1. How do we handle recurring rentals when a beneficiary changes plans in mid-stream? Will the first authorization carry forward to the new payer? How will we even know when a patient changes plans?

A new authorization request would need to be submitted if the member changed plans to Carolina Complete Health. Carolina Complete Health will not notify providers when members change or update their plans.

1. Will any documentation requirements change from payer to payer?

  PHP’s will be following NC Medicaid’s clinical policies and requirements. They may choose to be less restrictive, but may not be more restrictive. Therefore, there could be differences in what is required from payer to payer.

1. Can we be sent an email when a patient of ours changes plans?

  Carolina Complete Health will not notify providers directly when members change or update their plans; NC Tracks will update this information.

1. Will the coverage criteria be the same from plan to plan?

  No, each Health Plan has their own clinical policies.

1. Will the new MCOs follow current Medicaid policy regarding coverage criteria?

  Carolina Complete Health is remaining consistent with current Medicaid policies 5A-1, 5A-2, 5A- 3, and 5B.

1. How will claims be submitted to each participating insurance contracted for managed care?

  Carolina Complete Health claims can be submitted through:

 the Provider Portal

EDI subsmission- CCH is using the following clearinghouses, Ability, Availity, or Change. If your current clearinghouse has a connection to one of these, the claim will be passed onto us. Our Payor ID is 68069.

Mail: EDI Payor ID 68069

Carolina Complete Health Attn: Claims, PO Box 8040 Provider Service Farmington, MO 63640

1. Will NC Tracks be available for prior approval or will I go through each contracted insurance?

You will need to go through Carolina Complete Health to request prior approval for our members. You may submit a prior authorization request with Carolina Complete Health through the provider portal, by phone 1-833-552-3876 or fax 1-833-238-7694.

1. Will NC Tracks be used for any beneficiary information or for submitting any claims?

  No. Beneficiary information and claims information can be seen in Carolina Complete Health’s provider portal.

1. Will each individual insurance have it’s own time limit for submitting claims or will they abide by Medicaid time limits?

  Carolina Complete Health’s timely filing is 180 days

1. My number 1 concern is coordination of current authorizations or lifetime Oxygen authorizations.

  Carolina Complete Health will not be honoring lifetime authorizations for Oxygen.

1. Authorizations – we need more information on process for each transitioning current NC Tracks authorizations to the new MCO.
2. Some items like Oxygen have lifetime Authorizations. Carolina Complete Health will not be honoring lifetime Authorizations.
3. Will we need new forms and physician signatures or will they accept CMNPA DMA372-131

Any new authorizations submitted to Carolina Complete Heath will need to follow our PA guidelines. You may submit a prior authorization request with Carolina Complete  Health through the provider portal, by phone 1-833-552-3876 or fax 1-833-238-7694. The PA tool will inform you what information is needed for the PA.

1. How soon will we be notified of which plan the recipient will have?

  Carolina Complete Health will not notify which members have chosen us.

13. For incontinence supplies will it only be a physician order and notes showing need for the supplies or will there be an additional for to be completed like it is now (CMN/PA form for Medicaid)?

  The PA tool will inform what necessary information is required for a PA.

14When will the MCO’s start accepting information from HME providers to continue service for equipment and supplies already authorized?

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 or when the authorization expires (whichever comes first) after implementation to ensure continuity of care for members. A new authorization request will need to be submitted after that. These existing authorizations should be accessible in the provider portal at this time.

15Wound care coverage – as far as we understand, most wound codes are not covered as DME under NC fee for service.  So is that changing under managed care? If so, what codes are covered and what's the basis for reimbursement?

  Carolina Complete Health DME contracts are paid at 100% of the current Medicaid fee   schedule. Please refer to the current fee schedule.

16CGM coverage – would it be covered under Medical/DME or RX benefit or dual. The State has it under RX benefit only today.

 The monitor would be DME. The supplies would be a pharmacy benefit with the exception of a non-PDL CGM. Non-PDL CGM and supplies would be DME.

17What algorithm or enrollment formula will the State use starting May 15, 2021 during the Auto Enrollment period for beneficiaries who have not selected a health plan?

  The PHP’s methodology for assigning beneficiaries to an PCP/AMH includes the following components to the extent that such information is available:

Prior PCP/AMH assignment;

Member claims history;

Family member’s PCP/AMH assignment;

Family member’s claims history;

Geographic proximity;

Special medical needs; and

Language/cultural preference

This does not apply to DME providers.

18Will the MCO plans have specific portals used for prior authorizations/eligibility? If so, how soon?

Providers will be able to submit prior authorizations through the provider portal with Carolina Complete Health. **It should go live 7/01/2021.**

19Will we be able to bill with the NC MCD ID# or will we need unique ID’s?

Carolina Complete Health will use the NC Medicaid ID for members. This will be the ID number on their member cards.

20Medicaid Prior Approvals can take several days to be received/approved. With most MCOs, items over $500 will require PA which would include enteral pumps for tube fed patients. What is the turn-around time for authorizations on these timely items needing to be dispensed?

You may use our prior auth check tool on our website to check if a prior authorization is required once it is live.

Page 51 of the Provider Manual: 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). “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service. 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. Please see page 51 of the Provider Handbook for more information.

21Will providers be able to submit prior authorization requests before 7/1/21 to help spread out the transition over the full 90 days? Will providers have enough time to submit and receive back all authorizations for existing rentals before the end of the transition period along with all their new authorization requests for new equipment?

Yes, providers can submit authorization request via fax before 07/01/2021. The form prior authorization request form is location on our website.

22Will Coverage guidelines and Medical policy remain unchanged under managed care?

 Carolina Complete Health is remaining consistent with current Medicaid policies 5A-1, 5A-2, 5A- 3, and 5B.

23We spend an inordinate amount of time “on-hold” with insurance companies every day, which is frustrating.  People get impatient on-hold after a few minutes (we have some insurers with 4+ hours hold times), but waiting a few hours for an e-mail response is acceptable to most people.  Will the MCO’s have people that we can contact by e-mail for answers to questions that we have?

  You may email networkrelations@cch-network or call 833-552-3876 to reach the Provider  Relations team.

Continuity of Care Questions

* Once open enrollment begins and beneficiaries select their plans, when will providers be made aware of the patient’s choice of plan? We would like to have some preparation time to coordinate the billing on these patients to ensure a smooth transition.

Carolina Complete Health will not inform providers of which patients chose our plan.

* Similarly, on the auto-assignment of health plans, when will the information of the selected health plan be made available to providers? The date of auto assignment is May 15, 2021. May 22, 2021 is the date (approximate) that is mentioned that the information will be transmitted to the Health Plan for the beneficiaries assigned to each one. Will providers know very shortly after May 22?

Medicaid Auto-assignment only applies to PCP and AMH providers. DME providers do not get members assigned to them.

* Is there reciprocity for authorizations between health plans when a beneficiary switches from one plan to another? Specifically concerning the DME industry because of rentals and other care that is continual.

If you join Carolina Complete Health from another health plan, we will work with your previous  health plan to get your health information, like your service history, service authorizations and  other information about your current care into our records. x You can finish receiving any services that have already been authorized by your previous health plan. After that, if necessary,  we will help you find a provider in our network to get any additional services if you need them.   In almost all cases, your providers under your former plan will also be Carolina Complete  Health providers.

* According to the Provider Playbook, Mandatory beneficiaries can change their Health Plan assignment in the first 90 days. Then if they want to change again, they have to have cause, how long is the expectation of the turn-around time for those “Cause” forms to be reviewed and the beneficiary to choose another plan? Will providers be made aware of the submission of the request to change plans? Again, specifically concerning to the DME industry because of rentals and other care that is continual.

Carolina Complete Health did not specify a timeline in the manual but providers will not be made aware of the change request.

* How are the Health Plans handling retroactive eligibility? Will providers be allowed to request authorizations retroactively in those cases?
* For dual eligible plans, has there been any discussion of how the process will work? Does the primary autocross over to the secondary without the provider having to send the claim? Will the primary dual eligible policy payment be considered payment in full? What about non-covered services for Medicare and Medicare MCOs, will those need to be billed to the “secondary” in those cases? Example, shower chairs, or incontinence supplies (diapers and underpads).
* How are local code items going to be handled by each Health Plan? Example, Any item on the Medicaid fee schedule with a “W” or “T” code. Are we to bill the local code, or the cross-walked HCPCs code?
* How will EPSDT situations be handled? Here are some scenarios where EPSDT is used.
* If an item has an existing HCPCs code, but the patient requires a custom product that exceeds the fee schedule allowable.
* Quantity overrides- if a doctor prescribes a monthly quantity greater than the max quantity in the policy.
* Codes not on the fee schedule-EPSDT is available for items that are not on the fee schedule for individual consideration.
* If a beneficiary is over 21, and not eligible for EPSDT, how would custom items, items not on the fee schedule, or miscellaneous items be handled?
* The provider manual has limited billing information when it comes to DME-specific billing. The Medicaid Manuals 5A-1, 5A-2, 5A-3 and 5B are extremely detailed and important for billing staff to prepare billing systems for submitting claims. Are there any expectations for billing manuals to be released from the Health Plans?

Carolina Complete Health is remaining consistent with the Medicaid policies.

Is there an expectation that Health Plans will accept claims in the same format as described in the attached document from the Medicaid manual 5A-2, specifically regarding rentals and enteral supply kits?

Yes, Carolina Complete Health is remaining consistent with the Clinical Policy 5A-2

Contracted provider questions

* What escalation process does a provider follow if there is an issue with a “Health Plan”? Can the provider submit complaints to the department at DHHS? Is there an Ombudsman that handles complaints?

If issues persist, providers may contact the Medicaid Provider Ombudsman   at Medicaid.ProviderOmbudsman@dhhs.nc.gov or 919-527-6666

* In other states, there are situations where Health Plans had contracted with providers, then after a year or so, restricted the network. Now providers are getting notices they are no longer in network after a certain date. Is this also an option in North Carolina to the health plans? If so, what kind of appeal process does a provider have? Do the Health Plans have to report on their ‘provider network capacity’?  What will reimbursement look like for an out of network provider if a rental will continue past the date of contract termination?

Carolina Complete Health will not be restricting their network. We are an open network.

* If a provider changes their address, they need to make the necessary address change in NC Tracks, but will the provider also be required to inform the contracted Health plans with a W-9 or some other form? Additionally, will the health plans allow all claims submitted after the address change to have the current address? Or will it be date of service driven like NC Tracks?

Carolina Complete Health Network will require a Roster to be completed if there is an address change. Per the billing manual, a claim with the incorrect address can be delayed as it is not a “clean” claim.

* Will there still be a same/similar electronic check to determine months on rent or requests for duplicate equipment already purchased or on rent with another provider?