carolina complete health

Behavioral Health Training 08/23/2022: Questions & Answers

Utilization Management: Prior Authorizations

- How many unmanaged visits of outpatient therapy are there for adults and children?

Both adults and children are allowed 24 unmanaged visits (cumulative across providers) per state Fiscal Year (July 1 – June 30).

The 24 unmanaged visits are specific to individual, family, and group therapy. The following codes that fall into the unmanaged visits are: 90832, 90834, 90837, 90846, 90847, 90849, 90853

- How are additional units requested once a member utilizes all unmanaged visits?

Authorizations can be requested via fax, phone, or provider portal. See Behavioral Health Utilization Management Authorization Guidelines here for more specific information regarding authorization requests.

If faxing or using the provider portal, necessary clinical information can be sent with your request (included in same fax/uploaded in provider portal with authorization request).

- Is an authorization needed for outpatient therapy crisis codes (90839 & 90840)?

Crisis codes 90839 & 90840 do not require authorization; however, refer to Clinical Coverage Policy, 8C for visit limits and additional requirements (two per State FY and 90840 must be used with code 90839).

- What is the response time for a decision on an authorization request?

The turn-around time for a decision on an authorization request depends on the service requested as well as clinical need. For outpatient therapy requests, the turn-around time is 14 calendar days.

- **How does credentialing affect prior authorizations?**

Carolina Complete Health does not credential providers. All credentialing is managed through NC Tracks.

Covered/Non-Covered Benefits

- **What (b)(3) services are covered under standard plan versus tailored plan?**

Standard plans do not cover (b)(3) services.

- **Will Specialized Consultative Services (SCS) for BCBA ever be covered for members with behavioral support needs?**

SCS is an Innovations service and is not covered under Standard Plan. For more information related to SCS benefits contact the LME-MCO (future Tailored Plan) for your region.

- **Are Dialectical Behavioral Therapy (DBT) and Trauma-Focused Cognitive Behavior Therapy (TF-CBT) codes covered?**

Carolina Complete Health does not delineate treatment modalities for authorization. The base code for outpatient therapy would be used.

- **If a member needs to transition from a Standard Plan to a Tailored Plan (currently LME-MCOs), how can this occur?**

The member or provider can submit a Request to Move form when necessary. See additional information here.

Claims

- **What telehealth modifiers are needed?**

Per Clinical Coverage Policy 8C, the following is noted:

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not

appropriate for services provided via telephonic, audio-only communication.
Telephonic Claims: Modifier KX must be appended to the CPT or HCPCS code to indicate that a service has been provided via telephonic, audio-only communication.

- **Are there any updates on claims denials related to NPI Taxonomy issues?**

For specific claims questions, email NetworkRelations@cch-network.com.

Additionally, the Known Issues Tracker found here is updated every Thursday and can be reviewed to see projected resolution dates for known concerns across the network.

NC HealthConnex

- **Are outpatient therapy providers required to connect to NC HealthConnex?**

See NC Department of Information Technology here for more information on NC HealthConnex