

## **Prior Authorizations & Referrals:**

**Q: How will prior authorizations be submitted for speech therapy? Will it be on the provider portal or a third party?**

*A: Via provider portal – prior auth check tool, by calling 1-833-552-3876 faxing 919-670-4948 or mailing <https://network.carolinacompletehealth.com/resources/prior-authorization.html>*

**Q: How long will CCH honor the current Medicaid authorization on file after July 1?**

*A: DHHS has us honoring for 90 days at Medicaid Transformation launch or the life of the authorization*

**Q: Will we need a referral number (not an authorization number)?**

*A: Per the Carolina Complete Health provider manual it states; Referral-approval required prior to a beneficiary seeing a specific in-network specialty provider for an office visit.*

## **Q: TRANSITION OF CARE Questions:**

- For current patients, how will existing prior authorizations be treated? Will they be recognized and accepted for a period of time after July 1st?
- When can we start requesting authorization for patients who need it after July 1st?
- How far in advance can we request PA for ongoing services?
- Is there a 90 day transition of care window for any patient moving to/from a PHP – initially and thereafter?
- When will the CCH Portal open for training and use?

*DHHS requires Carolina Complete Health to be recognized/accepted up to 90 days after July 1st or the life of the authorization.*

**Q: Will prior authorizations be necessary for pediatric speech therapy, occupational therapy and physical therapy? If so, how often?**

*A: Prior authorizations may be needed for select pediatric PT/ST/OT services; you can check which services will need a PA by using our PA tool.*

*<https://network.carolinacompletehealth.com/resources/prior-authorization.html>*

## **Q: PRIOR AUTHORIZATION OF CARE:**

- Can you please provide a copy of the Prior Authorization Request Form for speech therapy services for children? (You had shared with me that ST doesn't require PA but I just want to ensure that this is the case. If you don't have PA for speech therapy then the following PA questions aren't relevant)
- What specific clinical information or documents will be needed to make a decision on the request?
- Who will review and make determinations regarding Prior Authorization requests for speech therapy services for children?
- How long does it take with Carolina Complete Health to respond to requests for Prior Authorization of services for speech therapy services for children?
- What is the typical length of authorization for speech therapy services for children?
- When reauthorization of services is needed, what is the process and when should the process begin in advance of the current auth end date?
- If there really is no PA (all other PHPs using the same PA form) then how will NIA

*A: Prior authorizations may be needed for select pediatric PT/ST/OT services; you can check which services will need a PA by using our PA tool. Carolina Complete Health's Utilization Management department handles all Prior Authorization requests. For standard service authorizations, the decision*

*will be made within two*

*(2) business days from receipt of necessary medical information and notification within one (1) business day after the decision is made (not to exceed a total fourteen (14) calendar days from receipt of the request unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required.*

**Q: Is prior authorization required for PT, OT, and ST? If so, where do we submit? Is it electronic or paper/fax?**

*A: Yes it is required and you may do that through the provider portal, via fax, mail or call*

**Q: Is there a copy of the prior authorization form available for us to review? Can you provide a list of clinical information and/ or documents that will be required for prior authorization for speech and occupational therapy?**

*A: There is no hard copy PA form posted for use as of right now. The prior authorization tool will tell you what supporting documents/clinical information is needed when submitting a PA for select services.*

**Q: Where will the prior auth for radiology be handled?**

*A: NIA will handle PA for radiology/imaging. More info can be found on our website:*

*<https://network.carolinacompletehealth.com/resources/prior-authorization.html>*

**Q: What modality do you require prior auth for and what time frame do we have to obtain one after the services are rendered?**

*A: Authorization must be obtained prior to the delivery of certain elective and scheduled services. Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified. You can determine if a PA is needed through our PA tool.*

**Q: Are referrals required from pcp for specialist visits?**

*A: Yes. Referrals can be submitted by PCPs via phone, fax or web portal;*

*Referrals will cover the beneficiary's office visits to the specialist indicated on the referral for a span of six (6) months from the date of submission*

**Q: Will secondary claims require prior authorization, current Medicaid does not currently require this?**

*A: We cannot be more restrictive than current Medicaid Policy*

**Q: How do providers request prior authorization for advanced imaging studies?**

*A: CCH Uses NIA for Imaging/Radiology Pas find more info on our website*

*<https://network.carolinacompletehealth.com/resources/prior-authorization.html> You may obtain PA for NIA through RADMD website*

**Q: For patients with active Prior Authorizations on July 1, will the current PA be honored? If so, for how long before we need to get a PA via Carolina Complete?**

*A: Yes, the current PA will be honored for 90 days after July 1st or the length of the PA. PA are required to be submitted 5 days prior to the service being rendered or when it is deemed necessary.*

**Q: Are referrals/authorizations required for specialist office visits?**

*A: Yes, referrals are required by PCPs for members to see specialists.*

**Q: What documentation is required to submit with prior authorizations for speech, occupational and physical therapy?**

**A:** The PA tool will inform providers of any supporting documentation needed. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required

**Q: How do we access the prior authorization process?**

**A:** Via provider portal, by calling 1-833-552-3876 faxing 919-670-4948 or mailing <https://network.carolinacompletehealth.com/resources/prior-authorization.html>

**Q: Do PT OT and Speech Evaluations require authorizations or just treatments?**

**A:** Select PT/ST/OT services may require PA.

**Q: Will prior auth or referrals be needed for a routine office visit for a specialty visit?**

**A:** Yes, a referral is needed for routine visits at a specialty office. Referrals will cover the beneficiary’s office visits to the specialist indicated on the referral for a span of six (6) months from the date of submission

**Q: What documentation needs to be sent in with the prior authorization for speech therapy?**

**A:** The PA tool will inform providers of any supporting documentation needed. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required.

**Q: How many days do we have to obtain a prior auth after services are performed?**

Authorization must be obtained prior to the delivery of certain elective and scheduled services. Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified.

**Q: Would we submit information for prior approval for outpatient PT/OT/SP with Choice, or with the new therapy reviewers at Carolina Complete?**

**A:** Any documentation needed for a PA will need to be sent to Carolina Complete Health to review.

**Q: Are you requiring authorizations for CT, MR, Ultrasound and PET procedures? Are in patient going to be required now, current Medicaid does not require this for inpatient?**

**A:** Carolina Complete Health utilizes National Imaging Associates (NIA) to provide prior authorization and utilization management services which includes CT, MRI and PET procedures. Emergency department, observation and inpatient imaging procedures do not require authorization.

**Q: Is it safe to say that all services that Medicaid currently does or does not require authorization - will be required with CCH?**

**A:** No, we may differ from Medicaid in what services require PA. Please utilize our PA tool.

**Q: What services require prior authorization? What services are considered non urgent and what services are considered emergent and what are your time frames for turn around on those?**

**A:** The below list is not all inclusive. Please visit Carolina Complete Health’s web site at <https://www.network.carolinacompletehealth.com/> and utilize the Prior Authorization Tool to determine if prior authorization is required. This tool will be available closer to 7/1. You can also reference our Provider Manual.

Services that require Prior Authorizations include: 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.

*Additional services that require PA include, **but are not limited to:***

*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*

*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*

*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*

*Authorization must be obtained prior to the delivery of certain elective and scheduled services. Prior authorization should be requested at least five (5) calendar days before the scheduled service delivery date or as soon as need for service is identified. Carolina Complete Health decisions are made as expeditiously as the beneficiary’s health condition requires. For standard service authorizations, the decision will be made within two (2) business days from receipt of necessary medical information and notification within one (1) business day after the decision is made (not to exceed a total fourteen (14) calendar days from receipt of the request unless an extension is requested) For urgent/expedited requests, a decision and notification is made within twenty-four (24) hours of the receipt of the request. Approval or denial of non-emergency services, when determined as such by emergency department staff, shall be provided within thirty (30) minutes of request. Involuntary detentions ninety-six (96) hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect.*

**Q: Will CCH process the SAIOP/SACOT authorizations or the current LME/NCO?**

*A: SAIOP and SACOT are covered under the Tailored Plan launching July 2022. Until then, they will continue to be covered by the LME-MCO*

**Q: Does ABA/RB-BHT require preauthorization and if so what is the procedure and documentation required?**

*A: Applied Behavioral Analysis is considered a Researched-Based Behavioral Health Treatment/Intervention. Research-Based Behavioral Health Treatment services do require prior authorizations. See section 5.2 of Policy 8F for Prior Approval Requirements and additional information in the following link: [https://files.nc.gov/ncdma/documents/files/8F\\_1.pdf](https://files.nc.gov/ncdma/documents/files/8F_1.pdf)*

**Q: We are a pediatric office pcp. Are referrals required to see specialist? If not do patients self-refer?**

A: A referral is required by a PCP in order for a member to see a specialist.

**Q: Where do we go for outpatient high end imaging such as MRI, CT, US. Can we continue to use Evicore? Where do we go to find out if an imaging even requires an authorization?**

A: NIA is the vendor we use for imaging Pas - you can view this via our website and prior auth tool

**Q: Will retro PAs be allowed for beneficiaries that change PHPs? Will Carolina Complete honor an existing Prior Auth approved by another PHP?**

A: Carolina Complete Health will honor PA for 90 days after 07/01 or for the current length of the PA.

**Q: Can we continue using CoverMyMeds for medication prior authorizations or would we go through your portal?**

A: PA for medications will be handled by Envolve Pharmacy Solutions. Envolve Pharmacy Solutions  
Contacts - Prior Authorization

Fax: 1-866-399-0929

Web: <https://pharmacy.envolvehealth.com/>

Phone: 1-844-330-7852 (Monday - Friday 8:00 a.m.-8 p.m. CST)

**Q: Currently we go through Choice PA to obtain authorized visits for OT/PT/SLP. Are we going to go through Carolina Complete to obtain these?**

A: Yes, you would go through Carolina Complete Health.

**Q: Will current auths for ST, OT and PT therapy be grandfathered in if we already have an auth on the go live date?**

A: It could be honored up to the 90 day mark during the transition period or through the length of that prior authorization depending on the authorization.

**Q: Where will prior auths be completed for therapy services?**

A: Prior authorizations will be completed through the Carolina Complete Health provider portal, by phone 1-833-552-3876, or fax 1-833-238-768. See the following link for information on how to obtain a prior authorization:

[https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH\\_N\\_Current\\_PDF-NC-PriorAuthGuide.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH_N_Current_PDF-NC-PriorAuthGuide.pdf)

**Q: All current auths for ST, OT and PT go thru Choice PA currently, How will you handle auths?**

A: Prior authorizations will be completed through the Carolina Complete Health provider portal. There is a prior authorization tool there to be used for completing prior authorizations. See the following link for information on how to obtain a prior authorization:

[https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH\\_N\\_Current\\_PDF-NC-PriorAuthGuide.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH_N_Current_PDF-NC-PriorAuthGuide.pdf)

**Q: Do we have to coordinate speech therapy services with school based speech therapy services?**

A: Yes, providers are obligated to coordinate and cooperate with school based programs as appropriate

**Q: Currently, Medicaid approves speech therapy for a 26 week period. Will CCH provide this same length of an authorization for therapy services?**

*A: The following are guidelines set by the state for beneficiaries under 21 Years of Age: Speech-Language and Audiology Therapy services are based on upon the severity. 1. Mild Impairment range of visits: 6–26  
2. Moderate Impairment range of visits: Up to 46  
3. Severe Impairment range of visits: Up to 52. Please see the following link for more information clinical policies: [https://files.nc.gov/ncdma/documents/files/10A\\_10.pdf](https://files.nc.gov/ncdma/documents/files/10A_10.pdf)*

**Q: Can we use Cover My Meds for Medication PA's?**

*A: PA for medications will be handled by Envolve Pharmacy Solutions. Envolve Pharmacy Solutions Contacts - Prior Authorization  
Fax: 1-866-399-0929  
Web: <https://pharmacy.envolvehealth.com/>  
Phone: 1-844-330-7852 (Monday - Friday 8:00 a.m.-8 p.m. CST)*

**Q: If a specialist sees a patient and orders a test, like an MRI or CT, or refers a patient to another specialist, can they initiate the referral and they do now with NC MCD since they have all of the information to be able to do so instead of making the PCP do this?**

*A: The specialty physician may order diagnostic tests without PCP involvement by following Carolina Complete Health referral guidelines.*

**Q: If a client switches from one PHP to Carolina Complete but there is an auth approved AFTER 7/1/21, will Carolina Complete honor this auth from the other PHP?**

*A: Carolina Complete Health will honor PA for 90 days after 07/01 or for the current length of the PA.*

**Q: Are prior authorizations submitted through the portal or through a 3rd party?**

*A: Prior authorizations can be submitted via fax, phone, or the provider portal*

**Q: For Speech therapy, will the clinical review part of the prior auth request be conducted by an actual speech therapist and will Medicaid policies 10A and 10B be used?**

*A: CCH has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. The determination is based on medical information provided by the beneficiary, the beneficiary's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the beneficiary. All such determinations must be made by qualified and trained Health Care Providers. Providers may obtain the criteria used to make a specific determination by contacting Medical Management at 1-833-552-3876. CCH Clinical policies will be similar or less stringent than current policies from Medicaid consistent with Medicaid policies 10A and 10B <https://network.carolinacompletehealth.com/resources/clinical-policies.html>  
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/specialized-therapies-clinical-coverage-policies>*

**Q: When a patient is admitted to the hospital from the ER will we still need to obtain an authorization for spine surgery or will we be covered by the hospital admission authorization?**

*A: Please see the Prior Auth tool located on our website <https://network.carolinacompletehealth.com>*

**Q: Do we need prior Auth. for Echo's and ultrasounds?**

A: Yes, The best place to find detail information is on the Provider Website  
<https://network.carolinacompletehealth.com> Please see the prior Authorization Guide

**Q: The prior auth guide stated both: Normal newborn does not require authorization under elective admissions but Notification of Urgent/Emergent Admissions it does state Newborn deliveries must be notified and must include birth outcomes--what are the birth outcomes that needs to be sent?**

A: *The prior auth guide states both: Normal newborn does not require authorization under elective admissions but under Notification of Urgent/Emergent Admissions it does state Newborn deliveries must be notified and must include birth outcomes--what are the birth outcomes that needs to be sent? Newborn nursery for the 2 days mom is approved s/p vaginal delivery or 4 days s/p C-section does not require PA. However we do need birth notification to include:*

1. Birth weight
  2. Apgar at 1 and 5 minutes
  3. Gestational Age
  4. Planned delivery (Y/N) ie: scheduled C section
  5. Discharge Plan
    - a. Healthy, home with mom
    - b. Healthy, held for adoption or foster care
    - c. Sick/Hospitalized (Special Care Nursery or NICU would require auth)
    - d. Stillborn/Expired
  6. Mom's name should be included, dads also if available.
- Contact your Provider Engagement Coordinator for additional information.

**Q: Do you allow retro authorizations?**

A: *Process is still being finalized. Check back with PE Coordinator*

**Q: They answered about ST PT OT PAs for THERAPY, but not for EVALUATION. Will you please ask this question?**

A: Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a Carolina Complete Health nurse for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required. Carolina Complete Health clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Beneficiary's name, Beneficiary ID number

- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)



- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

**Q: Will secondary claims require authorization?**

*A: Yes, any service that requires a PA will still be required even if Medicaid is the secondary payor.*

**Q: If a family wants to change ST/PT/OT providers and that provider has an existing auth in place, will they have to Discharge the auth before the new provider’s auth be approved?”**

*A: We aren’t able to have to authorizations for the same service in the system with overlapping dates, so this would be our process:*

1. *Provider 1 has an approved auth.*
2. *Provider 2 has a request for the same services.*
3. *Staff would confirm with provider 1 that they are no longer provider services.*
4. *Staff would obtain the last date of service with provider 1 and end the authorization for the day after the last date of service.*
5. *Provider 2’s request would be reviewed at that time, and approved assuming criteria is met.*

**Eligibility & Enrollment:**

**Q: Will we be able to use NC Tracks for eligibility?**

*A: Yes, you can use NCTracks or provider portal to check member eligibility*

**Q: Will a practice be listed on a member’s card, if so, when a member wants to change providers, how long till they receive a new card? And can they be seen by a new provider if information is in NC Tracks but doesn't have the new card?**

*A: The PCP's name, office address and phone number will be listed on the member's card. If the member changes their PCP, it will take 7 -10 business days for them to receive a new card via mail. The member can be seen by any provider in network as long as they present their ID card; the provider needs to be in-network.*

**Q: Will the plan show in in real time eligibility?**

*A: Yes*

**Q: Will it be listed on the card if the patient has Medicaid or NCHC?**

*A: The ID card will reflect the member's Medicaid ID only.*

**Q: Will Medicaid members get to keep their NC Medicaid ID number? Is the only things that change is which PHP they enroll?**

*A: NC Medicaid responded that Medicaid IDs will not change. You will still be able to use NCTracks to verify member eligibility after go-live and see which PHP they are enrolled with.*



**Q: When will ID cards be distributed to patients for use?**

*A: Members will receive their ID cards in their welcome packet when they enroll with Carolina Complete Health.*

**Q: When will we know which kids are on which plan? (Which MCO they chose or assigned to) Will we know prior to July 1?**

*A: You will be able to see your patients enrolled on the provider portal prior to 07/01 but it will NOT show members that have chosen a different PHP.*

**Q: So if consumers were previously getting therapy and/or med management will it not go against the new bucket of visit starting July 1**

*A: Members unmanaged visits will reset on July 01, 2021.*

**Q: If an authorization is given for an elective surgery, how long is the authorization good for?**

*A: 30 days is the usual standard*

**Q: We are a DME company and the supplies we ship are Enteal Feeding with a lot of Prior authorization from NC Tracks. Will you honor those?**

*A: Prior authorizations submitted before go live on 7/1/21 will be honored for 90 days or life of the authorization request.*

**Q: What is the length of time we can request on an authorization request (i.e., 30-days, 90-days, or to the end of the fiscal year?). Is this service specific?**

*A: You can reach out via Provider Services at 1-833-552-3876 and request assistance.*

**Q: For OTP authorizations, what will be required in terms of documentation, how many units can be requested per auth period?**

*A: Prior authorizations submitted before go live on 7/1/21 will be honored for 90 days or life of the authorization request.*

**Q: When requesting additional visits, can you request through the end of the benefit yr or is there a time limit? Ex. Request for 6 months**

*A: The duration of a prior authorization can vary by specialty and service type. Please visit Carolina Complete Health's web site at <https://www.carolinacompletehealth.com/> and utilize the Prior Authorization Tool to determine if a prior authorization is required and the details*

**Q: Patients that are ages 0-3 receiving Occupational/Physical/Speech Therapy that are not currently through the CDSA: will they be required to have an IFSP and go through the CDSA to receive therapy?**

*A: live answered--Yes, CCH has billing specialists that will work with various type of payment/billing models to ensure accurate and timely payment for providers of all types*

**Q: What type of professional (nurse, doctor, and therapist) will review and make determinations regarding Prior Authorization requests for speech therapy services for children?**

*A: live answered--All will be reviewed by NIA peer consultants. You can access the clinical guideline at <http://www1.radmd.com/solutions/physical-medicine.aspx> page 54 Provider Manual*

**Q: If a Prior Auth for Occupational Therapy is put in by a specific group's provider; can any OT within the same practice see the beneficiary under that Prior Auth?**

*A: live answered- if you are referring to a provider located in several locations they can use either location. For additional information contact NIA at <http://www1.radmd.com/solutions/physical-medicine.aspx>*

**Q: If a physician signs a Physician Order for Speech Therapy services, does that physician need to be in-network with Carolina Complete Health in order for Prior Authorization to be approved? (I'm specifically talking about the Physician Order, NOT a referral.)**

*A: Reference: NC Medicaid and Health Choice Independent Practitioners Clinical Coverage Policy No: 10B Amended Date: January 1, 2021*

*"Medicaid and NCHC shall cover medically necessary outpatient specialized therapies when the service is ordered by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Certified Nurse Midwife (CNM), Physician Assistant (PA), or Nurse Practitioner (NP) and when prior authorization is received."*

*"Treatment services must adhere to the following requirements: a. A verbal or a written order must be obtained for services prior to the start of services. All verbal orders must contain the date and signature of the person receiving the order, must be recorded in the beneficiary's record and must be countersigned by the physician within 60 calendar days. All verbal orders are valid up to six months from the documented date of receipt. All written orders are valid up to six months from the date of the physician's signature. Backdating is not allowed."*

### **Member Benefits & Coverage:**

**Q: Will CBRS therapy be covered?**

*A: Cognitive Behavioral Rehabilitative Services is a therapy covered by the CDSA in the Infant Toddler program. Therapists who provide this therapy are credentialed by the CDSA and do not have individual NPIs. Claims for these services are billed under the group NPI.*

**Q: Are speech therapy and occupational therapy considered a specialty service or behavioral health?**

*A: Speech therapy and occupational therapy are considered specialty services.*

**Q: Is there a skilled nursing benefit included and is skilled community Medicaid included? How about Long-term care plan?**

*A: Nursing Home Services must be ordered by a physician and authorized by Carolina Complete Health. Includes short-term or rehabilitation stays and long-term care for up to 90 days in a row. After the 90th day, your nursing services will be covered by NC Medicaid Direct and not Carolina Complete Health. Home Health Services including time-limited skilled nursing services must be medically necessary and arranged by Carolina Complete Health.*

**Q: CCH documents indicate that duplicative services will not be covered. Can you please define 'duplicative services'?**

*A: Duplicate Services- Code auditing will evaluate prospective claims to determine if there is a previously paid claim for the same enrollee and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same enrollee on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example a nurse practitioner and physician bill for office visits for the same enrollee on the same day.*

**Q: CCH documents indicate the need for SLPs to provide an IEP for a child who is receiving services – what if a child doesn't have an IEP?**

**Q: Will CBRS therapy be covered?**

*A: Cognitive Behavioral Rehabilitative Services is a therapy covered by the CDSA in the Infant Toddler program. Therapists who provide this therapy are credentialed by the CDSA and do not have individual NPIs. Claims for these services are billed under the group NPI.*

**Q: Is there a visit limit for home health services. Typically Medicaid only allows 75 skilled nursing visit per year.**

*A: Limited to 1 visit per day of service. Limited to 75 visits per fiscal year.*

**Q: Are your coverage policies in line with DHB's current clinical coverage policies or were significant changes made?**

*A: We cannot be more restrictive than current Medicaid Policy*

**Q: Will vaccinations be VFC or private**

*A: Providers who administer vaccines to Medicaid enrolled children under 21 will participate in the Vaccines for Children (VFC) program. The VFC program is a federally funded program that provides vaccines at no cost to children, under 19 years of age, who might not otherwise be vaccinated because of an inability to pay. Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program, however, Carolina Complete Health will reimburse the provider for both the vaccine and administration for privately purchased vaccines administered to North Carolina Health Choice members.*

**Q: just to clarify, the members with Medicaid will get VFC, but HealthChoice will get private, correct?**

*A: Yes*

**Q: Will teletherapy be covered for ST/OT/PT?**

*A: Carolina Complete Health will cover Telemedicine services when medically necessary under the following conditions: The beneficiary will be present at the time of consultation. The medical examination of the beneficiary must be under the control of the consulting provider 116 of 119 2020-11-09. The distant site of the service(s) must be of a sufficient distance from the originating site to provide service(s) to a beneficiary who does not have readily available access to such specialty services. The consultation must take place by*

**Q: Will virtual visits be covered?**

*A: Carolina Complete Health will cover Telemedicine services when medically necessary under the following conditions: The beneficiary will be present at the time of consultation. The medical examination of the beneficiary must be under the control of the consulting provider 116 of 119 2020-11-09. The distant site of the service(s) must be of a sufficient distance from the originating site to provide service(s) to a beneficiary who does not have readily available access to such specialty services.*

**Q: Are SAIOP and SACOT covered under standard or tailored plans? Is OTP covered under standard or tailored plan?**

*A: SAIOP and SACOT are covered under the Tailored Plan launching July 2022. Until then, they will continue to be covered by the LME-MCO*

**Q: After the unmanaged outpatient visits are exhausted, what is the limit that can be requested? What is the procedure to do this? What documents are needed to accompany the request?**

*A: Prior approval is required for outpatient services that will exceed the unmanaged limit and assures medical necessity. To request a prior authorization you can go through the provider portal, call 1-833-552-3876, or fax 1-833-238-7689. Please see Section 5.2 of Policy 8C for Outpatient Behavioral Health Services Prior Authorization Requirements: [https://files.nc.gov/ncdma/documents/files/8C\\_6.pdf](https://files.nc.gov/ncdma/documents/files/8C_6.pdf) Please see the following link for prior authorization information: [https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN\\_Current\\_PDF-NC-PriorAuthGuide.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN_Current_PDF-NC-PriorAuthGuide.pdf)*

**Q: Is there a max number of hours for psychological testing? If so, should more time be needed, will they be authorized?**

*A: There is a limit of eight units (hours) of Psychological Testing allowed per date of service. Prior approval is required for services that will exceed the unmanaged limit. Prior approval assures medical necessity and authorizes the number of hours necessary to complete the psychological testing.*

**Q: How many unmanaged sessions do adult and children receive for outpatient?**

*A: Consistent with current Medicaid Policy*

**Q: Will treatment orders/authorizations be required from MD's for associate-level clinicians to provide outpatient mental health services?**

*A: Yes, a written service order by a Physician, Licensed Psychologist (doctorate level), Nurse Practitioner or physician assistant is required for Associate Level Professionals prior to or on the first date of treatment (excluding the initial assessment). Services provided by the licensed professionals, other than the Associate Level Professionals, do not require a separate written service order.*

**Q: Will you be following Medicaid Policy 8C for unmanaged visit limits (8 for adults and 16 for children)? Or will you have a different limit?**

*A: Consistent with current Medicaid Policy*

**Q: Will Carolina Complete Health require co-pays for beneficiaries to pay for behavioral health services?**

*A: Co-pays will remain consistent with what is in place today for Medicaid beneficiaries. For more information on copays, you can visit the Member Handbook.*

**Q: it was said that OTP is considered a standard plan as long as there is NO enhanced service with it... please elaborate on what this means?**

*A: Outpatient behavioral health services provided by direct-enrolled providers are part of the Standard Plan. If at any point a services is rendered that would be covered exclusively by the Tailored Plan (or the LME-MCO prior to TP launch), then the patient would need to transition back to Medicaid Direct and the LME-MCO system until July 2022 when the Tailored Plans launch, then they would transition to a TP. To compare the BH plan benefits between Standard and Tailored plans, please reference slide 30 on the January 7 DHHS and AHEC Back Porch Chat. Certain BH services have been identified as being covered exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)*

**Q: Do you anticipate any future LTSS services that might be covered under this part of Medicaid?**

*A: That would depend on what the state decides to cover as CCH mirrors all of the policies/coverage of the state and current Medicaid program*

**Q: When we are verifying a member's insurance source will we still continue to use NCTracks or should we use your portal?**

*A: While you can use our portal or call to verify, best practice is to use NCTracks as the source of truth*

**Q: Will your clinical policy be the same as Medicaid policy?**

*A: We will not have policies that will be any more stringent than NC Medicaid and our clinical policies will be posted sometime in April on our website*

**Q: Will PCS Services be authorized by a nurse assessment? Is there a process to request that assessment?**

*A: Not for CCH. PCS services are authorized if the need is identified by a person-centered comprehensive and functional assessment completed by the LTSS Care Manager. If beneficiary disenrolls from CCH back to FFS Medicaid the LTSS disenrollment form would be sent to the CIAE to trigger the need for the nurse assessment.*

**Q: Similar question to the Care Management question, will CCH utilize HIV case management providers or do their own case management?**

*A: CCH will use their own case management for LTSS, but will also collaborate with community agencies to ensure that the member's needs are met.*

**Q: How are you handling rates for IDD providers? Is there a general document you can share with a basic set of rates from which negotiations can begin?**

*A: CCH will use their own case management for LTSS, but will also collaborate with community agencies to ensure that the member's needs are met.*

**Q: Some Health Choice patients have \$ 5.00 copays. Will that continue?**

*A: Per the Member Handbook: Copays if your child has NC Health Choice: If you do not pay an annual enrollment fee for your child or children: Office visit \$0, Generic prescription brand prescription when no generic is available over-the-counter medications \$1 for each prescription, Brand prescription when generic is available \$3 for each prescription, Non-emergency department visits \$10 per visit. If you do pay an annual enrollment fee for your child or children: Office visits/outpatient hospital \$5, Generic prescription brand prescription when no generic is available over-the-counter medications \$1 for each prescription, Brand prescription when generic is available \$10 for each prescription, Non-emergency department visits \$25 per visit.*

**Q: Clarification, If my practice does not contract with Carolina Complete, but on 07/01 our long time auto assigned patient was assigned placed with Carolina Complete and we are also not listed as the PCP. You are stating we will can still see that patient on 07/01 and paid at 90% vs. 100% until fixed.**

*A: Yes, you can see them on 7/1/2021. If you are NOT contracted with CCHN - Out of Network Providers are reimbursed 90% of Medicaid Fee Schedule rate. Out of Network Indian Health Providers are reimbursed 100% of Medicaid Fee Schedule rate. Family planning and Emergency services are reimbursed at 100% of Medicaid Fee Schedule regardless of in or out of network status.*

**Q: How will we update the Patient Roster with the plan if a Patient is not ours, they are another providers?**

A: You can reach out via Provider Services at 1-833-552-3876 and request assistance.

**Q: Medicaid eligibility requires an ID number to be entered on NC Tracks therefore, what number format is NC Tracks capable of recognizing besides what NC Tracks already recognizes?**

A: *Members Medicaid numbers will not change.*

**Q: Will a practice be listed on a member's card, if so, when a member wants to change providers, how long till they receive a new card? And can they be seen by a new provider if information is in NC Tracks but doesn't have the new card?**

A: The PCP's name, office address and phone number will be listed on the member's card. If the member changes their PCP, it will take 7 -10 business days for them to receive a new card via mail. The member can be seen by any provider in network as long as they present their ID card; the provider needs to be in-network.

**Q: If Medicaid is the 2nd payor, does the outpatient visit limit still apply?**

A: *The Legislative Visit Limit of 30 visits (22 mandatory visits and 8 optional visits) is counted by specific CPT codes. The codes attached....*

*The only exceptions to the Annual Visit Limitation are:*

*1) Beneficiaries not subject to this Limitation include under age 21; those with Medicare or enrolled in CAP; and those receiving prenatal and pregnancy-related services.*

*2) A provider may request an exception when additional, medically necessary, care is anticipated for a specific condition. Requests should be made prior to rendering services*

### **Claims & Billing:**

**Q: How do I sign up for EFT? What is the payer ID for electronic claims?**

A: *CCH's Payor ID is 68069 and you can sign up for payspan for EFT. Additional info is on CCHN Website <https://network.carolinacompletehealth.com/resources/claims-and-billing.html>*

**Q: What is the payor ID?**

A: *Carolina Complete Health's Payer ID is 68069*

**Q: Will claims be submitted through provider portal or a 3rd party? Is there a fee if it is through a third party?**

A: *Through the provider portal, clearinghouse or via paper and there is no fee.*

**Q: Do you have a Check write schedule? We currently get paid weekly on the same day each week. Will this be the same or different?**

A: *Weekly every Tuesday & Friday starting July 20, 2021*

**Q: How do we set up EFT and with whom?**

A: *Via PaySpan which will be available 30 days prior to go-live and is on our website:*

*[https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN\\_Current\\_PDF-PaySpan.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN_Current_PDF-PaySpan.pdf)*

**Q: Are you ready for providers to have EDI agreement set up for claims with the clearing house we use?**

*A: You will be able to register via PaySpan 30 days prior to go-live*

**Q: Which clearinghouse are you partnering with?**

*A: We are working with Ability Availity and Change Healthcare (formerly Emdeon)*

**Q: What is the average turnaround time for payment of claims?**

*A: A clean medical claim at the lesser of thirty (30) calendar days of receipt of the clean claim or the first scheduled provider reimbursement cycle following adjudication.*

**Q: We currently have 12 months to submit a claim, what is the time filing limit going to be as of July 1. What about for claim adjustments?**

*A: timely filing for first-claims is 180 days from DOS the billing manual is also posted on our website for additional information. Providers must submit claim adjustments in writing within one hundred eighty (180) calendar days from the date of the EOP or ERA. Claims will not be adjusted three hundred sixty five (365) days or more past the Date of Service billed.*

**Q: If we submit claims via a clearing house do we still need to set up EFT with PaySpan?**

*A: You do not need to enroll with Payspan. Payspan is a free service that Carolina Complete Health is offering for providers.*

**Q: Will we be able to do test claims?**

*A: Yes, please reach out to [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com)*

**Q: Are there any limitations to the clearinghouse we can use?**

*A: Yes, currently we work with Change Healthcare (formerly Emdeon), Ability & Availity*

**Q: Will billing be the same as it is now with Medicaid. Will we still use the same Modifiers as we do now? Will dental varnishing be covered with the same codes as Medicaid?**

*A: Carolina Complete Health will use HCPCS Code Modifiers and will have same billing guidelines as current Medicaid. Dental Varnish will be covered just as it has been. SERVICE LIMITED TO BENEFICIARIES UNDER 37 MONTHS OLD. LIMITED TO 6 PER LIFETIME.*

**Q: Will the Medicaid specific modifiers, such as EP and TJ for physicals still be used?**

*A: The EP modifier will be used when services provided as part of the Medicaid early periodic screening diagnosis and treatment (EPSDT) program.*

**Q: Will you be using the same modifier requirements as standard Medicaid?**

*A: Carolina Complete Health will use HCPCS modifier codes.*

**Q: Are Taxonomy's required on the claim form?**

*A: Taxonomy codes are not required but we strongly encourage including taxonomy codes to avoid any delays in processing.*

**Q: If you are billing through a clearinghouse, do you need to sign up with Payspan for EFT?**

*A: You do not need to enroll with Payspan. Payspan is a free service that Carolina Complete Health is offering for providers.*



**Q: Is CCH fee schedule available? Is it same as Medicaid?**

A: Carolina Complete Health will pay 100% of Medicaid Fee Schedule for in-network providers; 100% of Payer Fee Schedule for Behavioral Health; 60% of Medicaid Fee Schedule for Labs.

**Q: We are on the coast. If members from regions 3, 4, 5 visit the coast and need our services as a pediatric practice, must we be providers for Carolina Complete Health to see them?**

A: You may see the member. If you are in network you will be reimbursed at 100% vs 90% if you are out of network.

**Q: How do I sign up for EFT? What is the payer ID for electronic claims?**

A: Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation. Payspan will be available 30 days before go live.

Link to Billing Manual

<https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf>

PaySpan

[https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH\\_N\\_Current\\_PDF-PaySpan.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH_N_Current_PDF-PaySpan.pdf)

**Q: Will we be able to submit claims electronically through our Clearinghouse?**

A: Electronic Clearinghouses

Three clearinghouses for Electronic Data Interchange (EDI) submission. Availity, Change HealthCare (Formerly Emdeon), Ability. (As long as the provider's clearinghouse, has a connection to one of the previously mentioned clearinghouses, then the claim can be passed on to CCH). Carolina Complete Health Medical Payer ID 68069

**Q: Can we use our own clearing house, such as Availity, to file claims? Or are we only allowed to file electronic claims through PaySpan and your portal?**

A: Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation. Payspan will be available 30 days before go live.

Providers can submit claims electronically either:

The Secure Provider Portal located on:

<https://network.carolinacompletehealth.com/>

Electronic Clearinghouses

Three clearinghouses for Electronic Data Interchange (EDI) submission.

Carolina Complete Health Medical Payer ID 68069

Availity, Change HealthCare (Formerly Emdeon), Ability

As long as the providers clearinghouse has a connection to one of these three clearinghouses, the claim can be passed onto Carolina Complete Health.

For questions or more information on electronic filing please contact: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT 1-800-225-2573, ext. 25525 or by e-mail at EDIBA@centene.com

Providers can also mail paper-claims

Mail:

Carolina Complete Health

Attn: Claims  
PO Box 8040  
Farmington MO 63640-8040

**Q: What is the reimbursement time for an EDI claim? Currently with our LME-MCO is one week turn around?**

A: 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. CCH will be running check writes each Tuesday and Friday beginning on 7/20/2021.

**Q: Where can I obtain the “Fee Schedule” for OTP for CPT 90791, 90837, 90847, etc.?**

A: Feel free to contact Network Relations by emailing [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876 for the BH Payer Fee Schedule

**Q: Will you be paying at Medicaid current fee schedule?**

A: CCH reimburses at 100% of the Medicaid Fee Schedule and the Payor Fee Schedule for Behavioral Health. The Carolina Complete Health Payor fee schedule is based on State-wide pricing data provided by DHHS. For the CCH BH Payer Fee Schedule, feel free to contact Network Relations by emailing [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876

**Q: How will the billing process be with someone receiving suboxone for opioid treatment with a physician in office, but also attending SAIOP with a clinician in office? Will it all be billed to LME MCO? Or will med management be billed to you guys & SAIOP to LME MCO?**

A: If a patient needs to receive SAIOP services, then they should remain in Medicaid Direct to continue receiving all of their services as they do today, through NC Medicaid and the LME-MCO. When the Tailored Plans launch, Tailored Plans will be the only Medicaid plan to offer SAIOP services and therefore a member will receive all of their benefits (physical & behavioral health) by the Tailored Plan and all services would be billed to the Tailored Plan. To compare the BH plan benefits between Standard and Tailored plans, please reference slide 30 on the January 7 DHHS and AHEC Back Porch Chat. Certain BH services have been identified as being covered exclusively by BH I/DD Tailored Plans (or LME-MCOs Prior to Launch)

**Q: Is the BH fee schedule available?**

A: For the CCH BH Payer Fee Schedule, feel free to contact Network Relations by emailing [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876

**Q: Will the inpatient claims be billed to the LME or be billed to Carolina Complete?**

A: If the member has Carolina Complete Health as their Medicaid insurance, providers should bill CCH. If the member stays in Medicaid Direct because they are Tailored Plan eligible, then the provider would bill the LME

**Q: What are the timely filing limit on clean and denied and corrected claims?**

A: The timely filing deadline for initial claims is 180 calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility. Providers must submit claim adjustments in writing within one hundred eighty (180) calendar days from the date of the EOP or ERA. The Plan processes adjustments only on

*previously adjudicated claims. Adjusted clean claims will be paid or denied within thirty (30) calendar days of receipt of the complete requested adjustment documentation. Appeals of adverse actions must be filed in writing within thirty (30) calendar days of the date of the EOP or ERA resulting from the adverse action. The Plan will acknowledge receipt of an appeal within five (5) calendar days of its receipt.*

**Q: Where would we sign up for EFT and 837 to be sent electronically?**

*A: Carolina Complete Health offers Payspan, a free solution that helps Providers transition into electronic payments and automatic reconciliation. Payspan will be available 30 days before go live.*

*Providers can submit claims electronically either:*

*The Secure Provider Portal located on:*

*<https://network.carolinacompletehealth.com/>*

*Electronic Clearinghouse*

*Three clearinghouses for Electronic Data Interchange (EDI) submission.*

*Carolina Complete Health Medical Payer ID 68069*

*Availity, Change HealthCare (Formerly Emdeon), Ability*

*As long as the providers clearinghouse has a connection to one of these three clearinghouses, the claim can be passed onto Carolina Complete Health.*

*For questions or more information on electronic filing please contact: CAROLINA COMPLETE HEALTH C/O CENTENE EDI DEPARTMENT 1-800-225-2573, ext. 25525 Or by e-mail at EDIBA@centene.com Paper Claim Submission All paper claims and encounters should be submitted to: Carolina Complete Health Attn: Claims PO Box 8040 Farmington MO 63640-8040*

**Q: What is the timeframe for notification/authorization on inpatient behavioral claims?**

*A: All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit. Notification for all Urgent/Emergent Admissions: Within one (1) business day following date of Admission.*

**Q: What is the timely filing limit for submission and corrected claims?**

*A: The timely filing deadline for initial claims is 180 calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility. Providers must submit claim adjustments in writing within one hundred eighty (180) calendar days from the date of the EOP or ERA. The Plan processes adjustments only on previously adjudicated claims. Adjusted clean claims will be paid or denied within thirty (30) calendar days of receipt of the complete requested adjustment documentation. Appeals of adverse actions must be filed in writing within thirty (30) calendar days of the date of the EOP or ERA resulting from the adverse action. The Plan will acknowledge receipt of an appeal within five (5) calendar days of its receipt.*

**Q: Will any claims be billed to the LME?**

*A: Claims should be billed to the LME for any Medicaid members not enrolled with a health plan who remain in Medicaid Direct.*

**Q: How long before claims are paid after submission?**

*A: 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. CCH will be running check writes each Tuesday and Friday beginning on 7/20/2021.*

**Q: Can we file electronic claims via NC-Tracks?**

*A: For members who have Carolina Complete Health as their Medicaid insurance, you will submit claims to CCH in one of the three ways:*

*The Secure Provider Portal located on:*

*<https://network.carolinacompletehealth.com/>*

*Electronic Clearinghouse*

*Three clearinghouses for Electronic Data Interchange (EDI) submission. Availity, Change HealthCare (Formerly Emdeon), Ability. (As long as the provider's clearinghouse, has a connection to one of the previously mentioned clearinghouses, then the claim can be passed on to CCH). Carolina Complete Health Medical Payer ID 68069*

*Mail*

*Carolina Complete Health*

*Attn: Claims*

*PO Box 8040*

*Farmington MO 63640-8040*

**Q: What is the payment frequency for claims?**

*A: Tuesdays and Fridays beginning July 20*

**Q: I'm sorry if I missed this, but will you honor 90837 claims for outpatient mental health?**

*A: Yes outpatient mental health services will be part of the Standard Plans. If you have questions on specific CPT codes you are welcome to reach out to Provider Support [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or 1-833-552-3876*

**Q: For the corrected claims is the 180 days from the date of the EOB from the initial claim?**

*A: Providers must submit claim adjustments within 180 days from the date of the EOP or ERA. Claims will not be adjusted past 365 days or more from the Date of Service billed.*

**Q: When patient admits to a SNF and not known if going to be at facility for 90 days or more, are the claims filed for the first 90 days to CCH and if stays longer than the 90 days then at that point traditional Medicaid is billed?**

*A: If residence in the facility is expected to extend beyond the end date shown on the initial Level 1 screen, further approval and evaluation must be obtained before the authorized period ends. If the resident is Medicaid eligible and is approved for continued stay through the updated level process, Medicaid's fiscal agent must be contacted for payment to continue*

**Q: If an out of network provider (PCP) sees a patient will Carolina Complete pay for the visit and will this have a reduction in payment? If so what percent will you pay?**

*A: Out of Network Providers are reimbursed 90% of Medicaid Fee Schedule rate.*

**Q: Will CCH require NDC's on Outpatient hospital UB-04 claims?**

A: this might help:

<https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf>

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units

**Q: So just to clarify you guys pay the provider depending where the member resides and not where the provider is located?**

A: The provider is paid based on their contract as to whether they are in or out of network...

**Q: Currently there is a form we complete to update COB information, and send it to NC Tracks. If we need to update COB information on behalf of the patient, how will we now do that?**

A: Coordination of Benefits- page 14 Billing Manual

<https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf>

CCH, like all Medicaid programs, is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CCH enrollees. If an enrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for an Enrollee with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If an Enrollee has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal.

**Q: Will Carolina Complete Health mirror NC Medicaid modifiers?**

A: Carolina Complete Health will use HCSPC modifiers

**Q: Does the provider portal allow submission of batch files in 837p format rather than data entry of individual claims for high volume providers.**

A: Yes, you may submit batch claims and 837 files via the portal. Refer to slide 87 of orientation deck for step by step instructions

**Q: Would claims require modifiers like GT or 95 for telehealth, and also would we still use pay codes 90837, 90832, 90791?**

A: Telehealth claims require modifier GT to the CPT or HCPCS code.

**Q: Is there a list for reimbursement amounts for service codes?**

A: please email [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or call 1-833-552-3876 for reimbursement amounts

**Q: If Medicaid is secondary to BCBS commercial, how will you handle claims denied by BCBS?**

A: If an enrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed.

**Q: A typical patient we see on a daily basis is a child with accommodative esotropia where eye turn (strabismus) is corrected by full time wear of glasses. Such a visit incorporates both medical and refractive diagnosis as well as multiple exam elements. We bill the codes below for these visits and are paid by NC Medicaid. Please give me a detailed run of how this visit be handled by your plan?**

**99213 H50.43**

**92060 H50.43**

**92015 H52.03**

A: CCHN will still cover the array of services as Medicaid. Link to Medicaid policy <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/ophthalmological-services-clinical-coverage-policies>

**Q: Will Medicare crossover claims to Carolina Complete?**

A: *If an enrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. We will not have a crossover claim functionality*

**Q: Are payments bulk like Medicaid or individual?**

A: *Payments will be in bulk as it was with Medicaid.*

**Q: Do we bill Well child visits same as regular Medicaid? With all the modifiers?**

A: *Billing will be consistent with Medicaid policies today*  
[https://files.nc.gov/ncdma/documents/Providers/Programs\\_Services/EPSTD/Program-Guide-2020.pdf](https://files.nc.gov/ncdma/documents/Providers/Programs_Services/EPSTD/Program-Guide-2020.pdf)

**Q: Starting 7-20? So you are holding claims from 7-1 to 7-19?**

A: Per state requirement, if the claim is clean, the health plan must pay or deny within 30 days of receipt. CCH will be running check runs each Tuesday and Friday beginning on July 20, 2021.  
<https://files.nc.gov/ncdma/NCMT-Provider-FactSheet-Playbook-Provider-Payment-20200331.pdf>  
<https://files.nc.gov/ncdma/documents/Providers/playbook/NCMT-Provider-FactSheet-Claims---PA-Routing-Part-2-FAQ-20210405-DRAFT.pdf>

**Q: Will you follow Medicaid billing guidelines currently in place?**

A: *Yes, all PHPs will follow the current billing guidelines.*  
<file:///C:/Users/cn264533/Desktop/Carolina%20Complete%20Health-%202020%20Provider%20Billing%20Manual.pdf>

**Q: How will out of network claims be processed for a PCP visit? If patient card does not reflect correct PCP at time of service?**

A: *Live answered---It will be processed the same way either electronically or on paper. The rate it is paid will depend on if the provider is in or out of network. Please refer to billing manual for additional details and contact info.*

**Q: Why is CCH's timely filing shorter than current NC Medicaid (it is one year)?**

A: *Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one*

*hundred eighty days after the date of the member's discharge from the facility; CCH accommodates exceptions to the one hundred eighty day timely requirement pursuant to N.C. Gen. Stat. §58-3-225(f) and CCH will not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by CCH and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.*

**Q: I apologize for asking for clarification, but if we are in-network and the patient has a different clinic as their PCP, will we still be able to file the claim without getting any special authorization and get paid at 100% of our fee schedule?**

*A: Yes, you can see them on 7/1/2021. If you are NOT contracted with CCHN - Out of Network Providers are reimbursed 90% of Medicaid Fee Schedule rate. Out of Network Indian Health Providers are reimbursed 100% of Medicaid Fee Schedule rate. Family planning and Emergency services are reimbursed at 100% of Medicaid Fee Schedule regardless of in or out of network status.*

**Q: If Medicaid is the 2nd payor, does the outpatient visit limit still apply?**

A: Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility; CCH accommodates exceptions to the one hundred eighty day timely requirement pursuant to N.C. Gen. Stat. §58-3-225(f) and CCH will not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by CCH and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

**Q: Can a provider group bill for OT/PT/SLP on the same day from same company for the same beneficiary?**

A: Reference: NC Medicaid and Health Choice Outpatient Specialized Therapies Clinical Coverage Policy No: 10A Amended Date: January 12, 2020 20A10 45

*"All treatment services must be provided on an individualized basis except speech-language services, which consist of group speech therapy with a maximum total number (that is, both non-eligible and Medicaid-eligible beneficiaries) of four children per group. Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid or NCHC beneficiary as a single visit, shall not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment."*

**Q: Can you copy a claim over for the next month when only the date of service needs to be changed?**

A: The claim would need to be re-keyed with the correct DOS and DX.



**Q: With Medicaid patient's eligibility change from month to month, is it the same with CCH?**

A: To verify beneficiary eligibility, please use one of the following methods:

1. Log on to the secure provider portal at <https://provider.carolinacompletehealth.com>. Using our secure provider website, you can check beneficiary eligibility. You can search by date of service and either of the following: beneficiary name and date of birth.
2. Call our automated beneficiary eligibility IVR system @ Call 1-833-552-3876
3. Call Carolina Complete Health Provider Services. If you cannot confirm a beneficiary's eligibility using the methods above, call our toll-free number at 1-833-552- 3876. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will need the beneficiary name to verify eligibility.

Provider Manual (PDF): Provider Manual, Page 13, since eligibility changes can occur throughout the month and the beneficiary list does not prove eligibility for benefits or guarantee coverage, please use one of the above methods to verify beneficiary eligibility on date of service.

**Q: Do claims need to have the referring MD included to process?**

A: Billing Manual (PDF): Billing Manual, page 42- Appendix IV: Claims Form Instructions. Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Fields 17, 17a, and 17b are all conditional fields for the referring provider's information.

**Q: Do you still have to contract with the LME's to provide outpatient office visits or just NC Tracks**

A: They would only need to be contracted with the LMEs if they are going to be providing services to members covered only by the LME.

**Q: I am very worried about the paucity of independent BH providers in the southeastern NC region who see children - especially for psych testing. My practice cannot field all the referrals - we are one only of two groups right now in this region. What are the plans for ongoing network development for certain niches like that particular need?**

A: Yes – agree this is more of a network/contracting topic however, at a high level, part of CCH's community strategy absolutely includes expanding our provider networks, especially in the areas where we identify the biggest gaps for the community.

**General Health Plan Questions:**

**Q: How do we find out who our Provider Engagement person is?**

A: feel free to email [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) and we can introduce you! You can also see our team members here: <https://network.carolinacompletehealth.com/about-us/provider-engagement-team.html>

**Q: Are you covering region 6 now?**

A: Currently no, CCH is only available to members who reside in regions 3, 4 or 5.

**Q: When will the provider portal be live?**

A: The CCH portal is open for training and use as of April 1<sup>st</sup> (90 days prior to go-live).

**Q: Will multiple members of staff be able to register on the portal from a clinic?**

A: Yes

**Q: What is the phone number and email for network relations?**

A: 1-833-552-3876 [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com)

**Q: Is PaySpan on your website or its own?**

A: Yes, there's a link on the website for PaySpan

[https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN\\_Current\\_PDF-PaySpan.pdf](https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN_Current_PDF-PaySpan.pdf)

**Q: When (prior to go live and then reoccurring after) will you all provide the practices with patient attribution lists for your plan? How will those be shared- through the portal?**

A: You will have access to your patient panels via provider portal and/or NCTracks

**Q: Is there anywhere to see what your cards look like?**

A: Yes, you can view a sample card in the provider manual, the QRG or the orientation slide deck

<https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCHN-Current-PDF-QRG-Form.pdf>

**Q: Did I understand correctly that during the first 90 days after Go Live that members can change plans?**

A: Yes, they can change for any reason during the first 90 days and thereafter for specific circumstances only

**Q: Will the members ID card show whether the member has Medicaid versus Health Choice?**

A: Yes

**Q: What if the practice discharges a patient from the practice. Will that be able to happen since the plan only allows 1 practice switch in the year.**

A: Yes, care mgmt can help with this

**Q: What is the phone # for Provider Services and please repeat the phone # for Provider Relations.**

A: 1-833-552-3876 [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com)

**Q: If currently enrolled with Carolina Complete what is the best way to update providers who are no longer with us and new providers added?**

A: Please reach out to the provider relations team at [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) and they can assist you with updating your roster

**Q: Are they able to change plans multiple times or just once?**

A: They can change as many times as they want first 90 days but after that only for certain reasons

**Q: What is the reimbursement timeline? How long will it take for providers to be reimbursed for clean claims?**

A: A clean medical claim at the lesser of thirty (30) calendar days of receipt of the clean claim Or the first scheduled provider reimbursement cycle following adjudication.

**Q: is speech considered a specialist?**

A: Yes, speech therapy is considered a specialist.

**Q: Will the plan be keeping PCP's up-to-date about in-network specialists?**

A: Yes

**Q: Is notification required for newborn births and is clinical information required to be sent?**

A: A hospital must notify Carolina Complete Health within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

**Q: Are Hospitals required to submit notification of a newborn birth? This is currently not required under Medicaid/NC Tracks**

A: A hospital must notify Carolina Complete Health within one business day of delivery with complete information regarding the delivery status and condition of the newborn.

**Q: I may have missed this but we can sign up for provider updates newsletter?**

A: yes, please reach out to [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) to be added to the email distribution list.

**Q: How will providers know if the patient has Medicaid or Healthchoice? This is of importance when administering vaccines. Healthchoice now would be administered private vaccine, Medicaid now gets VFC.**

A: Check Eligibility via NCTracks or provider portal

**Q: What if the practice discharges a patient from the practice. Will that be able to happen since the plan only allows 1 practice switch in the year.**

A: Yes, Care Management can help with this

**Q: Is sterilization form required and if so how do we find out if sterilization has been approved?**

A: The PHP shall require providers to follow Clinical Coverage Policy 1E-3 which includes the completion and submission to the PHP of the Sterilization Consent Form outlined in– Attachment B ([https://files.nc.gov/ncdma/documents/files/1E-3\\_3.pdf](https://files.nc.gov/ncdma/documents/files/1E-3_3.pdf)) and maintain completed consent forms consistent with the PHP contract and federal statute.

**Q: Will reimbursements be the same as Medicaid is now or does it vary per PHP?**

A: It will vary per PHP. Carolina Complete Health will pay 100% of Medicaid Fee Schedule for in-network providers; 100% of Payor Fee Schedule for Behavioral Health; 60% of Medicaid Fee Schedule for Labs.

**Q: Will CCH provide interpretation services for non-English speaking members?**

A: YES

**Q: Is OTP classified as non-urgent or emergent?**

A: Outpatient behavioral health services provided by direct-enrolled providers are typically not classified as emergent. For a list of BH service covered for CCH members, visit the Member Handbook and also view the January 7 Back porch Chat from NC DHHS AND NC AHEC

**Q: Can you verify eligibility on NC tracks?**

A: Providers will continue to be able to verify member eligibility for members on NCTracks after go live

**Q: Will we need to submit the treatment plan or Person Centered Plan and the assessment with submitted requests?**

A: We will follow Medicaid's Policy 8C on when you need a comprehensive assessment or person centered plan. See link: [https://files.nc.gov/ncdma/documents/files/8C\\_6.pdf](https://files.nc.gov/ncdma/documents/files/8C_6.pdf)

**Q: Do unmanaged visits run calendar or fiscal yr?**

A: Fiscal Year, consistent with current policy

**Q: I currently reside in Cumberland County. Should I participate in your network?**

A: Yes. Cumberland County is part of Region 5, which is a region that CCH will serve. This means that members who reside in Cumberland County will be able to select CCH if they are enrolling in a Standard Plan. CCH Provider Network is open to any willing provider, regardless of the Provider's location in the state. You can visit our website and click Join the Network to inquire, or call Network Relations at 1-833-552-3876 or email us at [NetworkRelations@CCH-Network.com](mailto:NetworkRelations@CCH-Network.com)

**Q: Where and when can I locate the Q&A transcripts from today BH meet and greet?**

A: NC AHEC Website

**Q: Who is the best contact for provider enrollment?**

A: Feel free to contact Network Relations by emailing [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876

**Q: Do I need to be connected to the NC Health Connex and/or be ASAM trained in order to participate/bill/provide services to clients?**

A: Providers need to be credentialed with NC Medicaid on NCTracks, and then they can contract with Carolina Complete Health. For questions about joining our network, feel free to contact Network Relations by emailing [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876

**Q: Does Carolina Complete Health allow associate licensed clinicians to provide services for behavioral health? (LCMHCA, LCSWA, LPA)**

A: CCH will not be more restrictive than current NC Medicaid policies around associate licensed clinicians

**Q: How do I add other clinicians to my group practice?**

A: To add clinicians to your roster, contact Network Relations at [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or calling 1-833-552-3876

**Q: How are the recipients and families being educated on these plans?**

A: Through the enrollment broker, Maximus. Information about Medicaid Transformation was mailed to beneficiaries starting March 1

**Q: BCBA's do not enroll in NC Tracks. Does NC Complete Health credential the BCBA or just the LP they work under?**

A: Carolina Complete Health only contracts licensed practitioners for the group. BCBA's would not be able to contract since they do not enroll through NC Tracks. BCBA are considered Certified Qualified professionals unless they hold a professional license that is recognized in North Carolina and listed in CCP 8F: [https://files.nc.gov/ncdma/documents/files/8F\\_1.pdf](https://files.nc.gov/ncdma/documents/files/8F_1.pdf)

**Q: Where will the slides and answers to the questions be located?**

A: NC AHEC recordings <https://www.ncahec.net/medicaid-managed-care/>

**Q: I am late to this webinar but does Carolina Complete Health cover Peer Support Services?**

A: Yes. Peer Support Services are a covered service under the Standard Plan

**Q: How can we add a new service such as Peer Support?**

*A: Provider Support networkrelations@cch-network.com or 1-833-552-3876 CCH is an open network to any willing provider. Peer Support service are a covered service under the standard plan. For questions related to contracting or network status, reach out to*

**Q: Will Carolina Complete Health be conducting routine monitoring/audits?**

*A: Per the Provider Handbook: Carolina Complete Health will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to beneficiaries, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. Carolina Complete Health will provide written notice prior to conducting a medical record review. Carolina Complete Health will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. At that time, you may receive a call from a medical record review representative if any 103 of 119 2020-11-09 of your patients are selected in the HEDIS samples.*

**Q: Do you guys connect with CAQH for credentialing?**

*A: Our credentialing goes through the normal Medicaid process. You need to be credentialed with NC Tracks in order to contract with Carolina Complete Health.*

**Q: If my agency contracted with Carolina Complete back in 2019 prior to the postponement of the switch to managed care. Does my agency have to re-contract? If so, who do we contact?**

*A: No, if you contracted in 2019 you should still be contracted but may want to check in with networkrelations@cch-network.com just to see if you need to update any data*

**Q: Will Carolina Complete have a certain EVV vendor that they will use?**

*A: CCH uses HHA Exchange as our EVV vendor*

**Q: If a provider would like to add an additional location. What will this process look like?**

*A: Update NCTracks to include all your locations and reach out to networkrelations@cch-network.com to make sure your roster and data is updated*

**Q: Once an updated roster is completed how long does it take to update your provider directory?**

*A: 10 business days*

**Q: Will you be sending out contracts to providers?**

*A: No, providers may request a contract via our website <https://network.carolinacompletehealth.com/join-cchn/contract-request-form.html>*

**Q: As LTSS applies to many categories (like patients receiving services like home health, high behavioral health needs) how will we know which patients you are managing?**

*A: Those receiving PCS, HHA, PDN, HIT, Hospice, and NF < 90 days will be managed by LTSS Care Managers. Care Plan documentation will also be available in the Provider Portal for those in care management.*

**Q: We have ICFs in Region 1 and one of our residents has their home Medicaid in a county in one of your regions. If they choose you, how will that work?**

*A: Even though the provider is in a different region they are open to contract with CCH. If a CCH member will be using an out of network provider they will likely get paid 90% if good faith efforts to contract have been met. The provider must also get prior authorizations for services/procedures that are out of network.*

**Q: Will current authorizations in FFS be maintained after transitioning to CCH for a period of time? For example, I'm receiving PCS services and a Independent Assessment was done by a vendor of Medicaid Direct, the authorization is for a year, will CCH maintain same level of service for 90 days after transitioning?**

*A: The Health Plan must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice for the first ninety (90) days after implementation to ensure continuity of care for members. Manage care team will complete assessments to verify if care will need to be continued after the 90 days.*

**Q: What contracting timeline do you suggest for agencies that will be a CMA instead of an AMH?**

*A: To continue supporting providers interested in obtaining certification as an Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA), the Department is extending the Round 1 application deadline from March 1, 2021 to June 1, 2021.*

**Q: Do we have to send provider changes/updates to CCH as well as NC Tracks?**

*A: Yes, at this time we ask that you update NCTracks First and also notify the plan*

**Q: I thought that NC Tracks was supposed to upload the changes and sent out to the plans - is this not true?**

*A: Yes, NCTracks is the source of truth but there are pieces of information that the plan collects that are not included in NCTracks at this time*

**Q: If we provide both LTSS and BH services will we need two separate contracts?**

*A: If the provider is operating under the one TIN/NPI they will only need 1 contract. Multiple comp exhibits can be included on 1 contract*

**Q: Will NCTracks updates be sufficient for new provider information, or should it be related to network relations at CCHN as well?**

*A: At this time we ask that you update NCTracks First and also notify the plan*

**Q: What if our practices are located in the regions you cover and other regions? We are in Wilmington, Pender, Onslow, and Carteret.**

*A: CCH covers region 3, 4, and 5. any services or members outside of the regions are considered out of network.*

**Q: If you have multiple home health offices throughout NC, will you assign one rep.?**

*A: Yes, multisite will count as 1 provider in terms of PR/PE assignment*

**Q: Per page 26 of the Carolina Complete Health manual, Specialty care providers must schedule new patients for an appointment time within 30 calendar days. Does Speech Therapy classify as a “Specialty Care Provider”? – Does the 30 calendar day requirement apply to Speech Therapy?**

A: Yes, Speech Therapy is considered a specialist and the 30 day requirement would apply.

**Q: The Carolina Complete Health provider search allows Members to search for Providers with the “specialty” of “Speech Therapy”, but no Providers appear in the results. Providers only appear in the “specialty” of “Speech-Language Pathologist”. How do we get them to show under both?**

A: Carolina Complete Health is aware of the directory issue when searching by provider specialty and is working on a solution prior to 07/01.

**Q: Can we have Kelly Phillips contact information?**

A: *networkrelations@cch-network.com or the Provider line 1-833-552-3876*

**Q: What region is Northeastern NC specifically Elizabeth city, NC affiliated with and if we are not included in the regions at this time, will we be included soon.**

A: *That is region 6, we will not have members who reside in that region but will contract with any willing provider regardless of the region as we realize patients receive care across county/region lines. Our hope is to eventually be a state wide PHP*

**Q: So...is there a need for our office to enroll with Carolina Complete since we are not included in the regions and will get few referrals?**

A: *Yes we encourage you to contract regardless of region since members get care from outside of their county/region*

**Q: Will the credentialing process still go thru NC Tracks or each PHP after July 1**

A: Providers must submit at a minimum documentation to the state Medicaid program and credentialing determinations will be based off Medicaid provider data credentialing file provided to all contracted MCOs.

**Q: My agency is contracted and today I registered for an account on the provider portal, but it does not give me access to any features such as authorizations, submitting claims, or searching for claims. What should I do to get a functional account?**

A: *The portal will not have authorization or claim information until 07/01 as we have not launched yet.*

**Q: Can we schedule an in-office orientation for our team? If yes, how?**

A: you can reach out to [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or call provider services. We will also have orientation training recorded and posted to our website so that you can view at your leisure and then reach out with specific questions as well.

**Q: You said that CCH will only accept Physician Orders from Physicians are Medicaid providers (they can be in-network or out-of-network). - How will we know which Physicians are Medicaid providers with DHHS?**

A: *You can use the DHHS Medicaid “Find A Provider” tool to find Medicaid providers*



**Q: Is Carolina Complete planning to come to Region 6 since this is where our office is located? If not, then we could have patients being denied for their services with our physician.**

*A: We are currently in Regions 3, 4 and 5. We cannot determine when and if we would be covering Region 6 as the regions are determined by the state.*

**Q: How many unmanaged outpatient services are each client afforded per benefit year? When requesting additional units, is there a limit on the number of units or time period we can request?**

*A: Members are allotted up to 8 unmanaged services. There is no limit established at the moment.*

**Q: Another plan has indicated today that EPSDT is covered only by tailored plans - such as Child First. So what is the answer on that - standard plan or MCO / tailored plan?**

*A: EPSTD is covered by the Standard Plan.*

**Q: on the map Duplin co was not colored so does that mean that consumers are not able to select this insurance?**

*A: That is correct, Duplin is region 6 and our plan is not available for members who reside in that county at this time.*

**Q: Is Carolina Complete an open network? If so, how long will it remain an open network?**

*A: Yes, CCH as per advised by the state will contract with any willing provider*

**Q: Will provisionally license clinician be credential with your plan? We signed a contract in 2019 and have recently added two new location how can we add the new locations?**

*A: Yes, we will credential provisionally licensed practitioners. In order to add two new locations you can email [networkrelations@cch-network.com](mailto:networkrelations@cch-network.com) or call provider relations to speak with a Provider Relations Representative at 1-833-552-3876. They will be able to provide you with a blank Roster that you will fill out and email back to them. From there, they will submit the update to our provider contracting team.*

**Q: If the provider is already credentialed with NC tracks and Medicaid, would they have to be credentialed with Carolina Comp as well?**

*A: No, all credentialing is done through NCTracks, you will not need to credential with CCH. You will need to complete a contract to be in network once your Medicaid credentialing is complete.*

**Q: Will Sampson County be in your catchment area as well or is it the same as Duplin County?**

*A: Sampson is in region 5 and is in our regular catchment area*

**Q: Where can we find your Provider Directory to ensure that we are listed?**

*A: <https://findaprovider.carolinacompletehealth.com/location>*

**Q: We are located in Region 1. Our CIN has contracted with Carolina Complete Health because are in an area that has lots of visitors - so we are in-network. If we see a patient that we are not the PCP after 09-30-2021, what will we need to do to get paid?**

*A: We will work with providers and they will be paid at 90%. Call PCP to obtain authorization if it is a sick visit*

**Q: What is registration code we need to sign up under PaySpan?**

A: Please call PaySpan at 1-877-331-7154 to request a code or email them at [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com). The code will allow you to access your info in PaySpan including EOB's/remits and EFT's. You do not have to use PaySpan for your claims if you are using another clearinghouse. This is an option for those that do not currently have an electronic means for their claims. CCH's Payor ID is 68069

**Q: Will you offer Family Planning only or Toddler and Infant only plans for patients that do not qualify for NC Medicaid full coverage?**

A: Service Coverage remains the same under CCH/CCHN as it does with the current Medicaid program.

**Q: The question about COB is really this - when another payer is primary but Carolina Complete does not have this payer on file, how can the provider update the record with Carolina Complete so they know another payer is primary? Right now, we can do this via an online form NC DHHS Health Insurance Information Referral Form. Will we continue to use this form or is there a payer specific form / process we should follow?**

A: When CCH identifies Other Insurance Coverage (OIC) for Participants, CCH will report this information in one of two ways. The online form "Health Insurance Information Referral Form" can be utilized to report the other insurance coverage information to the department or the workbook supplied by DHHS will be allowed for multiple policies to be entered and reported.

Key participant information will be populated in the required fields indicated.

- The online health form can be accessed at Health Insurance Information Referral Form.

Once completed, the workbooks are sent via secure email to the department's TPL/OFI inbox:

[Medicaid.TPLInsuranceNotifications@dhhs.nc.go](mailto:Medicaid.TPLInsuranceNotifications@dhhs.nc.go)

**Q: Do you know when NC Tracks will have the managed care plan listed that the family has selected? Is there a deadline date?**

A: Based on feedback from providers regarding the AMH Medicaid Direct/Managed Care PCP Enrollee Report, and to better assist providers, NC Medicaid is in process of updating functionality to include health plan members and the name of the health plan to which each is assigned. Although the timeline for the addition is yet to be determined, the report will display the health plan name beginning in July 2021 when managed care assignments become effective."

**Q: For residents in adult care homes, their county of residence is the county the community is in, but they may have a different MMIS county or county that benefits were applied for..... which county will be used to determine region?**

A: This could be subject to change; however, this looks to be the stance from the state at this point. "DETERMINING COUNTY RESIDENCE A. Non-institutional Living Arrangement An individual has residence in the county in which he lives. This applies even if the individual owns a home in a different county or state. B. Institutional Living Arrangement An individual in a hospital, mental institution, nursing facility (SNF, ICFMR), Adult Care Home (rest homes/domiciliary care facility/assisted living) or a similar institution/facility: 1. Is a resident of the county in which he lived immediately prior to entering the facility. 2. If an individual moves from another state directly into an institutional living arrangement, the individual is a resident of the county in which the facility is located. If the individual moves to more than one institution/facility, the county of residence is the county where the first institution/facility is located. NOTE: Residence in an adult care home does not establish county residence, even when the individual

*was a private paying adult care home resident. Establish his county of residence prior to entering the adult care home”*

**Q: This could be subject to change; however, this looks to be the stance from the state at this point. “DETERMINING COUNTY RESIDENCE A. Non-institutional Living Arrangement An individual has residence in the county in which he lives. This applies even if the individual owns a home in a different county or state. B. Institutional Living Arrangement An individual in a hospital, mental institution, nursing facility (SNF, ICFMR), Adult Care Home (rest homes/domiciliary care facility/assisted living) or a similar institution/facility: 1. Is a resident of the county in which he lived immediately prior to entering the facility. 2. If an individual moves from another state directly into an institutional living arrangement, the individual is a resident of the county in which the facility is located. If the individual moves to more than one institution/facility, the county of residence is the county where the first institution/facility is located. NOTE: Residence in an adult care home does not establish county residence, even when the individual was a private paying adult care home resident. Establish his county of residence prior to entering the adult care home”**

A: We are setting this at 24 unmanaged visits for individual, group, and family therapy; no authorization is required for assessments or medication management, services also referenced in Clinical Coverage Policy, 8C

**Q: Will CCH systems interface with provider's EHR?**

A: *Still to be determined*

**Q: Is residential units (Addictions/ Drug units or Facility base crisis) covered?**

A: -Standard Plan services do not include Residential services BUT does cover several of the SUD specific services found in Clinical Coverage Policy, 8A such as Facility-Based Crisis. • Facility Based Crisis (S9484)

- Non- Hospital Medical Detox (H0010)
- Medically Supervised or ADATC Detox Crisis Stabilization (H2036)
- Ambulatory Detox (H0014)
- Residential Tx will continue to be covered by the LME’s