



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

REVISED March 2020

EMERGENCY DEPARTMENT/ACUTE CARE FACILITIES WITHIN AND OUTSIDE OF THE PARTNERS 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.
- *W9 Form*
Request for Taxpayer information and certification.
- *Partners 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 .
- *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 LME/MCO

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.

Partners accepts the Hospital and/or Health Systems' enrollment in NC Tracks in lieu of credentialing and recredentialing. This *includes all facilities and sites enrolled in NC Tracks and affiliated with the hospital/ health system and all practitioners billing through the hospital/health system's NPI(s)*. Hospital and/or Health Systems may request to contract with Partners by submitting the appropriate request form posted on the Partners website.

To apply to be enrolled in the Partners Network, providing behavioral health inpatient services to members from the Partners' nine-county catchment area, please visit *Hospitals Working with Partners* on our website at <https://providers.partnersbhm.org/hospitals-working-partners> and complete the **Hospital Data Form** for a full contract or contact Provider Network Specialist, Kimberly Houston at 704-772-4328.

INPATIENT BEHAVIORAL HEALTH FACILITIES OUTSIDE OF PARTNERS 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:

- *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

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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.

Utilization Management (UM)

Partners UM reviews all Inpatient Service Authorization Requests (SARs). Acute Services Team (AST) Utilization Management (UM) staff are available 8:00AM to 7:00PM, seven (7) days per week, including weekends and holidays. Inpatient UM staff can be contacted at 704-842-6434.

A SAR begins with the admission day and does not include the day of discharge. Hospital staff are responsible for determining the number of days needing authorization and when the next SAR is due.

Submitting Inpatient Requests

Information requested on the **Inpatient Review Form** is **required** with each SAR.

<https://providers.partnersbhm.org/hospitals-working-partners/>

The **Inpatient Review Form** can be completed and attached to the SAR. If the form is completed and attached, 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 that form needs to be documented in the SAR justification.

The Initial or Continued Stay SAR information will be reviewed, and the requested service will be approved if Medical Necessity criteria (CCP 8B) for inpatient Hospitalization has been established. If further clinical information is needed, UM staff will attempt to contact the identified Hospital UR staff via phone outreach to obtain additional information. If UM is unable to approve based on the information received, the request will be referred for a Peer Review. In the result of an Adverse Decision, a provider can request a Peer to Peer Review within Five (5) business days by calling the UM Appeals Department, 704-884-2650.

If it is after traditional business hours (i.e.: after 5:00pm), UM will attempt to set up a Peer to Peer review. If there is no Hospital UR coverage and/or UM cannot obtain an attending physician's contact information, a Peer Review may be done without consultation. In the result of an Adverse Decision, a provider can request a Peer to Peer Review within Five (5) business days by calling the UM Appeals Department, 704-884-2650.

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.

Initial Inpatient Requests

Medicaid (101) and State Funded (YP820).

Authorization is required for Initial Medicaid and State Funded Service Authorization Requests (SARs) **within 48 hours of admission.**

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

Refer to Partners Medicaid and State Benefit Grids <https://providers.partnersbhm.org/benefit-grids/> for most up-to-date benefit limits and documentation requirements.

Clinical Coverage Policy 8B, allows a hospital **up to 48 hours from time/date of admission** to notify a MCO of the admission. If Initial SARs are submitted within 48 hours of admission, Partners BHM 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 medical staff determine medical necessity is not met, the request may be fully or partially denied.

If SARs are submitted after the first 48 hours, UM will review for the 48 hours prior to the submission date of the SAR and will not process days outside of that 48-hour timeframe.

IMD Medicaid (160)

Medicaid beneficiaries age 21-64, who meet medical Necessity for inpatient care may be treated at an Institute for Mental Disease (IMD) **up to fifteen (15) days per calendar month***. **Effective July 1, 2018**, Hospitals can submit a Service Authorization Requests (SAR) **within business one day of discharge**, for the entire Length of Stay (LOS), up to maximum 15 days per calendar month) for MH IMD requests and unlimited for SU IMD requests.

Hospitals do have the option of seeking authorization upon admission.

Refer to Partners Medicaid and State Benefit Grids <https://providers.partnersbhm.org/benefit-grids/> for most up-to-date benefit limits and documentation requirements.

***For 0160-** IMD admissions spanning 2 consecutive months, the total length of stay may exceed 15 days, but no more than a 15-day LOS each month is eligible for authorization for Mental Health IMD admissions. **Effective July 1, 2019**, SU IMD Length of Stay may exceed 15 days per month.

Three (3)-Way (YP821, YP821SA, YP822, YP822SA)

Authorization is required for Initial Three (3)-Way Funded Service Authorization Requests (SARs) **within three calendar days of admission.**

Three-Way Hospital providers have **up to three calendar days, after midnight of the day of admission** to submit a Service Authorization Request (SAR). Partners Utilization Management staff will review the documentation and SAR for medical necessity back to the date of admission. 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 medical staff determine medical necessity is not met, the request may be fully or partially denied.

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

Refer to Partners Medicaid and State Benefit Grids <https://providers.partnersbhm.org/benefit-grids/> for most up-to-date benefit limits and documentation requirements.

Continued Stay (Concurrent) Inpatient Requests

PRIOR AUTHORIZATION IS REQUIRED for any Continued Stay Service Authorization Requests (**Medicaid, 101; State, YP820; or Three Way YP821/SA, YP822/SA**). Continued stay SARs will not be reviewed retroactively. A SAR must be submitted in the Alpha MCS **on the last day of the current authorized time-frame or on the first day service is continued.**

Refer to Partners Medicaid and State Benefit Grids <https://providers.partnersbhm.org/benefit-grids/> for most up-to-date benefit limits and documentation requirements.

Hospitals do have the option of submitting continued stay SARs during a LOS. In that case, A Service Authorization Request (SAR) must be submitted in the Alpha MCS **on the last day of the current authorized time-frame or on the first day service is continued.** Continued stay SARs will not be reviewed retroactively.

Exceptions for Inpatient Benefit Plan Limits

Involuntary Commitment (IVC) Admissions:

Partners recognizes when an involuntary commitment leads to a consumer being admitted to a psychiatric inpatient unit, the facility needs time to fully assess the need for the commitment to stand or be dismissed. Since the law related to involuntary commitments, legally allows the facility to take up to 72 hours to complete their evaluation, **UM will authorize the initial 3 days for these admissions.**

If the 3rd day of the authorization falls on a Saturday or Sunday, Partners will allow the request to extend to Monday as outlined below:

Weekends

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Effective 6/20/2018, Partners began allowing an exception for SARs with a length of stay covering including a weekend day. Specifically, hospitals submitting SARs with an end date of Saturday can request **one additional day** to extend the maximum allowed days requested to 4 (allowing a request for Thursday, Friday, Saturday and Sunday). A continued stay SAR must be submitted **on or** by end of Inpatient business day hours on Monday. SARs will be reviewed for Medical Necessity.

UM inpatient staff will still be available 7 days a week including holidays. If a hospital needs or chooses to submit a SAR during that time, UM staff will be available from 8:00 am until 7:00 pm

Monday Holidays

Effective 4/24/2019, Partners has begun a similar exception for Holidays that are on a Monday. Hospitals can submit a SAR for one additional day (maximum 4-day length of stay request) to make a request through a holiday weekend. For example, if a 3-day SAR is submitted with a start day of Friday, hospitals can request Friday, Saturday, Sunday and the Monday-holiday. A continued stay SAR must be submitted **on or** by end of Inpatient business day hours on Tuesday. SARs will be reviewed for Medical Necessity.

Alternative Methods For Requesting Authorization (No Computer Access)

For efficiency and to minimize reimbursement/claims issues, it is strongly recommended that all requests be submitted in the AlphaMCS system used by Partners BHM UM. Providers may contact the [HelpDesk, 704-842-6431](tel:704-842-6431), to request login information and assistance.

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

- 1) **Live Review By Phone:** Hospital Staff will need to call 704-842-6434, to reach a UM Care Manager between the hours of 8:00 AM-7:00 PM, daily, Sunday-Saturday. The UM Care Manager will collect information detailed on the [Inpatient Review Form](#);
- 2) **Manual Review By fax:** A **Manual Service Authorization Request Form** must be completed to include information on the [Inpatient Review Form](#). Documents can be faxed to 704-884-2703.

Prior authorization guidelines still apply.

Medicaid Hospitals without a Partners contract

Hospitals that do not have an Inpatient contract with Partners will need to follow the [Out of Network Client Specific Agreements and Contracts Policy](#). 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.

Retroactive Medicaid Service Authorization Requests

Effective February 24, 2020, Partners Utilization Management (UM) Department will review requests for Retroactive Medicaid requests submitted within **90** days from the Modified Date in NC Tracks. All Retroactive Service Authorization Requests (SAR) must be submitted to UM for medical necessity review. For further questions on Retroactive Medicaid requests, please contact the AST UM Workgroup at **704-842-6436**

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.

Timely Filing Requests should be sent directly to claimsdepartment@partnersbhm.org prior to submitting the claims.

- Retroactive Medicaid: Claims based on retroactive Medicaid eligibility must have authorization requested within 90 days. Timely filing requests and submission of claims must be within 90 days of the date modified in NCTracks for eligibility date range.

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

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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

Several documents are referenced throughout this manual. The following can be found on the [Hospitals Working with Partners](http://providers.partnersbhm.org) 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
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>.)