



HOSPITAL BEHAVIORAL HEALTH AND
ACUTE CARE FACILITY
Contracting, Enrollment, Authorization, and
Claims Instructions

REVISED July 1, 2019

EMERGENCY DEPARTMENT/ACUTE CARE FACILITIES WITHIN AND OUTSIDE OF THE PARTNERS BHM NETWORK FOR NORTH CAROLINA ENROLLEES

Emergency Department/Acute Care Facility Providers who are not contracted/enrolled with Partners Behavioral Health Management (Partners) but will render Emergency Department Services to members whose Medicaid originates from any of Partners' nine counties (Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin) should submit required information to ensure claims are processed quickly and efficiently and payments are made without delay.

This information is included in the following required documents

(Visit <http://providers.partnersbhm.org/hospitals-working-partners> to download documents.

- *Emergency Department Services Provider Enrollment/Medicaid Reimbursement Form*
This form provides us information to establish the Emergency Department's Payment Profile in the AlphaMCS system.
- *Hospital-Based Clinician Registration Worksheet*
This form registers Hospital Based Licensed Practitioners that provide professional services in the Emergency Department.
- *Partners Vendor Electronic Funds Transfer Form*
This form is used to establish Electronic Funds Transfer with Partners BHM.
- *W9 Form*
Request for Taxpayer information and certification.
- *Partners BHM Trading Partner Agreement*
This document that is required to be completed for any entity that is transmitting or receiving HIPAA compliant X12 Electronic Transactions with Partners Behavioral Health Management
- *Certificate of Insurance*
Partners must be listed as the certificate holder.

Forms should be submitted within 90 days of when services were first provided. Send the forms to the attention of Tammie Cribb via email at contracts@partnersbhm.org.

CONTRACTING WITH THE MCO

Ver 06/27/2019

Partners Behavioral Health Management

A prospective hospital that will be delivering behavioral health inpatient services to members with Medicaid eligibility from the Partners nine-county catchment area, may apply and be enrolled as a provider with Partners and qualify for reimbursement for Hospital services under the Partners Medicaid Waiver. Hospitals **must** have a signed contract to qualify for reimbursement for hospital services with State (North Carolina) funds.

To apply to be enrolled in the Partners Network, providing behavioral health inpatient services to members from the Partners' nine-county catchment area, please contact Provider Network Specialist, Shawn Causby at 704-884-2521

INPATIENT BEHAVIORAL HEALTH FACILITIES OUTSIDE OF PARTNERS BHM NETWORK

Inpatient Behavioral Health Providers outside of the Partners Network who provide service to a single member that has Medicaid in one of Partners' nine counties (Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry and Yadkin) should complete the *Out of Network Hospital Consumer Specific Agreement* along with required, supporting documentation to ensure claims are processed quickly and efficiently and payments are made without delay. This information can be found on Partners' website at the following link <https://providers.partnersbhm.org/hospitals-working-partners/> and includes:

- *Out of Network Hospital Consumer Specific Agreement*--This form provides information to establish the Provider's Payment Profile in the Partners' AlphaMCS system.
- *Hospital-Based Clinician Registration Worksheet*--This form registers Hospital Based Licensed Practitioners that provide professional services in the Hospital.
- *Inpatient Review Form*
- *Manual SAR*
- *Partners' Trading Partners Agreement*--Required to be completed for any entity that is transmitting or receiving HIPAA compliant X12 Electronic Transactions with Partners BHM.
- *Partners Electronic Funds Transfer Form*
- *W9 Form*
- Request for Taxpayer information and certification.

Also, submit a copy of each of the following:

Ver 06/27/2019

Partners Behavioral Health Management

- *W-9*
- *Facility License*
- *NPI Certification Letter*
- *Medicaid Letter*
- *Taxonomy*
- *Certificate of Insurance*

Inpatient Behavioral Health Providers outside of Partners Network who provide service to a single member that has Medicaid in one of Partners nine counties should email all required information to the secure email address at Providers@Partnersbhm.org.

HOSPITAL PATIENT ENROLLMENT & DISCHARGE INSTRUCTIONS - BEHAVIORAL HEALTH FACILITIES

INDIGENT: Three Way Contract, State Benefits

- A. **STATE FUNDED MEMBERS** (indigent) – will be enrolled by one of the following methods....
1. Keying the enrollment information directly into the Partners’ AlphaMCS system. Free training is available for those hospitals interested in this method of submission by contacting the Partners’ Service Desk at 704-842-6431.

OR

2. Submitting a completed **Special Project Enrollment Form (SPEF)** by encrypted email or fax to the Partners’ Access to Care Department.
 - a. Email – AccessStaff@partnersbhm.org
 - b. **DAYTIME FAX** (8:00 a.m. TO 4:30 p.m.) 336-835-2075
 - c. **AFTER HOURS FAX** (4:30 p.m. TO 8:00 a.m.) 336-527-8010

The Access to Care Service Department will review the SPEF/Enrollment Request for completion and will enter into Alpha within 24 hours of receipt and will approve if all required information is submitted. If all required information is not documented correctly, the SPEF will be returned to the hospital for correction.

MEDICAID

- B. **MEDICAID MEMBERS**
1. Hospitals do **NOT** need to submit the SPEF for a Medicaid member

2. Hospitals should confirm that the member has Medicaid originating from one of Partners' nine counties (Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry or Yadkin). Hospitals can confirm Medicaid County of origin by using their own internal process of verification, or by using one the following methods.
 1. Requesting recipient's Medicaid Eligibility Card
 2. Medicaid Global Eligibility File
 3. The Alpha MCS system
 4. Calling the Partners' Access to Care Department at-888-235-4673

DISCHARGE

DISCHARGE FOLLOW UP APPOINTMENTS – Partners' Access to Care Department will schedule Discharge Follow up appointments 24/7/365 for:

- a. Medicaid Enrollees whose Medicaid originates from one of our nine counties.
- b. Indigent members who reside in one of our nine counties

Discharge Follow Up appointments for members with Private Insurance, Health Choice, Medicare or Medicaid originating from a county covered by another Managed Care Organization (MCO) must be handled through the entity managing that member's payer source.

For more information regarding member enrollment, please contact:

Access to Care Department at 1-888-235-4673 or email EnrollmentEligibility@partnersbhm.org.

HOSPITAL PATIENT AUTHORIZATION INSTRUCTIONS

Partners Behavioral Health Management Enrollment

For authorization and reimbursement, patients must be enrolled with Partners. Enrollment status can be determined by checking the Alpha MCS system or calling Access to Care at 1-888-235-4673.

Initial Inpatient Requests

Effective October 1, 2015, Utilization Management (UM) staff will be available 8:00 a.m.to 7:00 p.m., seven days per week. Partners has stopped allowing a 72-hour pass through for inpatient admissions for Medicaid (101) and State Funded (YP820).

Ver 06/27/2019

Partners Behavioral Health Management

Clinical Coverage Policy 8B, allows a hospital up to 48 hours from time/date of admission to notify MCO of the admission. If Service Authorization Requests, (SARs) are submitted within 48 hours of admission, Partners Utilization Management (UM) will review back to the first day of treatment. If Medical Necessity is met, the request will be approved beginning with the first day of admission. When Medical Necessity is questionable, the request will be reviewed by Partners medical staff. If the Partners medical staff determine medical necessity is not met, the request can be denied for some or all days requested. There will be no payment for any of the denied days.

Hospitals accept financial responsibility for all denied days.

If SARs are submitted after the first 48 hours, UM will review for the 48 hours prior to the submission of the SAR but will not process days outside of the 48-hour timeframe. Example: *If patient admits on Friday @ 2100, the SAR should be submitted by Sunday @ 2100. If the SAR is not submitted until Monday by 2100, UM will review for Saturday Sunday and Monday only. Requests for Friday would not be processed as that is considered a retroactive request.* In a situation like the example given above, the hospital staff should only request authorization, on the SAR, for Saturday, Sunday and Monday. If the SAR that is submitted includes Friday, UM will be Unable to process the SAR and the facility will need to resubmit a SAR with correct dates. For Three (3)-Way (YP821, YP821SA, YP822, YP822SA) contracted admissions, unmanaged admission pass-through days will remain in effect as detailed below.

A SAR begins with the admission day and does not include the day of discharge.

UM staff will respond to Initial Inpatient Service Authorization Requests (SARs) within 12 hours.

Continued Stay Inpatient Requests

The, above, process is *only* for the initial requests. PRIOR AUTHORIZATION IS REQUIRED for any Concurrent SAR. Any concurrent request for additional days must have a SAR submitted through Alpha MCS and should be submitted prior to or on the last date of the current authorized time-frame. Continued stay SARs will not be reviewed retroactively. Concurrent requests (SARs) are limited to three (3) days or less. UM is unable to process SARs with retroactive start dates. UM staff will respond to Continued Stay (Concurrent) Inpatient SARs within 24 hours.

Submitting Inpatient Requests

The **Inpatient Review Form** (located at <http://providers.partnersbhm.org/hospitals-workingpartners/>) can be completed and attached to the SAR. If the **Inpatient Review Form** is completed and attached to the SAR, then that information does not need to be duplicated in

the SAR justification. However, if the Inpatient Review Form is not completed and attached, then the information requested on the form, needs to be addressed in the SAR justification.

SAR information will be reviewed and the requested service will be approved, if Medical Necessity] criteria for inpatient has been established. If further clinical information is needed, UM staff will attempt to call the hospital to obtain additional information. If Utilization Management (UM) is unable to approve based on the information submitted, UM staff will make 2 documented phone calls within a 3 hours period to attempt to set up a Peer to Peer Review. If it is after traditional business hours (i.e.: after 5:00pm, weekends or holidays) and there is no hospital UR coverage and/or UM cannot obtain an attending physician's contact information, a Peer to Peer Review will be done w/o consultation.

Hospital Utilization Staff will need to check the Alpha MCS system to determine the number of days authorized and when the next review is due.

No Alpha access or alternative methods for requesting authorization:

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the Alpha MCS system used by Partners BHM UM. Providers may contact the Service Desk, 704-842-6431, to request login information and assistance.

For circumstances when Alpha cannot be utilized, Service Authorization Requests can be handled:

- 1) **Live Review by Phone:** Hospital Staff will need to call 704-842-6434, to reach a UM Reviewer between the hours of 8:00AM-7:00 pm. , Sunday-Saturday. The UM Reviewer will collect information detailed on the Inpatient Review Form
- 2) **Manual Review By fax:** The Inpatient Review Form or Manual Service Authorization Request Form (located at <http://providers.partnersbhm.org/utilization-management/>) must be completed. Documents can be faxed to 704-884-2703.

Prior authorization guidelines still apply.

Contract-Specific Instructions

3-WAY FACILITIES (YP821, YP821SA, YP822):

Community Hospitals identified as Three Way Facilities may submit SARs to Partners **3-WAY**

Pass-through Days:

YP821 = Mental Health, Seven Days

YP822 = Enhanced Mental Health, Three Days

YP821SA = Substance Abuse, Four Days

YP8225A = Enhanced Substance Abuse, Three (3) Days

Ver 06/27/2019

Partners Behavioral Health Management

INDIGENT/State CONTRACTS (YP820)

Community Hospitals contracted with Partners for indigent fund reimbursement may submit SARs to Partners

No YP820 Pass-through Days. Authorization is required, per above.

MEDICAID (0101):

A prospective hospital that will be delivering behavioral health inpatient services on a regular basis, to members with Medicaid eligibility from the Partners' nine-county catchment area, must apply and be enrolled as a provider with Partners to qualify for reimbursement for Hospital services under the Partners Medicaid Waiver. Regular basis is defined as serving three or more Partners' members within a 12-month timeframe. Hospitals must have a signed contract to qualify for reimbursement for hospital services with State (North Carolina) funds.

Medicaid Hospitals without a contract with Partners will need to follow Out of Network process outlined on page 3 of this manual. If the Hospital does not have access to AlphaMCS, Initial and Concurrent Service Requests can be submitted via Manual SARs. These should be emailed to providers@partnersbhm.org.

No 101 Pass-through Days. Prior Authorization is required, per above.

HOSPITAL CLAIMS INSTRUCTIONS - BEHAVIORAL AND ACUTE CARE FACILITIES

Claims may be submitted from hospitals for Emergency Department, Inpatient, and Hospital Outpatient. Partners contracts with Emdeon for hospital clearinghouse services. Claims may be submitted through the hospital's Clearinghouse, Direct 837I submissions and Direct Entry Individual claims into the Partners Claims Management System.

Rates paid to the hospital under the terms of this agreement will be equal to the current published per diem rate by the NC Division of Health Benefits for services provided after January 31, 2013. For emergency room services, the reimbursement rates will be calculated using the Hospital's unique RCC outpatient percentage in effect on January 31, 2013, times 80% of the hospital's billed service costs. These rates may be adjusted as the NC Division of Health Benefits updates their rates based on changes in hospital costs.

ICD-10 diagnosis codes between F01-F99 must be used. Any services for other diagnosis should be billed to the NC Division of Health Benefits (Medicaid) in Raleigh.

Only members with Medicaid Coverage for one of the covered counties will be paid. Members with Medicaid coverage outside of the Partners' nine- county area should be billed to the appropriate MCO based upon recipient's county eligibility.

Claims are required to be submitted within 90 days of member's discharge date. Providers may submit claims to Partners up to 180 days from the date of service in the event of Coordination of Benefits has occurred.

Only appropriate services/codes will be paid. They are:

Emergency Room

- RC450-RC459
- Bill Type 13X
- Ancillary charges are paid as appropriate
- Subject to coordination of benefits
- No Partners BHM Authorization is required
- ICD-10 codes between F01-F99
- Paid at 80% times the RCC of the Approved Medicaid rate

Inpatient Hospital Charges

- Revenue Codes 101, 113, 114, 116, 120, 123, 124, 126, 128
- Paid upon the state negotiated per diem rate, which includes ancillary charges, ED charges, labs, testing, etc.
- ICD-10 codes between F01-F99
- Bill Type of 0111-0114 or 0117-0118
- Admit Type of 11X
- Subject to coordination of benefits
- Reimbursement is limited to the # days authorized

Hospital Outpatient Charges

- Revenue Codes: 901-903, 905-907, 912-916, 918-919
- Bill Type 0130-0135, 0137-0138
- Admit Type of 3
- ICD-10 codes between F01-F99
- Subject to coordination of benefits
- Partners BHM authorization required

Ver 06/27/2019

Partners Behavioral Health Management

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Payments are required to be processed through EFT (Electronic Funds Transaction) transactions (Electronically deposited into the Hospitals bank).

For more information regarding claims please contact:

Rhonda Colvard, Claims Manager
Partners Behavioral Health Management
901 S. New Hope Road
Gastonia, NC 28054

For Claims Questions:

- Phone: 704-842-6486
- Fax: 704-854-4203
- Email: claimsdepartment@partnersbhm.org

DOCUMENTS FOR SUBMISSION

A number of documents are referenced throughout this manual. The following can be found on the [Hospitals Working with Partners](#) page, located on the Partners' Provider Knowledge Base (<http://providers.partnersbhm.org>).

Hospital-Based Clinician Registration Worksheet
Emergency Department Reimbursement Form
Inpatient Review Form
Out of Network Client Specific Agreements and Contracts Policy
Out of Network Hospital Consumer Specific Agreement
Special Project Enrollment FormW-9
Vendor Electronic Forms Transfer Form

Ver 06/27/2019
Partners Behavioral Health Management

Trading Partners Agreement

Information needed for authorization of Electroconvulsive Therapy (ECT) Procedures and a checklist are located on the Provider Knowledge Base under the Clinical Criteria Check Sheets ([http://providers.partnersbhm.org/clinical-criteria-checksheets.](http://providers.partnersbhm.org/clinical-criteria-checksheets))