Tailored Plan Claims Information Session for Providers

May 22, 2024

Agenda

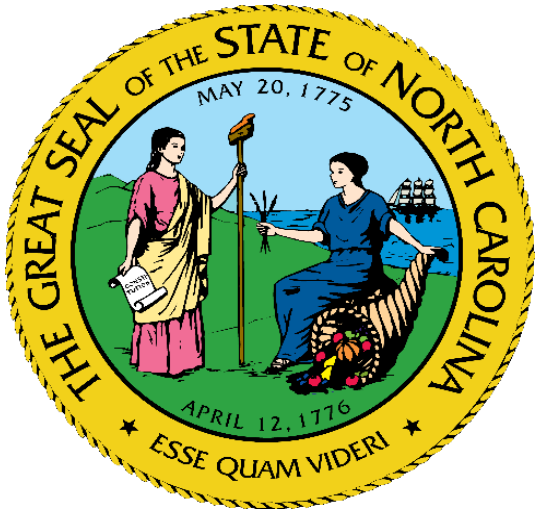
01 Opening Remarks

02 Managed Care: What's Changing

03 Day 1 Provider Information

04 Tailored Plans: Where To Go For Help

05 Q & A

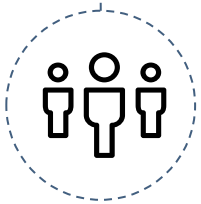
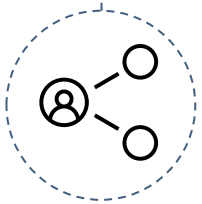
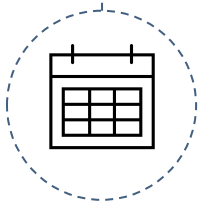


Managed Care: What's Changing ?

Adolph Simmons, Jr

Deputy Director – Managed Care Business Operations

Managed Care: What's Changing?

Member Eligibility	Claim Submission	Claim Filing and Payment Timelines	Prior Authorization	Reimbursement Methods
				
Medicaid Member Eligibility should be verified through NCTracks	Claims can be submitted through the health plans	Managed Care introduces new claim filing and payment timelines	Providers can identify services requiring prior authorizations through health plan lookup tools	Providers will be reimbursed at the Medicaid rate for services designated as rate floor programs unless otherwise negotiated according to the health plan contract and Department noted exceptions

How do I Determine Member Eligibility?

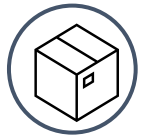
Medicaid Member Eligibility

Medicaid Member Eligibility should be verified through NCTracks, the recognized Real-Time Eligibility (RTE) system for providers contracting with the NC Division of Health Benefits.

Member Eligibility Validation can be accomplished through three ways in NCTracks:

Real Time Eligibility Verification Method

1. Log into the NCTracks Provider Portal
2. Follow the Eligibility > Inquiry navigation
3. Populate the requested provider, member, and time-period information



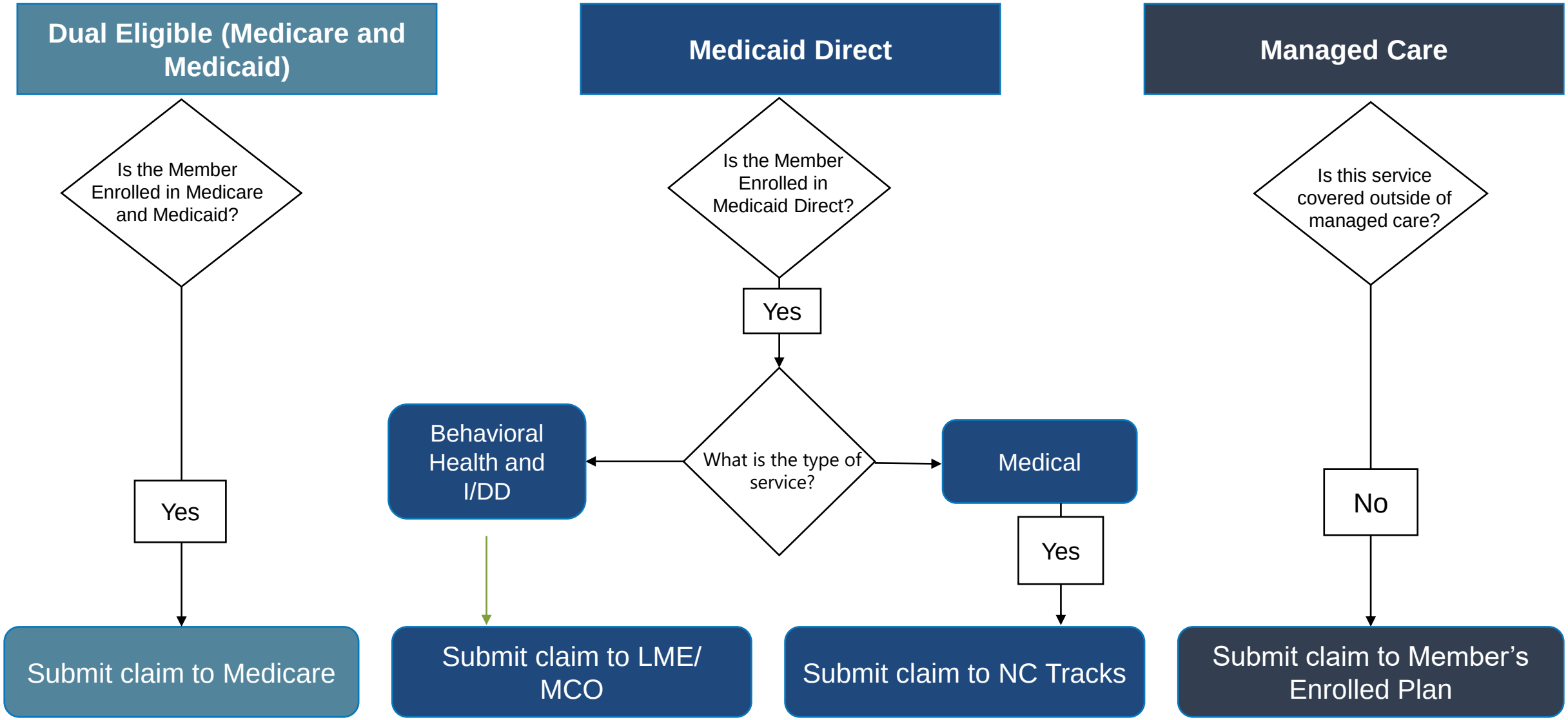
Batch Eligibility Verification Method

1. Log into the NCTracks Provider Portal
2. Follow the Eligibility > Batch verify
3. Upload the file by selecting browse > load from file

Via Automatic Voice Verification

Please call NCTracks Call Center at 800-688-6696 for voice verification.

Where Should a Provider Send Claims?



Glossary:
I/DD: Intellectual / Developmental Disabilities **LME/MCO:** Local Management Entity/Managed Care Organization **TBI:** Traumatic Brain Injury

Claim Filing and Payment Timelines

	Medical Claims	Pharmacy Claims
Timely Filing	Within 365 calendar days of covered service or discharge, or a time period set by the health plan that is no less than 365 calendar days	Within 365 calendar days of date of provision of care
Timely Filing for Retroactive Enrollees	365 calendar days of the approved enrollment	365 calendar days of the approved enrollment
Notify Providers of Clean* / Pended Claims	18 calendar days of receiving claims	14 calendar days of receiving claims
Pay or deny claims upon clean submission or a claim becomes clean	Within 30 calendar days of clean submission / becoming clean	Within 14 calendar days of clean submission / becoming clean
Deny claims if no additional information is submitted from the provider	90 days of the date the additional information was requested	90 days of the date the additional information was requested

*Clean Claim: A claim submitted to a health plan by a participating provider which can be processed without obtaining additional information from the Participating Provider or their authorized representative in order to adjudicate the claim

Please reference the Tailored Plan Prompt Pay Fact Sheet for more information.

Common Billing Errors

Failure to Follow Health Plan Billing Guidance

Transition to managed care model in NC Medicaid requires providers to follow billing guidance from health plans. While services remain largely unchanged, billing processes may differ and vary across individual health plans. Health plans must adhere to State and Federal claims processing requirements, with potential additional plan-specific requirements

Taxonomy Errors

Providers must select a taxonomy from the Provider Permission Matrix based on their license and scope of practice for credentialing purposes.

- For information on how to view the taxonomies you are enrolled in, please check the Taxonomy Enrollment Requirement Reminders for Claim Payment bulletin.
- It's important for providers to verify the taxonomies they are enrolled in and ensure accurate taxonomy data is submitted to health plans through their clearinghouses to avoid claim denials. For more information on including taxonomies in submissions, please check the Claims Denied – Taxonomy Codes Missing, Incorrect, or Inactive bulletin.
- For how to view and update taxonomies on the provider profiles, please check the View and Update Taxonomy on the Provider Profile in NCTracks User Guide.

Prior Authorization

Providers should check PA requirements for each health plan outlined in the lookup tools in Tailored Plan Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 and the Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 prior to patient visits to avoid unnecessary claim denials.

Coordination of Benefits

Providers should check if a patient has other insurance before submitting a claim. If the patient does have other coverage, providers should include coordination of benefits when submitting secondary claims to health plans. Refer to the TPL Billing Guide for more information.

When is Prior Authorization Required?

Prior authorization is necessary for:

- Inpatient Services
- Non-covered Services
- Certain Prescribed Medications
- Diagnostic and Treatment Services that fall within EPSDT
- Services performed by an out of network (OON) provider; except for emergency services or post stabilization services
- Services identified by each plan per the plan's prior authorization requirements *

Please reference the Tailored Plan Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2 for more information.

**See Maintaining Continuity of Care slide for Tailored Plan PA relaxation guidelines*

Maintaining Continuity of Care

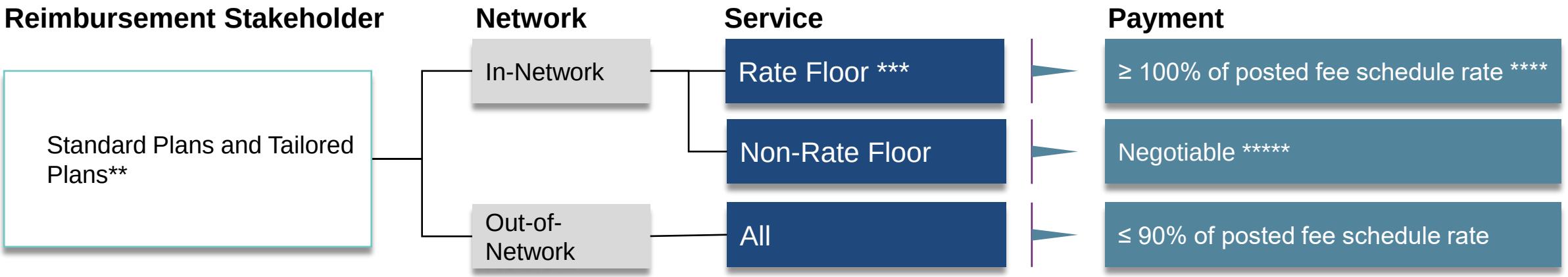
In addition to transition of care requirements for Members in an ongoing course of treatment, the Department and Tailored Plans will offer the following flexibilities to support providers to reduce administrative burden during the transition.

Policy Lever	Duration	Time Frame
Relax Medical PA requirements	91 days	7/1/2024 – 9/30/2024
Relax Pharmacy PA requirements	91 days	7/1/2024 – 9/30/2024
Non-Par Providers Paid at Par Rates	91 days	7/1/2024 – 9/30/2024
Non-Par Providers Follow In-Network Prior Authorization Rules	122 additional days	10/1/2024 – 1/31/2025
Ability to Switch PCP	214 days	7/1/2024 – 1/31/2025
Continuity of Care for Ongoing Course of Treatment	7 months	7/1/2024 – 1/31/2025

Note: The Department may opt to extend any of these flexibilities after the designated timeframe above, based on Tailored Plan operations to ensure the stability of Medicaid operations for Tailored Plan beneficiaries.

Reimbursement Methods

Please see the Provider Requirements related to Billing Medicaid Beneficiaries bulletin for more information.



How do I determine which fee schedules are rate floors?

Fee schedules with an asterisk (*) denote rate floors e.g., Nursing Facility Rates (below). Rate floors are the established NC Medicaid Direct (fee-for-service) rate that health plans are required to reimburse Medicaid providers (no less than 100% of the applicable NC Medicaid Direct rate), unless the health plan and provider mutually agree to an alternative reimbursement arrangement.

Program	Fee Schedule	Excel	Revision Date
Laboratory	Laboratory	Download File	2022-10-21
Dialysis	Dialysis+	Download File	2022-10-21
Community Alternatives Program+	CAP for Children (CAP/C)+	Download File	2023-01-13
Targeted Case Management	HIV Case Management	Download File	2022-10-21
Hearing Aid Program	Hearing Aid Program	Download File	2023-01-19
Nursing Facility Rates*	SNF Short Stay Managed Care	Download File	2023-01-20

** Tailored Plans and Prepaid Inpatient health plans have the authority to maintain a closed network for behavioral health services and may require an out of network agreement to receive payment.

*** For any provider subject to a rate floor as outlined in Section V.B.4.iv. Provider Payments, a BH I/DD Tailored Plan may include a provision in the provider's contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of the Durable Medical Equipment, the Physician Administered Drug Program rate floors, and any rate floor program that receives a supplemental payment based on that program's rate floor rate that has been built into Health Plan Capitation rates.

**** Unless provider and health plan have agreed to an alternative rate or reimbursement methodology through provider contracts.

***** Providers should refer to their respective contracts with each health plan for the negotiated service rates.

Member Payments

Outside of copays, providers may not bill Medicaid beneficiaries for:

1. Services covered by NC Medicaid, if the provider accepts the member as a Medicaid beneficiary

2. Services or goods NOT covered by NC Medicaid unless the beneficiary was notified in advance that the service is not covered by Medicaid and the beneficiary is financially responsible.

Tailored Plans Presentations – Where to Go For Help

Alliance Health

Tailored Plan Provider Claims and Authorization Education

Alliance and Delegates

Service	Primary UM Entity	Initial Prior Authorization	Member Appeal	Second Level Member Appeal	Claims
BH UM	Alliance	Alliance	Alliance (or IRO)	Alliance	Alliance
Core PH UM	Alliance	Alliance	Alliance (or IRO)	Alliance	Alliance
Specialty PH UM	WellCare	WellCare	WellCare	Alliance	Alliance
Durable Medical Equipment (DME)	Northwood	Northwood	Alliance	Alliance	Northwood
Vision	Avesis	Avesis	Alliance	Alliance	Avesis
NEMT	ModivCare	ModivCare	Alliance	Alliance	ModivCare
Pharmacy Benefit Management	Navitus	Navitus	Alliance	Alliance	Navitus
Physician Drug Program (PDP)	Alliance	Alliance No PA Required	Alliance No PA Required	Alliance No PA Required	Alliance

Claims and Enrollment Guide

- AllianceHealthPlan.org/document-library/59347
- Links to the delegate portals are available in the Alliance Health Claims and Enrollment Guide
- Insurance Validation
  - Providers may view member insurance information in the Alliance Claims System (ACS) Provider Portal by navigating to the Patient Maintenance module and viewing member insurance for the most updated coverage information provided to ACS

Interest and Penalties

- The Health Plan shall pay interest on late payments to the provider at the annual percentage rate of 18% beginning on the first day following the date that the claim should have been paid as specified in the contract
- In addition to the interest on late payments required by this section, the Health Plan shall pay the provider a penalty equal to 1% of the claim for each calendar day following the date that the claim should have been paid as specified in the contract

Interest and Penalties

- The Health Plan shall not be subject to interest or penalty payments under circumstances specified in NC General Statute § 58-3-225(k)

Split Claims

- Claims payable by DRG do not require claims to be split for submission. Claim should be submitted to first eligible payor of record at time of admission.
- Claims not payable by DRG will need to be split based on benefit plan year. Dates of service prior to 7/1/24 should be on a separate claim from dates of service beginning 7/1/2024.

EFT and Payments

- EFT AllianceHealthPlan.org/document-library/59645
- Checkwrite (payment) schedule – July 9 AllianceHealthPlan.org/document-library/75179/

EDI/Setup

- Claims can be submitted through 837 EDI compliant file or through the Alliance Claim System (ACS) Provider Portal
  - Alliance can accept 837 from clearinghouse
  - TPA/Connectivity and EDI certification process AllianceHealthPlan.org/document-library/60057

Claim Escalations

- Claims reconsideration requests must be submitted in writing to: claimsreconsiderations@alliancehealthplan.org
  - Request must be received within 30 calendar days of the claim denial's appearance on the remittance advice report
  - Request should include a list of claims requiring review, reasons for the reconsideration request and justification for the reconsideration

* Claims status requests can be made to: 855-759-9700
* Claims questions (not related to appeals/reconsiderations/status) can be sent to: claims@alliancehealthplan.org or 919-651-8500

Claim Escalations

- Written responses to reconsideration requests are sent to providers within 30 calendar days of receipt
  - Claims reconsideration: ClaimsReconsiderations@AllianceHealthPlan.org
  - Reconsideration requests will not be reviewed for denials related to lack of authorizations, Medicaid eligibility issues or provider enrollment errors
  - Should Alliance be responsible for any denials related to the aforementioned reasons, Alliance will review the reconsideration request

Prior Authorization Process

- UM Jiva Provider Portal Forms, Instructions and Videos
- Jiva Provider Portal will be the platform used to submit prior authorizations *only for services reviewed by Alliance*
- A **Jiva service agreement** needs to be completed by the agency/facility/provider which includes a list of individual staff who will need access to Jiva Provider Portal
  - This form will be sent out from Provider Networks via email

Prior Authorization Process

- Once the document is returned to PrivacySecurity@AllianceHealthPlan.org there is *up to* a 10-day turn-around on access being granted to Jiva Provider Portal
- Access to Jiva Provider Portal will utilize Okta single-sign on and the individual staff will receive an email if there is not a previous Okta account for the staff

Jiva Provider Portal Trainings

- To access Jiva Provider Portal training sign up through KnowledgePoint at bit.ly/3WICnjo by entering registration code **newuser**
- Trainings geared toward Utilization Review staff who submit for prior authorizations
  - 90-minute trainings separated by Inpatient (IP) and Outpatient (OP) services
- Attend as many as you need to get your questions answered

Jiva Provider Portal Trainings

- KnowledgePoint Quick Reference Guide

  AllianceHealthPlan.org/document-library/86506/

- Send KnowledgePoint questions to KnowledgePoint@AllianceHealthPlan.org

Delegate Information for Authorizations

Delegate Information	Links	Phone/Fax Number
Avesis (Vision)	Avēsis (myavesis.com)	Fax: 855-591-3566
ModivCare (NEMT)	Modivcare | Home	
Navitus (Pharmacy)	Pharmacy Guidance for Providers AllianceHealth (AllianceHealthPlan.org)	
Northwood (DME)	Northwood Provider Portal login (northwoodinc.com)	Fax: 877-403-6164
WellCare (Specialty Radiology)	WellCare login Sub-delegates Evolent: 1.radmd.com/radmd-home.aspx Evicore: Homepage | EviCore by Evernorth	

Services Requiring Prior Authorization Through WellCare

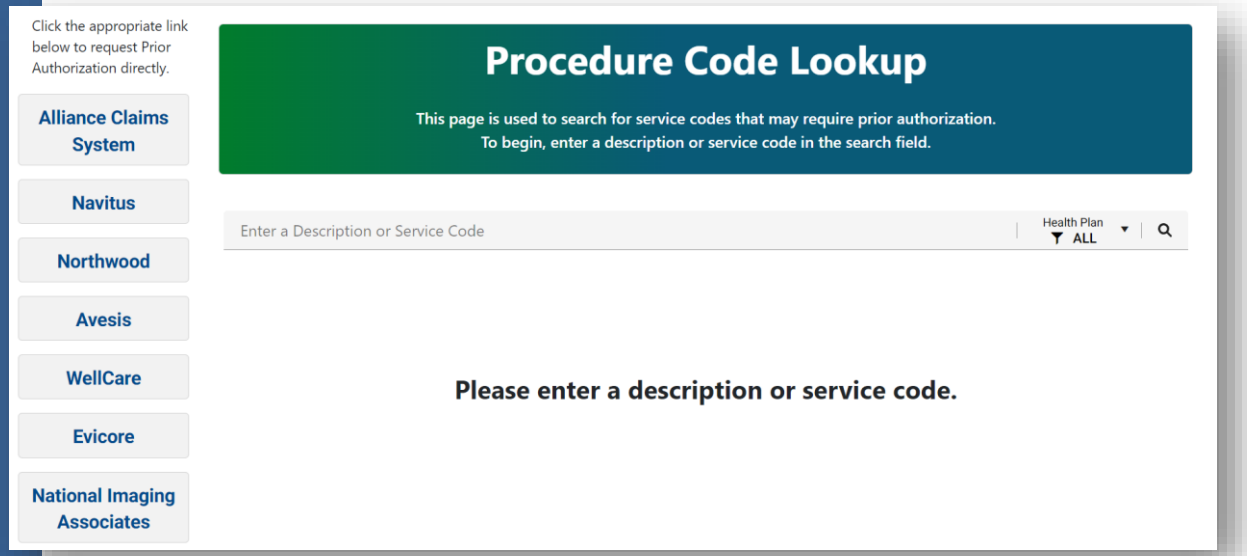
- Imaging (CT, MR, PET)
- Cardiac imaging (TTE, TEE, stress echo, stress MUGA, CCTA)
- Radiology
- Oncology
- Musculoskeletal and orthopedics
- Complex labs

WellCare Subcontractors

Subcontractor/Address Where Work is Performed	Description of Service Provided
EviCore Healthcare (CareCore LLC) 400 Buckwalter Place Boulevard Bluffton, SC 29910	Certain medical benefits management and utilization review services, including utilization review for Plan members who require complex labs/genetic testing
EVOLENT New Century Health (NCH) 675 Placentia Ave Ste 300 Brea, CA 92821	Provides benefit management across several key specialty healthcare areas, including radiation oncology, medical oncology, and cardiology
EVOLENT National Imaging Associates, Inc. (NIA) 8621 Robert Fulton Drive Columbia, MD 21042	Utilization management (prior authorization) of high-tech imaging (CT, MR, PET) or cardiac imaging (echocardiology, echo-stress, nuclear card, and nuclear stress) and orthopedic and spine surgeries

Alliance Procedure Code Look-up Tool

- For questions around a particular service or procedure code requiring authorization, reference our Procedure Code Look-up Tool at auth.alliancehealthplan.org
- Site indicates whether a service or procedure code requires authorization, and if so, directs you to the appropriate delegate portal
- Currently still in Beta testing, but will be live prior to Tailored Plan launch (July 1, 2024)



Tailored Plan Launch

Provider Preparations

Tailored Plan Claims Submission Process

- Trillium's claims submission protocol is built around the existing framework of Medicaid Direct to help simplify the claims submission process for our providers. If a provider bills Medicaid Direct today for physical health, they will submit that claim to our partner, Carolina Complete Health, for Trillium's Tailored Plan covered members. If the provider is currently billing Trillium for behavioral health, they will continue to submit claims to Trillium.

Claims Submission Options	Behavioral Health Claims	Physical Health Claims
Direct Data Entry	Trillium's Provider Direct Portal	Trillium's Tailored Plan Physical Health Portal
Clearinghouse/SFTP	Behavioral Health claims can be submitted using one of two clearinghouses: Change Healthcare The SSI Group	Physical Health claims can be submitted through Availity
Payor ID	Change Healthcare: 56089 The SSI Group: 43071	68069
Paper Claims	Trillium Health Resources PO Box 240909 Apple Valley, MN 55124	Carolina Complete Health Attn: Claims PO Box 8002 Farmington, MO 63640-8002
Claims Submission Errors	Behavioral Health claims submitted to Physical Health processing system: **EX1e – Deny: Please submit to Trillium for processing**	Physical Health claims submitted to Behavioral Health processing system: **1377 – Please submit to Carolina Complete Health for processing**

- If providers have any questions about claims submission, they can find our Claims Submission Protocol on our Provider More Information Page

Tailored Plan Inpatient Hospital Claims Submission

- DPU Providers will submit their Physical Health claims to Carolina Complete Health
- DPU Providers will submit their Behavioral Health claims to Trillium Health Resources

- For Tailored Plan services, Non-DPU providers submitting both Physical Health and Behavioral Health services on a single claim will submit their claims to Carolina Complete Health

Tailored Plan - Pharmacy, NEMT and Vision Claims

- Pharmacy Claims
  - Pharmacy claims for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy, point-of-sale claims may be submitted to PerformRx using the most current NCPDP HIPAA-approved format with Rx BIN Number 019595 and PCN – PRX10811.
- Non-Emergent Transportation to Medical Care
  - Claims for Non Emergency Medical Transportation (NEMT) and Non Emergent Ambulance Transportation (NEAT) services are processed through Trillium's contractor Modivcare
  - Modivcare responsibilities also include booking of reservations/rides
  - Providers can bill electronically through Modivcare's web portal, by an Automated Transportation Management System (ATMS), or by submitting paper claims.
- Vision
  - Claims for Vision services are processed through Envolve, a subsidiary of CCH
  - Claims may be submitted using HIPAA Standard Electronic Transaction set or via a secure web-based portal linked here.

Tailored Plan – Provider Portals & Training Resources

- To access the secure provider portals, please visit trillium's website at www.trilliumhealthresources.org and select "For Providers"
- The Behavioral Health I/DD Portal and Physical Health Portal are web-based systems available to Trillium partners upon completion of a Trading Partner Agreement (TPA)
  - Both portals provide access to behavioral health and physical health claim entry screens
- Billing through these portals is Direct Data Entry (DDE) where an electronic CMS1500 or UB04 form is accessed and billing information is entered and submitted for reimbursement
  - Trillium Provider Direct Webinars are available in the secure Behavioral Health IDD - Provider Direct Module to assist with completing CMS1500 and UB04 claim forms
  - Secure Physical Health Portal training resources may be found on Carolina Complete Health Network's Education and Training Page.
- For Additional Training information on How to Submit Claims to the Provider Portal
  - Behavioral Health I/DD Portal
    - Trainings available within the Behavioral Health I/DD Secure Provider Portal – Provider Direct
    - Trainings available on My Learning Campus from the Trillium's website
      - www.trilliumhealthresources.org
  - Physical Health Portal
    - Trainings available at Carolina Complete Health Network's Education and Training Page
      - https://network.carolinacompletehealth.com/resources/education-and-training.html

Tailored Plan – Additional Resources

- For additional details regarding Tailored Plan, please visit Trillium's website and view the Tailored Plan Provider Manual which is also available to providers via Trillium Provider Direct under the Training tab
- Providers can use Trillium's Provider Direct to validate other insurance by searching for the member and choosing "Third Party Insurance Plans". Providers can use the filters to also see Inactive third party insurance plans.
- Providers can also view information about Tailored Plan billing on our physical health partners website Tailored Plan Information for Providers
- Providers can call our Provider Support Services Line at 1-855-1539 or send claims questions via email to ClaimsSupport@trilliumnc.org
- For questions/concerns about the outcome of claims processing, providers can submit a Claims Inquiry Form and the claims will be reviewed by a Claims Processing Assistant. To request an adjustment to an already processed claim, providers can submit a Claims Request Form. Both of these forms are found on Trillium's website

Important Claims Processing Information

- Under Tailored Plan, Trillium Health Resources will adopt a timely filing period of 365 for Tailored Plan members and claims
- Medical claims will be processed within 18 calendar days of receipt and approved claims will be paid within 30 calendar days of receipt
- In the event claims are not paid within the prompt payment standards, interest and penalties will be paid to the provider at an interest rate of 18% along with a penalty of 1% per day beginning the first day following the date the payment should have been made
- If a behavioral health claim is routed to the physical health processing system, the provider will receive a denial code EX1e – Deny: Please submit to Trillium for processing
- If a physical health claim is routed to the behavioral health processing system, the provider will receive a denial code 1377 – Please submit to Carolina Complete Health for processing

Electronic Funds Transfer

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

- Providers may submit an **"Authorization Agreement for Direct Deposit"** form with official bank letter or voided check to receive EFT payment

- **Form is on our website at:**

https://www.trilliumhealthresources.org/sites/default/files/docs/Provider-documents/Claims/Trillium-EFT-Authorization.pdf

- Payments are processed weekly on Wednesdays

Electronic Funds Transfer

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

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

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).

1-833-552-3876
carolinacompletehealth.com

Vaya Tailored Plan Presentation

Wednesday, May 22, 2024

George Ingram, MBA
Vice President of Physical Health Network Operations and Value Based Contracting

VAYAHEALTH

Vaya's Website information

- The Vaya TP Provider Manual: providers.vayahealth.com/learning-lab/provider-manual/
- Information about claims submission: providers.vayahealth.com/authorization-billing/
- Providers must submit authorization requests using the Vaya Provider Portal: providers.vayahealth.com/provider-portal/
- Vaya members' eligibility can be confirmed by using NCTracks or the Vaya Provider Portal: providers.vayahealth.com/provider-portal/

Utilization Management

- Prior Authorization Process
  - Providers must use the Vaya Provider Portal to submit service authorization requests (SARs) and admission notifications: providers.vayahealth.com/provider-portal/.
  - Providers should contact their Systems Access Administrator for log-in information.
  - You can find out more information about our Prior Authorization Process here: providers.vayahealth.com/authorization-billing/authorization-information/prior-authorization/.
  - If the portal is unavailable, providers can fax SARs to the following numbers starting July 1, 2024:
    - 828-398-0571 Behavioral Health Outpatient/Other
    - 828-348-4141 Behavioral Health Inpatient
    - 828-707-9356 Physical Health Inpatient
    - 828-759-2161 Post-Acute Facility
    - 828-262-1859 Physical Health Outpatient
  - Please email UM@vayahealth.com if you have questions about a submission or contact our Provider Support Service Line at 1-866-990-9712.
    - Authorization guidelines: providers.vayahealth.com/authorization-billing/authorization-information/authorization-guidelines/.

Utilization Management Special Processes

Vaya partners with delegated vendors to process the following services:

- vayaprovidestg.wpengine.com/learning-lab/forms/pa-request-forms/
  - Navitus Health Solutions is Vaya's delegated Pharmacy Benefits Manager (PBM).
  - Submit requests for pharmacy through the Navitus provider portal, by calling 800-540-6083 or faxing 855-668-8552.
- avesis.com/
  - Avesis is Vaya's delegated vendor for prior authorization for vision services.
  - Submit requests for vision services on the myavesis.com/ website.
- tripcare.modivcare.com/login
  - Modivcare is Vaya's delegated vendor for NEMT.
  - Submit requests for NEMT through their facility portal: tripcare.modivcare.com/login.
- Radiology, Cardiology, Durable Medical Equipment (DME), Physical Therapy, Occupational Therapy, Speech Therapy, and musculoskeletal therapies
  - EviCore is Vaya's delegated vendor for the services listed above.
  - Submit requests for these services using the EviCore portal: evicore.com/provider.

Utilization Management

- How do I request a peer-to-peer consultation?
  - Include request in the SAR or when submitting additional information.
  - Contact Vaya UM, UM@vayahealth.com or Vaya's vendors directly to make this request.
  - Providers may also request a peer-to-peer at the time of the appeal following an adverse benefit decision.

- Please visit providers.vayahealth.com/ for additional trainings, forms, and other useful resources.

Claims

- Interest and penalties for claims– Interest and penalties are system generated. The system uses the received date (clean date) to flag when interest and penalties will apply. If the claim is not finalized or paid within 30 days from the receipt date of the claim, the claim system is configured to apply interest on the 31st day at 18% plus a 1% daily penalty.

- The EFT Authorization Agreement for Automatic Deposit and other important forms can be found here: providers.vayahealth.com/learning-lab/forms/.

- How will split claims be processed? Vaya will adjudicate both physical and behavior health claims in the Vaya claim system following the NCDHHS Billing guidance.

- Issue/concerns with clearinghouse set up of new payors – Please refer to Vaya's website for steps on how to register if billing via clearinghouse. If providers have any questions, please send inquiries to: EDI@Vayahealth.com.

Claims

- Appeals and grievances- Providers can submit a claim appeal or grievance request using the Vaya Provider Portal. If the provider does not have access to Vaya's Portal, the provider can submit the request using the request form from the external website and email to: claims.appeals@vayahealth.com.

- When can providers expect first payment after 7/1 go-live? First payment for clean claims received on July 1 will be targeted for release on July 12 and no later than 30 days from receipt of claim.

- When and how can providers submit claims to your plan? Vaya accepts claims billed through the provider's Clearinghouse (EDI) or through Vaya's Provider Portal. Paper claims are accepted when necessary.

- How can providers validate other insurance? The provider can review other insurance information (TPL) via Vaya's Provider Portal. Vaya is currently working to have the 270/271 process available to providers and will advise once in production.

Claims Inquires

- If a providers has questions about the claim disposition or payment the provider can:
  - Call Vaya Provider Support Service Line at 1-866-990-9712 to speak with a claim specialist about your claims.
  - Request a claim review by submitting an email to the claims email address: claims@vayahelath.com.

- If for any reason the claims team is not responsive:
  - Please escalate your concerns to one the following supervisors: Jody.Mewyes@vayahealth.com or Kimberly.Watson@vayahealth.com and include your Provider Rep.
  - If the supervisors are unable to assist, please forward any concerns to the interim VP of Claims Administration, Kisha Price@vayahealth.com.

Network Inquires

- If a provider has network related questions about policies or procedures or need general assistance the provider can:
  - Call Vaya Provider Support Service Line at 1-866-990-9712 to speak with a provider services representative or request the name and contact number of your Network Contracting Manager.
  - You can send general questions to : provider.info@vayahealth.com.
- If for any reason the network related question goes unanswered:
  - Please escalate your concerns to your Network Contracting Manager (there will be a list of the PH Network Contracting Managers that covers your county on the Vaya website in early June)
  - If your Network Contracting Manager is unable to assist you, please contact the Assistant Vice President of Network Operations, Kurt.Boldt@vayahealth.com.
  - If the Assistant Vice President of Network Operation is unable to assist, please forward any concerns to the Vice President of PH Network Operations, George.Ingram@vayahealth.com.

Partners Plan Slide

Beth Lackey, MBA, MSW, LCSW,
Senior Provider Network Director

Rhonda Colvard, Claims Director

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Improving Lives. Strengthening Communities.®

Partners Health Management Tailored Plan

Proudly Serving 15 Counties in North Carolina

Important Provider Resources for Partners Tailored Plan

Learn More About Partners Health Management

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

Member Eligibility – Partners Tailored Plan

- Possession of an ID card does not guarantee eligibility.
- Check member eligibility via the following ways:
  - Secure web portal: https://providers.partnersbhm.org/category/providerconnect/ **or**
  - Provider Line: 1-877-398-4145.

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Member ID Card

Partners Tailored Plan
901 S. New Hope Rd.
Gastonia, NC 28092
www.partnersbhm.org

Name:
Medicaid ID#:
Date Issued:

PCP Information:
PCP Name:
PCP Address:

PCP Phone:

RxBIN: 025052
RxPCN: MCAIDADV
RxGRP: RX22AC
Pharmacy: 1-866-453-7196

This card is not a guarantee of eligibility, enrollment or payment

Important Contact Information/Información importante de contacto

Member and Recipient Services/Servicio para miembros y destinatarios (7 a.m.-6 p.m. EST)....1-888-235-4673, TTY: 711
Partners MemberCONNECT....www.partnersbhm.org
24-Hour Nurse Line/Línea de enfermería las 24 horas....1-888-369-2452
24-Hour Behavioral Health Crisis Line/Linea de crisis de salud conductuallas 24 horas....1-833-353-2093

If you suspect a doctor, clinic, home health service or any other kind of medical provider is commiting Medicaid fraud, report it. **Call 919-881-2320.**

For a medical emergency, go to the nearest emergency room or call 911.

Prescriber Services (7 a.m.-6 p.m. EST)....1-866-453-7196
Provider Services (7 a.m.-6 p.m. EST)....1-877-398-4145

Partners

Validation of Other Insurance: How can a Provider Validate?

- Providers can verify insurance coverage in Alpha+ and Availity.
- The Partners Provider Operations Manual is an additional resource for this information as well. https://providers.partnersbhm.org/wp-content/uploads/partners-provider-operations-manual.pdf.

Payment Expectations and Interest/Penalties

- Providers can expect the first checkwrite by July 9, 2024.
- This checkwrite will include dates of service July 1, 2024, forward.
- Partners will include interest and penalties as part of claims processing according to the contractual agreement.
- The payment will be reflected on the Remittance Advice/Explanation of Payment using Claim Adjustment Reason Code (CARC) 225 – Penalty or Interest Payment by Payer.

Issues/concerns with Clearinghouse Setup of New Payers

- Partners Health Management has partnered with **Availity®,** an independent company, to operate and service our electronic data interchange (EDI) and portal transactions.
- Physical Health Claims can be submitted through **Availity** beginning with Dates of Service July 1, 2024.
- For Questions regarding set up or additional information please refer to Partners' Provider Knowledge Base, https://providers.partnersbhm.org/alphamcs-zixmail-sign/
- Providers with questions regarding Availity can contact the Availity Help Desk by calling 1.800.AVAILITY (282.4548). The help desk is available Monday – Friday, 8 a.m. – 7 p.m. Eastern Standard Time.

Existing Availity Trading Partners

If you are currently sending EDI Transactions for other Health Plans via a secure FTP account with Availity, follow your standard business process to work with Partners Health Management. If you need assistance, please refer to the resources in this EDI Quick Start Guide for Availity.

New to Availity?

If you do not already have an Availity Account, please register with the links below:

1. Go to www.availity.com
2. Click **Register** and complete the process. For registration guidance or tips, we recommend you refer to the following resource prior to starting your registration application:
   - Register and Get Started with Availity Portal microsite
   - EDI Quick Start Guide for Availity
   - Submitting a Claim on Availity Essentials

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Claims Submission Process

Method	Physical Health Provider Claims Submission	Behavioral Health Provider Claims Submission
Provider information	Physical Health providers who have been submitting their PH claims to NC Medicaid Direct will submit to CCH/Availity.	Behavioral Health Providers should continue to submit your claims to Partners/Alpha+.
Electronic	ProviderConnect, https://id.partnersbhm.org/ then choose **Physical** Health Claims to submit **Physical** Health Claims, this brings you to Availity.	ProviderConnect, https://id.partnersbhm.org/ then choose **Behavioral** Health Claims to submit **Behavioral** Health Claims, this brings you to Alpha+.
Paper	Carolina Complete Health Attn: Claims PO Box 8002 Farmington, MO 63640-8002	901 S. New Hope Road, Gastonia, NC 28054
Clearinghouse/ SFTP	Provider's Clearinghouse connection to Availity for Claims processing.	Behavioral Health Claims will be submitted to Alpha+.
Payor ID	68069	13141
Misrouted Claims	**If a Physical Health Provider accidentally sends their claims to Partners' BH system (Alpha+) they will receive this code:** **Partners Code: Exps – DENY**: Please submit to Availity/CCH for physical health processing.	**If a Behavioral Health Provider accidentally sends their claims to CCH/Availity Physical Health claims system, they will receive this code:** **CCH Code: Exps – DENY**: Please submit to Alpha+/Partners for Behavioral Health processing.

Claims Submission Tips

- **Inpatient Claims Submission Tips**
- **Physical Health Claims**

- Physical Health claims uses the primary diagnosis on inpatient claims to determine the claim is physical health vs. behavioral health and processes the claim accordingly.
- If an inpatient claim has a primary diagnosis for physical health but the member also received behavioral health services during the stay, the claim will be processed using the appropriate DRG for the full stay.

- **Behavioral Health Claims**

- Behavioral Health claims uses the primary diagnosis on inpatient claims to determine if the claim is behavioral health vs. physical health. If an inpatient claim has a behavioral health primary diagnosis, the claim will be processed at the per diem rate for the room and board revenue code.

- **Outpatient Claims Submiss Tips**

- Child presents for an EPSDT Well Child Check and the PCP also manages ADHD diagnoses
- Adult member sees their PCP for ADHD management and has a cough. The PCP runs a COVID test during the visit.
- Today, these claim scenarios are billed to Medicaid Direct, and **July 1, 2024, they will be processed by Carolina Complete Health for Partners' Tailored Plan providers.**

Partners Plan Slide

Electronic Funds Transfer (EFT) Process/Sign-Up

Behavioral Health Claims	Physical Health Claims
Partners EFT process: Please contact Partners Vendor Group for EFT and banking information set up: vendorsetup@partnersbhm.org	**Payspan: A Faster, Easier Way to Get Paid (PDF)** **To contact Payspan:** Call 1-877-331-7154, Option 1 or email providersupport@payspanhealth.com Monday thru Friday 8:00 am to 8:00 pm est. Providers must register with each line of business (LOB): there will be registration codes specific for Partners and Trillium. **Payspan offers monthly training sessions for providers covering the following topics:** How to Register with Payspan (New User) How to Add Additional Registration Codes to an Existing Payspan Account How to navigate through the Payspan web portal How to view a payment How to find a remit How to change bank account information How to add new users Registration information can be found through CCH: https://network.carolinacompletehealth.com/training

Claims Appeals/Reconsideration – How to submit?

- Partners works diligently with Providers to resolve their issues; however, there are times when a Provider is dissatisfied with a Claims Processing outcome.
- If dissatisfied with the Claims Processing outcome, Providers can complete the **Reconsideration Form** listed below.
- Claims Analysts will review claims submitted on the form for accuracy and provide the research outcome.
- If dissatisfied with the outcome of the Claims Reconsideration, Providers have the option to **File a Grievance/Complaint**.

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

Ways Providers Can File a Grievance

- Intake Points: Any Partners staff may receive provider grievances via the following methods:
  - Telephone – Call 1-888-235-HOPE (4673)
  - Mail – Partners Health Management, c/o Grievance/Complaint, 901 South New Hope Road, Gastonia, NC 28054
  - Email – Grievances@partnersbhm.org
  - Online –Feedback form https://www.partnersbhm.org/feedback/
  - In person – Every employee at Partners is able to receive your grievance or complaint.
  - ProviderCONNECT (Provider Portal)

Prior Authorization Process

- 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
  Inpatient Requests 336-527-3208
  Outpatient Requests 704-884-2613
  Transplant Requests 866-753-5659
  Pharmacy PADP Requests 704-772-4300

- How can providers determine which services require prior authorization for a health plan?
- Partners Benefit Grids and Service Pre-Authorization Lookup Tool can be located at: https://providers.partnersbhm.org/benefits/
- *Physical Health services will be available for viewing on the Benefit Grids and PA Lookup Tool prior to 7/1/2024.*

Who to Contact at Partners?

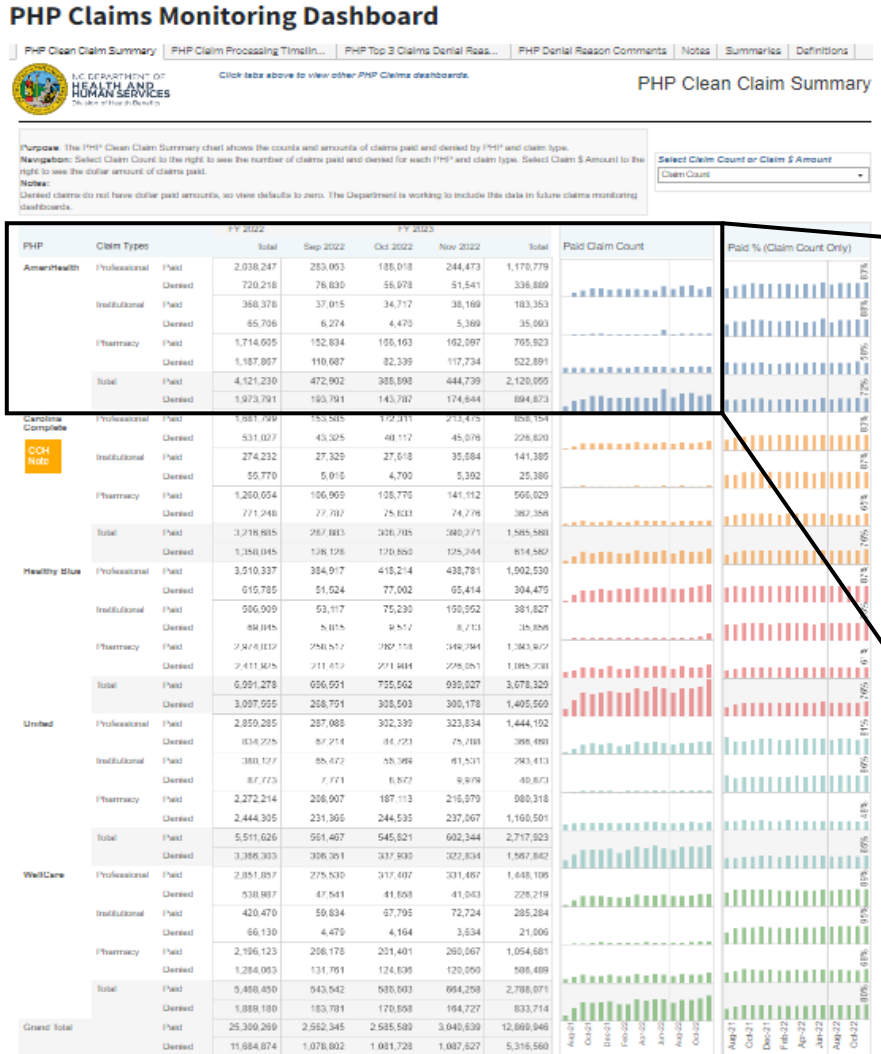
Claims Department
Call 704-842-6486 or email claimsdepartment@partnersbhm.org

Provider Services Line
1-877-398-4145. If you are a provider in the Partners network, or are interested in joining our network, please call our dedicated Provider Line.

PHP Claims Monitoring Dashboard

Metrics: Claims Metric Dashboard

Providers can see real-time Clean Claim Submission Summary, Claim Processing Timelines, Top Claim Denial Reasons, etc. on the PHP Claims Monitoring Dashboard. Tailored Plans will be added to this Claims Monitoring Dashboard post-launch.



PHP	Claim Types		FY 2022 Total	FY 2023 Sep 2022	FY 2023 Oct 2022	FY 2023 Nov 2022	FY 2023 Total
AmeriHealth	Professional	Paid	2,038,247	283,053	188,018	244,473	1,170,779
		Denied	720,218	76,830	56,978	51,541	336,889
	Institutional	Paid	368,378	37,015	34,717	38,169	183,353
		Denied	65,706	6,274	4,470	5,369	35,093
	Pharmacy	Paid	1,714,605	152,834	166,163	162,097	765,923
		Denied	1,187,867	110,687	82,339	117,734	522,891
	Total	Paid	4,121,230	472,902	388,898	444,739	2,120,055
		Denied	1,973,791	193,791	143,787	174,644	894,873

QUESTIONS


Thank You...

At-A-Glance Contact Information

Topic		Provider Portal Link	Phone #
NC Tracks		nctracks.nc.gov/	800-688-6696
Tailored Plan (TP)	Alliance	https://alliancehealth.okta.com/	855-759-9700
	Partners	id.partnersbhm.org/login/?realm=/alpha#/	877-398-4145
	Trillium	https://www.ncinno.org/	855-250-1539
	Vaya	https://providers.vayahealth.com/provider-portal/	866-990-9712
Standard Plan (SP)	Amerihealth	amerihealthcaritasnc.com/	888-738-0004
	Carolina Complete	provider.carolinacompletehealth.com	833-552-3876
	Healthy Blue	provider.healthybluenc.com	844-594-5072
	United Healthcare	uhcprovider.com/en/claims-payments-billing.html	800-638-3302
	WellCare	wellcare.com/en/NorthCarolina/Providers/Medicaid	866-799-5318

Provider Playbook & Fact Sheets

Key Fact Sheets Available Include:

- Managed Care Claims Submission: What Providers Need to Know – Part 1
- Tailored Plan Managed Care Claims and Prior Authorizations Submission:
  Frequently Asked Questions – Part 2
- NC Medicaid Managed Care Provider Playbook Site
- What Providers Need to Know Before Tailored Plan Launch
- Tailored Plan Provider Contracting Deadlines Questions and Answers
- Tailored Plan Auto-Enrollment & Opt-In Scenarios
- Medicaid and NC Health Choice Provider and Health Plan Lookup Tool
- NC Medicaid Managed Care: Provider Training
- Provider Payment and Reimbursement
- Prompt Payment

Additional Key Resources

Day 1 Resources:

- Day One Provider Quick Reference Guide

Tailored Plan Provider Portal & Provider Service Line

- **Contact Information for all health plans is available at:**

https://medicaid.ncdhhs.gov/health-plan-contacts-and-resources

NC Medicaid Managed Care Provider Ombudsman

- Phone: 866-304-7062
- Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov