Partners Health Management and Carolina Complete Health

Frequently Asked Questions

Provider Training May 21, 2024: Slides | Recording

Claims

- **Question:** For reconsiderations, are there specific timelines or is this driven by contract language?
    - **Answer:** For claim reconsideration, providers have 365 calendar days from the date of service to file a claim reconsideration.

- **Question:** Please elaborate on Behavioral Health (BH) and Physical Health (PH) Billing. Many BH patients are seen for something physical that resulted due to a behavioral issue.
    - **Answer:** When a provider is seen by their PCP and the PCP addresses BH diagnoses, the PCP will bill this as one claim and the claim is processed by Carolina Complete Health (CCH) as medical. Partners Health Management (Partners) providers should use the PH claim submission methods outlined in this training.

- **Question:** What is the difference between Reconsideration and Grievance/Complaint?
    - **Answer:** 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 the provider is unsatisfied with the outcome of the claim review. https://providers.partnersbhm.org/grievance- incident-reporting/

- **Question:** Are BH vs PH services defined by whether the provider is enrolled with Partners as a BH provider? If a family practitioner provides BH services in their office (i.e., anxiety) don't they have to follow the PH prior authorization guidelines and billing goes to CCH since they are not enrolled with Partners for BH services?
    - **Answer:** BH vs. PH Services are defined by the provider specialty. In the scenario you described, the family practitioner would bill using Partners PH claim submission methods for the claim to be processed by CCH.

- **Question:** How do we bill for transportation?
    - **Answer:** Non-emergent transportation is to be billed to ModivCare.

- **Question:** Will appeals on denied health claims be filed to Partners or to CCH?
    - **Answer:** Providers can submit appeals to Partners.

- **Question:** Will claim follow up calls for health claims be the Partners number?
    - **Answer:** Providers can contact Partners at 1-877-398-4145.

- **Question:** If I am seeing a patient for ADHD only, does it still go to CCH only?
    - **Answer:** If you are a PH provider, yes, claim would be submitted as PHand processed by CCH.

Contracting

- **Question:** If we are in-network with Carolina Complete Health and NC Medicaid, are we automatically in-network with Partners?
    - **Answer:** No, if you are currently contracted with CCH, you will need to have an additional amendment to be in-network with Partners. Please email networkrelations@cch-network.com to verify your Partners status.

- **Question:** We were told that since we are members in CCPN, we do not have to do separate contracting because we fall under them and are automatically contracted. Is this correct?
    - **Answer:** CCPN is contracting with Partners on behalf of providers, that is correct. Please confirm with CCPN that you are included in their Partners network.

- **Question:** Do we need to have a separate contract with Carolina Complete Health since they are processing claims?
    - **Answer:** If you are providing PHservices, you will contract with Partners Tailored Plan through our PH delegate, CCH. You can request a contract through their Contract Request Form and check the box for Partners: https://network.carolinacompletehealth.com/join-cchn/contract-request-form.html

Payment

- **Question:** If we already are signed up with PaySpan do we need to do anything else?
    - **Answer:** You will need to confirm you are registered with PaySpan for Partners specifically.

PCP Assignment

- **Question:** Will the assigned PCP on the member's card be required to match the billing PCP in order to get paid? Also, if the PCP is listed on the member's card incorrectly how do we get it updated?
    - **Answer:** The assigned PCP on the member's card is not required to match the billing PCP in order to receive payment for primary care services. The member may contact Partners to change their PCP. Members can change their PCP in the member portal or by calling 1-888-235-4673. Providers can contact Partners Member Services to change the PCP on the ID card.

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Prior Authorization

- **Question:** We are an acute care hospital and we are not licensed for BH, but we see many patients with a BH diagnosis. Would we file those claims and requests authorizations for inpatient and observation stays under BH or would that be considered physical?
    - **Answer:** Authorizations: if previously sent to NC Medicaid Direct, then they should be submitted to Partners as a medical request. If authorizations were previously sent to Partners as BH, then continue to send to Partners as a BH request.

- **Question:** Once prior authorizations are approved, will the authorization start date be the day that the authorization was submitted or will the tart day be the actual day that the authorization gets approved?
    - **Answer:** Authorizations that are valid and complete will be approved with the effective date requested as long as that date is on or after the date submitted. This will be true AFTER the 91-day flexibility period for outpatient services. During the 91-day flexibility, providers will not need to request prior authorization. If a service has not been billed prior to the flexibility ending, then a retroactive authorization will be accepted. Inpatient Services continue to require Concurrent Authorizations. PCS authorizations will follow EVV process.

- **Question:** Will all Inpatient claims require authorization? How long do you give for notification (weekday and weekend admissions)?
    - **Answer:** Emergency admissions will require notification to Partners' Utilization Management department, within one business day following the date of admission, to conduct medical necessity review. This includes observation stays. All non-emergency inpatient admissions require prior authorization from Partners.

- **Question:** What paperwork for medical is required to do the prior authorization?
    - **Answer:** NC Medicaid Clinical Coverage Policies will outline information needed for prior authorization requests.

- **Question:** Do outpatient PH prior authorizations need to be submitted through Evolent/NIA?
    - **Answer:** Evolent/NIA is specific to non-emergent outpatient imaging services.

- **Question:** For clarification, prior authorizations for pediatric OT, PT and speech are through RADMD? Is that correct?
    - **Answer:** Evolent, through their RADMD portal, is only for non-emergent outpatient imaging services. OT/PT/ST providers should submit authorizations through ProAuth via ProviderCONNECT.

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- **Question:** Who is the correct prior authorizations entity for pediatric outpatient OT, PT and speech therapy services?
    - **Answer:** Prior authorizations can be submitted through one of the following methods for Tailored Plan OT, PT and ST:
        - ProAuth is Partners platform for authorization submission through our secure provider portal, ProviderCONNECT.
        - Providers will be given instructions to access ProAuth when they join the network and access ProviderCONNECT.
        - ProAuth is the preferred method for service authorization request submission.
        - Phone - 1-877-398-4145
        - Physical Health Fax Numbers Outpatient Requests - 704-884-2613

Member Eligibility

- **Question:** Does member eligibility check confirm Standard Plan (SP) vs Tailored Plan (TP)?
    - **Answer:** Providers can continue using NCTracks to verify member eligibility which will indicate which plan the member is assigned. For Tailored Plan members, NCTracks will also indicate the Tailored Care Management provider.

- **Question:** Will all kids on NC Medicaid Direct be switched to a Tailored Plan or will some stay on NC Medicaid Direct?
    - **Answer:** No, there will still be members carved out of Managed Care and who remain in NC Medicaid Direct. For example, Foster Care. Providers can continue using NCTracks to verify member eligibility, which will indicate which plan the member is assigned. For Tailored Plan members, NCTracks will also indicate the Tailored Care Management provider.

- **Question:** If a child/adult still has NC Medicaid Direct will they also have an LME/MCO payer?
    - **Answer:** If NC Medicaid Direct, yes LME/MCO payer stays the same.

- **Question:** How soon will we know if our children will be switching to Tailored Plan? By June 15 or will it be on July 1?
    - **Answer:** Providers can verify member eligibility using NCTracks. NCTracks will display the member's Tailored Plan and their Tailored Care Management provider.

- **Question:** Does the Dual Medicare/Medicaid apply to adults as well? If they are dual, will Tailored Plans then not apply to them?
    - **Answer:** Individuals with Medicaid/Medicare (aka "dual eligibles") are carved out of managed care.

- **Question:** Can we check eligibility on NCTracks as well?
    - **Answer:** Yes, eligibility may also be checked using NCTracks. Thank you.

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- **Question:** Where will we be able to find out who the care manager is for our patients and also be able to see those care plans?
    - **Answer:** NCTracks will display a Tailored Plan member's Tailored Care Management provider.

- **Question:** Will all children on NC Medicaid Direct be switched to a Tailored Plan or will some stay on NC Medicaid Direct?
    - **Answer:** Not all children will move to the Tailored Plans; there are exceptions such as Foster Care and dual eligibility.

- **Question:** So, if NCTracks is not the source of truth for Medicaid patients with other health insurance, do many of your members have other health insurance and if so, where is the best place to check the eligibility?
    - **Answer:** Eligibility can be viewed in NC Tracks, Availity, and Alpha +.

- **Question:** If a child/adult still has NC Medicaid Direct will they also have an LME/MCO payer?
    - **Answer:** LME/MCO is still involved in NC Medicaid Direct for BH components. PH will continue to go to NC Medicaid Direct.

- **Question:** Does the Dual Medicare/Medicaid apply to adults as well? If dual, Tailored Plans will not apply?
    - **Answer:** Pediatric and Adult "dual" eligible members are carved out, unless they are part of the Innovations Waiver.

Miscellaneous

- **Question:** Where does Speech Therapy, Occupational Therapy and Physical Therapy fall? Under physical? Or behavioral?
    - **Answer:** It is under physical.

- **Question:** Must the case manager be notified to provide a medical service?
    - **Answer:** No, Care Management should not play a role in determining medical services.

- **Question:** Will the member ID# be the same as their NC Medicaid Direct Recipient ID# or will it be different?
    - **Answer:** The number will stay the same; the plan will change.

- **Question:** If we are not on the patients' card, can we still see patient and received reimbursement?
    - **Answer:** Yes