

PARTNERS HEALTH MANAGEMENT

Billing Guide

Medicaid Tailored Plan, State and Medicaid Direct





Partners Health Management Billing Guide

This manual is a reference tool for submitting Medicaid Tailored Plan, State and Medicaid Direct claims to Partners Health Management via Alpha+. Partners has contracted with Carolina Complete Health (CCH) as a Third-Party Administrator (TPA) for claims processed as Medicaid Tailored Plan physical health.

Claims questions can be directed to Partners Claims Department at 704-842-6486 or ClaimsDepartment@partnersbhm.org. Claims training can also be scheduled with the Claims Department. Additional useful documents are available on Partners Provider Knowledge Base.

Providers can attend the virtual Provider Open House for additional claims assistance. The Provider Open House occurs the first Thursday of each month from 9-10am and is open to new and existing providers in the Partners Health Management Network. Register here partnerstraining.org

Providers are encouraged to review Partners Communication Bulletins, Partners Provider Alerts, and the Known Issues Tracker to stay up to date on claims billing information. Subscribe here: partnersbhm.org/subscribe

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Prior to Claim Submission

Alpha+, ZixMail and Billing Set-up

Alpha+

Partners uses Alpha+ for its Managed Care Operations. More details regarding Alpha+ are available in the Partners' Provider Operations Manual. [Provider Operations Manual.PDF](#)

- **Request Individual/Unique Alpha+ Logins**

Each staff member will need their unique Alpha+ Provider Portal login. To obtain an Alpha+ login or to schedule Alpha+ Provider Portal online training, call the Partners' Information Technology Service Desk at **704-842-6431**.

- **Alpha+ Provider Set Up**

Provider agencies that transmit or receive HIPAA-Compliant X12 Electronic Transactions must mail an original, completed and signed [Trading Partner Agreement](#) (TPA) to:

Partners Health Management

Attn: Information Technology

901 S New Hope Rd.

Gastonia, NC 28054

Please allow 72 hours for processing.

ZixMail

Partners uses ZixMail, a desktop email encryption solution that offers a high level of email security. ZixMail lets users encrypt and decrypt emails and attachments with a single click, rendering any hacked or stolen information indecipherable to anyone outside of the Partners' Provider Network. ZixMail safeguards information and ensures compliance with the Health Insurance Portability and Accountability Act (HIPAA). All email sent from Partners is encrypted. To view encrypted email, individuals and providers should set up their individual profiles in the [Zixmail Portal](#).

Billing Set Up

- **Electronic Data Interchange (EDI) Format Testing**

To set up EDI, providers need to submit a test 837 file by uploading it to Partners' secure file transfer protocol (FTP) site. Once the format testing is complete, providers will receive their login credentials for a permanent FTP site inside of Alpha+. Instructions for completing this testing are included within the [Trading Partner Agreement](#).

- **Adding Users for Third-Party Billers**

To establish access for the third-party biller, contact the IT Service Desk at 704-842-6431.

Electronic Funds Transfer (EFT)

Medicaid Tailored Plan Behavioral Health, Medicaid Direct and State Benefit

- To set up Electronic Funds Transfer (EFT) in our software system download and complete a [Trading Partner Agreement](#). The Trading Partner Agreement must be submitted to the following address with original signatures.

Partners Health Management
901 South New Hope Road
Gastonia, NC 28054
Attn: IT Department

- The TPA can also be located at www.partnersbhm.org by following the steps below:
 1. Provider Knowledge Base
 2. Provider Tools
 3. Alpha+, ZixMail and Billing Set-up
- Providers must complete banking information forms before payment can be received. Banking information forms can be requested from April Cash at acash@partnersbhm.org.

Medicaid Tailored Plan Physical Health

- See EFT and ERA section located at:
<https://network.carolinacompletehealth.com/resources/claims-and-billing.html>
- Providers are contractually required to submit billing electronically through the Carolina Complete Health (CCH) claims system upon completion of a Trading Partner Agreement (TPA).
 - Billing through the CCH system is either by:
 1. Paper Claims, mailed to:
 - P.O. Box 8002
Farmington, MO
63640-8002
 2. Direct entry of data where an electronic CMS1500 or UB04 form is accessed, and billing information is entered and submitted to Partners for reimbursement
 3. 837 Claims Submissions: the HIPAA-compliant ANSI transactions are standardized. Partners only accepts HIPAA-compliant transactions as required by law
- Partners provides the following transaction files back to providers:
 - 999 acknowledgment files
 - 824 line by line acceptance/rejection file
 - 835 files, which is an electronic version of the electronic remittance advice (ERA)

Known issues can be tracked at <https://network.carolinacompletehealth.com/>

Claim Submission

Providers will access Provider Connect for claim submission.

<https://id.partnersbhm.org/>

- Alpha+
 - Medicaid Tailored Plan Behavioral Health
 - State
 - Medicaid Direct
- Availity
 - Medicaid Tailored Plan Physical Health

Claim Format Requirements

- Professional Claims
 - Professional services include Outpatient Therapy, NC Innovations, B3 Waiver, Enhanced and State-Funded Residential Services.
 - If submitting directly to the Partners Alpha+ Portal use the CMS1500 form.
 - If submitting electronically use the 837P.
 - Additional guidance can be found at Alpha+ University located within Alpha+.
- Institutional Claims
 - Institutional services include Inpatient Hospital Services, Outpatient Revenue Codes, Medicaid-Funded Residential Services, ICF Services and Therapeutic Leave.
 - If submitting directly to the Partners Alpha+ Portal use the UB04 form.
 - If submitting electronically use the 837I.
 - Additional guidance can be found at Alpha+ University located within Alpha+.

Replacement Claims

- Providers can submit replacement claims for previously approved or denied claims that were submitted within the timely filing guidelines.
- The original claim will be reverted, and any payment will be recouped.
- Replacement claims submitted for previously voided or recouped claims will deny. No further processing can be done on Voided and recouped claims.
- Replacement claims submitted past the allowed days will be denied for exceeding billing days and cannot be resubmitted.

Voided Claims

- Providers can submit void claims for previously paid claims.
- Void claim submissions will be reverted, and the original payment recouped from the provider.

Timely Filing Guidelines

State Benefit

- New Claims
 - All claims must be submitted within 90 days of the date of service to ensure payment, unless otherwise specified in the Provider's contract.
 - Claims filed outside of the 90 days will deny for payment.
- Replacement Claims
 - Providers may submit replacement claims for originally processed claims within 180 days from the date of service.
 - Replacement claims submitted outside of these guidelines will be denied due to the timely filing requirements.
 - Replacement claims originally denying for timely filing will continue to deny.

Medicaid Benefit

- New Claims

- All claims must be submitted within 180 days of the date of service to ensure payment, unless otherwise specified in Provider's contract.
- Claims filed outside of the 180 days will deny for payment.
- Replacement Claims
 - Providers may submit replacement claims for originally processed claims within 270 days from date of service.
 - Replacement claims submitted outside of these guidelines will be denied due to the timely filing requirements.
 - Replacement claims originally denying for timely filing will continue to deny.

Timely Filing Override Consideration

Timely filing override consideration requests should only be submitted for the following reasons:

- Retroactive Medicaid
 - Claims based on retroactive Medicaid eligibility must have authorization for services requested within 90 days.
 - Timely filing consideration request and submission of claims must be within 90 days of the date modified in NCTracks, if outside the claim submission timely filing guidelines.
- Retroactive Medicare/TPL
 - If claims are recouped due to retroactive Medicare/TPL, the claim can be resubmitted to Partners after receiving the EOB from the third-party plan.
 - The resubmitted claim must include the COB information.
 - State Benefit claims cannot be resubmitted if the date of service falls outside the current fiscal year for State Benefit.
 - Timely filing consideration request and submission of claims must be within 90 days of the date modified in NCTracks or from the date of Partners recoupment, if outside the claim submission timely filing guidelines.
- NCTracks Clinician License Added/Updated
 - Request must be submitted within 30 days of date modified in NCTracks.
- NCTracks Provider or Clinician NPI Added/Updated
 - Request must be submitted within 30 days of date modified in NCTracks.
- NCTracks Provider or Clinician Taxonomy Added/Updated
 - Request must be submitted within 30 days of date modified in NCTracks.
- Eligibility issue with NCTracks
 - Request must be submitted within 30 days of date modified in NCTracks.

Timely filing override consideration requests should be sent directly to

ClaimsDepartment@partnersbhm.org prior to submitting claims. The request must include a completed [Claims Denial Review Form](#) and one or more of the consideration reasons listed above.

Coordination of Benefits

Partners pays Coordination of Benefit claims according to the "lesser of" methodology. If the Medicaid allowed amount is more than the third-party payment, Partners will pay the difference up to the

contracted allowed amount not to exceed the patient responsibility. If the other insurance payment is greater than the Partners contracted amount, no additional amount will be paid.

- Federal and state regulations require Medicaid to be the “payor of last resort,” except when that member is also accessing State-Funded Services where State-Funded Services are “the payor of last resort.”
- Providers are required to collect all first and third-party funds before submitting Medicaid claims to Partners for reimbursement.
- Third-party payers are any other funding sources that can be billed to pay for the services provided to the member. This can include worker's compensation, disability insurance or other health insurance.
- Third-party payers, including Medicare and private health insurance carriers, must process the claim before Partners processes a Medicaid claim.
- Providers must report any payments or denial reasons from third-party payers on Medicaid claims filed with Partners. Medicaid claims submitted without third-party information will be denied.
- Partners will not pay for any service that could have been paid for by Medicare or other private insurance plans had the member or provider complied with the plan's requirements. Examples of common private plan non-compliance denials include, but are not limited to:
 - Failure to get an authorization referral from a primary care physician
 - The provider is a “Non-participating provider” in the first and/or third-party plan
 - Failure to obtain prior approval
- Partners will not reimburse providers for covered services provided by clinicians who are non-paneled or not enrolled under the recipient's third-party coverage plans.
- If the provider is not enrolled or have paneled staff with the primary payer, the provider should refer the member to an eligible provider of third-party covered services.
- First-party payers are the clients/member or their guarantors.
- Providers are not required to bill Medicare/Third Party Liability (TPL) for service codes that are listed on the current bypass list. The Medicare/Third Party Liability Bypass Codes can be found by going to:
 1. Provider Knowledge Base
 2. Finance, Claims and Billing
 3. Claims and Rates Information
 4. Documents and Forms

Partners applies the same guidelines when processing claims for State-Funded Services.

Provider Member Eligibility Determination

Providers should conduct a comprehensive eligibility determination process whenever an individual enters the service delivery system.

- Partners recommends checking eligibility at the time each service is rendered.
- Providers should update the eligibility information to determine if there are any first or third-party liabilities for this individual.

- It is the responsibility of the provider to monitor this information and to adjust the billing accordingly.

Obligation to Collect

- Providers should make good faith efforts to collect all first and third-party funds prior to billing Partners.
- First party charges should be shown on the claim whether they were collected or not.

Reporting Third-Party Payments

- Providers are required to record the payment or denial information from a third-party payer on the claim.
- Explanation of Benefits (EOB) from third-party payers must be retained by the provider.
 - Partners will request EOBs for electronic claims submissions during the auditing process.
 - Partners requires EOBs to accompany all paper claims.
- Providers are required to bill all third-party insurance carries. This includes but not limited to:
 - Worker's Compensation
 - Medicare
 - EAP Programs
- Providers must wait a reasonable amount of time to obtain a response from the third-party insurance company.
- Providers may submit claims to Partners up to 270 days from the date of service in the event of Coordination of Benefits has occurred.
- If a member receives retroactive Medicare/TPL, claims must be submitted within 90 days of the date added in NCTracks for consideration, if outside the claims submission timely filing guidelines.
 - If the claim submission falls outside of timey filing guidelines contact the Claims Department at ClaimsDepartment@partnersbhm.org for timely filing review before submitting the claim.

Uniform Copayment for Non-Medicaid Services

- Provider shall indicate on the claim form submitted to Partners all required first party fees and copays owed by the member regardless of whether those fees have been collected. Payments to the Provider from Partners shall be reduced dollar for dollar by first party liability.
- If a member does not qualify for State funding based upon the current poverty guidelines, the member must pay one hundred percent (100%) of the cost of the services being provided by Provider and should not be enrolled into the Partners System. Claims for these services should not be billed to Partners.
- Documentation shall be maintained by the Provider showing how all first party liability was calculated.

- Enforcement of this procedure is a contractual requirement. The Finance Department will conduct periodic audits to determine if Providers are following the policy. Copayments or other forms of cost sharing from Medicaid members is prohibited.

Claim Determination

Medicaid Tailored Plan Behavioral Health, Medicaid Direct and State Benefit

- Claim Status
 - Remittance Advice (RA)
 - Partners communicates how claims were adjudicated via the RA.
 - RAs can be found in the Partners Alpha+ Portal.
 - Additional guidance can be found in Alpha+ University.
 - Electronic Remittance Advice (ERA)
 - 837 Providers will also receive an ERA.
 - The ERA is known as the 835 file.
 - The 835 returns claim status and payment information in standard HIPAA compliant format.
 - Download Q
 - Providers have the capability to view their daily claim status by utilizing the Download Q located in Partners Alpha+ Portal.
 - Formatting Instructions for the Download Q can be found at [Download Q Instruction Guide](#) or by going to:
 - Partners Public Website
 - Provider Knowledge Base
 - Finance, Claims and Billing
 - Claims and Rates Information
 - Download Q Instruction Guide

Denials

- Alpha + Denials Guide can be found in Alpha University. The [Denials Guide](#) can also be found on Partners Public Website under Claims and Rates Information.
- Providers can submit claim denial questions to ClaimsDepartment@partnersbhm.org.
 - The request must include a completed [Claims Denial Review Form](#).
- Providers can contact the Claims Department at 704-842-6486 or ClaimsDepartment@partnersbhm.org for claims related questions.
- Providers and third-party billers requesting claim detail must have an Alpha+ login to receive information.

Prompt Pay

- Partners follows the North Carolina prompt pay guidelines.
 - Claims will be processed within 18 calendar days of receipt to either:

- Approve
 - Deny
 - Pend
- Approved claims will be paid within thirty calendar days of adjudication.

Balance Billing

As noted in [Provider Communication Bulletin #90 published Feb. 21, 2019](#), providers cannot “balance bill” Medicaid patients, i.e., bill them for the difference between your charges and Medicaid payments. Once a provider accepts a Medicaid patient, the provider can only bill the patient for the items allowed by law, specifically 10A NCAC 23J.0106. Effective September 1, 2018, NCDHHS readopted the rule with only small changes. [Click here](#) for the full, detailed and updated regulation.

Frequently Asked Questions

Frequently asked questions can be found at [Frequently Asked Questions and Answers](#) or by going to:

- Partners Public Website
- Provider Knowledge Base
- Finance, Claims and Billing
- Claims and Rates Information
- Frequently Asked Questions and Answers