please refer to Partners Provider Communication Bulletin #152 for information regarding Tailored Plan authorization flexibilities. Provider Communication Bulletin #152 - Partners Health Management - Provider Knowledge Base (partnersbhm.org)

- **Question:** For authorizations for speech, occupational or physical therapy. Would current auths be recognized or will an additional authorization for services need to be obtained through your portal?
    - **Answer:** If you have an approved authorization with an end date beyond June 30, 2024, you do not need to submit a new service authorization request/prior authorization request. Partners will honor the authorization request through the approved end date.
    - If you are authorized for an end-date of July 1, 2024, or later, you would need to submit a new service authorization request/prior authorization request for Medical Necessity Review at the end of the current authorization.
    - Providers only need to submit a service authorization request/prior authorization request if service has not been previously requested for the member (e.g., a new service) or authorization ends after June 30, 2024 (submit at end of current authorization). https://www.partnersbhm.org/tailoredplan/providers/prior-authorization-submissions/
    - Please refer to Partners Provider Communication Bulletin #152 for information regarding Tailored Plan authorization flexibilities. Provider Communication Bulletin #152 - Partners Health Management - Provider Knowledge Base (partnersbhm.org)

## Billing

- **Question:** I am DME provider, if a patient has a tailored plan but need a Nebulizer Machine. Would I process it through the Tailored plan or the Standard plan?
    - **Answer:** DME is a covered benefit for Tailored Plan members and is considered a physical health service. This is processed through the Tailored Plan with our physical health partner, Carolina Complete Health. Physical health services for TP Partners members may be billed in one of the following ways: Partners secure Provider Portal using Availity for physical health claims or through a clearinghouse using Payer ID 68069. Carolina Complete Health will process physical health claims.

- **Question:** Does this impact where claims need to be sent?

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- **Answer:** Please reference Partner's Quick Reference Guide.

- **Question:** What was that Payer ID for electronic claims?
  - **Answer:** The Payer ID for physical health claims is 68069.

- **Question:** When billing through a clearinghouse, are claims filed to CCH?
  - **Answer:** Physical health claims, yes. The Payer ID is 68069.

- **Question:** For speech therapy, will claims go through Partners or CCH?
  - **Answer:** Physical health services for TP Partners members may be billed in one of the following ways: Partners secure Provider Portal using Availity for physical health claims or through a clearinghouse using Payer ID 68069. Carolina Complete Health will process physical health claims.

## Contracting

- **Question:** If a provider is contracted with CCH will that automatically allow the ability to service beneficiaries who are enrolled in a Tailored plan?
  - **Answer:** Please ensure that you have Tailored Plan network(s) added to your existing contract with Carolina Complete Health. You can fill out the contract request form or email NetworkRelations@cch-network.com

- **Question:** We are seeing members with both Medicaid Direct and Trillium or Alliance Health...will they lose their PCS services under Medicaid Direct on 5/16?
  - **Answer:** If a current Medicaid Direct member is eligible for a Tailored Plan, they will be able to get PCS services through their Tailored Plan upon TP launch on 7/1/24.

- **Question:** We are a specialist group that only provides physical medicine to our patients. We are not contracted with Partners at this time. When this was originally set to launch, we were told we could still see patients who are under TCM and bill CCH for services because we are contracted with them. Is that still the case?
  - **Answer:** As a physical health specialist, to remain in network with Partners when Tailored Plan launches, you should ensure that Partners Tailored Plan is added to your existing CCH Standard Plan contract. You can complete the Contract Request form and/or reach out to our team at NetworkRelations@cch-network.com. Physical health services for TP Partners members may be billed in one of the following ways: Partners secure Provider Portal using Availity for physical health claims or through a clearinghouse using Payer ID 68069. Carolina Complete Health will process physical health claims.

- **Question:** If we are already contracted and set up with Partners regarding our behavioral health services will we have to do another contract for physical Health?

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- **Answer:** If you are an existing Partners behavioral health provider and also provide physical health services, you will need to complete the contracting steps through our partner Carolina Complete Health: Contract Request Form.

- **Question:** We are a non-medical PCS provider, and we have been trying to expand to Behavioral Health services under the Tailored Plan. There are few resources /guidance on how to do that.
  - **Answer:** If you would like to join Partners network, please submit the Request for Consideration Form.

    Please note that your enrollment with NCTracks is required. The agency, NPI, taxonomy, sites and clinicians must be enrolled in NCTracks in order to continue to contract with Partners and in order to make changes to your contract with Partners.

    Please contact us at CredentialingTeam@PartnersBHM.org or by phone at 704-842-6483 if you have questions about the status of your enrollment and contract with us.

- **Question:** As a DME provider we are contracted with Carolina Complete Health. Do we need a separate contract with Partners to provide members in the Tailored Plans?
  - **Answer:** Please ensure that you have Tailored Plan network(s) added to your existing contract with Carolina Complete Health. You can fill out the Contract Request Form or email Network Relations.

- **Question:** Will providers have to do a new Tailored Plan contract with Partners although we are already contracted to provide Medicaid Direct Behavioral Health services? under the LME?
  - **Answer:** If you are currently a Medicaid Direct provider with Partners, you would receive a Tailored Plan contract as well. They are two separate Medicaid products. If you are currently contracted with us for Medicaid Direct, please reach out to pas@partnersbhm.org.

- **Question:** Will providers need to enroll all clinicians in those areas with CCH?
  - **Answer:** To remain in network when TP launch, physical health providers should enroll clinicians in the Tailored Plan areas. All clinicians should be credentialed with NC Medicaid through NCTracks. With Partners, physical health providers may work with Carolina Complete Health to contract for Partners Tailored Plan. If you have an existing CCH Standard Plan contract, you may need to add the Tailored Plan to your contract: Contract Request Form.

- **Question:** With Tailored plan launch, do ABA providers need an amendment to the existing contract?
  - **Answer:** If you need to look at your contract or have questions, please contact us at pas@partnersbhm.org.

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## Coverage

- **Question:** Will CCH expand into regions not previously assigned to CCH, with the partnering of Trillium and Partners? Will CCH be available as a standard plan in those regions?
    - **Answer:** Carolina Complete Health Standard Plan will continue to be available for Standard Plan members in regions 3, 4 and 5 when Tailored Plans launch.

- **Question:** Trillium reaches into regions 5 and 6; while Partners reaches into region 1. Will CCH not be available as standard plan in these regions?
    - **Answer:** Carolina Complete Health Standard Plan will not be available outside of region 3, 4 and 5. CCH will support Tailored Plan physical health network services in these additional areas with Partners and Trillium.

- **Question:** Does this pertain to DME Providers?
    - **Answer:** DME is a covered benefit for Tailored Plan members and is considered a physical health service. This is processed through the Tailored Plan with our physical health partner, Carolina Complete Health. Physical health services for TP Partners members may be billed in one of the following ways: Partners secure Provider Portal using Availity for physical health claims or through a clearinghouse using Payer ID 68069. Carolina Complete Health will process physical health claims.

- **Question:** What about DME services?
    - **Answer:** DME is a covered benefit for Tailored Plan members and is considered a physical health service. This is processed through the Tailored Plan with our physical health partner, Carolina Complete Health. Physical health services for TP Partners members may be billed in one of the following ways: Partners secure Provider Portal using Availity for physical health claims or through a clearinghouse using Payer ID 68069. Carolina Complete Health will process physical health claims.

- **Question:** Where would pervasive autism/autism services fall?
    - **Answer:** There are services that would apply based on the Member's Medicaid. If the member is a Tailored Plan member, they could still be receiving ABA services through the RB-BHT clinical coverage policy. If the member is Medicaid Direct, they would be able to continue those services. Innovations members would be a Tailored Plan population. If that member is on the wait list for Innovations, then we would also be assisting with services.

- **Question:** I represent a specialty practice (neurosurgery). How will we know if a patient is qualified for a Tailored Plan? Will recipients get an insurance card that reflects this information, or will it be documented on either NC Tracks or the Carolina Complete site?
    - **Answer:** Members will receive a Tailored Plan Partners member ID card. You may also use NCTracks to verify a member's eligibility.

- **Question:** For nonclinical services such as personal care services and peer support services, if clients have any of those ICDs, will they now be Tailored Plan?

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- **Answer:** PCS and PSS are also covered benefits under Standard Plans. You will be able to verify member eligibility and identify if the member is part of TP or SP using NCTracks.

## Miscellaneous

- **Question:** Are there webinars like this for the caretakers?
    - **Answer:** Partners has a Member Engagement Team that offers Member Cafe's and other topics for members, family members and caretakers: https://www.partnersbhm.org/tailoredplan/members/ and https://www.partnersbhm.org/member-cafe/

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- **Question:** What is an SP?
    - **Answer:** SP stands for Standard Plan. Standard Plans launched on 7/1/21 under Medicaid Managed Care. Please review fact sheets from NC DHHS on Standard Plans.

- **Question:** WellCare and CCH are the only Standard Plans partnering with LME/Tailored plans. If there is not a partnering Standard Plan in those regions, are you able to say how this will work?
    - **Answer:** This fact sheet from NC DHHS outlines each Tailored Plan and their Standard Plan partner along with operational information at a high level.

- **Question:** What is Partners doing to help lessen the administrative burden on providers? For example, what is the process for prior authorization for outpatient therapy services?
    - **Answer:** Providers can submit prior authorization requests, review progress and access adverse decision letters via ProviderCONNECT. The preferred method of prior authorization submission is through ProAuth, which can be accessed through ProviderCONNNECT. Partners Utilization Management department can also accept prior authorization requests sent via fax or email or requested via telephone.
    - Please refer to Partners Provider Communication Bulletin #152 for information regarding Tailored Plan authorization flexibilities.
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- **Question:** Will BCBA's need to incorporate conversations with the CMA's during reassessments or does this not impact our current process of just reassessing the patient and then submitting for authorization?
    - **Answer:** Partners is happy to set up a meeting to discuss this further to ensure we are answering your questions. As a general standard, you should be working with the CMAs for a comprehensive assessment and planning purposes. If you would like a meeting or to discuss further, please contact your assigned Provider Account Specialist at Partners or through pas@partnersbhm.org.