New Provider Orientation

Updated February 2024

Additional Onboarding Trainings

View the PHP Streamlined Orientation

- Recording
- Slides

On-demand CCH Orientation

- Recordings

Additional onboarding trainings: Education & Training

1. Cultural Competency
2. EPSDT
3. Provider Compliance

Attestation and Feedback:

- https://www.surveymonkey.com/r/CCHNPO

Agenda

General Overview

- Who We Are – North Carolina's Provider Led Plan
- Provider Engagement and Relations Support

Operational Information

- Website and Secure Portal
- Value Added Services
- Grievances and Appeals
- Prior Authorizations
- Claims
- Provider Compliance Training
- Clinical Policy and Quality Committees
- Specialty Companies and Vendors
- Cultural Competency Resources

Why we're in business

OUR PURPOSE

Transforming the health of the community, one person at a time

What we do

OUR MISSION

Better health outcomes at lower costs

What we represent

Focus on the Individual +

Whole Health

Active Local Involvement

What drives our activity

OUR BELIEFS

- We believe healthier individuals create more vibrant families and communities.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well.
- We believe in treating the whole person, not just the physical body.
- We believe local partnerships enable meaningful, accessible healthcare.

North Carolina's Only Physician-Led Medicaid Plan

A joint venture between **Centene Corporation**, the **North Carolina Medical Society (NCMS)**, the **North Carolina Community Health Center Association (NCCHCA)** and the shareholders in the CCH Network to collaborate on a patient-focused, provider-led approach to Medicaid Transformation.

A first-of-its-kind partnership

Carolina Complete Health is the result of a collaboration between the North Carolina Medical Society, the North Carolina Community Health Center Association, and Centene Corporation.

Provider-led

We give doctors and FQHCs (Federally Qualified Health Centers) a voice in key policymaking. We believe providers are essential to Medicaid Transformation and are committed to helping providers remain strong and viable, especially important during the pandemic.

Patient-centered

Carolina Complete Health helps patients get the care they need, when they need it, through local, regional and community-based resources.

About Carolina Complete Health

Carolina Complete Health is the first and only Physician-Led Medicaid health plan in North Carolina, established through a joint venture between the Centene Corporation, the North Carolina Medical Society (NCMS), the North Carolina Community Health Center Association (NCCHCA). We believe that providers are essential to providing leadership and strategic direction to Medicaid Managed Care and are committed to giving them a voice in key policymaking.

Centene Corporation	• **Fortune 25** company with over 30 years of Medicaid experience • **#1 in Medicaid and #1 in Marketplace** in the U.S., operating in **50** states • Insure over **26 million** members
NC Medical Society	• **8,000+** members including doctors and physician assistants • Lead health policy in North Carolina • Engaged in practice transformation and provider recruitment strategies • Advocate for medically underserved and rural populations
NC Community Health Center Association	• **39** health center grantees and look-alike organizations • Serving over **500,000** underinsured and uninsured • **270** clinical sites across 100 counties in North Carolina

Provider-Led Entity (PLE)

Medical Policy

In partnership with providers, Carolina Complete Health is helping to lead the way on medical policy and initiatives that can innovate and improve care for Medicaid members.

Enhanced Engagement

Dedicated Provider Engagement and Network Support teams to provide one-on-one support to Providers with elevated customer service.

Innovation

We partner with providers and stakeholders to launch innovative pilots aimed to improve health outcomes and health equity.

Transparency

Leveraging multiple communications channels to keep providers informed of known issues and resolutions; staying responsive and closing the loop.

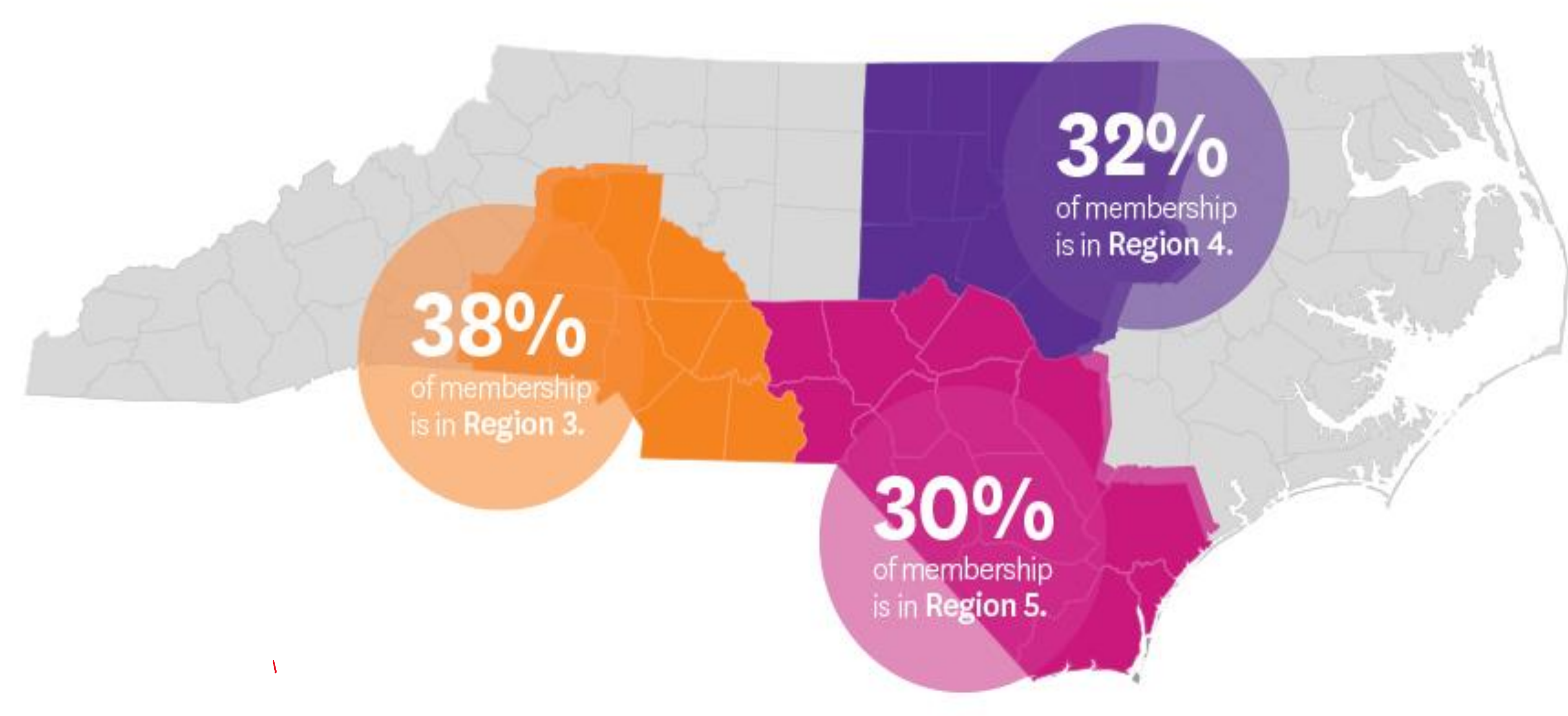
Proactivity

Fostering relationships with Provider Associations, Societies, and Clinically Integrated Networks to better address provider needs; using a data-driven approach to develop education strategies.

Our Commitment to North Carolina

Carolina Complete Health

- Provides Medicaid in 41 counties
- Over 238,000 members
- 152,000+ babies and children
- 830 Long-Term Service and Support (LTSS) members
- 350+ employees
- Offices in Charlotte, Durham and Wilmington

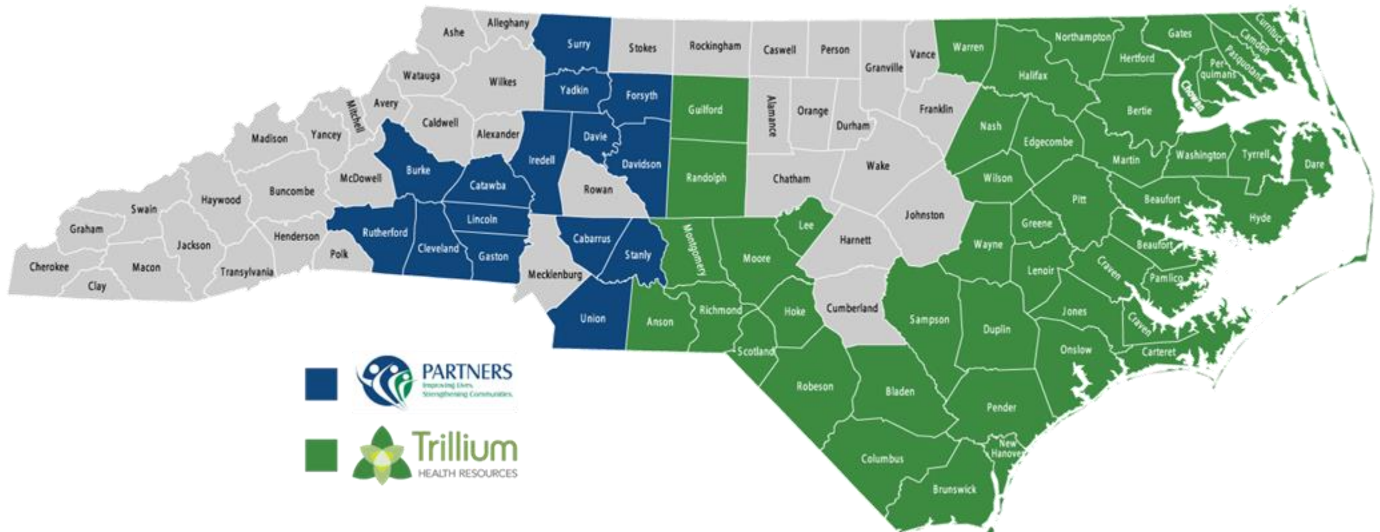


This is confidential and proprietary information. Please do not copy or distribute.

Tailored Plans

CCH Tailored Plan Partners

- Carolina Complete Health (CCH) will work with two Tailored Plans – Partners Health Management and Trillium Health Resources.
- North Carolina will launch the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans on July 1, 2024. This is an integrated health plan for individuals with behavioral health needs and intellectual/developmental disabilities (I/DDs).
- Physical Health Tailored Plan providers should review specific training and materials specific to their Tailored Plan on our [Tailored Plans page]



Medicaid Expansion

What is Medicaid Expansion?

- **Medicaid Expansion is going live December 1, 2023**
- Governor Cooper signed **HB 76 into law on March 27, 2023.** This is a historic moment for the health and wellbeing of our state.
- Over **600,000** North Carolinians will gain access to health care coverage
- Medicaid Expansion in NC increase eligible populations to **all adults aged 19 through 64 who have incomes up to 138% of the Federal Poverty Level**
  - Single adults 19 through 64 who have incomes of approximately $20,000 per year
  - Parents with low incomes – for a family of 3, an annual income below about $34,000 each year
    - Prior to expansion, the cutoff for parents is about $8,000 each year
- **Same ways of getting care** as existing Medicaid
- **Same Comprehensive benefits and copays** as other non-disabled adults in Medicaid
- **NCDHHS and other external stakeholders** will partner together to drive implementation, outreach and engagement, and support our counties in this work.

Who is Covered under Expansion?

Low-income parents
(above current coverage levels and with income less than $34,000 each year for a family of 3)

Low-income childless adults
(with income less than $20,000 per year for a single adult)

Low-wage workers (agriculture, childcare, construction, etc)

Some veterans and their families

Children who age out of Medicaid

Women who would be covered if they were pregnant

What Are Some of the Service Included in Medicaid Expansion

Medicaid covers many of the same essential benefits that other health insurance does including:

- Primary care
- Inpatient and outpatient hospital services
- Vision and hearing services
- Prescription drug benefits
- Behavioral health
- Preventative and wellness services
- Devices and other therapies
- Maternity and postpartum care

Medicaid Expansion and the End of Continuous Coverage

- During the COVID-19 pandemic. people who were enrolled in Medicaid at the beginning of the COVID-19 Pandemic remained enrolled (Continuous Coverage). They did not have to recertify they still were eligible for Medicaid.
- That automatic continuous enrollment ended March 31st. NC Medicaid started recertifications **April 1, 2023.**
  - This means that NC Medicaid began the process to determine if people are still eligible for Medicaid (Recertification)
  - Recertification could result in termination or reduction of benefits
- This process will last from April 1, 2023 until May 31, 2024
- People who are currently enrolled in Medicaid should **update their contact information** to ensure that they do not inadvertently lose coverage
  - More info can be found here: medicaid.ncdhhs.gov/End-of-PHE

Getting Acquainted

Key Contact Information

Provider Services: 1-833-552-3876

Carolina Complete Health Network:
NetworkRelations@cch-network.com

Provider Engagement Team

Online:

network.carolinacompletehealth.com

Network Support Specialist Team

The **Carolina Complete Health Network Support** team includes trained Network Support Specialists who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:

- Credentialing/Network status
- Claims
- Secure Portal registration and Pay Span
- Inquiries related to administrative policies, procedures, and operational issues
- Contract Questions

You can also email Provider Relations and Support: networkrelations@cch-network.com

Provider Engagement Administrator Team

Each Provider will have a Carolina Complete Health Network Provider Engagement Administrator assigned to provide boots on the group support with:

- Provider education and orientation
- HEDIS/care gap reviews
- Financial analysis on P4P or risk arrangement in VBC
- Innovation and Transformation
- AMH oversight in partnership with CCH
- EHR utilization
- Facilitate inquiries related to administrative policies, procedures, and operational issues
- Monitor performance patterns

Provider Engagement Administrator Team site

Website, Secure Portal, and Tools

www.carolinacompletehealth.com

Enter Keyword Search

Contrast On Off a a a language

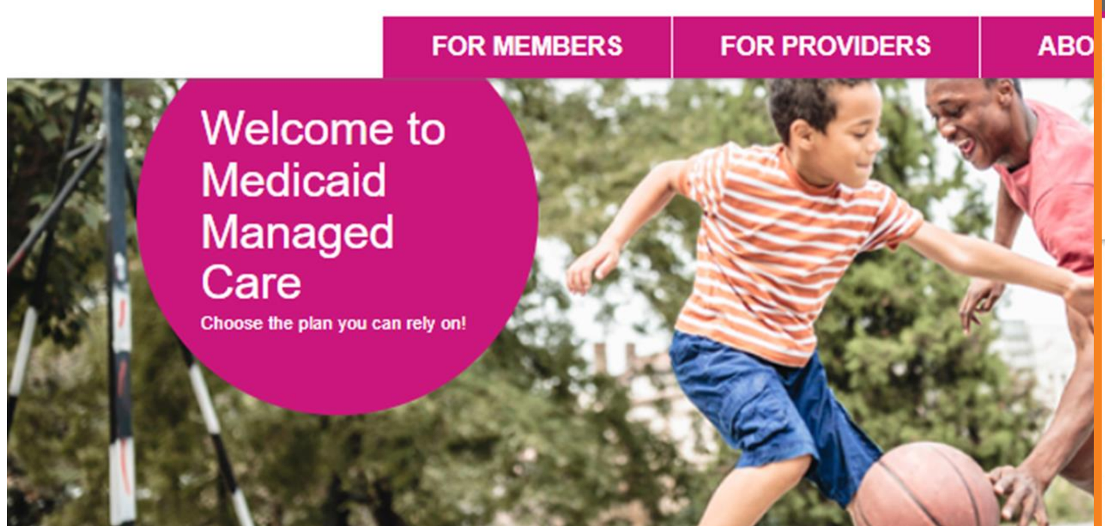
FOR MEMBERS | FOR PROVIDERS | ABOUT US | CONTACT US

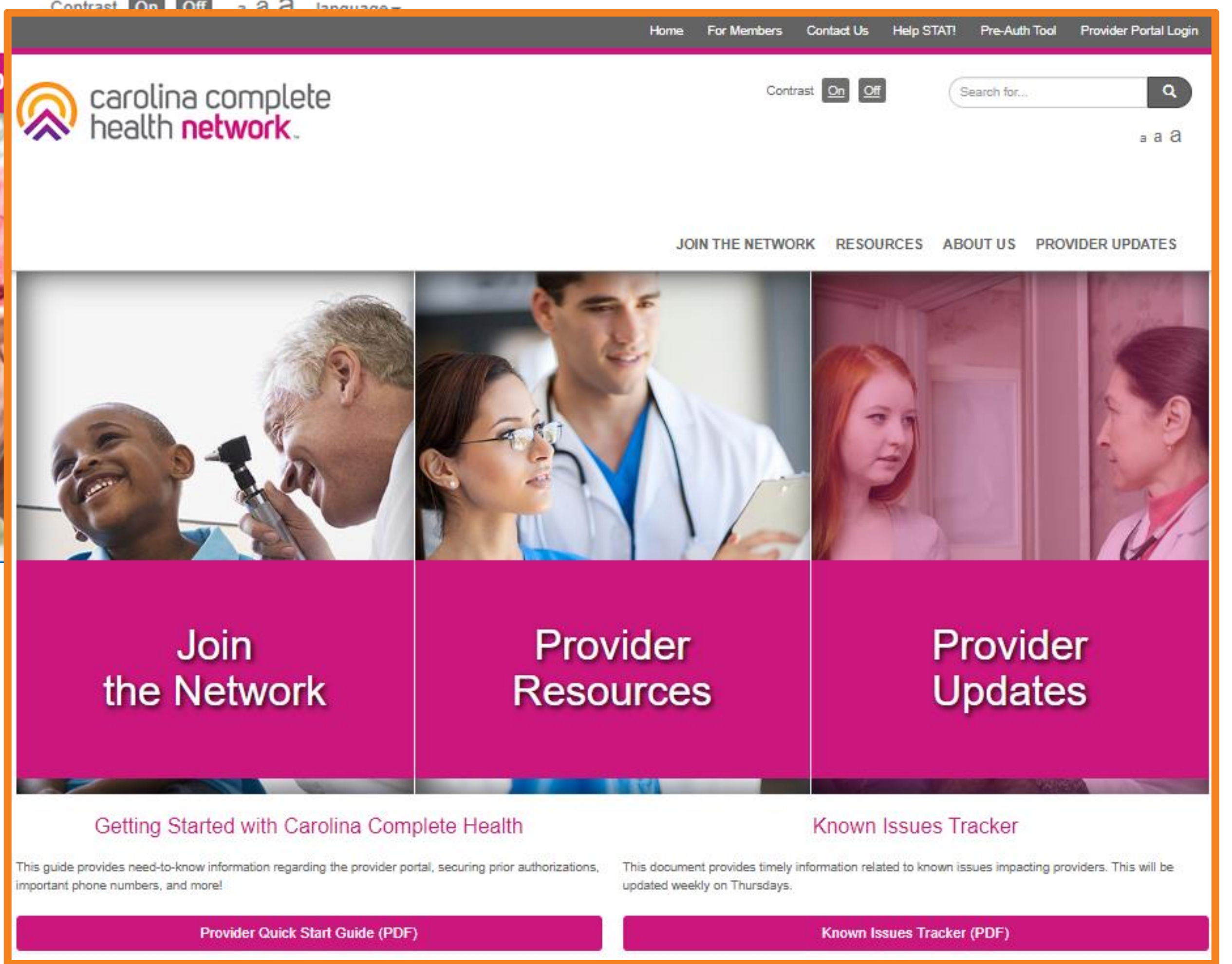
Welcome to Medicaid Managed Care

Choose the plan you can rely on!

Provider Website (Public)

Home For Members For Providers Find A Provider Member Login
COVID-19 1-833-552-3876
Enter Keyword Search





network.carolinacompletehealth.com

Web-Based Tools

- Web-Based Tools
  - Public site at www.carolinacompletehealth.com
  - For Providers: network.carolinacompletehealth.com

- Provider information for medical services
  - Prior Authorization tool
  - Forms
  - CCH's plan news
  - Clinical guidelines
  - Provider bulletins
  - Contract request forms
  - Provider Engagement contact information

- **Carolina Complete Health is committed to enhancing our web-based tools and technology, provider suggestions are welcome!**
  - https://www.surveymonkey.com/r/CCHWEBSITE

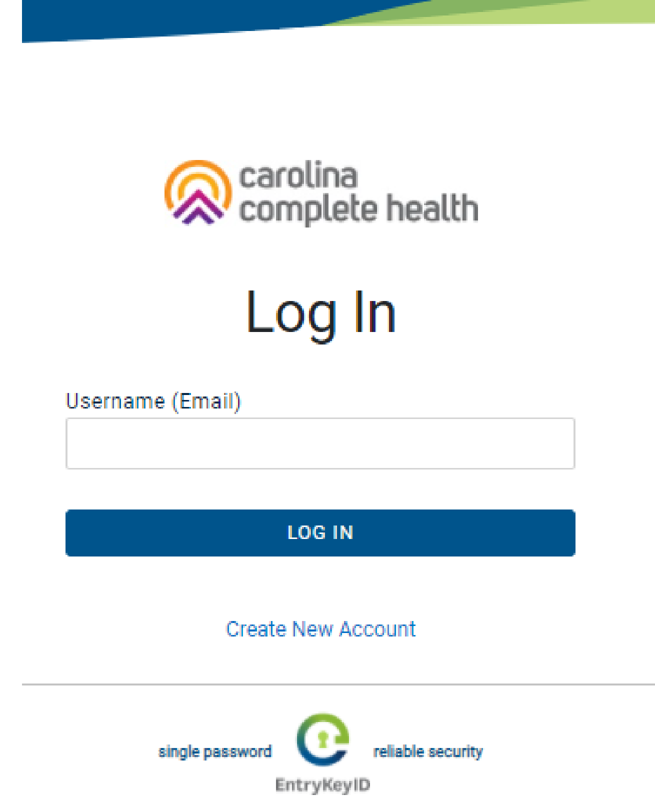
Provider and Billing Manuals

- The Manuals includes a wide array of important information relevant to providers including, but not limited to:
  - Network information
  - Billing guidelines
  - Claims information
  - Regulatory information
  - Key contact list
  - Quality initiatives
  - And much more!
- Both can be found in the Manuals and Forms section of Provider Resources on the CCHN Website: https://network.carolinacompletehealth.com/resources.html
- You will be notified of updates via notices posted on our website and/or in the monthly Provider Pulse newsletter.

Provider Portal (Secure)

https://provider.carolinacompletehealth.com

- For Carolina Complete Health Standard Plan
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Health records & care gaps
  - Prior Authorizations
  - Claims submissions & status
  - Payment history
  - Monthly PCP cost reports
  - ...and more!
- Secure Portal Training:
  - Recording
  - Slides (PDF)



Interactive Voice Response (IVR) System

Call 1-833-552-3876 from any touch tone phone and follow the appropriate menu options to reach our automated beneficiary eligibility-verification system twenty-four (24) hours a day

Beneficiary Functionality

- Verify PCP demographic information
- Obtain benefit information such as office, emergency, inpatient and outpatient co-payments
- Check claims status

Provider Functionality

- Verify beneficiary demographic information
- Check claim status
- Obtain benefit information such as office, emergency room, inpatient and outpatient coverage, long-term care, and community services
- Obtain co-payment information when checking beneficiary eligibility
- Connect to care coordinators and referral specialist
- Connect with our vendors who supply medically necessary covered services

Non-Emergency Medical Transportation (NEMT)

Reminder: Non-Emergency Medical Transportation (NEMT)

- Carolina Complete Health can arrange and pay for member transportation to and from appointments for Medicaid-covered services.
- Call **ModivCare**, Carolina Complete Health's transportation provider, up to 30 days before the appointment to arrange for round-trip transportation. There is no limit to the number of trips during the year between medical appointments, healthcare facilities, or pharmacies.
- **ModivCare Member Reservations Number:** 855-397-3601
- For more information: Carolina Complete Health Transportation Services
- For PHP NEMT Information: NC DHHS NEMT Fact Sheet

Value-Added Services (VAS)

Value-Added Services (VAS)

- School supplies
- Math and/or reading tutoring
- After school programs
- New parents' package
- Cell phone
- My Health Pays®
- WeightWatchers
- YMCW Support Programs
- Room to Breathe Asthma Program
- Vision
- GED Exam Voucher
- MyStrength Mobile App
- Tribal Talking Circles

For more on VAS, visit Carolina Complete Health website:

- https://www.carolinacompletehealth.com/members/medicaid/resources/vas.html

Members and providers can also call Member Services: As a member, you are able to get extra services in addition to your regular benefits. These are called Value-added Services (VAS). For questions or to learn how to get these services, please contact Member Services at 1-833-552-3876

Language Assistance

Language Assistance

Carolina Complete Health provides free language assistance to all members in person and telephonically/virtually

Telephonically/virtually

- Language Line: Toll Free 1-866-998-0338
- Account Number 13982
- Medicaid PIN #6329

In-person via Language Services Associates (LSA)

- Contact vendor by phone: 866-827-7028
- Enter Account Number #47716855
- Speak with representative on the details of language needed for appointment or home visit.

Care Management and Care Coordination

Care Management

Carolina Complete Health is committed to supporting the success of the local care management model

Carolina Complete Health
Care Management Department
1-833-552-3876

Care Management and Care Coordination

- Carolina Complete Health's Care Coordination model is designed to help beneficiaries obtain needed services from our array of covered service or from the community services at the right time and the right place.
- It is a multi-disciplinary care management team inclusive of **CCH and Advanced Medical Home (AMH) and LHD (Local Health Department) providers,** focused on:
  - A holistic approach to yield better outcomes
  - Promoting continuity of care
  - Increase positive medical outcomes—highest levels of wellness, functioning, and quality of life
  - **Ensuring that each beneficiary receives quality, comprehensive care services within the community**
  - Discharge planning and personalized treatment plans

LTSS Care Management

- **Care Managers (CM) will work collaboratively with AMH providers and/or co-lead the creation of the Comprehensive Care Plan (CCP) depending on AMH capability for complex Beneficiaries receiving LTSS services**
- CM will coordinate support AMHs to coordinate and assist beneficiaries in gaining access to needed services—covered, non-covered, medical, social, housing, educational, and other services and supports
- If CCH is leading Care Management then the CM with support the beneficiary to identify strengths, goals, development of CCP, evaluations, reassessments, and leveling of care. Service Plans are reviewed with beneficiaries during regularly scheduled face-to-face meetings
- The CM will further support the AMH in providing referrals to community resources if the beneficiary is no longer Medicaid eligible

Behavioral Health Coordination

- CCH will ensure that Care plans will incorporate both covered and non-covered services to reflect the range of health, behavioral health (BH), functional, social, and other needs that are within the scope of BH population covered (not TBI or severe BH)
- Work with delegated AMHs on holistic care of eligible beneficiaries
- Pay careful attention both to compliance with prescribed medications as well as potential impact of each medication on all **PH and BH conditions**
- Rapid and thorough identification and assessment of program participants, especially beneficiaries with special health care needs

Specialty Referrals and Prior Authorizations

Specialty Referrals

When a member need to visit a specialist know that:

- ***Referrals are not required for members to seek care with in-network specialists***
- Carolina Complete Health educates them to seek care or consultation with their Primary Care Provider (PCP) first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers

How to Secure a Prior Authorization

Emergency services, family planning, post stabilization services, and tabletop x-rays do not require prior authorization.

Use the Prior-authorization needed tool on the network.carolinacompletehealth.com

Need a Prior Authorization? It can be requested in the following three ways

1. Secure Web Portal
   This is the preferred and fastest method network.carolinacompletehealth.com
   Login in the upper right-hand corner

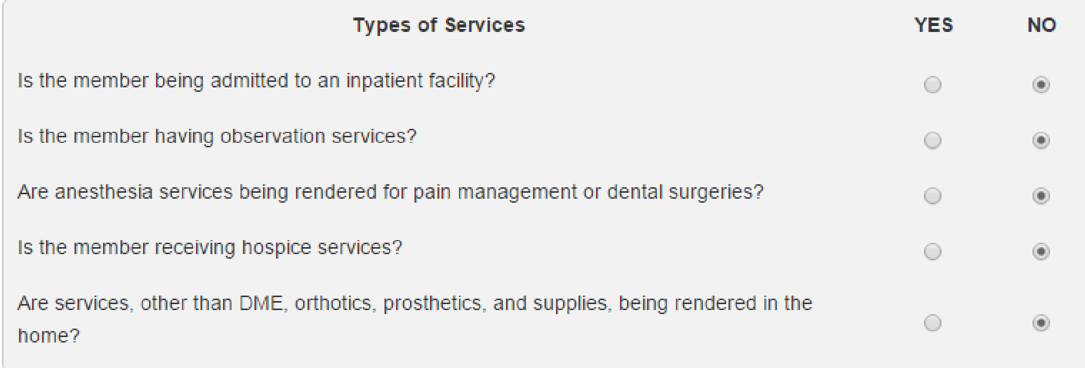
2. Phone
   1-833-552-3876

3. Fax*
   Medical PA Fax: **1-833-238-7694**
   BH Inpatient Fax: **1-833-596-2768**
   BH Outpatient Fax: **1-833-596-2769**
   Pharmacy PA Fax: **1-866-399-0929**

*There is a specific standardize fax form available online: Prior Authorization Fax Form (PDF)

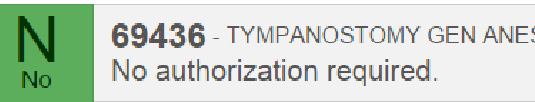
Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Will be available on the provider section of the Carolina Complete Health website
- https://network.carolinacompletehealth.com/resources/prior-authorization.html



Enter the code of the service you would like to check:

69436 Check



Services Requiring Prior Authorization

All out-of-network (non-par) services and providers require prior authorization, *excluding emergency services, family planning, post stabilization services, and table top x-rays*

Ancillary Services

- Air Ambulance Transport (non-emergent fixed wing airplane)
- DME purchases costing $500 or more or rental of $250 or more
- Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
- Orthotics/Prosthetics billed with an "L" code costing $500 or more or rental of $250 or more
- Hearing Aid devices including cochlear implants
- Genetic Testing

Inpatient Services

- All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn
- All services performed in out of network facility
- Hospice care
- Rehabilitation facilities
- Skilled nursing facility
- Transplant related support services including pre-surgery assessment and post-transplant follow up care
- Notification for all Urgent/Emergent Admissions:
- Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes

Procedures/Services

- All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)
- Potentially Cosmetic including but not limited to:
    - bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures
- Experimental or investigational
- High Tech Imaging (i.e. CT, MRI, PET)
- Hysterectomy
- Oral Surgery
- Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

PA, Notification, and Determination Timeframes

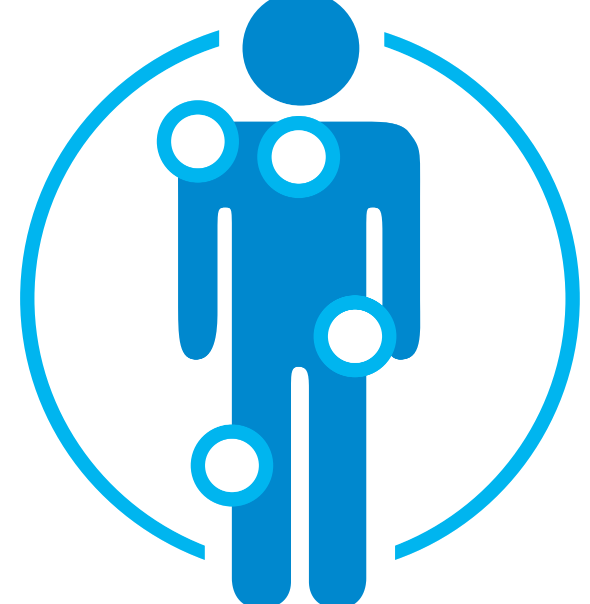
Authorization Type	Timeframe for Provider to Notify CCH	Timeframe for Determination by CCH upon receipt of medical necessary medical information.
Standard Service Auth (inpatient)	Prior Authorization required at least fourteen (14) business days prior to the scheduled admission date	Within fourteen (14) business days from receipt of necessary medical information.
Standard Service Auth (outpatient)	Prior Authorization required at least fourteen (14) business days prior as soon as the need for service is identified	Within fourteen (14) business days from receipt of necessary medical information.
Emergent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Urgent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Retrospective Review		The health plan will have 30 calendar days to review. If the request lacks clinical information, the organization may extend the retrospective review time frame for up to 15 calendar days (total 45 calendar days for review).

NIA’s Prior Authorization Program

Carolina Complete Health will use National Imaging Associates, Inc. (NIA) to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services.**

Effective July 1, 2021: Any services rendered on and after July 1, 2021 will require authorization. Only non-emergent procedures performed in an outpatient setting require authorization with NIA.

- 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

NIA's Prior Authorization Program

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

Please visit NIA's website for Carolina Complete Health to download policies and procedures specific to both ordering providers and imaging facilities. These include quick reference guides and FAQs. You can also view information designed to assist you in using the RadMD Website to obtain and check authorizations.

Medical Management

- Carolina Complete Health Med Mgmt department hours are Monday through Friday 8AM-5PM

Medical Management

Phone: 1-833-552-3876

Fax: 1-833-238-7689

Claims

Claims Definitions

Clean Claim

A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions

If a claim meets the definition above, but either of the following circumstances apply, it will not be considered a clean claim

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

How to Submit Claims

Claims may be submitted in three ways:

1. The secure provider portal
   https://provider.carolinacompletehealth.com
2. Electronic Clearinghouse
   Carolina Complete Health Payer ID: 68069
3. Mail
   Carolina Complete Health
   Attn: Claims
   PO Box 8040
   Farmington, MO 63640-8040

Timely Filing Guidelines

Initial Filing (Contracted and HOP Providers)	**365 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Initial Filing (Non-contracted providers)	**180 calendar days from the date of service (Professional) or date of discharge (Hospital)**
Coordination of Benefits (Carolina Complete Health as secondary)	365 calendar days from the primary payer’s determination
Claims Corrections	365 calendar days from the date of service to file a timely corrected claim
Claims Reconsideration (Level I)	365 calendar days from the date of the EOP or ERA
Claims Grievance (Level II)	30 calendar days from the date of the EOP or ERA

Claims Submission for Home Health and Personal Care Services

Section 12006 of the 21st Century Cures Act (Cures Act) and The Centers for Medicare & Medicaid Services (CMS) requires that states begin utilizing an Electronic Visit Verification System (EVV) for all Personal Care Services (PCS) by November 1, 2021, and all Home Health Care Services (HHCS) by January 1, 2023.

Carolina Complete Health partners with HHAeXchange to provide you with a free EVV system and billing tool for member placement, scheduling, authorization management, communication, and EVV compliance

General Support: NCSupport@hhaexchange.com

EDI Support: EDISupport@hhaexchange.com

Phone: 866-242-2465

Provider Portal Resource Page: Access from Provider Portal Support Center

Training Links:

- PHP Pre-Go Live Webinar
- Billing Refresher Training
- HHAeXchange North Carolina Resources Page

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
- Nursing facility and hospice clean claims will be resolved (finalized paid or denied) within 30 days, following receipt of the claim.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- CCH Medical Claims are paid weekly on Monday and Thursday
- For more information, view our Billing Manual.

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

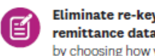
Electronic Funds Transfer

Payspan: A Faster, Easier Way to Get Paid

Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation.

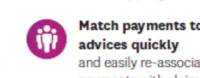
Improve cash flow by getting payments faster

Maintain control over bank accounts by routing EFTs to the bank account(s) of your choice



Eliminate re-keying of remittance data by choosing how you want to receive remittance details

Settle claims electronically through Electronic Fund Transfers (EFTs) and Electronic Remittance Advices (ERAs)



Match payments to advices quickly and easily re-associate payments with claims

Create custom reports including ACH summary reports, monthly summary reports, and payment reports sorted by date

Manage multiple payers, including any payers that are using Payspan to settle claims

Questions?

1-833-552-3876

Provider Relations can help

Please keep this information for when it's time to set up our Payspan account. At this time, you can visit payspanhealth.com and click Register.

You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

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1-833-552-3876
carolinacompletehealth.com

Provider Claim Reconsideration (Level I)

A Claim Reconsideration is a formal expression by a Provider, which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service.

- Contracted providers must submit requests for claim reconsideration within 365 calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).
- Non-Contracted providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA. Providers must complete a claim reconsideration prior to submitting a claim grievance.

Claim reconsiderations may be submitted via provider secure web portal or to the address below.

Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms

Provider Claim Grievance (Level II)

A Claim Grievance is the mechanism following the exhaustion of the claim reconsideration process that allows providers the right to express dissatisfaction regarding the amount reimbursed or the denial of a particular service. All claim grievances must be submitted from the provider within thirty (30) calendar days from the date of the EOP or ERA.

- Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process.

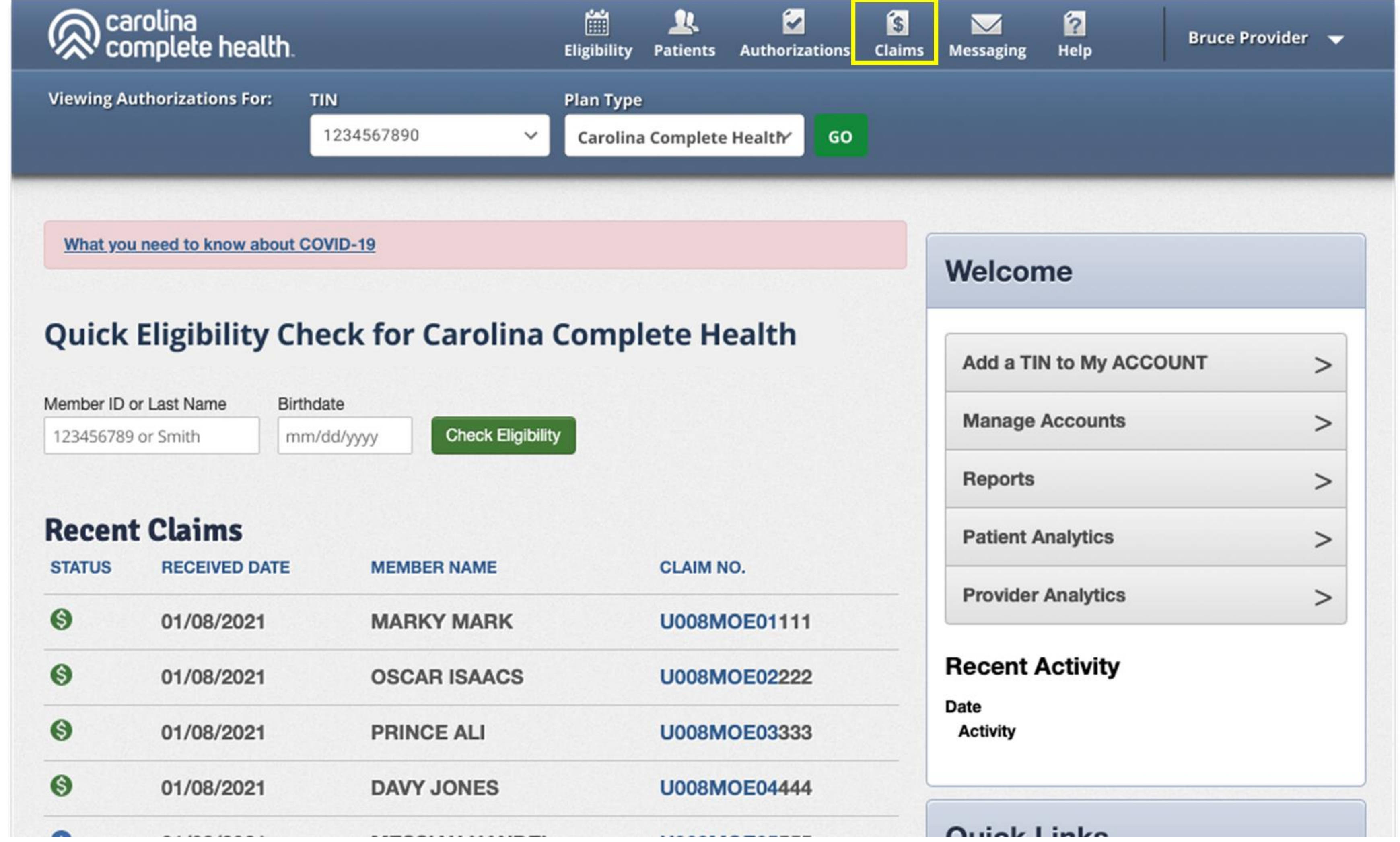
Please submit eligible claim grievances via provider secure web portal or to the address below:

Claim Grievances
Carolina Complete Health
P.O. Box 8040
Farmington, MO 63640-8040

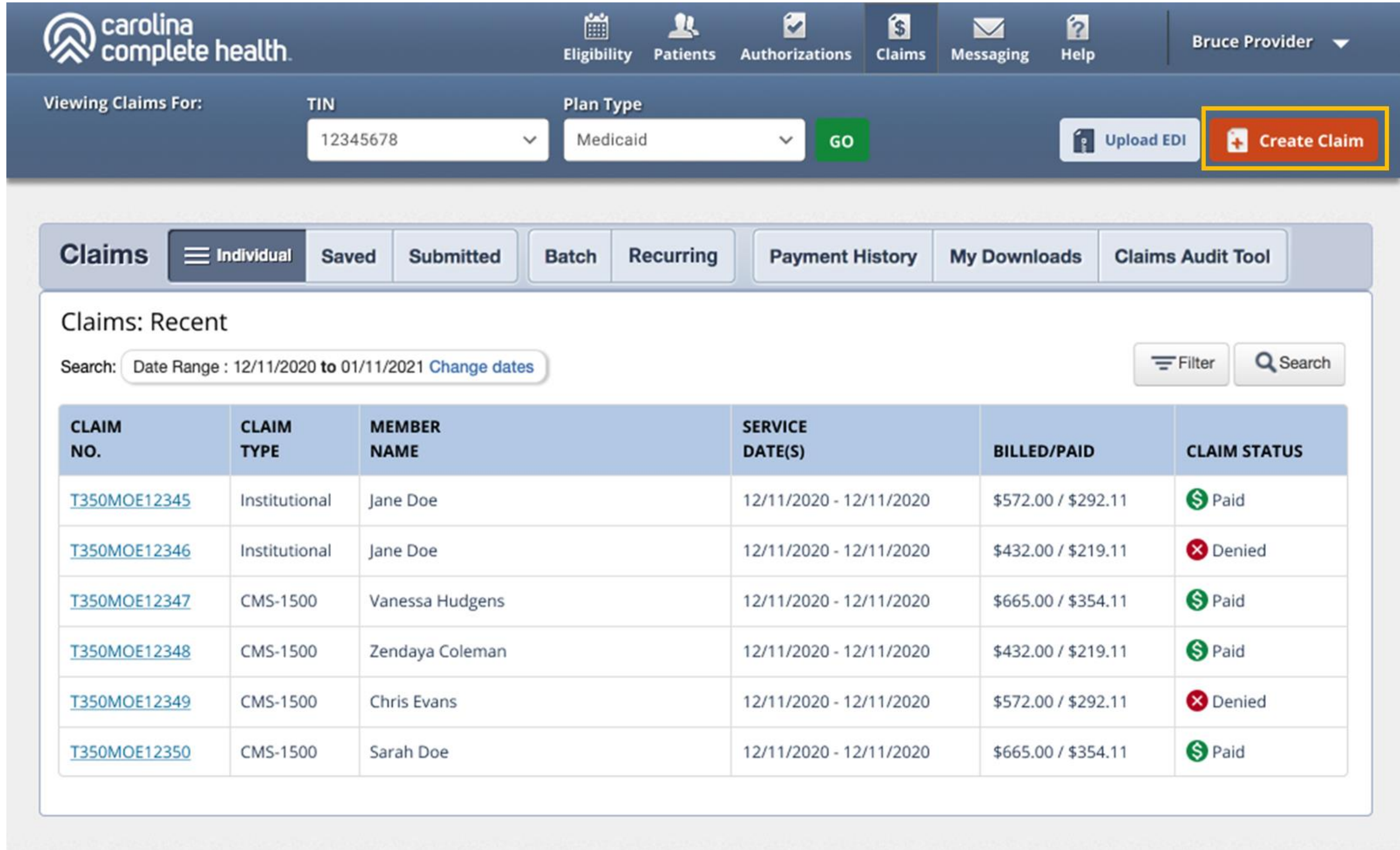
NOTE: If submitting a claim reconsideration or grievance through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms.

A decision will be made, and appropriate notification of the decision must be received by the Provider within 30 calendar days of Carolina Complete Health's receipt of the request.

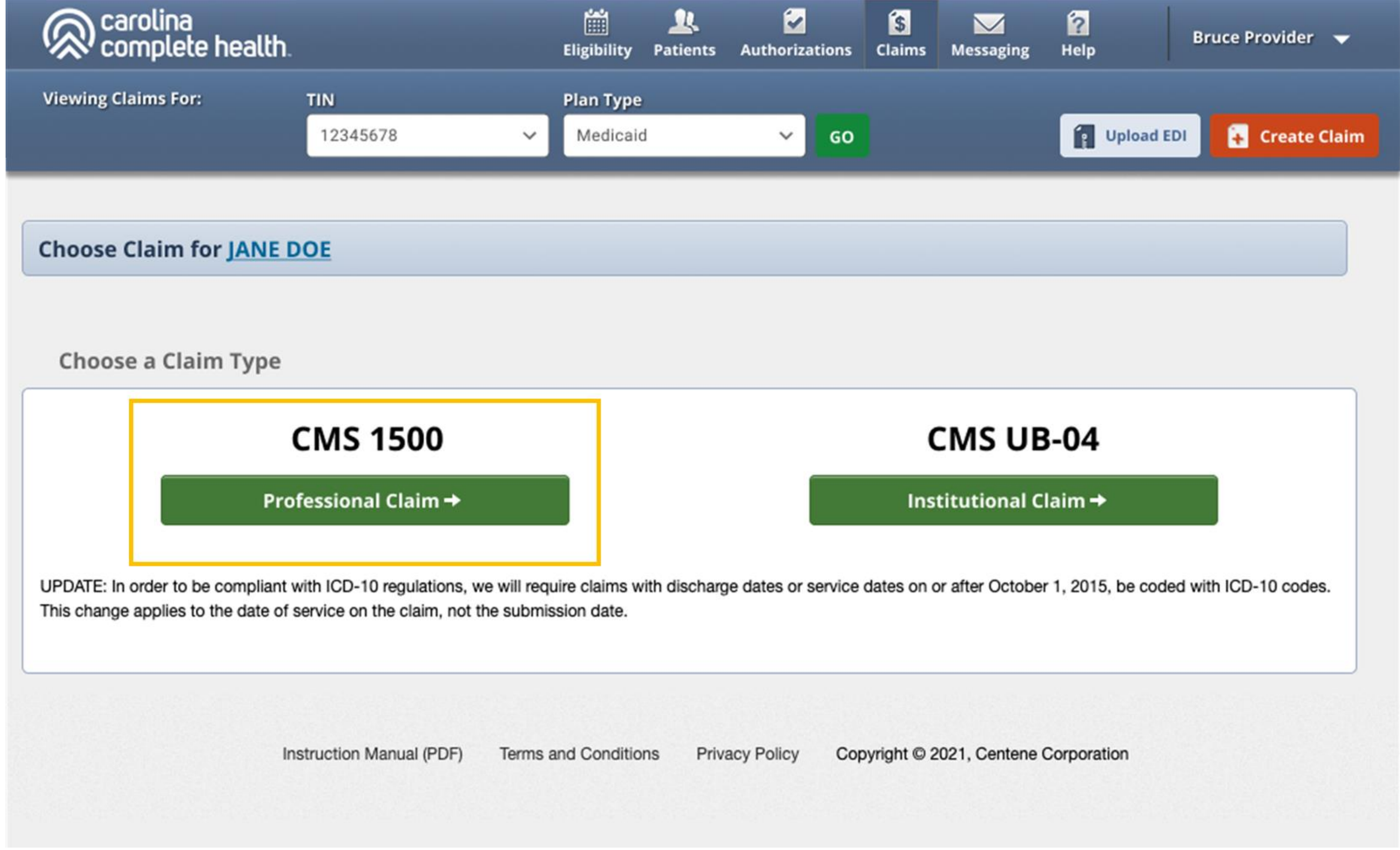
Claims Submissions on the Portal



Claims Submissions on the Portal

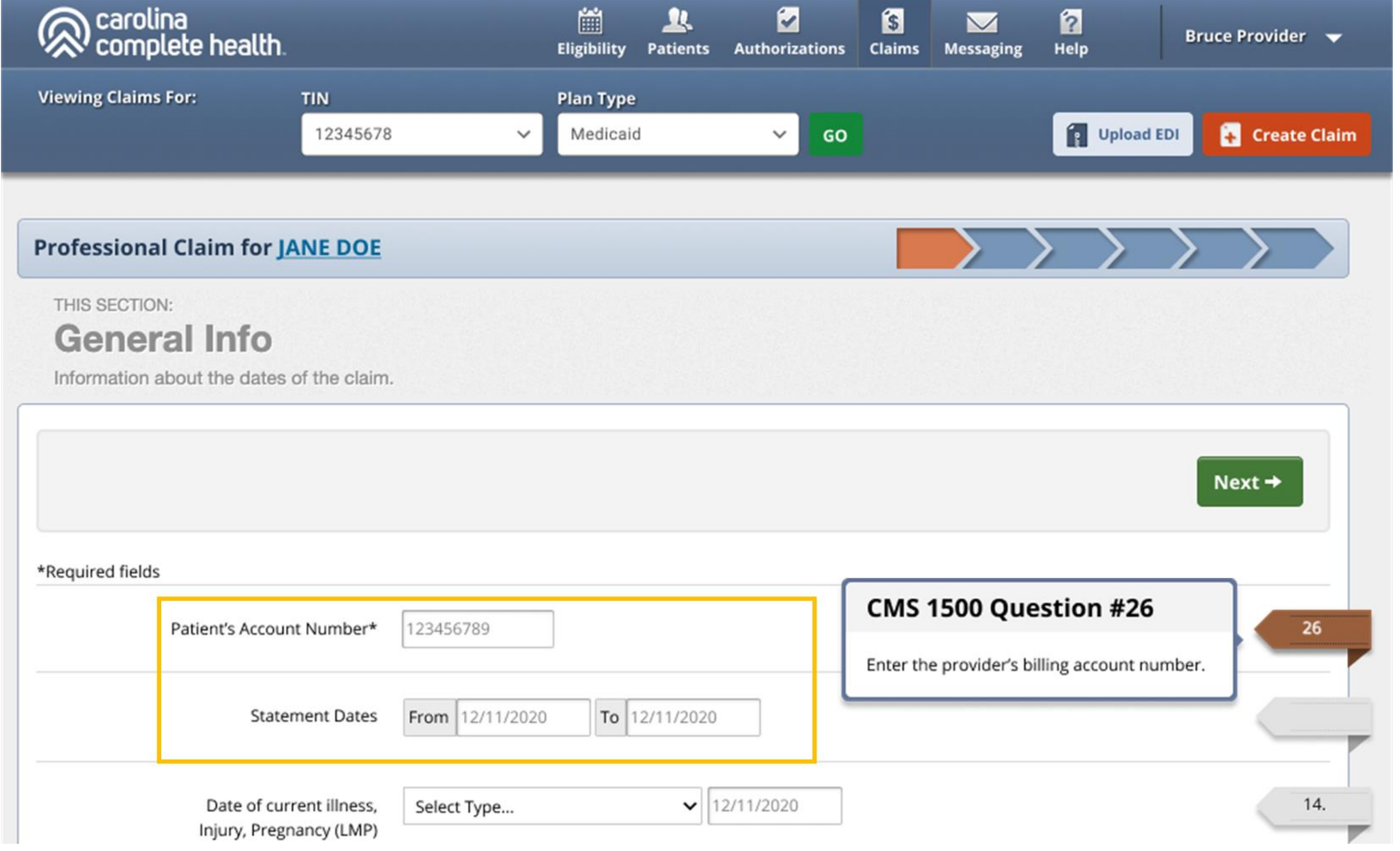


Claims Submission- Professional



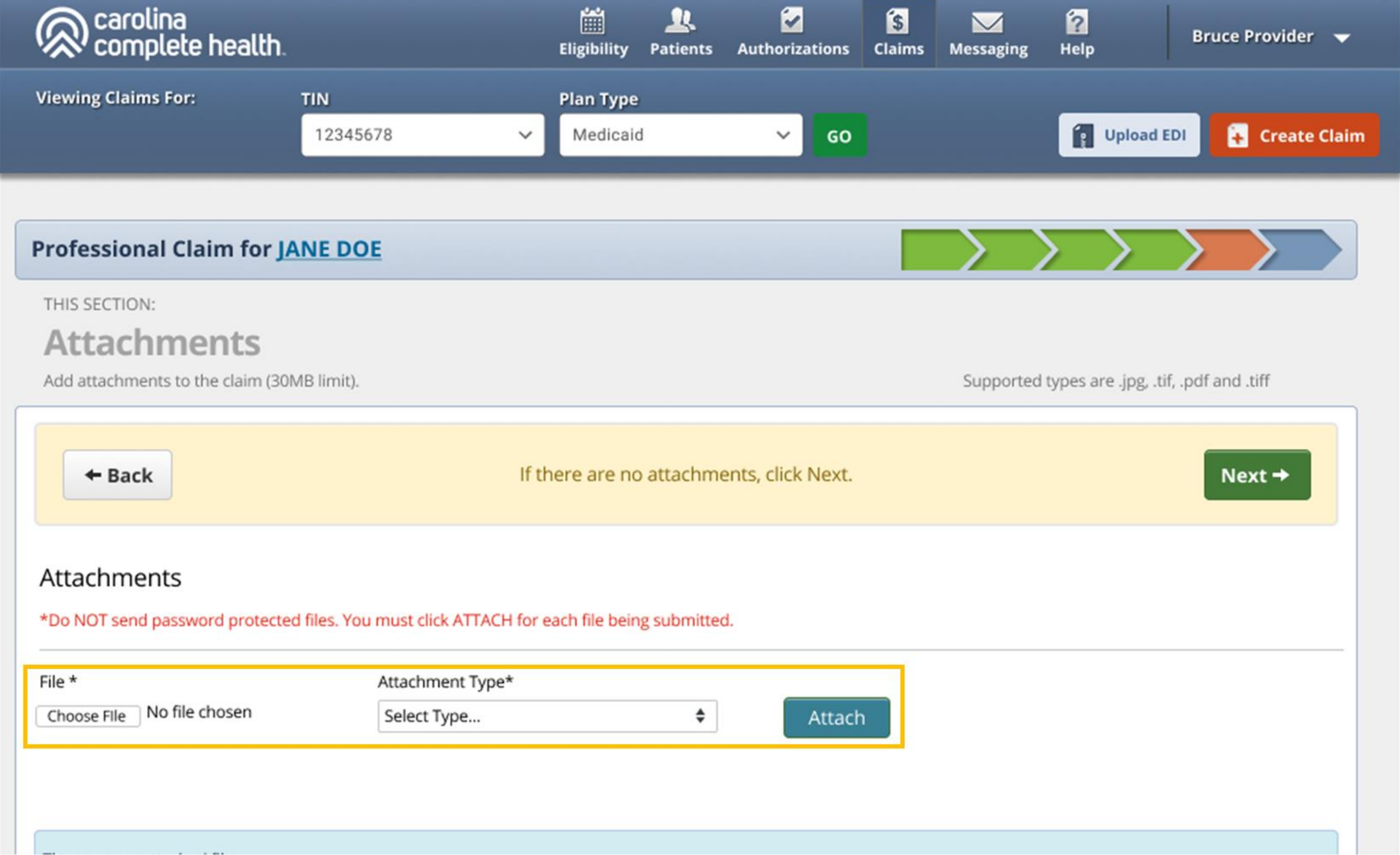
Claims Submission – Professional

- In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields.
- Then click Next, and follow the prompts to add diagnosis codes, coordination of benefits information, and other required information.



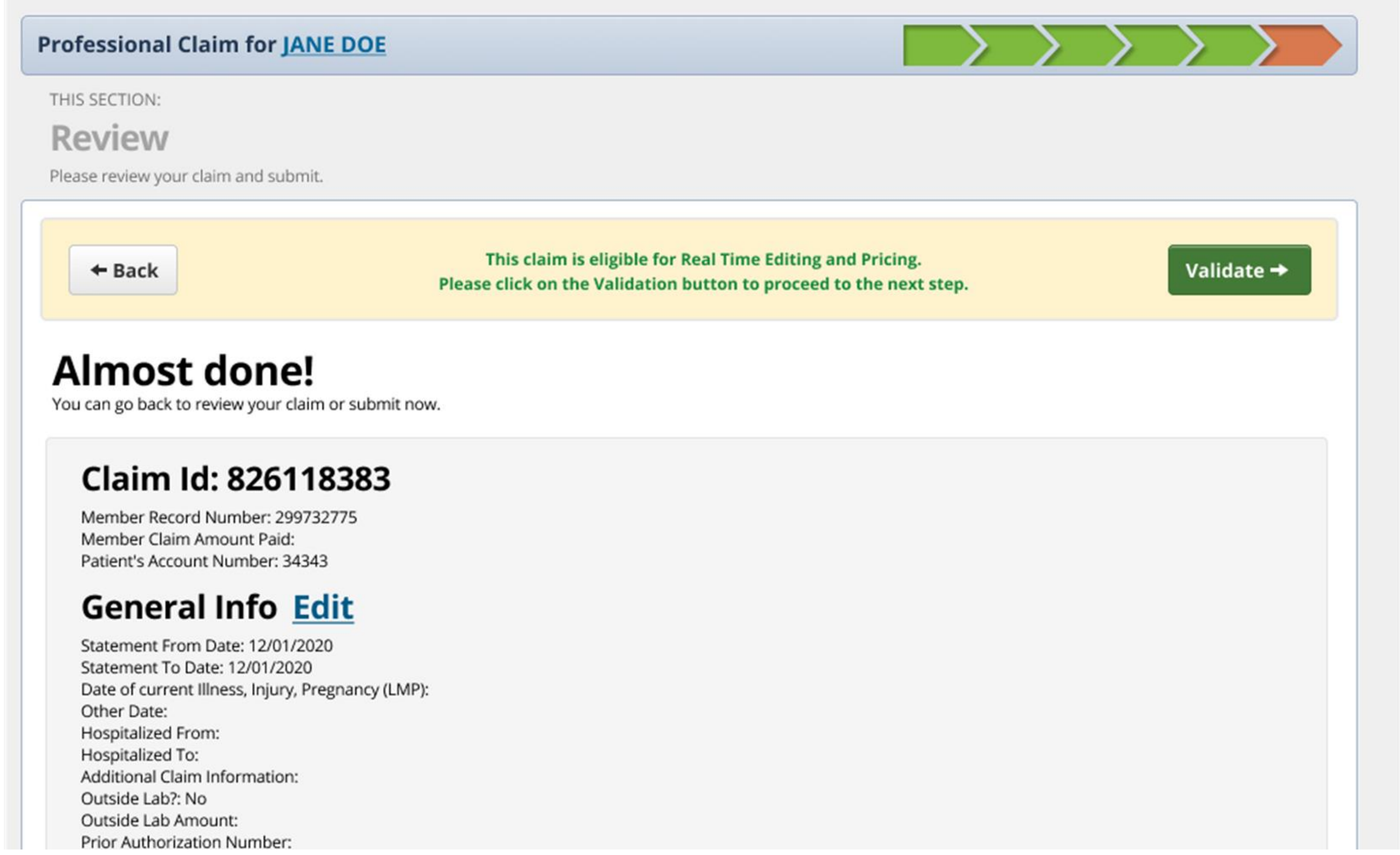
Claims Submission - Professional

- If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.



Claims Submission - Professional

- Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Validate button, then Submit button



Claims Submission - Institutional

carolina complete health

Eligibility | Patients | Authorizations | Claims | Messaging | Help | Bruce Provider

Viewing Claims For: TIN 12345678 Plan Type Medicaid GO

Upload EDI | Create Claim

Choose Claim for JANE DOE

Choose a Claim Type

CMS 1500	CMS UB-04
Professional Claim →	Institutional Claim →

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

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Claims Submission - Institutional

- In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.
- Then click Next, and follow the prompts to reflect the Billing Provider, Pay-to Provider, and Attending Provider, etc, and then click Next.

carolina complete health

Eligibility Patients Authorizations Claims Messaging Help Bruce Provider

Viewing Claims For: TIN 12345678 Plan Type Medicaid GO Upload EDI Create Claim

Institutional Claim for JANE DOE Your Progress

THIS SECTION:

General Info Enter Information for the Admission and Condition Codes

*Required fields

Next ➔

Patient Control #* 123456789 3.a

Medical Record # 123456789 3.b

Type Of Bill* Select... 4.

Claims Submission - Institutional

- In the Service Lines section, enter the information about the services provided.
- Click **Save/Update**, and to add a new service line click the **+ New Service Line** button on the left to add additional service lines.
- Click the **Next** button.

Claims Submission - Institutional

- If you have medical records or other documentation that needs to be attached to the claim, submit it using the Attachments screen. You may use the Browse button to attached any documents pertinent to the claim. If you have no attachments, you may skip this section.

carolina complete health
Eligibility Patients Authorizations Claims Messaging Help
Bruce Provider

Viewing Claims For: TIN 12345678 Plan Type Medicaid GO
Upload EDI Create Claim

Institutional Claim for JANE DOE

THIS SECTION:
Attachments Add attachments to the claim (30MB limit).
Supported types are .jpg, .tif, .pdf and .tiff

Back
If there are no attachments, click Next.
Next

Attachments
*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File *
Choose File No file chosen

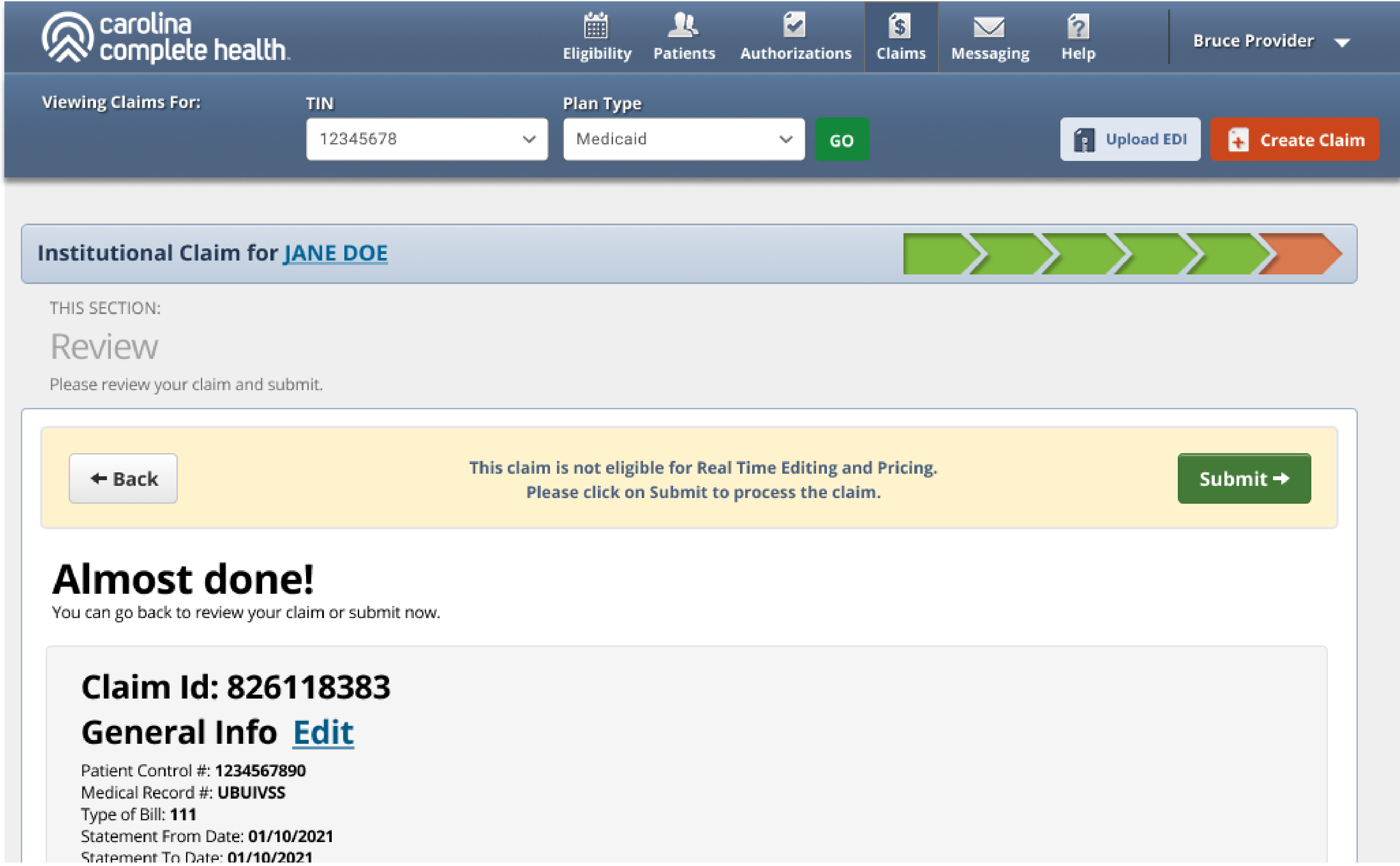
Attachment Type*
Select Type...

Attach

There are no attached files.

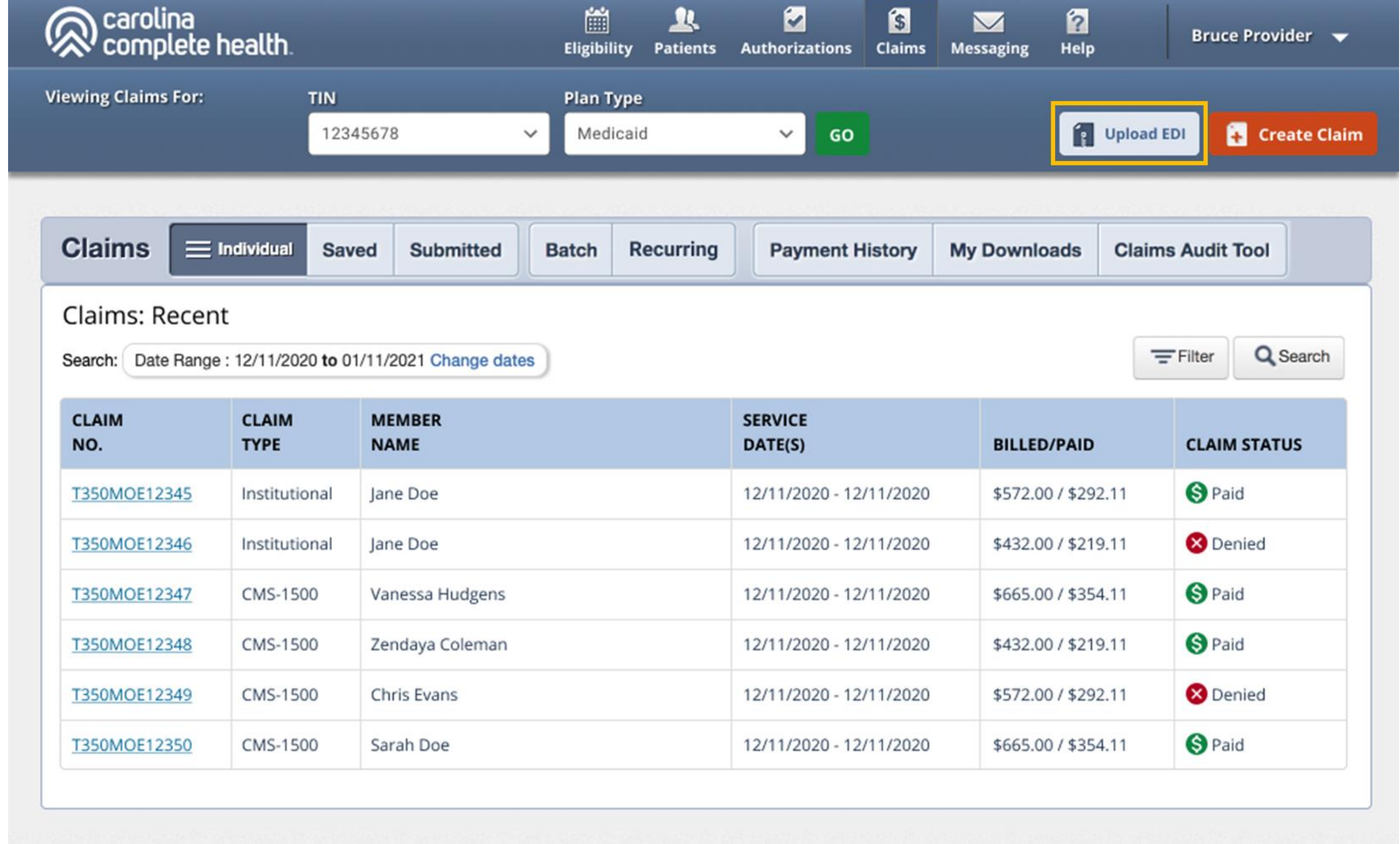
Claims Submission - Institutional

- Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Submit button



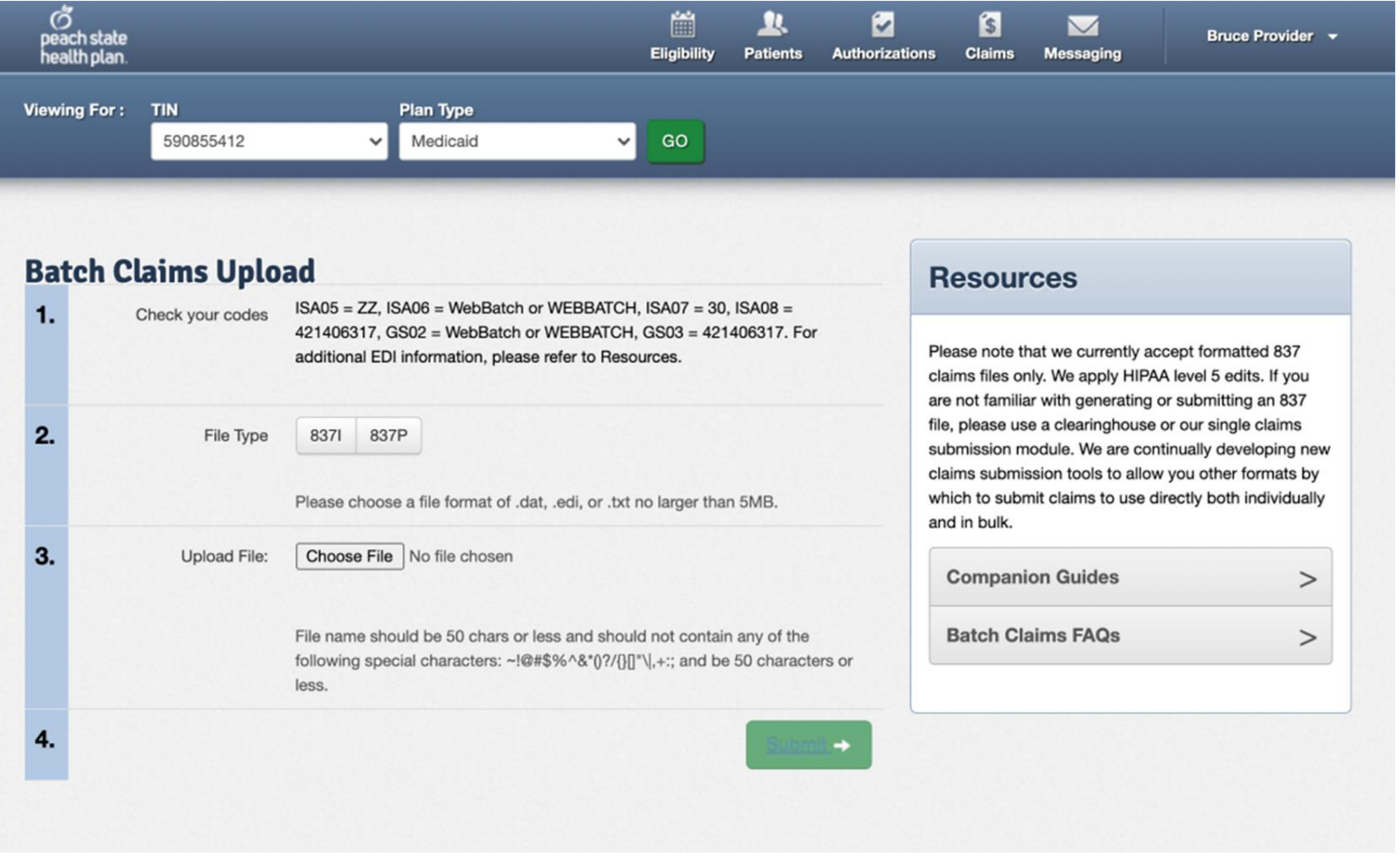
Claims Submission – Batch Claims

- Batch claims can be submitted through the portal by selecting the **Claims** tab at the top of the home page.
- On the claims landing page, select **Upload EDI**.



Claims Submission – Batch Claims

- Once on the Batch Claims Upload screen, follow the instructions. There is a Companion Guide and FAQ included if you have any questions.



Grievances and Appeals

Provider G&A Process

- A **Grievance** is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, claims, or any aspect of Carolina Complete Health functions.
    - After the complete review of grievances, **not** related to claims, Carolina Complete Health shall open communication with the provider to review the status of the grievance. If the grievance cannot be resolved in fifteen (15) days, the Plan will provide a status update at that time and will fully resolve all grievances within thirty (30) calendar days from the date the grievance was received.

- Complaints may be submitted in writing via mail or fax, or orally by contacting provider services.
  Filing a Provider Grievance & Appeal (Non-Claim):
    1. Online through the provider portal provider.carolinacompletehealth.com
    2. Talking to your Provider Engagement or Relations Team Member
    3. Calling our Provider Services: 833-552-3876
    4. Mailing
       Carolina Complete Health
       Attn: Appeals and Grievances
       P.O. Box 8040 Farmington, MO 63640-8040

- **Providers may also submit a complaint to Managed Care Provider Ombudsman Program by phone 1-866-304-7062 or by email: Medicaid.ProviderOmbudsman@dhhs.nc.gov**

Member G&A Process

- A beneficiary's authorized representative, or beneficiary's provider (with written consent from the beneficiary) may file an appeal or grievance.
- Beneficiary **Grievances** include but are not limited to quality of care; personal behavior of provider or employee; failure to respect a beneficiary's rights; harmful administrative process or operation.
- Carolina Complete Health will send a letter to acknowledge the grievance within 5 days of receipt of the grievance and to notify of our decision within 30 days of receipt of the grievance.
  - Exception- If a 14-day extension is requested by the party that submitted the grievance or Carolina Complete Health required additional information.
  - External review of second level grievances may also occur.
- Beneficiary Appeals and grievances can be filed several ways:
  - Call Beneficiary Services: 1-833-552-3876
  - Electronically by fax: 1-833-318-7256
  - Email to: CCHGrievancesAppeals@carolinacompletehealth.com
  - In person or by mail at:
Carolina Complete Health
Appeals and Grievances
1701 North Graham St, Suite 101, Charlotte, NC 28206
  - If a Beneficiary needs support or education about their rights and responsibilities under NC Medicaid they can contact the NC Medicaid Ombudsman by email at: ncmedicalidombudsman.org or by Phone: 1-877-201-3750
- In addition to the two levels of appeals, there is a **State Fair Hearing** process.
  - Beneficiaries will be notified of their rights to a State Fair Hearing, if applicable, in writing upon resolution of their appeal.

Clinical Policy

Clinical Coverage Policies

- Providers contracted with Carolina Complete Health are responsible for upholding CCH clinical policies.
- Providers with questions about any clinical policy should contact their provider relations representative for additional information or ask to be connected with the plan's medical management team.
- Clinical policies are posted to the Provider website https://network.carolinacompletehealth.com/resources/clinical-policies.html

Medical Management

Phone: 1-833-552-3876

Fax: 1-833-238-7689

CCHN Clinical Policy Workgroup

Medical policy work is currently focused on five target groups:

- Primary Care
- Pediatrics
- Behavioral Health
- Emergency Medicine
- OB/GYN

Roles/Responsibilities for Medical Policy Workgroup participation include, but are not limited to:

- Participate in parliamentary style run of all workgroup meetings
- Support ongoing efforts to identify, develop and maintain necessary medical policies and clinical care guidelines
- Email CCHNMedicalPolicy@cch-network.com with interest and/or feedback.

Provider are encouraged to provide feedback on clinical policies, particularly if providers notice any barriers to treatment due to a clinical policy.

- Feedback will be shared with CCHN clinical policy workgroups

Compliance Training

Compliance Training

- As a Carolina Complete Health medical provider, you are provided annual awareness training about the following topics:
  - Privacy and Confidentiality
  - General Compliance and Business Ethics
  - Fraud, Waste, and Abuse
  - Administrative Firewalls
  - Conflict of Interest
  - Gifts, the Workplace, and You
- Please review General Compliance and Fraud, Waste and Abuse Training for Medical Providers Training
  - Available on our Education and Training site
  - Attestation: https://www.surveymonkey.com/r/CCHNPO

Cultural Competency

Cultural Competency Resources

- **Cultural Competency and CLAS Tribal training available on Education and Training page**
- Complimentary Interpretation Services
  - As a CCH provider, you have access to interpretation services:
  - **Language Line:**
    Toll Free 1-866-998-0338
    Account Number 13982
    Medicaid PIN #6329
- All customer service phone lines will be TTY and TDD capable for different languages and the deaf
- CCH material is available minimally in English and Spanish
- For assistance with cultural competency issues and/or educational sessions, please contact provider services at the number above or discuss with you provider engagement specialist

Infection Prevention and Control

Infection Prevention

Training provided by Trillium Health Resources, in partnership with Carolina Complete Health:

- Slides (PDF)

Wrap Up

Evaluation

- We value your feedback!
  - Please take the time to evaluate this course and add any comments you may have.
  - We will tabulate responses and comments. These summaries will be used in the formation of future courses on any specific topic that our participating providers find beneficial.
  - Future courses may be held regionally, face-to-face, or via webinars. Our intent is to keep all of you informed as much as possible.
  - https://www.surveymonkey.com/r/CCHNPO

Contact Us!

- Contact us!
  - Phone Number:
    1-833-552-3876
    TDD/TTY: 1-800-735-2962
  - Email: networkrelations@cch-network.com
- To get a copy of training and educational materials:
  - https://network.carolinacompletehealth.com/resources/education-and-training.html

Questions?