Back Porch Chat: Medicaid Managed Care Launch Edition with:

July 15, 2021

RCC (Relay Conference Captioning)
Participants can access real-time captioning for this webinar here: https://www.captionedtext.com/client/event.aspx?EventID=4834070&CustomerID=324

Dr. Shannon Dowler
NC Medicaid

Dr. George Cheely
AmeriHealth Caritas (AMHC)

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Dr. Michael Ogden
Healthy Blue (BCBS)

Dr. Michelle Bucknor
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Dr. William Lawrence Jr.
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Logistics for today's webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

A New Way of Q&A

We have committed an **hour+** to answering your questions tonight.

Please indicate: ***All or Plan (Specific)*** and response ***Public or Private***.

- Ex: Public-Plan X: Why don't you cover Alien Abduction scans?
- Ex: Private-Plan Y: We can't get anyone to call us back on getting a contract. Help!
- Ex: Public-All: I want to thank all of you for being amazing human beings. That is all.
- Ex: Public-Plan Z: I have heard from several of my colleagues that you offer CME for free in Barbados, is that true?

We will do our best to answer your questions during the webinar; some questions may require follow-up.

AGENDA

01 Updates from the Division of Health Benefits

02 CMO Rounds: Debrief on Launch

03 What Our Call Centers Are Hearing

04 Your Survey Responses

05 Open Q&A

Audience Response 1

Which category BEST describes you?

A. Primary Care Physician/Advanced Practitioner (AP)
B. Specialty Physician/AP
C. Hospital Administrator
D. Ambulatory Administrator
E. Nurse Manager/Quality Manager
F. Pharmacy
G. Behavioral Health (non-Physician/AP)
H. Behavioral Health (Physician/AP)
I. Specialized Therapist (Physical Therapy/Occupational Therapy/Speech Therapy)
J. Audiology/Podiatry/Other

Audience Response 2

Regarding you and your teams overall experience with the transition to managed care in July, you would describe the transition as:

A. Better than expected

B. Same as expected

C. Messier than expected

Provider Playbook: Medicaid Managed Care

Fact Sheet Updates

- **Managed Care Claims and Prior Authorizations Submission – Part 1 (Updated) --** This fact sheet contains references to resources each Prepaid Health Plan (health plan) has created to inform both in-network and out-of-network providers about their claims submission process and their billing guidelines, and also includes details on where providers should route their claims. ***Added additional definitions for services carved out of Medicaid Managed Care.***
- **Managed Care Claims and Prior Authorizations Submission – Part 2 (Updated)** – An overview of frequently asked questions regarding providers and health plans during the claims and prior authorization submission process. ***Now includes provider payment schedule from July to October 2021 and revised information needed to file a claim.***
- **Combined health plan Quick Reference Guide (Updated)** – A quick reference guide (QRG), with updated contact numbers, designed for providers to use beginning on day one of NC Medicaid Managed Care go-live. This QRG gives providers access to the information they will most frequently use such as contact numbers, email addresses, as well as prior authorizations and claims information for each of the health plans. ***New contact numbers for health plans and NEMT/NEAT services.***

For more information and the calendar, please refer to the NC Medicaid Fact Sheets.

Prepaid Health Plan Flexibility for Prior Authorizations During First 60 Days after Managed Care Launch

NCDHHS has continued to receive feedback from NC Medicaid providers indicating confusion about prior authorization requirements during the state's transition to NC Medicaid Managed Care. The Department shared this feedback with the prepaid health plans (health plans). In response to these concerns, the health plans will implement the following solution during the first 60 days after managed care launch to ensure beneficiaries continue to have access to services during this transition without unnecessary interruption.

1) Between July 1 and Aug. 30, 2021, medically necessary services that normally require prior authorization will still be reimbursed at 100% of the NC Medicaid fee-for-service rate for both in- and out-of-network providers. To ensure that providers fully understand each health plan's prior authorization requirements during the transition, the health plans will still process and pay for these services if:
   a. a provider fails to submit prior authorization prior to the service being provided and submits prior authorization after the date of service, or
   b. a provider submits for retroactive prior authorizations.

   This exception does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period.

2) Beginning Aug. 31, 2021, the health plan may deny payment for services that require prior authorization. For in-network providers this will apply to those services that normally require prior authorization. Out-of-network providers will need to seek authorizations for all services.

3) The Department expects all providers to maintain scheduled medical care for beneficiaries through this transition.

4) The Department expects the health plans and providers to continue to work to resolve any outstanding contracting barriers during this time to mitigate out-of-network challenges.

Prescribing for Substance Use Disorder (SUD)

Why you may receive a new approval for a PA that was previously approved (aka, during the transition, why is the new PHP making a redetermination on a Prior Authorization (PA) request)?

- 42 Code of Federal Regulations (CFR) Part II regulations prohibit the disclosure of patient records absent patient consent
  - Disclose means to communicate any information identifying a patient as being or having been diagnosed with a substance use disorder, having or having had a substance use disorder, or being or having been referred for treatment of a substance use disorder
  - Records include information regarding diagnosis, treatment, referral for treatment, billing information, emails, voice mails, and texts
  - Withdrawal management means the use of pharmacotherapies to treat or attenuate signs and symptoms arising when heavy and/or prolonged substance use is reduced or discontinued

- To ensure a smooth transition of care during Managed Care Launch, North Carolina required plans to ingest existing Prior Authorizations (PAs) to reduce administrative burden and improve patient experience
  - For most cases, Plans are required to honor existing and active pharmacy services PAs through the expiration date of the active service authorization
  - Plans are also expected to transfer open service authorizations when a member changes Plans or moves to Medicaid Direct or an LME-MCO

- The **Exception** to ingesting PAs is any medication related to treatment of SUD
  - 42 CFR 2.32 prohibits re-disclosure of records disclosed under a patient's written consent
  - The Department's expectation is that PAs for SUD services- including Pharmacy PAs- are not transferred
  - Where a PA involves an SUD treatment, service, or medication, Providers should be asked to re-submit previously approved PAs to the member's new PHP

- GDIT will be doing outreach to providers who will need to resubmit authorization

Non-Emergency Medical Transportation (NEMT) and Non-Emergency Ambulance Transportation (NEAT)

Overview

- PHPs have contracted with transportation brokers that work with public and private transportation providers to arrange and provide transportation for their members. The brokers are:
  - ModivCare: AmeriHealth Caritas of NC, Healthy Blue, Carolina Complete Health, and UnitedHealthCare of NC
  - One Call: WellCare of NC

Transition of Care Protections

- To help ensure continuity and access to care during this transition, if a provider fails to schedule NEMT or NEAT through the broker for the first 60 days after Managed Care Launch (through August 30, 2021), the PHPs and their transportation brokers will honor those trips and pay NEMT and NEAT providers equal to that of in-network providers.

NEMT and NEAT Contracting

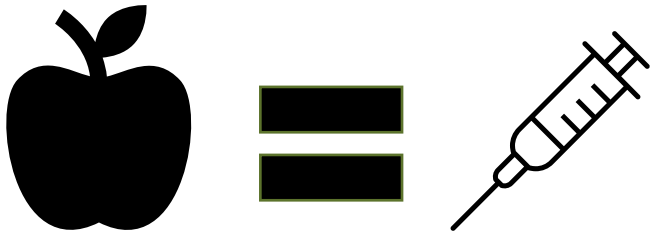
- NEMT and NEAT contracting is an ongoing process.
- All NEMT and NEAT providers are strongly encouraged to contract with both transportation brokers to ensure PHP members have adequate access to care.

Emergent Care

- For emergent ambulance transport, ambulance providers do **not** need to schedule transportation through the transportation broker and will submit claims for payment directly to the member's PHP.

DHB and the PHPs are committed to beneficiaries receiving timely transportation for critical health needs during this transition. Please escalate to the member's PHP if beneficiaries are not receiving timely transportation and report failures to the Provider Ombudsman if the PHP is unable to resolve.

COVID Vaccinations



- Please remember how important you are for counseling and providing vaccine in your offices; all plans reimburse 99401!

- Whether primary care, specialty, specialized therapy or behavioral health (BH), asking if your patient is vaccinated shows it is important to you and is a step towards vaccine acceptance!

- Data will be available soon to measure rate of vaccinated Medicaid beneficiary by PHP and by Medical Home
  - Actionable individual data will lag broad rates

CMO Rounds: Debrief on Launch

Audience Response 3

Regarding supporting you and your team in the transition, which has been the most effective method of communication with the plans for issue resolution:

A. Portal

B. Email

C. Fax

D. Phone

Administrative Simplification Workgroup

The CEOs of all 5 Participating Health Plans committed significant resources to an ongoing workgroup to identify means to reduce the collective administrative burden of working with 5 different Medicaid entities. They are as follows:

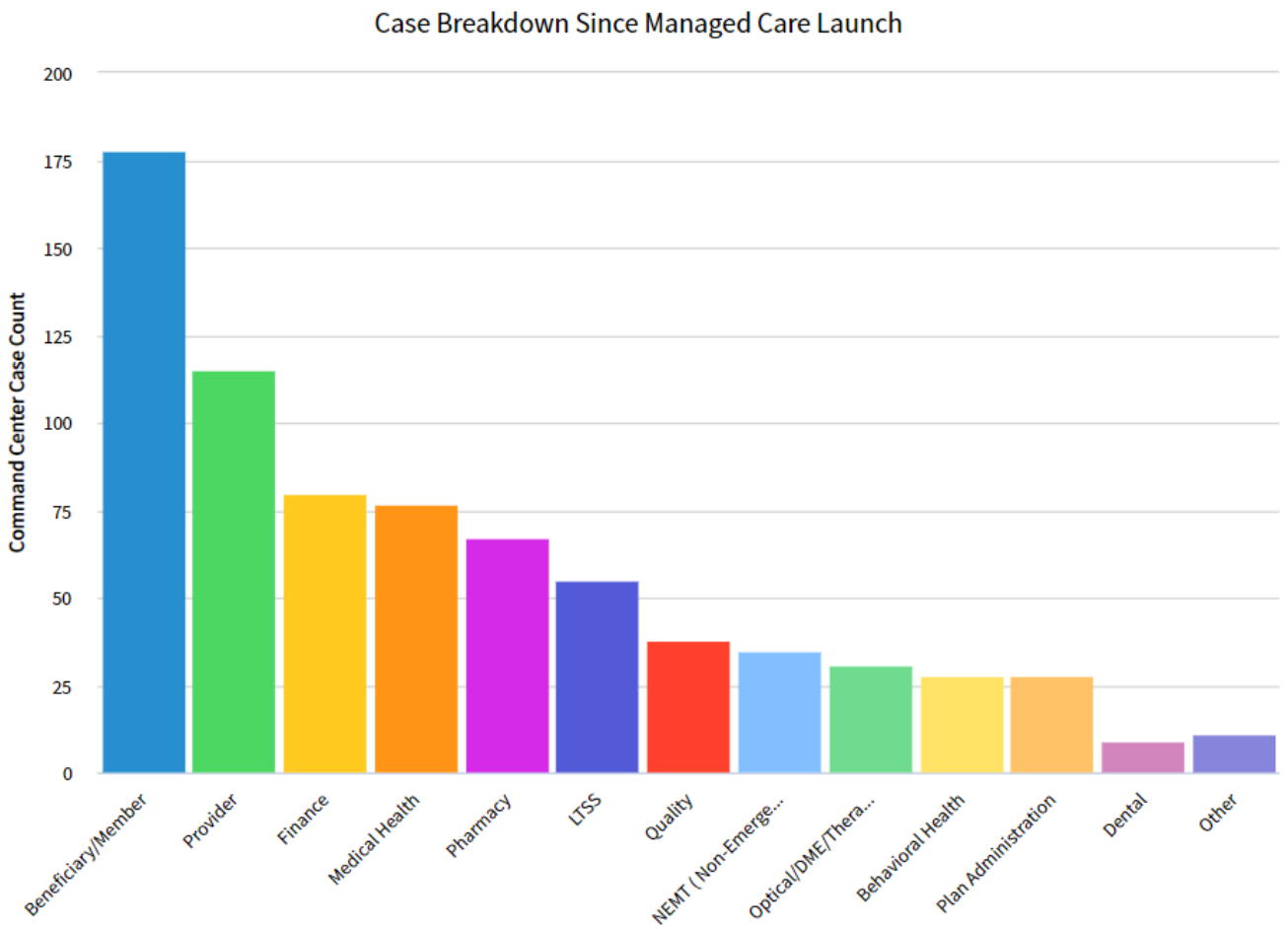
- Agreed upon a **uniform approach to Quick Reference Guides (QRGs)** to make frequently used and/or critical information available at one's fingertips and with ease of navigation
- Worked with the Department to **revamp the required Prior Authorization Form**, eliminating several elements that were perceived to require time & effort with limited return
- Collaborated on a **uniform section of provider orientation topics** that apply equally across all plans. The final product resulted in a reduction of 138 slides of content to a 27-slide deck representing the key concepts
- In collaboration with Department of Health & Human Services (DHHS) and Area Health Education Centers (AHEC), our group achieved a modification of the Quality Forum requirements for health plans from holding a total of 24 meetings annually to conducting **3 Quality Forums per year with joint participation by all health plans**, DHHS and AHEC.

We have continued to meet regularly into implementation and look forward to exploring other opportunities that may lead to further enhancements.

What We Are Hearing from The Field

Medicaid Help Center

Weeks of July 1st - July 15th



Inquiry Category	Command Center Case Count	Percentage of Count
Beneficiary/Member	178	23.67%
Provider	115	15.29%
Finance	80	10.64%
Medical Health	77	10.24%
Pharmacy	67	8.91%
LTSS	55	7.31%
Quality	38	5.05%
NEMT (Non-Emergency Medical Transportation)	35	4.65%
Optical/DME/Therapies	31	4.12%
Behavioral Health	28	3.72%
Plan Administration	28	3.72%
Dental	9	1.2%
Other	11	1.46%
Total	**752**	**100%**

What Our Call Centers are Hearing from Members

Weeks of June 28th- July 10th

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	6,586	99%	0%
Healthy Blue	12,823	98%	0%
Carolina Complete	7,397	87%	3%
United	11,640	98%	0%
WellCare	8,997	98%	0%
Enrollment Broker	17,217	100% in 3m	0%
Medicaid Contact Center (MCC)	4,508	91%	1%
GDIT	3,880	97%	1%

Top Call Center Reasons		
EB	1	Changing Enrollments
	2	Health Plan Questions
	3	Check Enrollment Status
Health Plans	1	PCP Changes
	2	Benefits Questions
	3	Demographics Changes
	4	Find a Provider
	5	ID Card Requests

What Our Call Centers are Hearing from Providers

Weeks of June 28th- July 10th

Call Center	Calls Handled	% Calls Answered in 30s	Abandonment Rate
AmeriHealth	3,218	98%	0%
Healthy Blue	7,637	98%	0%
Carolina Complete	2,096	90%	2%
United	3,921	94%	0%
WellCare	1,625	96%	1%

Top Call Center Reasons		
Health Plans	1	Provider Enrollments
	2	Provider Network Status
	3	Authorization Status
	4	Demographics Changes
	5	Benefits and Eligibility
	6	Claims/ Reimbursement

AmeriHealth Caritas of North Carolina

- Prior Authorizations
- Out-of-Network Prior Authorization Requirements
- Durable Medical Equipment (DME)
- Inaccurate Co-payment Guidance

Dr. George Cheely
AmeriHealth Caritas (AMHC)
gcheely@amerihealthcaritasnc.com

Carolina Complete Health

- Pharmacy
- Primary Care Provider Assignments
- Prior Authorizations

Dr. William Lawrence Jr.
Carolina Complete Health (CCHE)
William.W.Lawrence@carolinacompletehealth.com

Healthy Blue

- Rejected Claims
- Billing Guide(s)
- Prior Authorizations
- Physician Administered Drug Program

Dr. Michael Ogden
Healthy Blue (BCBS)
michael.ogden@healthybluenc.com

Audience Response 4

As we refine tools to support you and your teams, it helps to know what brings value. Are the following ***True or False***?

- I have found the Online Prior Authorization Lookup Tools to be a helpful addition ***True or False***

- I have found the Quick Reference Guides from the health plans to be useful for myself/my team ***True or False***

UnitedHealthCare

- Out Of Network Providers, Specialty Providers and Referrals
- Prior Authorization Submission and Tracking Process
- Proper Billing and Claims Processing

Dr. Michelle Bucknor
UnitedHealthCare (UNHC)
michelle_bucknor@uhc.com

WellCare

- COVID Vaccine Billing and Claims Processing
- National Drug Codes (NDCs) and Pharmacy Point of Sale (POS)
- Non-Emergency Medical Transport (NEMT)
- Pharmacy Prior Authorizations

Dr. Eugenie Komives
WellCare (WCHP)
Eugenie.Komives@wellcare.com

Audience Response 5

When you think of your experience and your team's experience with patients' ability to access services since the transition, have your patients had challenges accessing (***select all you have observed***):

A. Radiology
B. Procedures
C. Pharmacy
D. Specialized Therapies
E. Durable Medical Equipment
F. Personal Care Services
G. Private Duty Nursing
H. Transportation

Medicaid Managed Care Webinar Survey (Fireside/Back Porch Chats):

The results you see represent each question and the number of people that responded

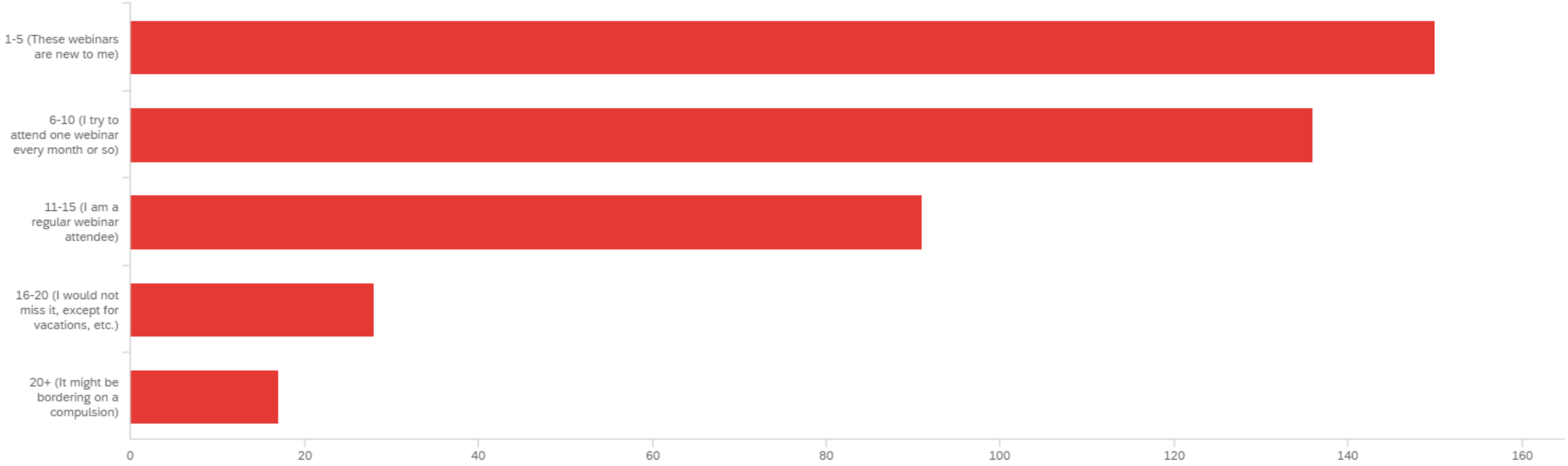
June 28, 2021-July 14, 2021

Total Number of Survey Recipients: 5567

Total number of Respondents: 425

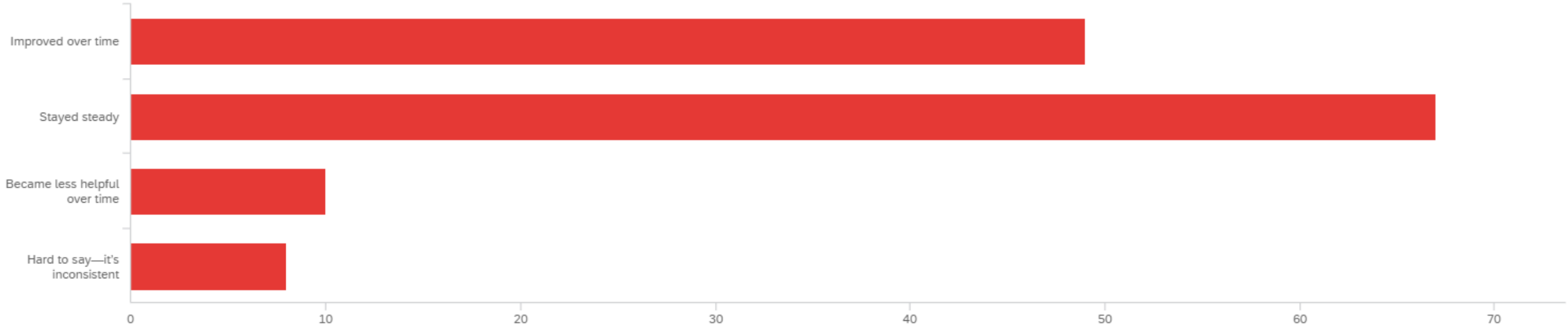
Response Rate 7.63%

How many Medicaid Managed Care webinars have you attended, since they began in March of 2020?



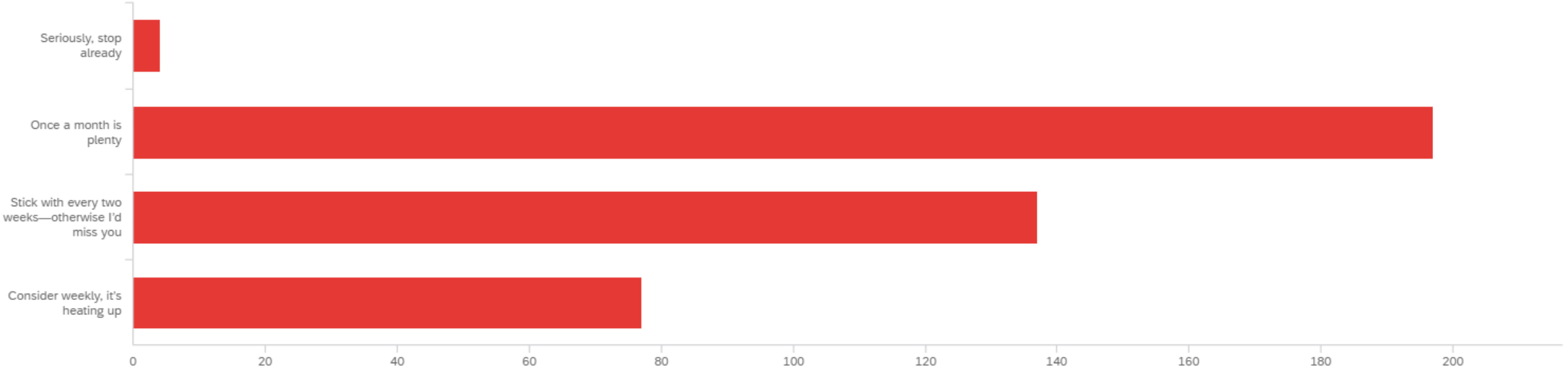
Total number of Respondents: 422

For long time attendees, do you feel like the chats have:



Total number of Respondents: 134

After launch, how often would you like to have these updates and opportunities to bring questions to the health plan teams?



We will have Back Porch Chats the 3rd Thursday of each month until March 2022, when we will add the 1st Thursday for Tailored Plan (TP) Launch Updates.

Total number of Respondents: 415

Audience Response 6

In the survey responses there were several requests to move this webinar to earlier in the day. Which of the following times would be BEST to hold these webinars?

A. 7:30AM-8:30AM

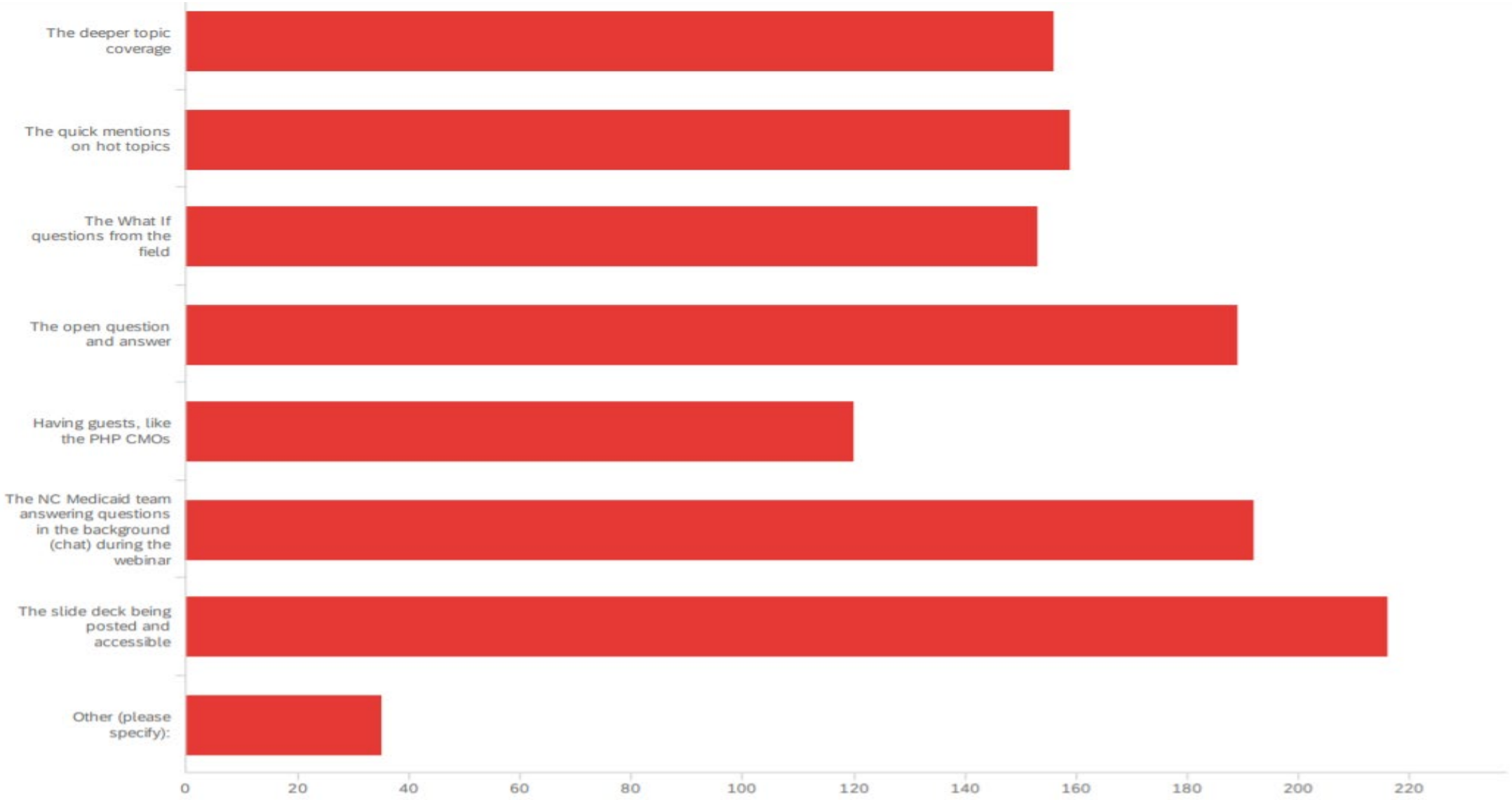
B. 9:00AM-10:00AM

C. 12:00PM-1:00PM

D. 4:00PM-5:00PM

E. 5:30PM-6:30PM

Regarding the format for the webinar/chats, which content is most valuable to you? (choose all that apply)



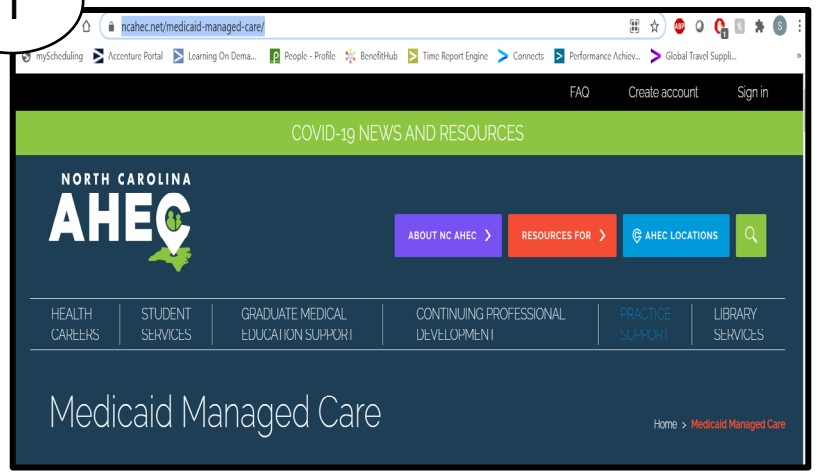
Total number of Responses: 1220


QUESTIONS?

APPENDIX

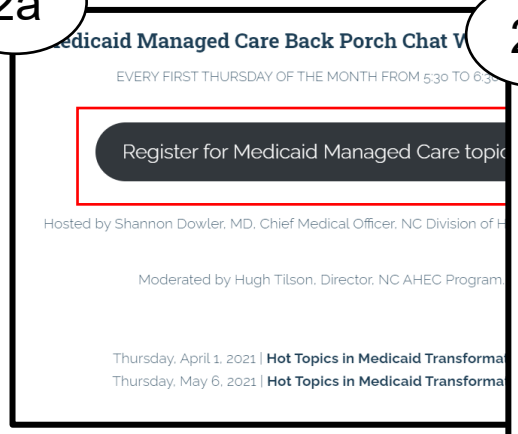
How To Sign up for the Back Porch Chat Webinar Series

1

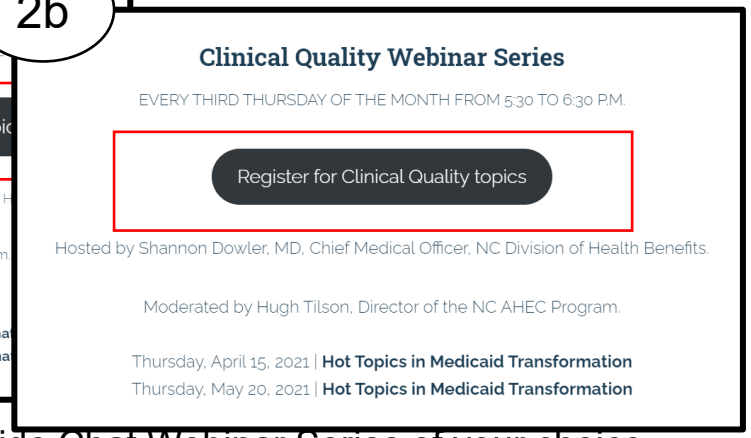


1. Navigate to the North Carolina AHEC Medicaid Managed Care page

2a



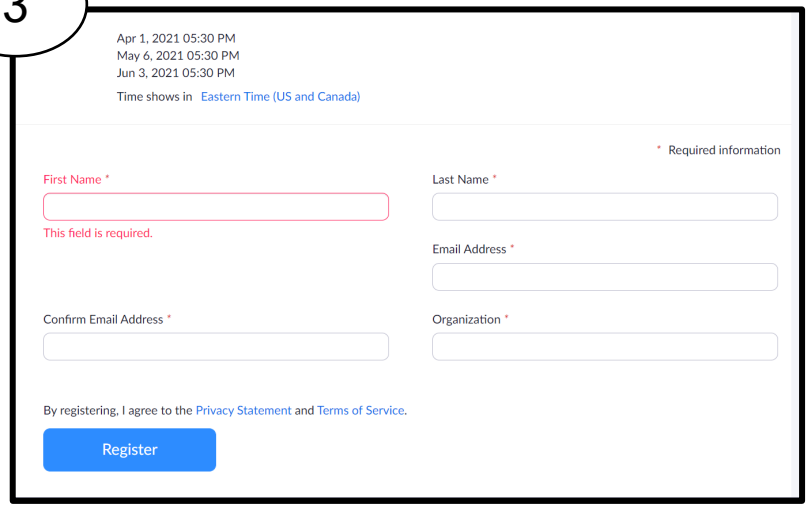
2b



2. Scroll down to the Fireside Chat Webinar Series of your choice

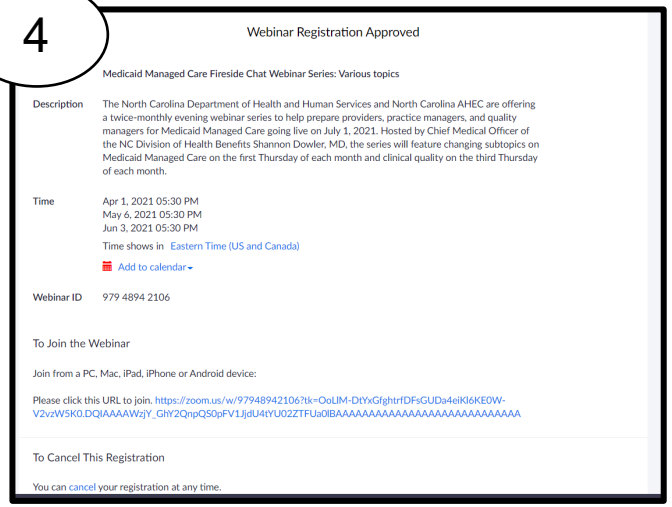
2b. Click on “Register for Medicaid Managed Care topics” or “Register for Clinical Quality topics”

3



3. Fill out all the required information and click register

4



4. When you see this page, your registration is successful.

Provider Resources

- NC Medicaid Managed Care Website
  - medicaid.ncdhhs.gov
  - Includes County and Provider Playbooks
  - Fact Sheets
  - Day One Quick Reference Guide
- NC Medicaid Help Center
  - medicaid.ncdhhs.gov/helpcenter
- Practice Support
  - ncahec.net/medicaid-managed-care
  - NC Managed Care Hot Topics Webinar Series, hosted by Dr. Dowler on the first and third Thursday of the month
- Regular Medicaid Bulletins
  - medicaid.ncdhhs.gov/providers/medicaid-bulletin

What should Providers do if they have issues?

1

Check in NCTracks for the Beneficiary's enrollment (Standard Plan or Medicaid Direct) and Health Plan

If you still have questions, call the NCTracks Call Center: 800-688-6696

2

Connect with the Health Plan (PHP) for coverage, benefits, and payment questions.

You can find a list of health plan contact information at health-plan-contacts-and-resources

3

Consult with the Provider Ombudsman on unresolved problems or concerns.

Call 866-304-7062 or email Medicaid.ProviderOmbudsman@dhhs.nc.gov

Day 1 Quick Reference Guide

VERIFICATION OF ELIGIBILITY AND PLAN

- **NCTracks:** Providers will be able to verify eligibility and Managed Care enrollment through the NCTracks Recipient Eligibility Verification function available in the Provider Portal
- **Real Time Eligibility Verification Method**
  a. Log into the NCTracks Provider Portal: https://www.nctracks.nc.gov/ncmmisPortal/loginAction?flow=PP
  b. Follow the Eligibility > Inquiry navigation
  c. Populate the requested provider, recipient and time period information
- **NCTracks Call Center:** 800-688-6696

PROVIDER PORTAL / PROVIDER SERVICES

- **AmeriHealth Caritas**: https://navinet.navimedix.com / Provider Services: 888-738-0004
- **Carolina Complete**: https://network.carolinacompletehealth.com / Provider Services: 833-552-3876
- **Healthy Blue**: https://provider.healthybluenc.com or https://www.availity.com / Provider Services: 844-594-5072
- **United Healthcare**: https://www.uhcprovider.com / Provider Services: 800-638-3302
- **WellCare**: https://provider.wellcare.com / Provider Services: 866-799-5318
- **NC Medicaid Provider Playbook**: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care

PRIOR AUTHORIZATIONS

- **AmeriHealth Caritas: Online**: Provider Portal / **Phone**: 833-900-2262 / **Pharmacy**: 866-885-1406
- **Carolina Complete: Online**: Provider Portal / **Phone:** 833-552-3876 / **Pharmacy:** 833-585-4309
- **Healthy Blue: Online**: Provider Portal / **Phone:** 844-594-5072 / **Pharmacy**: 844-594-5072
- **United Healthcare: Online:** UHCProvider.com / **Pharmacy: Phone:**855-258-1593 **Online**: CoverMyMeds: https://www.covermymeds.com/main/prior-authorization-forms/optumrx/; SureScripts: https://providerportal.surescripts.net/ProviderPortal/optum/login; Pharmacy Resources and Physician Administered Drugs: UHCprovider.com
- **WellCare: Online**: Provider Portal / **Phone:** 866-799-5318 / **Pharmacy**: Fax: 800-678-3189 **or** SureScripts: https://providerportal.surescripts.net/providerportal/

Day 1 Quick Reference Guide

CLAIMS

- **AmeriHealth Caritas: Online**: https://navinet.navimedix.com / **Phone**: 888-738-0004
- **Healthy Blue: Online:** www.availity.com / **Phone**: 844-594-5072
- **Carolina Complete: Online**: https://network.carolinacompletehealth.com
- **United Healthcare: Online**: https://www.uhcprovider.com / **Phone**: 800-638-3302
- **WellCare: Online**: https://www.wellcare.com/en/North-Carolina/Providers/Medicaid/Claims / **Phone:** 866-799-5318

Two Claims Submission Fact Sheets are available on the Provider Playbook at: https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed-care that address filing managed care claims.

NON-EMERGENCY MEDICAL TRANSPORTATION & NON-EMERGENCY AMBULANCE TRANSPORTATION

- **AmeriHealth Caritas, Carolina Complete, Healthy Blue, United Healthcare:**

ModivCare Health Care Provider Line: 855-397-3606 / ModivCare Transportation Provider Line: 855-397-3604

- **WellCare**: One Call Health Care Provider Line: 877-598-7602 / One Call Transportation Provider Line: 877-598-7640

If you are helping a member arrange transportation, call the PHP Member Services line on the member's Medicaid ID card.

PROVIDER OMBUDSMAN

Medicaid Managed Care Provider Ombudsman: **Phone:** 866-304-7062 / **Online:** Medicaid.ProviderOmbudsman@dhhs.nc.gov

HEALTH PLAN QUICK REFERENCE GUIDE LOCATION

- AmeriHealth Caritas: https://www.amerihealthcaritasnc.com/assets/pdf/provider/provider-reference-guide.pdf
- Carolina Complete: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHNCurrent-PDF-QRG-Form.pdf
- Healthy Blue: https://provider.healthybluenc.com/docs/gpp/NC_CAID_QuickReferenceGuide.pdf
- United Healthcare: https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/nc/training/NC-Medicaid-QRG.pdf
- WellCare: https://www.wellcare.com/North-Carolina/Providers/Medicaid

Key Resources for Managed Care Launch

Issue	**All fact sheets listed below can be accessed via this link**: Medicaid Managed Care Fact Sheets. **Links to other resources not on the fact sheet page are provided below.**
Check Beneficiary Plan	1. Day 1 Provider Quick Reference Guide (See NCTracks information under Verification of Eligibility and Plan section) 2. What Providers Need to Know: Part 2 - After Managed Care Launch (See information under Assist Your Beneficiaries with the Transition)
Beneficiary Request to Stay in NC Medicaid Direct and Local Management Entities/ Managed Care Organizations (LME/MCO)	Policy Guidance (See 1. Request to Stay in NC Medicaid Direct and Local Management Entities/ Managed Care Organizations (LME/MCO): Beneficiary and Provider Attestation Forms 2. Behavioral Health I/DD Tailored Plan Memo on Eligibility and Enrollment)
Covered Services (clinical policies/labs/vaccines) after July 1	Day 1 Provider Quick Reference Guide (See links under health plan Quick Reference Guide Location)
Prior Authorizations (PA) after July 1	Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1 and Part 2
Prescription Medication	Outpatient Pharmacy Services Physician Administered Drug Program
Referrals after July 1	Day 1 Provider Quick Reference Guide (See health plan contact information under Prior Authorizations)
Non-Medical Emergency Transport (NEMT) after July 1	Day 1 Provider Quick Reference Guide (See health plan contact information under NEMT)
Billing (e.g., global codes) after July 1	1. Day 1 Provider Quick Reference Guide (See health plan contact information under Claims) 2. Managed Care Claims and Prior Authorizations Submission: What Providers Need to Know – Part 1 and Part 2
Social Determinants of Health (SDOH) Supports	NCCARE360 DHHS Healthy Opportunities Site Healthy Opportunities Pilots (See Healthy Opportunities Fact Sheet)
Care Management Transitions	Transition of Care for Beneficiaries Receiving Long-term Services and Supports
Questions From Providers That Have Already Been Answered	NC Medicaid Help Center Knowledge Base to search through FAQs
Difference Between Medicaid Clinical Coverage Policy Floor and Utilization Management in Managed Care	NC Medicaid Help Center Knowledge Article: Utilization Management in Managed Care

*Direct **Issues** to the health plan patient is assigned to and **Escalations** to the Medicaid Managed Care Provider Ombudsman: Day 1 Provide Quick Reference Guide (see contact information for Provider Ombudsman)*

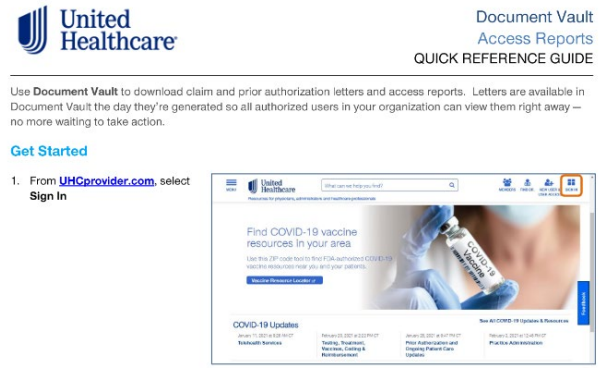
Paying Claims: The Process Across Plans

	AmeriHealth Caritas (ACNC)	Carolina Complete Health (CCH)	Healthy Blue (BCBS)	United Healthcare (UHC)	WellCare (WCHP)
Submit Claims via:	Electronic: https://www.changehealthcare.com/solutions/revenue-performance-advisor OR ACNC Payer ID: 81671 Mail: AmeriHealth Caritas North Carolina Attn: Claims Processing Department P.O. Box 7380, London, KY 40742-7380	Electronic: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT e-mail: EDIBA@centene.com CCH Payer ID: 68069 Mail: Carolina Complete Health Attn: Claims PO Box 8040 Farmington MO 63640-8040	Paper -Blue Cross NC | Healthy Blue Claims Department P.O. Box 61010 Virginia Beach, VA 23466; 1-844-594-5072, Electronic, https://www.availity.com	Paper: UnitedHealthcare Community Plan PO Box 5280 Kingston NY 12402-5280 Electronic: http://www.uhcprovider.com	Paper: WellCare Claims PO Box 31224 Tampa, FL 33631-3224 Electronic or Direct Data Entry (DDE): AdminisTEP:http://www.administep.com/Signup.aspx Change Healthcare: https://physician.connectcenter.changehealthcare.com
Errors Notified by:	Rejected with errors within **18 days** of receipt via mailed letter or https://identity.navinet.net/Account/Login	Claim rejected with errors identified within **18 days** of receipt via mailed letter	Rejected with errors within **18 days** of receipt - Paper - Reject letter via mail or Electronic notice of status via 277CA , https://www.availity.com	Rejected with errors within **18 days** of receipt via mailed letter or Electronic notice of status via 277report https://www.uhcprovider.com/en/resource-library/edi.html?CID=none	Rejected with errors within **18 days** of receipt via mailed letter
Denials Notified by:	Denied with reasons within **30 days** of receipt via mailed letter or https://identity.navinet.net/Account/Login	Claims denial notification within **30 days** of receipt via EOP	Check write or Electronic via https://www.availity.com (Daily Check runs) within **30 days** of a clean claim submission	Check write or Electronic via http://www.uhcprovider.com (Daily Check runs) within **30 days** of a clean claim submission	Check write or Electronic via Payspan (payspanhealth.com) (Daily Check runs) within **30 days** of a clean claim submission
Claims Paid:	Check write or electronic via HTTPs://enrollments.echohealthinc.com/efteradirect/enroll (1st 7/7/21, then every M/W) within 30 days of clean claim submission	Check write or electronic within 30 days of claim submission (Weekly; either check or EFT depending on how the provider is set up)	Check write or Electronic via https://www.availity.com (Daily Check runs) within 30 days of a clean claim submission	Check write or Electronic via http://www.uhcprovider.com (Daily Check runs) within 30 days of a clean claim submission	Check write or Electronic via Payspan (payspanhealth.com) (Daily Check runs) within 30 days of a clean claim submission
Submit Claims Dispute:	Electronic: HTTPs://identity.navinet.net/Account/Login or Mail: Provider Appeals Department | AmeriHealth Caritas North Carolina | P.O. Box 7379 | London, KY 40742-7379	Electronic: Carolina Complete Health Provider Tools (https://provider.carolinacompletehealth.com/sso/login) or Mail: Carolina Complete Health Attn: Appeals and Grievances P.O. Box 8040 Farmington, MO 63640-8040	Electronic via https:https://www.availity.com or Mail - Blue Cross NC | Healthy Blue Payment Dispute Unit P.O. Box 61599 Virginia Beach, VA 23466	Electronic: https://www.uhcprovider.com/ or Mail: UnitedHealthcare Community Plan Grievances and Appeals Unit P.O. Box 31364 Salt Lake City, UT 84131-0364	Via electronic at https://provider.wellcare.com or via mail to the address as outlined on the EOP.
Dispute Timing:	Claims disputes are accepted within **30 days** of receipt of denial. Resolution of disputes occur within **30 days** of receipt of dispute.	Claims disputes are accepted within **30 days** of notice of action. Resolution of disputes are typically achieved within **30 days** of receipt.	https://www.availity.com – Submit claim payment disputes within **30 days** of denial Claim payment dispute decision within **30 days** of receipt of claim payment dispute	Claims disputes are accepted within **30 days** of notice of action. Resolution of disputes are typically achieved within **30 days** of receipt.	Submit claims disputes **within 30 calendar days** of receipt of denial. Claim payment dispute decision within **30 calendar days** of receipt of appeal.

UnitedHealthCare

Out Of Network Providers, Specialty Providers and Referrals

- Find a Care Provider | UHCprovider.com



Prior Authorization Submission and Tracking Process

- Prior Authorization and Notification | UHCprovider.com
- Community Plan of North Carolina Medical Policies and Coverage Determination Guidelines
- UnitedHealthcare Community Plan Prior Authorization Requirements North Carolina Effective 7/1/2021 (uhcprovider.com)

Taxonomy billing					
CMS billing form		Provider type			
		Rendering		Billing	
CMS 1500	Paper	Block 24J		Block 33b	
	Electronic	Loop	Segment	Loop	Segment
		2310B	PRV03	2000A	
CMS 1450 (UB-04)	Paper	Block 78-79		Blocks 81A-81D	
	Electronic	Loop	Segment	Loop	Segment
		2310B If rendering provider is an attending physician	PRV03	2000A	

Proper Billing and Claims Processing

- https://www.uhcprovider.com/en/resource-library/edi/edi-quick-tips-claims.html