Behavioral Health Provider Training 3/14/2023

Q&A Updated 05/01/2023

Q: We have been receiving denials for unmanaged outpatient therapy codes for "No Auth" but the client still has unmanaged units available based on the CCH 24 unmanaged limit. How do we get these claims to be reprocessed?

A: The cause of these claim denials has been identified and reprocessing of claims is occurring specific to the incorrect denial of unmanaged visits. Should you encounter additional concerns related to incorrect denials for unmanaged units, please email networkrelations@cch-network.com

Q: Is the information from the 3/14/23 Provider Training applicable to FQHCs or specifically specialty providers?

A: This training reviewed requirements specific to Clinical Coverage Policy, 8C (Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers) and Clinical Coverage Policy, 8G (Peer Support Services). FQHCs should also refer to Clinical Coverage Policy, 1D-4 (Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics).

Q: Can you clarify if BH auth requests can be retroactive?

A: Outpatient requests can only be retro authorized one calendar day. If you have retrospective dates that need authorization, please fax your request with a cover sheet to justify reason for the retrospective authorization. These reviews should be faxed to 866-714-7991. Please also refer to the Provider Manual for additional information on Retrospective Reviews.

Q: Can retro BH authorizations be completed on the portal, or should the authorization form be faxed in?

A: Retro BH authorization requests should be faxed to 866-714-7991.

Q: If a retro BH auth was submitted with all required documentations and still denied, is the only option to appeal? Can it be resubmitted as retro again?

A: If a retro BH authorization has been denied, you would follow the appeals process if you wish for the case to be reviewed. Please also refer to the Provider Manual for additional information on Retrospective Reviews.

Q: Does Carolina Complete Health authorize code H0045U4? This code references community-based respite services, not medical personal care.

A: H0045 is a (b)(3) service that is not a covered benefit in Standard Plans.

Q: How long does it typically take for authorization to be reviewed?
A: Utilization Management has up to 14 days to review outpatient therapy requests.

Q: For outpatient therapy, do you require a treatment plan and/or a service order?
A: Service orders should be included with authorization requests. All documentation requirements indicated in Clinical Coverage Policies should be followed and kept in the member's record.

Q: How do we know when a client's unmanaged units have all been used?
A: At this time, the provider portal does not have the capability to monitor if a member has utilized unmanaged sessions with a prior provider. If you're unsure if a member has utilized unmanaged sessions, you can submit an authorization request. If you do know that a member has unmanaged visits remaining and claims are denying for no authorization on file, please reach-out to Network Relations for specific claims questions at networkrelations@cch-network.com

Q: Does this mean that youth ages 3-18 that need community-based services will only be able to receive outpatient therapy through Carolina Complete Health?
A: Refer to Standard Plan covered services available to members. For children/adolescents under the age of 21, EPSDT is applied when reviewing all services requests.

Q: How can I find out who my Provider Rep is? If we have locations in multiple counties, can we have one Provider Rep?
A: Carolina Complete Health Network is adopting a new Provider Engagement Operating Model (PEOM) so that specialists will have an assigned Provider Engagement Administrator (PEA). If you have locations across multiple counties, you will have one assigned PEA. Implementation is being phased, with BH providers being assigned in the summer. Until then, please reach out to Network Support at NetworkRelations@cch-network.com for help. You will receive more information about Provider Engagement Administrator assignment soon.

Q: Do CCA's have to be updated annually?
A: Comprehensive Clinical Assessments should be completed prior to the provision of services. CCAs should be updated based on clinical need. Additionally, some policies do indicate more specific requirements on timeframe for which a CCA needs to be completed. Please refer to Clinical Coverage Policies specific to the service you are recommending/providing.

Q: If we use 96132 in psych testing, we must use 96133 for additional hours used. How do we do this without PA?

A: 96132 does not require authorization for PAR providers. There are 16 unmanaged Psychological and Neuropsychological Testing units available without authorization for PAR providers, which includes code 96133. Please refer to the Pre-Auth Tool at if you're unsure of which codes require prior authorization.

Q: Does the auth number have to be on the claim form?

A: An authorization number should be included on the claim to prevent incorrect processing or denials.

Q: If you put in an authorization for the therapy visit, does the member lose the unmanaged visit?

A: Once an authorization is on file for therapy sessions, the claim will process against the authorization on file. If all units from that authorization have been used, the claim will deny.

Q: Has the request for authorization has changed for inpatient behavioral health service?

A: No changes have been made to inpatient behavioral health reviews. Please reference CCH BH authorization guidelines for specific information for each service.