

Transforming Lives.
Building Community Well-Being.



Tailored Plan Provider Sessions

Utilization Management Department





Today's Agenda

01

BH Authorization Guidelines

02

BH Out of Network/Single Case Agreement

03

Submitting a Treatment Authorization Request (TAR)
for BH services

04

PH Prior Authorization Process

05

Pharmacy Prior Authorization



BH Authorization Guidelines

Julie Doty MA, LPA

Karren Wheeler MSW, LCSW

Prior Authorization Guidelines

Prior Authorization Services

Please use this tool to determine if prior authorization is required for specific services and codes. However, using this tool does NOT guarantee payment. Member eligibility, benefit plans, codes in provider contracts, and other details may impact payment. Please refer to the provider manual or call the Provider Support Service Line at 1-855-250-1539 for more information.

[Behavioral Health Services](#) |
 [Physical Health Services](#)

ACTT - H0040 - Case Rate

SERVICE CODE
H0040 - Case Rate

DIAGNOSIS GROUP
Substance Abuse
Mental Health

AGE GROUP
18-20
Adult

BENEFIT PLAN
State
Medicaid

Authorization Guidelines:

Prior Authorization Required

Medicaid: Initial 180 days. Concurrent 180 days

State: 30 days for all authorizations. 5 month limit per rolling year. *Medicaid application required within first 30 days.

- [Medicaid Policy](#)
- [State Funded Policy](#)

This is the current package of State, Medicaid Direct, B3, Innovations, and 1915i benefits for Trillium Health Resources 2/1/2024. Codes/modifier combinations not mentioned within benefits for specialized services will be found within contracts.

SERVICE	SERVICE CODE	REQUIRED DOCUMENTS	AUTHORIZATION GUIDELINES	FUNDING
ACTT	H0040 / H0040 U1(shadow claim) 1 unit=case rate per month	TAR, CCA (for initial request), PCP/Update w/signatures and checkboxes, Service Order, ASAM (if applicable), step-down plan; please refer to clinical communication 007 for additional requirements as of 07/01/16	Initial: 180 days for Medicaid State: 30 days for all auths; Medicaid app required within first 30 days; 5 month limit per rolling year beginning 04/28/17 Auth at 1 unit per mth	Medicaid/ State

Utilization Review

- ❖ For Medicaid services, there will be a No Prior Authorization (NPA) required period for 91 days effective 7/1/24. This No Prior Authorization period will extend through 9/30/24. Prior authorization approval will be required effective 10/1/24. Providers may begin submitting Treatment Authorization Requests (TARs) beginning September 1 for services beginning 10/1/24. You may submit up to 30 days prior to the start date of service, so any submission dates during the month of September are permissible.
- ❖ Although we are under an NPA required period through 9/30/24, some providers are electing to submit a TAR with required clinical documentation for prior authorization. These TARs will be reviewed and processed.
- ❖ The No Prior Authorization (NPA) period for State Funded benefits will end 6/30/24. This does not apply to services that have an unmanaged benefit or NPA “pass through.” Please refer to the authorization guidelines on the MH/SU and IDD Trillium benefit plans found on the Trillium website to determine which services will require prior authorization. Please begin submitting TARs now to ensure authorizations are in place for claims for dates of services beginning July 1, 2024.

BH Out of Network/Single Case Agreement



Out of Network providers are still required to follow the Single Case Agreement process. Please email your requests to UM@trilliumnc.org and include the following for review.

Current CCA/Assessment that recommends the service(s) requested, PCP/ISP/Plan including the signature page with signed Service Order, and any other clinical documentation to support the review for medical necessity.

- ❖ Contact Name
- ❖ Contact Phone Number & Email Address
- ❖ Member Name
- ❖ DOB
- ❖ Service/Code
- ❖ Requested Dates
- ❖ Frequency/Units (per week/month/year)
- ❖ Diagnosis and ICD 10 Code
- ❖ Addition information:
 - ❖ Provider Name (as listed on a W-9)
 - ❖ Provider Tax ID
 - ❖ Provider NPI
 - ❖ Provider Taxonomy
 - ❖ Service Address



Pharmacy Prior Authorizations

Tracy Snowden-Muller

Director of Pharmacy Operations

Pharmacy Prior Authorizations



Prior Authorization (PA) forms are available on the Trillium Health Resources Provider website at: www.trilliumhealthresources.org/tailored-plan-medicaid-providers-pharmacy-benefits/prior-authorization-forms

For the first 90 days (7/1/2024 - 9/30/2024) PAs for historical claims will be relaxed.

- In the event that a historical prior authorization was not received from NCDHHS, but can be verified through the NCTracks system, Trillium will honor that authorization through the original end date.
- If a new PA is needed, it must be initiated with PerformRx and does not fall under the flexibilities allowed for the TP launch.

Submitting a Treatment Authorization Request for BH Services (TAR)

Stacey Henderson

Sr. Program Manager - IT Business Systems



Submitting a BH Treatment Authorization Request

Objectives

- Accessing the BH I/DD Provider Portal - Provider Direct
- Treatment Authorization Request (TAR) Process
 - Initial Setup Tab of the TAR Process
 - Entering Diagnosis Information in the TAR
 - Adding Services to the TAR
 - Entering Treatment History for the member in the TAR
 - Completing Medical Information in the TAR
 - SA History (Situational Information)
 - LOCUS/CALOCUS or IDD Information
- Submitting the TAR
- Reviewing the Authorization
- Training Resources within Provider Direct



Accessing the BH I/DD Provider Portal - Provider Direct



Accessing the BH I/DD Provider Portal - Provider Direct

- To access the secure provider portals, please visit trillium’s website at www.trilliumhealthresources.org and select “For Providers”
- Hyperlink to Provider Direct is displayed mid-way down on the “For Providers” page OR you can click on “Provider Contact Information and Portal”

The screenshot shows the 'For Providers' page layout. On the left, there are two columns of service links. The first column includes 'Provider Support Service Line' (1-855-250-1539) and 'Provider Direct' (Behavioral Health I/DD Provider Portal (Provider Direct)), which is circled in red. The second column includes 'IT Service Desk' (PDSupport@TrilliumNC.org) and 'Claim Ticket System'. On the right, there is a 'Provider Contact Information and Portal' section with a 'Learn More' button. Below this, there are two main sections: 'Behavioral Health I/DD Provider Portal (Provider Direct)' and 'Physical Health Provider Portal'. The 'Behavioral Health' section lists steps for accessing the portal and includes a link to 'Behavioral Health I/DD Provider Portal (Provider Direct)'. The 'Physical Health' section lists steps for accessing the portal and includes a link to 'Physical Health Provider Portal'.

- In addition, a direct link to Carolina Complete Health’s provider portal is available within each screen within Trillium’s Provider Direct portal

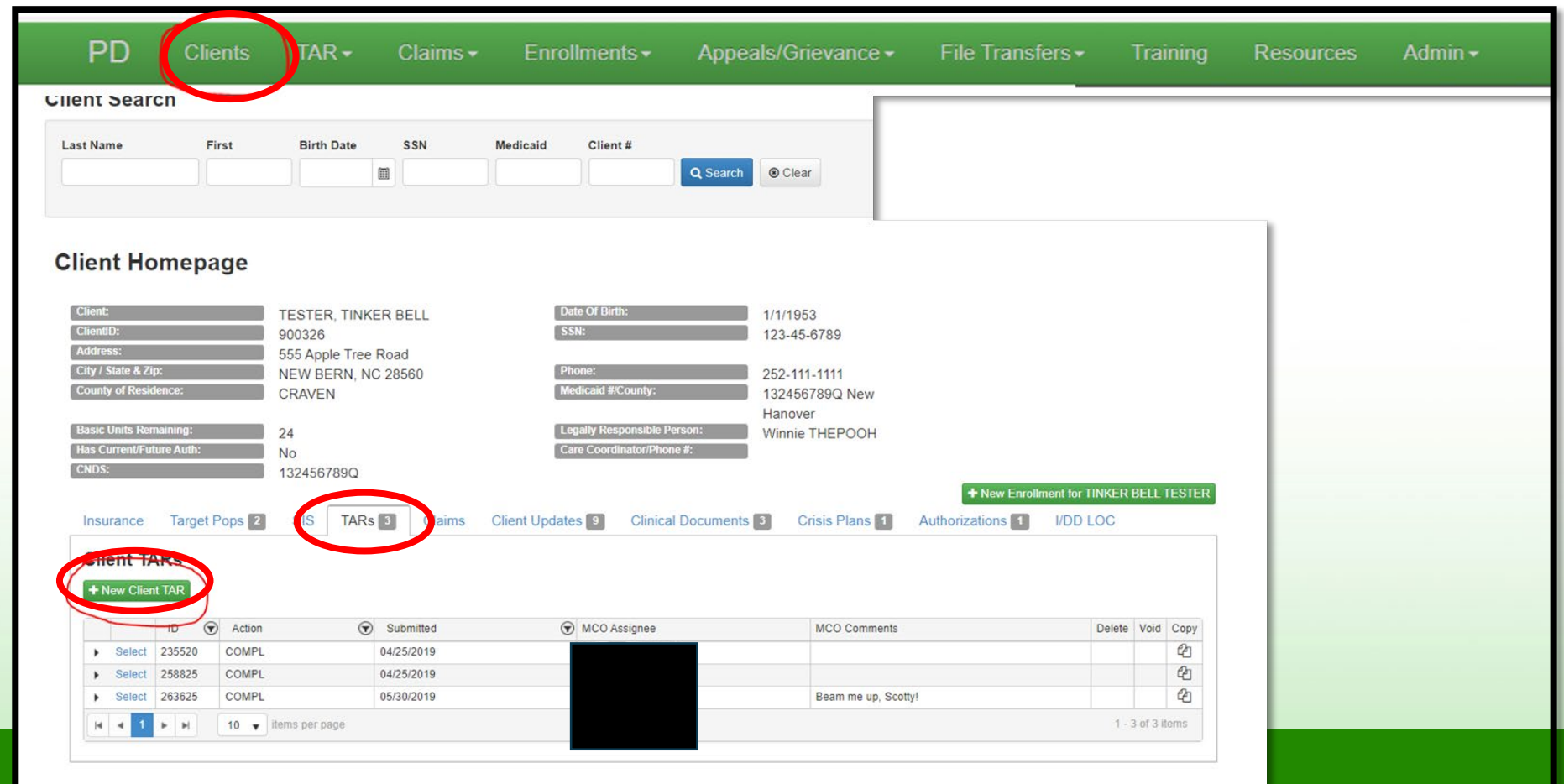
This banner features an orange header with the text "You are logged into MCO Trillium Health Resources". Below the header, on a white background, it states: "Carolina Complete Health will process all Tailored Plan physical health claims [Click here to access their portal.](#)"






Treatment Authorization Request (TAR) Process

Treatment Authorization Request (TAR) Process

- A Treatment Authorization Request (TAR) can be completed within Provider Direct to request an authorization for service for a member.
- This can be completed through the client search functionality by going to the TARs tab.



The screenshot displays the Provider Direct interface. At the top, a green navigation bar contains several menu items: PD, **Clients**, TAR, Claims, Enrollments, Appeals/Grievance, File Transfers, Training, Resources, and Admin. Below this is the 'Client Search' section with input fields for Last Name, First, Birth Date, SSN, Medicaid, and Client #, along with Search and Clear buttons. The main content area is titled 'Client Homepage' and displays client information for TESTER, TINKER BELL, including Client ID, Address, City/State/Zip, County of Residence, Date of Birth, SSN, Phone, Medicaid #/County, Legally Responsible Person, and Care Coordinator/Phone #. A green button '+ New Enrollment for TINKER BELL TESTER' is visible. Below the client information is a navigation bar with tabs: Insurance, Target Pops, IS, **TARs**, Claims, Client Updates, Clinical Documents, Crisis Plans, Authorizations, and I/DD LOC. The 'Client TARs' section is active, showing a '+ New Client TAR' button and a table of existing TARs.

ID	Action	Submitted	MCO Assignee	MCO Comments	Delete	Void	Copy
235520	COMPL	04/25/2019	[REDACTED]				
258825	COMPL	04/25/2019	[REDACTED]				
263625	COMPL	05/30/2019	[REDACTED]	Beam me up, Scotty!			



Initial Setup Tab of the TAR Process

Setup **Diagnosis** * This TAR has NOT been submitted to the MCO

Client Information

FIRST NAME: TINKER BELL M.I.: LAST NAME: TESTER SSN: 123-45-6789 DATE OF BIRTH: 01/01/1953 CLIENT ID: 900326

ADDRESS: 555 Apple Tree Road
NEW BERN, NC 28560

CLIENT SPECIALTY: DEVELOPMENTAL DISABILITIES MENTAL HEALTH SUBSTANCE ABUSE*

REQUEST TYPE: DISCHARGE INITIAL REQUEST REAUTHORIZATION*

SERVICE REQUEST TYPE: ACUTE ENHANCED INNOVATIONS IDD OUTPATIENT TCM* [More info...](#)

IDD SELF DIRECTION: AGENCY WITH CHOICE EMPLOYER OF RECORD N/A* [More info...](#)

Note: Fields with a red * must be completed before moving on to the next step in the TAR process

Note: Please choose the most appropriate response for the questions above. Move your mouse over "More Info" for further examples/definitions, where provided.

Provider Information

SUBMITTING PROVIDER: TRILLIUM HEALTH RESOURCES







CONTACT NAME: Stacey Henderson CONTACT PHONE: (000) 000-0000 CONTACT EMAIL: stacey.henderson@trilliumnc.org

[Back to Client](#) **Save & Continue**

Entering Diagnosis Information in the TAR

Setup | **Diagnosis*** This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced TAR #452516

CLASS	DX. CODE	ID#	EFF DATE	END DATE	DEL
Primary ▼	ICD-10 - F06.31 - Mood disorder due to known physiological condition ... ▼	20352	05/29/2024 	<input type="text"/> 	
-select- ▼	Start entering a Dx ID or Description ▼		<input type="text"/> 	<input type="text"/> 	

Psychosocial Stressors (check all that apply)

CHECK HERE IF NONE APPLY

<input checked="" type="checkbox"/> PROBLEMS WITH PRIMARY SUPPORT GROUP	<input checked="" type="checkbox"/> PROBLEMS RELATED TO THE SOCIAL ENVIRONMENT	<input type="checkbox"/> EDUCATIONAL PROBLEMS
<input type="checkbox"/> OCCUPATIONAL PROBLEMS	<input type="checkbox"/> HOUSING PROBLEMS	<input type="checkbox"/> ECONOMIC PROBLEMS
<input type="checkbox"/> PROBLEMS WITH ACCESS TO HEALTH CARE SERVICES	<input type="checkbox"/> PROBLEMS RELATED TO INTERACTIONS W/ LEGAL SYSTEM	<input checked="" type="checkbox"/> OTHER PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Back to ClientSave & Continue

Adding Services to the TAR

Setup Diagnosis Services * This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced TAR #452516

FOR DIAGNOSIS	DATE RANGE	SERVICE / PROVIDER	UNITS	DEL
DIAGNOSIS F06.31 - Mood disor	START DATE 06/01/2024 END DATE 11/30/2024	SERVICE T1017 HT- Tailored Care Management CARE MANAGEMENT SERVICE# 6027 PROVIDER 31052 - TRILLIUM HEALTH RESOURCES 1708 - TRILLIUM HE... 1708 E ARLINGTON BOULEV GREENVILLE, NC 27858 Provider# 31052	UNITS PER 1 Month TOTAL UNITS: 6	
DIAGNOSIS -select-	START DATE <input type="text"/> END DATE <input type="text"/>	SERVICE Start entering a Service SERVICE# PROVIDER Start entering a Provider PROVIDER#	UNITS PER <input type="text"/> -select- TOTAL UNITS: <input type="text"/>	

If you do not see your service listed, the following reasons may apply:

- The services listed are based on the Insurance Plan of this consumer. If you do not see the services you wish to provide, please verify the consumer is enrolled in the appropriate Benefit Plan. If you have any questions and concerns please contact your Eligibility Specialist for further assistance.
- The diagnosis code you selected on the Diagnosis page may not be appropriate for the selected Service.

If you do not see your provider listed, the following reason may apply:

- The Provider may not be contracted to provide the selected service.

NOTE: tips for common issues for not seeing the service you are requesting or your provider agency is provided on this tab to assist with troubleshooting.

Back to Client **Save & Continue**

A common reason for not being able to find the service you are requesting in the drop down is that the end date for the time period requesting exceeds the members eligibility span. You can check the member's eligibility on the client home page under the insurance tab.

Additionally, if you are able to select the service but you are not seeing your provider agency in the provider drop down, that service may not be in the your contract for that funding type.

Entering Treatment History for the member in the TAR

Setup Diagnosis Services **Treatment**

* This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced TAR #452516

Current Treatment

IS CONSUMER CURRENTLY RECEIVING ANY TREATMENT? No *

Previous Treatment

HAS CONSUMER RECEIVED TREATMENT IN THE PAST? No *

[Back to Client](#) [Save & Continue](#)

Completing Medical Information in the TAR



Setup Diagnosis Services Treatment **Medical** * This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced TAR #452516

MEDICATION	DOSE	REGIMEN	DEL
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Additional Information

PRIMARY CARE PHYSICIAN

SIGNED RELEASE (TO PHYSICIAN)? No

MEDICALLY COMPLIANT No

ALLERGIES

HAS PRIMARY CARE PHYSICIAN BEEN CONTACTED? No *

WHY NOT? *

WHEN WAS THE CONSUMER'S LAST APPOINTMENT WITH HIS/HER PRIMARY CARE PHYSICIAN?

HAS PRIMARY CARE PHYSICIAN BEEN INFORMED OF CURRENT TREATMENT EPISODE? No *

WHY NOT? *

RELEVANT MEDICAL ISSUES

MEDICAL COMMENTS

Back to Client **Save & Continue**

Note: If you select NO for either of the drop downs with a red * and hit "Save & Continue" an error message will show. This is simply prompting you to put in a reason for selecting NO in the drop down before continuing to the next step of the TAR process.


SA History (Situational Information)

- The SA History is a situational tab: If you put in a Substance Use diagnosis on the diagnosis tab, you will be prompted to complete the SA History page.

Setup Diagnosis Services Treatment Medical **SA History** IDD Review

This TAR has been submitted to MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Acute [TAR #258825](#)

PRIORITY	SUBSTANCE	ROUTE	AMOUNT	AGE 1ST USE	FREQUENCY	LAST USE
Primary ▼	03-Marijuana/Hash ▼	2-Smoking ▼	1	18	0-Not Used Past Mc ▼	03/01/2019 

LOCUS/CALOCUS OR IDD Information



If the primary diagnosis is a BH diagnosis and the Service is a BH, you will be prompted to complete the LOCUS/CALOCUS page

If the primary diagnosis is an IDD diagnosis and the service an IDD service, you will be prompted to complete the IDD page

Setup Diagnosis Services Treatment Medical **LOCUS / CALOCUS** * This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced TAR #452516

LOCUS

I. RISK OF HARM 1 2 3 4 5

II. FUNCTIONAL STATUS 1 2 3 4 5

III. CO-MORBIDITY 1 2 3 4 5

IV.A. RECOVERY ENVIRONMENT - STRESS 1 2 3 4 5

IV.B. RECOVERY ENVIRONMENT - SUPPORT 1 2 3 4 5

V. TREATMENT AND RECOVERY HISTORY 1 2 3 4 5

VI. ENGAGEMENT 1 2 3 4 5

LOCUS SCORE: 9
Score below level of care determination criteria.

COMMENTS

Back to Client **Save & Continue**

Setup Diagnosis Services Treatment Medical SA History **IDD** Review This TAR has been submitted to MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Acute TAR #258825

Support Needs Ratings

ACTIVITY SUB SCALES	TOTAL RAW SCORES	STANDARD SCORES
A. HOME LIVING	0	0
B. COMMUNITY LIVING	0	0
C. LIFELONG LEARNING	0	0
D. EMPLOYMENT	0	0
E. HEALTH AND SAFETY	0	0
F. SOCIAL	0	0

CHECK THIS BOX IF DD/SIS CHILD
Note: SIS Worksheet data below not required if Child.

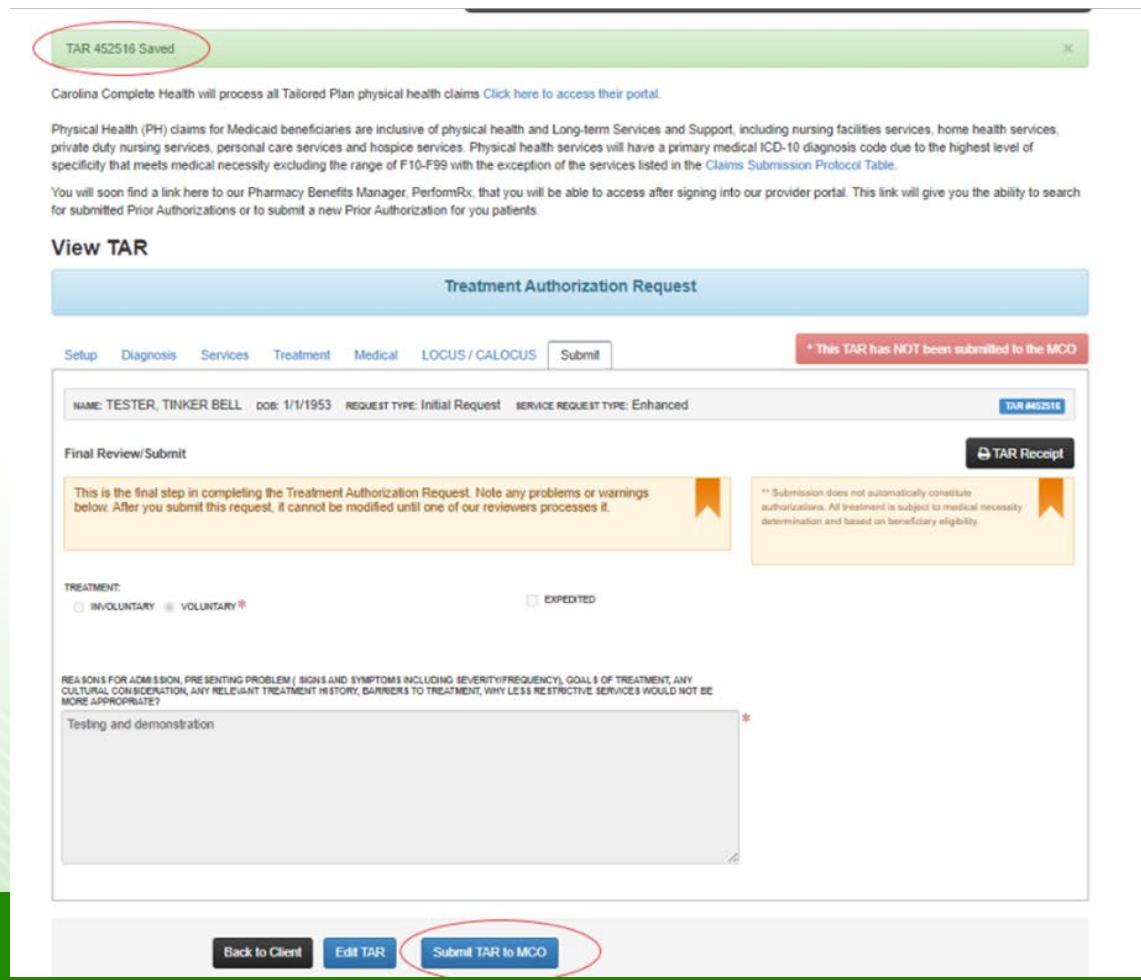
Support Considerations Based on Exceptional Medical and Behavioral Support Needs

A: Medical
TOTAL POINTS FROM PAGE 6 OF WORKSHEET:
 AT LEAST ONE "2" IS CIRCLED FOR MEDICAL SUPPORT NEED ON PAGE 6

B: Behavioral
TOTAL POINTS FROM PAGE 7 OF WORKSHEET:
 AT LEAST ONE "2" IS CIRCLED FOR BEHAVIORAL SUPPORT NEED ON PAGE 7

Reviewing, Saving and Submitting the TAR

- On the final tab, will indicate if this is involuntary, voluntary treatment and if this request needs to be expedited. In addition, you will be required to add a synopsis of the reason for the request. After you hit “Save & Continue” a TAR number will be populated and indicated in a green bar at the top of this screen. This has SAVED the TAR but has not submitted it to Trillium. You must click on “Submit TAR to MCO” for the TAR to be submitted for review by Trillium Utilization Management staff.



TAR 452516 Saved

Carolina Complete Health will process all Tailored Plan physical health claims [Click here to access their portal.](#)

Physical Health (PH) claims for Medicaid beneficiaries are inclusive of physical health and Long-term Services and Support, including nursing facilities services, home health services, private duty nursing services, personal care services and hospice services. Physical health services will have a primary medical ICD-10 diagnosis code due to the highest level of specificity that meets medical necessity excluding the range of F10-F99 with the exception of the services listed in the [Claims Submission Protocol Table.](#)

You will soon find a link here to our Pharmacy Benefits Manager, PerformRx, that you will be able to access after signing into our provider portal. This link will give you the ability to search for submitted Prior Authorizations or to submit a new Prior Authorization for you patients.

View TAR

Treatment Authorization Request

Setup Diagnosis Services Treatment Medical LOCUS / CALOCUS **Submit**

* This TAR has NOT been submitted to the MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced **TAR #452516**

Final Review/Submit **TAR Receipt**

This is the final step in completing the Treatment Authorization Request. Note any problems or warnings below. After you submit this request, it cannot be modified until one of our reviewers processes it.

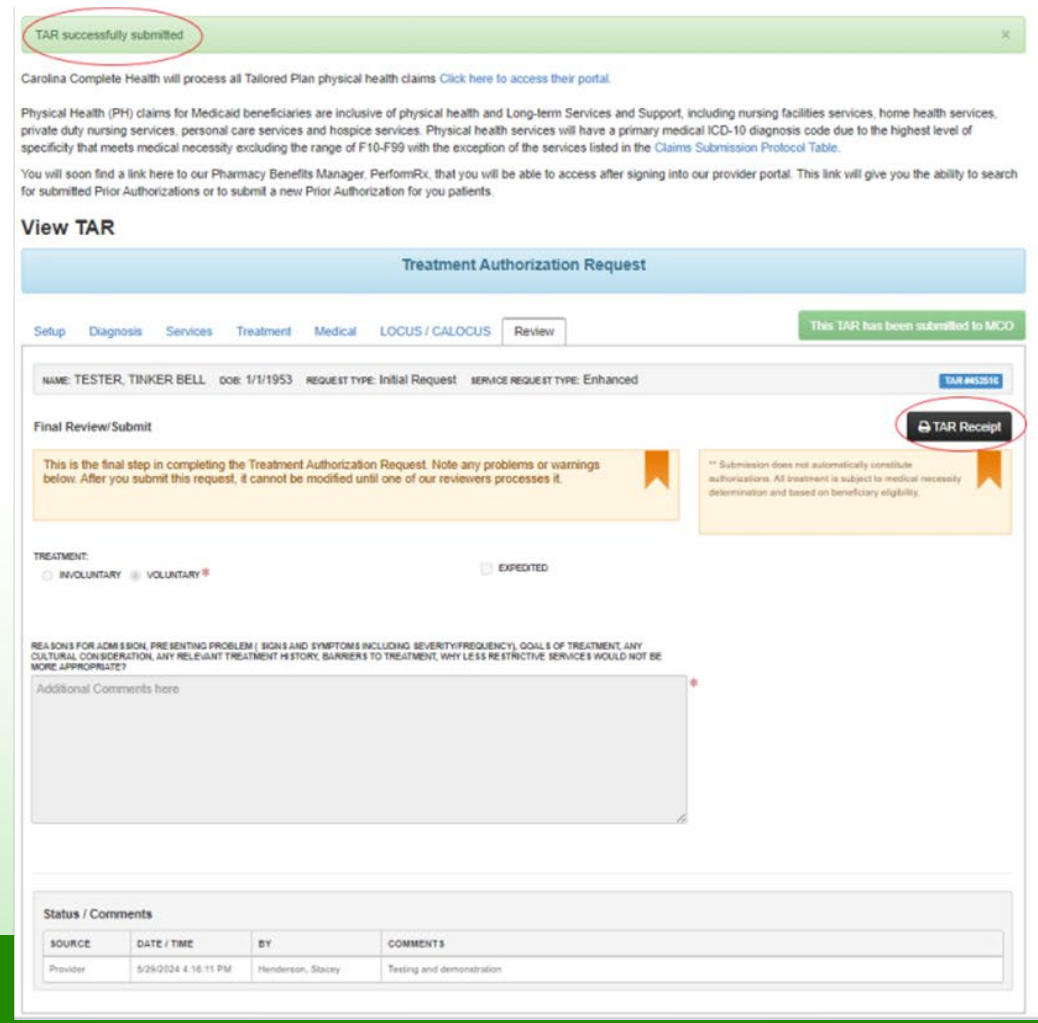
** Submission does not automatically constitute authorizations. All treatment is subject to medical necessity determination and based on beneficiary eligibility.

TREATMENT:
 INVOLUNTARY VOLUNTARY EXPEDITED

REASONS FOR ADJUSION, PRESENTING PROBLEM (SIGNS AND SYMPTOMS INCLUDING SEVERITY/FREQUENCY), GOALS OF TREATMENT, ANY CULTURAL CONSIDERATION, ANY RELEVANT TREATMENT HISTORY, BARRIERS TO TREATMENT, WHY LESS RESTRICTIVE SERVICES WOULD NOT BE MORE APPROPRIATE?

Testing and demonstration

Back to Client Edit TAR **Submit TAR to MCO**



TAR successfully submitted

Carolina Complete Health will process all Tailored Plan physical health claims [Click here to access their portal.](#)

Physical Health (PH) claims for Medicaid beneficiaries are inclusive of physical health and Long-term Services and Support, including nursing facilities services, home health services, private duty nursing services, personal care services and hospice services. Physical health services will have a primary medical ICD-10 diagnosis code due to the highest level of specificity that meets medical necessity excluding the range of F10-F99 with the exception of the services listed in the [Claims Submission Protocol Table.](#)

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View TAR

Treatment Authorization Request

Setup Diagnosis Services Treatment Medical LOCUS / CALOCUS **Review**

This TAR has been submitted to MCO

NAME: TESTER, TINKER BELL DOB: 1/1/1953 REQUEST TYPE: Initial Request SERVICE REQUEST TYPE: Enhanced **TAR #452516**

Final Review/Submit **TAR Receipt**

This is the final step in completing the Treatment Authorization Request. Note any problems or warnings below. After you submit this request, it cannot be modified until one of our reviewers processes it.

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TREATMENT:
 INVOLUNTARY VOLUNTARY EXPEDITED

REASONS FOR ADJUSION, PRESENTING PROBLEM (SIGNS AND SYMPTOMS INCLUDING SEVERITY/FREQUENCY), GOALS OF TREATMENT, ANY CULTURAL CONSIDERATION, ANY RELEVANT TREATMENT HISTORY, BARRIERS TO TREATMENT, WHY LESS RESTRICTIVE SERVICES WOULD NOT BE MORE APPROPRIATE?

Additional Comments here

Status / Comments

SOURCE	DATE / TIME	BY	COMMENTS
Provider	5/29/2024 4:16:11 PM	Henderson, Stacy	Testing and demonstration

Viewing the Authorization

Once the request has been processed and approved by Trillium's Utilization Management staff, you can see the members service authorizations via the Client Home page OR through the Print Authorizations functionality.

Client Homepage

Client:	TESTER, TINKER BELL	Date Of Birth:	1/1/1953
ClientID:	900326	SSN:	123-45-6789
Address:	555 Apple Tree Road	Phone:	252-111-1111
City / State & Zip:	NEW BERN, NC 28560	Medicaid #/County:	132456789Q New Hanover
County of Residence:	CRAVEN	Legally Responsible Person:	Winnie THEPOOH
Basic Units Remaining:	24	Care Coordinator/Phone #:	
Has Current/Future Auth:	No		
CNDS:	132456789Q		

[New Enrollment for TINKER BELL TESTER](#)

[Insurance](#) [Target Pops 2](#) [SIS](#) [TARs 3](#) [Claims](#) [Client Updates 9](#) [Clinical Documents 3](#) [Crisis Plans 1](#) **[Authorizations 1](#)** [/DD LOC](#)

Authorizations

[Print Authorization for ALL items on this page](#)

Auth #	Service Definition	Serv. Code	Auth Date...	Auth Units	Auth Effe...	Auth End	TAR #	Revised
1904233449	B3 SERVICES	H0043 U4	04/25/2019	12	11/02/2018	11/07/2018	235520	

10 items per page

1 - 1 of 1 items

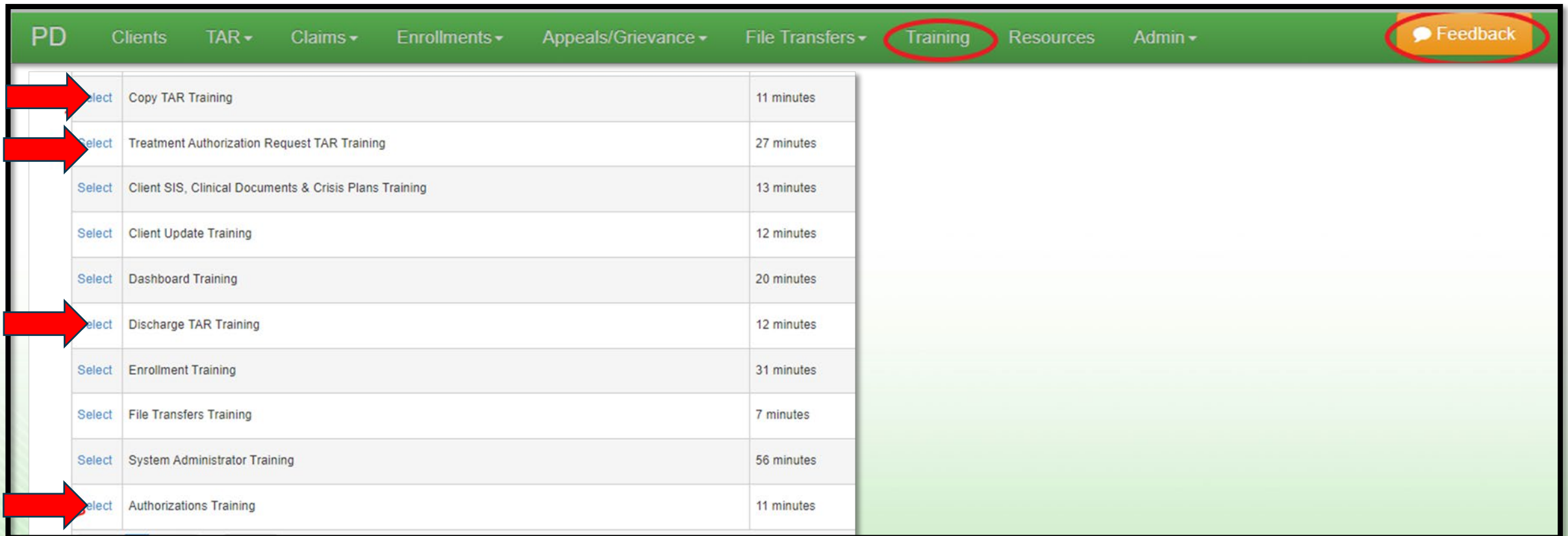
PD Clients **TAR** Claims E

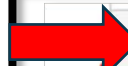

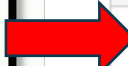
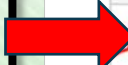
Search TARs

Print Authorizations

Training Resources within Provider Direct

- Training Materials can be found within Provider Direct for quick access
- Training resources are available for many Provider Direct functionalities, including several related to treatment/service authorization requests
- If you need technical assistance, you can reach out to PD Support via the FEEDBACK button within Provider Direct or email pdsupport@trilliumnc.org



	PD	Clients	TAR ▾	Claims ▾	Enrollments ▾	Appeals/Grievance ▾	File Transfers ▾	Training	Resources	Admin ▾	Feedback	
	Select							Copy TAR Training				11 minutes
	Select							Treatment Authorization Request TAR Training				27 minutes
	Select							Client SIS, Clinical Documents & Crisis Plans Training				13 minutes
	Select							Client Update Training				12 minutes
	Select							Dashboard Training				20 minutes
	Select							Discharge TAR Training				12 minutes
	Select							Enrollment Training				31 minutes
	Select							File Transfers Training				7 minutes
	Select							System Administrator Training				56 minutes
	Select							Authorizations Training				11 minutes



PH Utilization Management

Jesse Hardin

Carolina Complete Health Network

Director, Communications and Program Implementation



Objectives

- How to enroll with the Physical Health Portal
- Review authorization submission methods
- Review the PA Tool
- Share clinical coverage policy resources and review the Medical Affairs Committee (MAC)



Physical Health Authorizations



Auth Request Submission

- Trillium Physical Health authorizations are reviewed by Carolina Complete Health
- Providers have three methods to submit authorizations:
 - Portal: provider.trilliumhealthresources.org (preferred)
 - Phone: 855-250-1539
 - Fax ([Fax Form](#))
 - Physical Health Outpatient: 833-875-0930
 - Physical Inpatient:
 - Face Sheet: 833-875-0650
 - Concurrent Review: 833-875-2264

Prior Authorization Request

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be Medicaid Tailored Plan eligible and a Trillium member on the date of service. See reverse side for instructions.



I. GENERAL INFORMATION									
1. Name (Last, First, M.I.)				2. Date of Birth (MM/DD/YY)			3. NC Medicaid ID Number		
4. Address (Street, City, State, zip Code)									
5. Diagnosis Code					6. Diagnosis Description				
7. Name and address of facility where services are to be rendered, if other than home or office									
II. SERVICE INFORMATION							FOR PLAN USE ONLY		
8. REF. NO.	9. Procedure Code	10. From	11. Through	12. Description of Service/Item	13. QTY or Units	APPR.	Denied	Amount Allowed if Priced by Report	
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
14. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary)									
III. PROVIDER					IV. PRESCRIBING/PERFORMING PRACTITIONER				
15. Provider Name					19. Provider Name			20. Telephone	
16. Address					21. Address				
17. NPI and TAX ID					22. NPI and TAX ID				
18. Fax Number					By submitting this form, the Provider identified in this Section V. certifies that the information given in Section I and III of this form is true, accurate, and complete.				
V. FOR PLAN USE ONLY									
Denial Reason(s). Refer to table above by reference numbers (REF NO.)									
IF APPROVED: Services Authorized to Begin					Date		Reviewed by Signature		

Please Fax Completed Form to:

Outpatient Medical Requests: 833-238-7694 Physician Administered Drug Off Label Request: 833-465-1703
 Inpatient Medical Requests: 833-238-7692

Continued on page 2

Is Prior Authorization Needed?

All out-of-network services and providers require prior authorization, excluding emergency services, primary care, family planning, post stabilization services, and tabletop x-rays

Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.

carolinacompletehealth.com/trillium-preauth.html

Are Services being performed in the Emergency Department?
YES NO

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member having observation services?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

N
No **69436 - TYMPANOSTOMY GEN ANES**
No authorization required.



When a member needs to visit a specialist know that:

- **Referrals are not required for members to seek care with in-network specialists**
- Trillium educates members to seek care or consultation with their Primary Care Provider (PCP) first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers



(Formerly National Imaging Associations)

- Trillium, through its partnership with CCH, will use Evolut to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services**.
- Effective October 1, 2024: Providers may begin contacting Evolut to obtain prior authorization scheduled on or after October 1, 2024.
- Prior authorization requests can be made online at: www1.RadMD.com



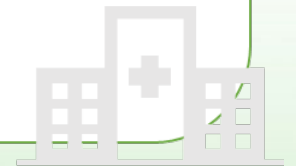
Procedures requiring PA*

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Stress Echocardiography



Exclusions include procedures performed in the following settings:

- Hospital Inpatient
- Observation
- Emergency Department
- Urgent Care
- Surgery Center



*Please see specific educational documents on RadMD for each Medical Specialty Solutions Program Services

Physical Health Authorization, Notification, and Determination Timeframes

Authorization Type	Timeframe for Provider
Standard Service Request (Inpatient)	All non-emergency inpatient admissions require prior authorization. Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.
Standard Service Request (Outpatient)	Prior authorization should be requested at least fourteen (14) calendar days before the scheduled service delivery date or as soon as need for service is identified.
Urgent Service Request (Inpatient)	Emergency admissions will require notification via authorization submission within one (1) business day, following the date of admission.
Urgent Service Request (Outpatient)	Prior authorization should be requested as soon as need for service is identified, prior to service being performed.

Physician Administered Drug Program



- Physician Administered Drug Program (PADP)
- A prior authorization is not required for a provider administering a PDP drug for an FDA approved indication.
- **Off-label use, where not listed on the PDP catalog, requires a case-by-case review via PA request**
- Providers may submit Physician Drug Program off-label use medication requests via:
 - Trillium Physical Health Provider Portal (provider.trilliumhealthresources.org/).
 - By fax: 833-754-0251

Durable Medical Equipment (DME)



- DME is considered a Physical Health benefit.
- DME claims and authorizations are processed by Carolina Complete Health using the submission methods shared on previous slide.
- Refer to the Durable Medical Equipment [Fee Schedule](#) for the rates associated with the equipment, supplies and services.
- Additionally, the clinical coverage policies listed can be references for information regarding benefit limitations, documentation and additional billing information.
- Clinical Coverage Policies: <https://network.carolinacompletehealth.com/resources/clinical-policies.html>
 - Physical Rehabilitation Equipment and Supplies, 5A-1
 - Respiratory Equipment and Supplies, 5A-2
 - Nursing Equipment and Supplies, 5A-3
 - Orthotics and Prosthetics, 5B

Specialized Therapies



- Speech, Occupational, and Physical therapies are considered physical health services for Tailored Plan.
- ST/OT/PT claims and authorizations are processed/reviewed by Carolina Complete Health.
- For Trillium Tailored Plan, please use claims and auth submission methods outlined in this training.
- ST/OT/PT [Provider Frequently Asked Questions Guide](#)

Clinical Coverage Policies



- All physical health services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.
- For details, view the [Clinical Coverage Policies](#).
- All medical services performed, even if a Prior Authorization is not required, must be medically necessary and may not be experimental in nature.



Physical Health Portal

Physical Health Secure Provider Portal



Using the “Trillium Physical Health Portal” is one way to submit physical health claims and authorizations to Carolina Complete Health for processing.

Secure Provider Portal Functions:

- Claims submissions
- Prior authorizations
 - ...and more!

Secure Physical Health Portal address:

<https://provider.trilliumhealthresources.org/>

Trillium
HEALTH RESOURCES

Log In

Username (Email)

LOG IN

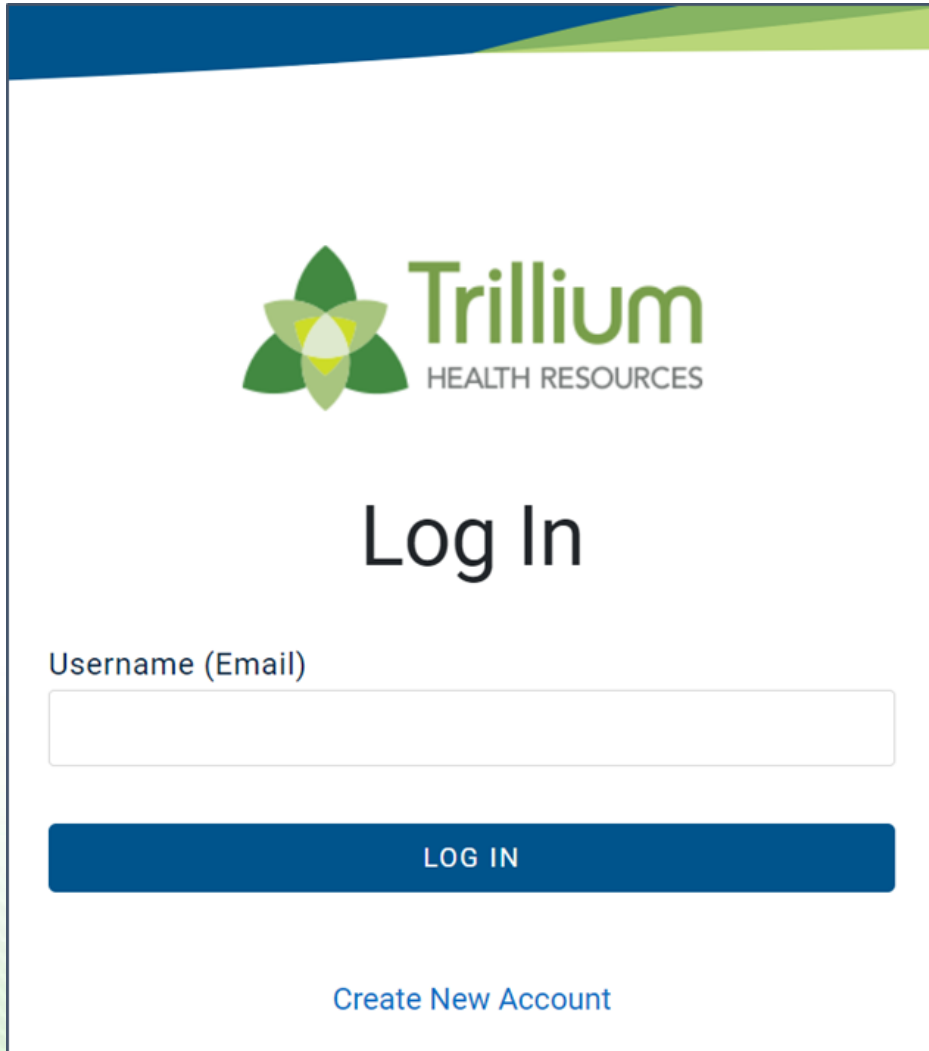
[Create New Account](#)

single password  reliable security
EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2022 Centene

Note: Providers should not use the Carolina Complete Health Standard Plan portal to submit Tailored Plan claims.

Physical Health Portal Registration

A screenshot of the Trillium Health Resources login page. At the top left is the Trillium Health Resources logo, which consists of a green and yellow stylized flower icon next to the text 'Trillium HEALTH RESOURCES'. Below the logo, the text 'Log In' is displayed in a large, bold, black font. Underneath 'Log In' is a text input field labeled 'Username (Email)'. Below the input field is a dark blue button with the text 'LOG IN' in white, uppercase letters. At the bottom of the page, there is a blue link that says 'Create New Account'.

Secure Portal address: <https://provider.trilliumhealthresources.org/>

1. **Assign Portal Account Manager:** To access the Trillium Physical Health Portal, in-network contracted providers must identify one individual who will serve as the Portal Account Manager. The Account Manager will be responsible for managing all other users for that provider organization.
2. **Create an account:** Visit provider.trilliumhealthresources.org to create a new account associated with your email address.
3. **Verify email:** Verify your email address by entering the one-time code sent by EntryKeyID.
4. **Register TIN:** Under the 'Success!' message, click continue to enter the Tax ID for the contracted entity, business phone and fax. Click 'Submit.'
5. **Email Provider Engagement:** After registering, email your assigned [Provider Engagement Administrator](mailto:ProviderEngagementAdministrator@cch-network.com) or ProviderEngagement@cch-network.com to request verification of your portal registration request and assignment as Portal Account Manager. Carolina Complete Health is responsible for setting up the first Account Manager account. Afterward, the Account Manager is responsible for user management.

What is an Account Manager?

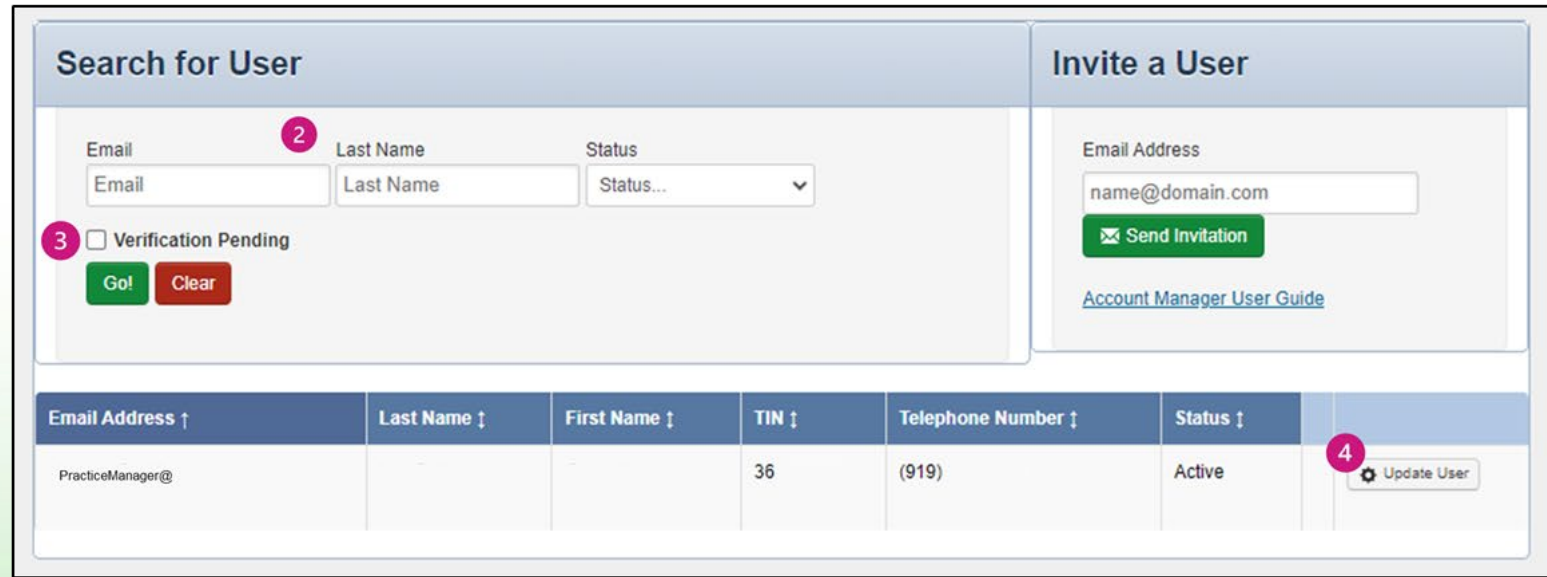
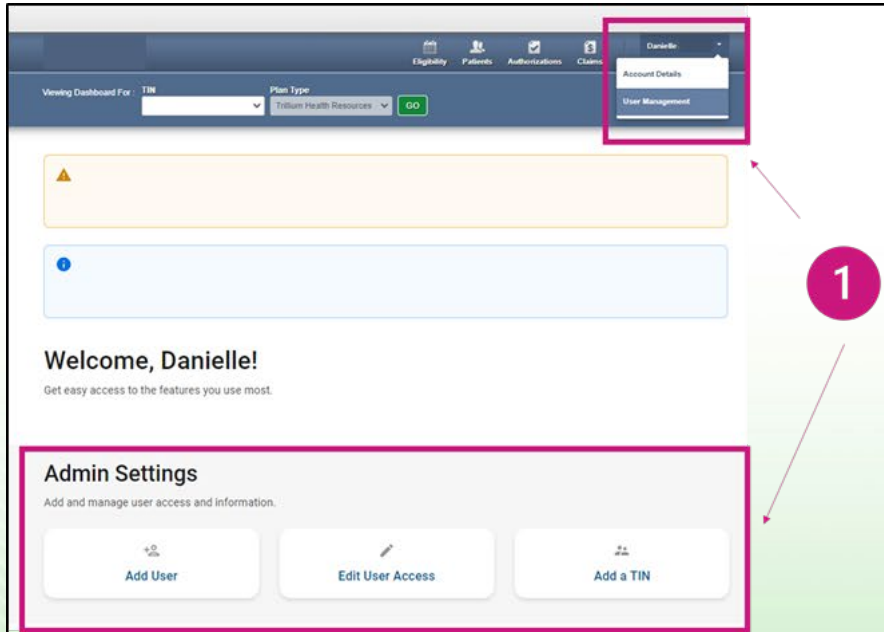


- Account Manager is a role within the Secure Portal that is assigned to the **primary contact within your practice. This is chosen at the discretion of the organization.**
- The purpose of this role is to help us maintain the safety and integrity of patient data.
- The Account Manager is responsible for day-to-day support of all Secure Portal user accounts that are registered under the same Tax Identification Number (TIN). These responsibilities include:
 - Approving access for new Secure Portal users
 - Assigning permissions for users based on their job responsibilities
 - Regularly adjusting the permissions of users whose roles may have changed
- Terminating users who no longer work at the practice

Accessing Account Manager Tasks



- 1) Click the User Management dropdown in the upper right-hand corner or use Admin Settings from the home screen to complete Account Manager actions.
- 2) Search for a specific user by entering their name and email address, or view a list of all users in your practice.
- 3) For new user accounts that need to be verified, select the Verification Pending box, click the Verify Account button, and follow instructions on the back page.
- 4) To view and edit details of existing accounts, click the Update User button and follow instructions on the back page



Account Manager Tasks



1. Enabling and Disabling Users

- Account Managers will receive an email when a user from their practice creates a new user account. The Account Manager will click Enable User to grant access to the user.
- If a user leaves the practice or no longer needs access to the Secure Portal information for that specific TIN, the Account Manager will click Disable User.

2. Selecting/modifying access levels for users

- Account Managers are responsible for selecting and managing the appropriate access for each user in their practice.
- Access levels include:
 - Health Records: View a patient's health records for number and type of visits, medications, Immunizations and labs, care gaps, etc.
 - Claims: View and submit claims.
 - Manage Account: Enable, disable, modify permissions for a specific TIN, and invite users to set up an account.
 - Eligibility: View and check eligibility for a specific patient.
 - Assessments: Complete or view a Health Risk Assessment (HRA) or Notification of Pregnancy (NOP) for a patient.
 - Authorizations: View and submit authorizations.

Update User status and permissions for Lee

User Information

Email: PracticeManager@ Status: Active
Name: Last Login Time: 2021-10-12 09:57:23
Telephone Number: (919)

Profile Information

TIN: 36 Verified: Yes

Can Access: Claims Assessments Manage Practice Health Passport Reports Health Record Manage Account
 Eligibility Authorizations

Update Status: Disable user

Comments: 200 characters left
(required)

Comments History:

Portal Training Tip Sheets



- [Secure portal slide guide](#)
- [How to Create an Account and Register with the Secure Provider Portal](#)
- [Portal Account Manager Tips](#)
- [Checking Member Eligibility and Health Record](#)
- [Submitting a Claim](#)
- [Submitting Reproductive Health Consent Forms via Secure Provider Portal](#)



Using the Trillium Physical Health Portal to View and Submit PH Authorizations

Accessing Authorizations in the Portal



- To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.

The screenshot shows the Trillium Health Resources portal dashboard. At the top, there is a navigation bar with the Trillium logo and icons for Eligibility, Patients, Authorizations, and Claims. Below the navigation bar, there is a section for "Viewing Dashboard For" with a dropdown menu for "TIN" and a "Plan Type" dropdown menu for "Trillium Health Resources", followed by a "GO" button. Below this, there are two informational banners: one with a warning icon about a healthcare outage and another with an information icon about tailored plans. The main content area starts with a "Welcome, Danielle!" message and a "Quick Actions" section. The "Quick Actions" section includes a form with fields for "Member ID or Last Name", "Member Date of Birth", and "Select Action Type", along with a "SUBMIT" button. The "Select Action Type" dropdown menu is open, showing options: "View Eligibility & Patient Information", "Create New Claim", "Create Recurring Claim", and "Create Authorization". Below the "Quick Actions" section, there is a heading for "Authorization Overview".

Patient Overview: Authorizations

[Back to Authorizations](#)

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP190	02/04/2020	12/31/9999	E87.6	INPATIENT	Medical
APPROVE	IP179	10/29/2019	11/01/2019	I50.9	INPATIENT	Medical
APPROVE	IP167	07/19/2019	07/22/2019	L03.115	INPATIENT	Medical
APPROVE	OP16	07/09/2019	09/06/2019	Z48.01	OUTPATIENT	Home Health
PARTIAL_APPROVE	IP162	06/08/2019	06/25/2019	L03.90	INPATIENT	Medical
APPROVE	IP161	05/21/2019	05/24/2019	L03.90	INPATIENT	Medical
APPROVE	IP158	04/24/2019	04/29/2019	I50.9	INPATIENT	Medical

[Create a New Authorization](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

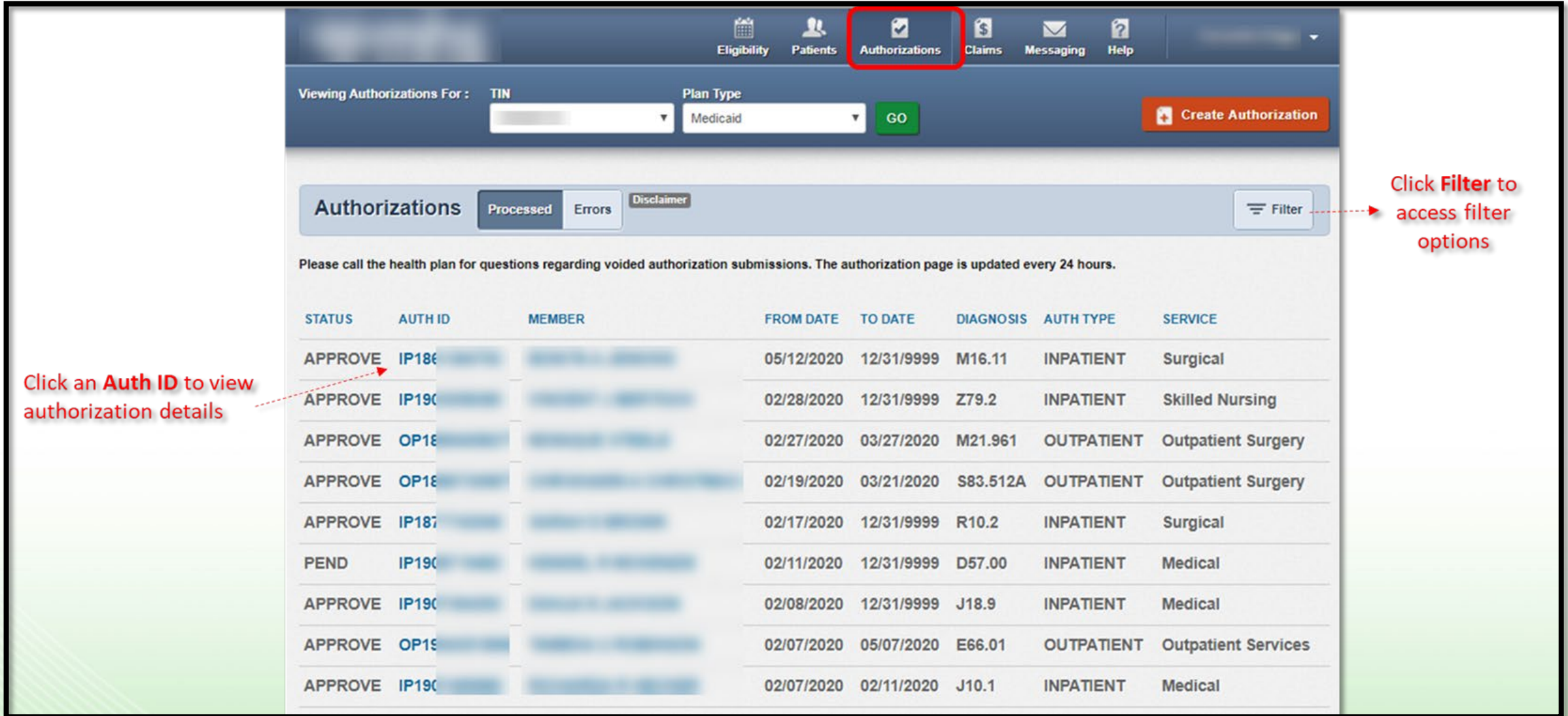
Claims

Power Account Service Estimate

Document Resource Center

Notes

Authorization Summary View



The screenshot shows the 'Authorizations' section of a web application. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below this is a search area with 'Viewing Authorizations For:' followed by a TIN dropdown, a Plan Type dropdown set to 'Medicaid', and a 'GO' button. To the right is a 'Create Authorization' button. The main content area has a header with 'Authorizations', 'Processed', 'Errors', and 'Disclaimer' tabs, and a 'Filter' button. A red arrow points to the 'Filter' button with the text 'Click Filter to access filter options'. Below the header is a disclaimer: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.' A table follows with columns: STATUS, AUTH ID, MEMBER, FROM DATE, TO DATE, DIAGNOSIS, AUTH TYPE, and SERVICE. A red arrow points to the 'AUTH ID' column with the text 'Click an Auth ID to view authorization details'. The table contains 10 rows of authorization data.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP186		05/12/2020	12/31/9999	M16.11	INPATIENT	Surgical
APPROVE	IP190		02/28/2020	12/31/9999	Z79.2	INPATIENT	Skilled Nursing
APPROVE	OP18		02/27/2020	03/27/2020	M21.961	OUTPATIENT	Outpatient Surgery
APPROVE	OP18		02/19/2020	03/21/2020	S83.512A	OUTPATIENT	Outpatient Surgery
APPROVE	IP187		02/17/2020	12/31/9999	R10.2	INPATIENT	Surgical
PEND	IP190		02/11/2020	12/31/9999	D57.00	INPATIENT	Medical
APPROVE	IP190		02/08/2020	12/31/9999	J18.9	INPATIENT	Medical
APPROVE	OP19		02/07/2020	05/07/2020	E66.01	OUTPATIENT	Outpatient Services
APPROVE	IP190		02/07/2020	02/11/2020	J10.1	INPATIENT	Medical

Authorization Details

[Back to Authorizations](#)

Overview
Auth Status: APPROVE
Auth Nbr: IP195
Admit Date: 05/12/2020
Provider of Service(s): HOSPITAL

Cost Sharing

Assessments
[Diagnosis Code\(s\):](#) T21.31XA
R69
T21.11XA

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Explanation: Pay
Auth Type: INPATIENT
Service: Surgical
Discharge Date: 05/20/2020
[Procedure Code\(s\):](#) 99221
99231
Notes & Attachments: [View](#)

Click hyperlink(s) to view additional codes

Hover your mouse over a Line Item to view the CPT, REV or HCPC code associated with it

Line Item	Service type	From Date	Medical Necessity	Decision Date
1	Medical	05/12/2020	APPROVE Met as requested	05/13/2020
2	Medical	05/13/2020	APPROVE Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020 Med/Surg Inpatient Hospital APPROVE Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020 Med/Surg Inpatient Hospital APPROVE Met as requested	05/18/2020

Diagnosis and Procedure Codes

Primary Diagnosis Code: T21.31XA
Additional Diagnosis Codes: R69 T21.11XA
Primary Procedure Code: 99221
Additional Procedure Codes: 99221

Create a Portal Authorization

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

1 Member ID or Last Name *

2 Member Date of Birth

MM/DD/YYYY

3 Select Action Type *

View Eligibility & Patient Information

Create New Claim

Create Recurring Claim

Create Authorization

SUBMIT

Claims Overview

Shows claims for the last 30 days from today's date.

REJECTED

DENIED

PENDING

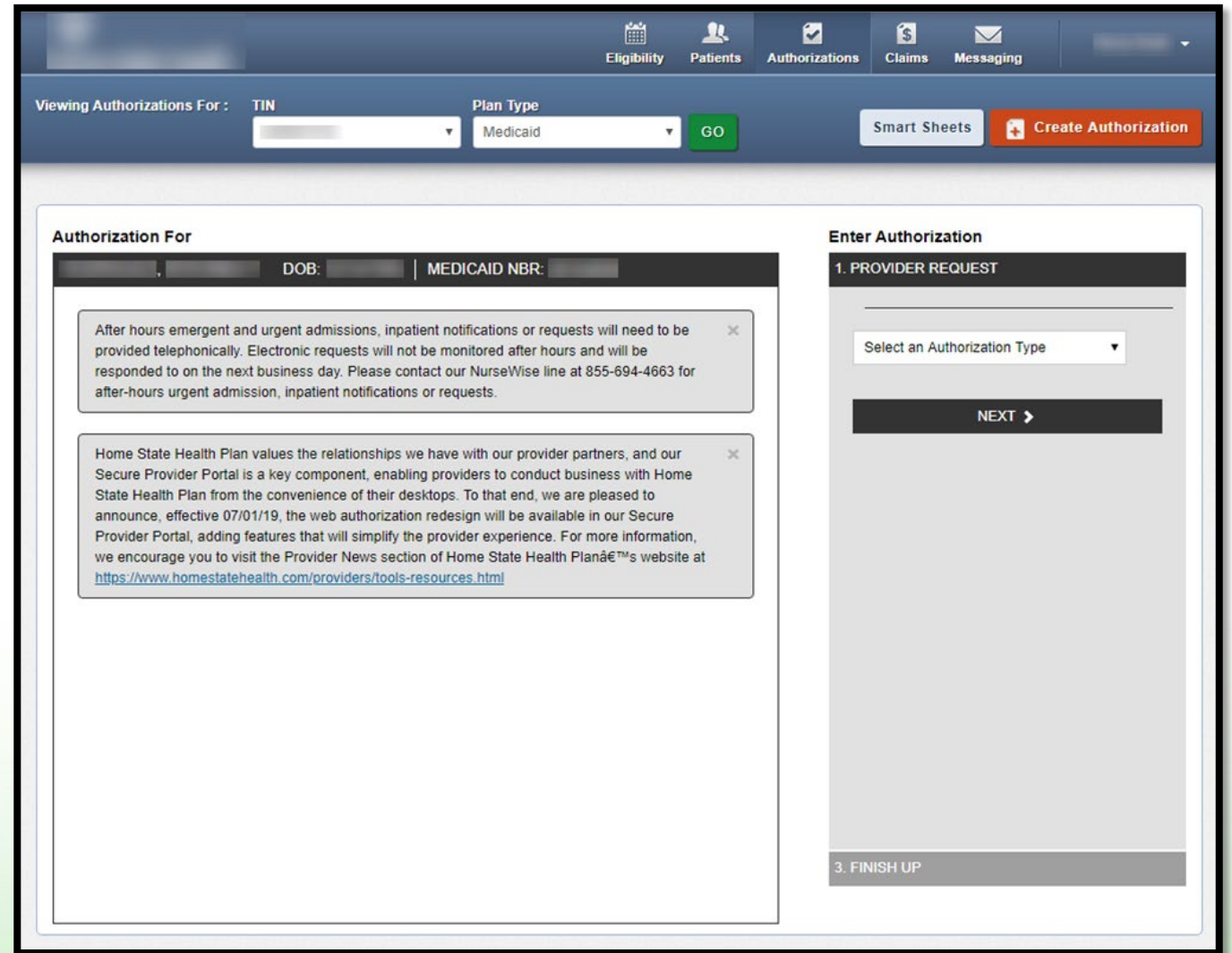
Web Authorization Request

Web Authorization request has three sections:

1. Provider Request
2. Service Line
3. Finish Up



Tip: Use the Tab key (on your keyboard) to move to fields in a web authorization request.



The screenshot displays the 'Web Authorization Request' web application interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section shows 'Viewing Authorizations For:' with a TIN dropdown menu, a Plan Type dropdown menu set to 'Medicaid', and a 'GO' button. To the right of the header are 'Smart Sheets' and a red 'Create Authorization' button.

The main content area is divided into two columns. The left column is titled 'Authorization For' and contains two text boxes with close buttons (X). The first text box contains the following text: 'After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 855-694-4663 for after-hours urgent admission, inpatient notifications or requests.' The second text box contains the following text: 'Home State Health Plan values the relationships we have with our provider partners, and our Secure Provider Portal is a key component, enabling providers to conduct business with Home State Health Plan from the convenience of their desktops. To that end, we are pleased to announce, effective 07/01/19, the web authorization redesign will be available in our Secure Provider Portal, adding features that will simplify the provider experience. For more information, we encourage you to visit the Provider News section of Home State Health Plan's website at <https://www.homestatehealth.com/providers/tools-resources.html>'.

The right column is titled 'Enter Authorization' and contains a section labeled '1. PROVIDER REQUEST'. This section includes a dropdown menu labeled 'Select an Authorization Type' and a 'NEXT >' button. At the bottom of the right column, there is a section labeled '3. FINISH UP'.

Finish Up - Comments (Medical)


Click **Add Comments** to enter comments.

Click **CLOSE COMMENTS**, to close and save comments.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

These are questions specific to Surgical Inpatient.

 **Note:** When selecting a Non-Participating Provider, you must include a comment about that selection. If you feel you have chosen a Non-Participating Provider in error you may edit your service line selection.

Additional Information:

[REDACTED]

Character limit: 2000

CLOSE COMMENTS

Enter Authorization

- 1. PROVIDER REQUEST [EDIT](#)
- 2. SERVICE LINE [EDIT](#)
- 3. FINISH UP

CONTACT IQC

[REDACTED]

Phone


[REDACTED]


Fax

[REDACTED]

Email

[REDACTED]

 Add Comments

 **Note:** When selecting a Non-Participating Provider, you must include a comment about that selection. If you feel you have chosen a Non-Participating Provider in error you may edit your service line selection.

Finish Up - Attachments


You can attach up to five (5) documents on web authorization requests. To attach a document:

1. Click **Choose File**. A separate window will display.
 2. Select document from your computer directory.
 3. Click **Open**.
 4. Click **Attach**.
- ❖ Repeat steps 1 – 4, as needed

Authorization For


DOB: | MEDICAID NBR: |




PROVIDER REQUEST


 **Provider Name** NPI: |
TIN: |
Phone: |
Primary Diagnosis: J35.01: CHRONIC TONSILLITIS

SERVICE LINES

Service Line 1

 **Service Line Name** NPI: |
TIN: *****6215
Participating: Yes
Phone: |
Dates: 09/20/2022 - 09/23/2022

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42820	Surgical	 Yes	 Attached	 Yes


 **Tip: Each file can be up to 10MB.**

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE [EDIT](#)
3. FINISH UP

Fax
|

Email
|

 Add Comments

Attachment:
Upload any relevant attachments. (10 MB limit)
Attachment name cannot contain any spaces or special characters.
 No file chosen



Web Authorization Submission

Once you complete:

- 1. Provider Request
- 2. Service Line
- 3. Finish Up
 - ❖ Click **Complete Now**
 - ❖ Complete Medical Review
 - ❖ Return to web authorization

Medical

- A. Add Comments
 - B. Add Attachment(s)
- ❖ Click **Submit**

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

[REDACTED] NPI: [REDACTED]
 [REDACTED] TIN: [REDACTED]
 Primary Diagnosis: J35.01: CHRONIC TONSILLITIS Phone: [REDACTED]

SERVICE LINES

Service Line 1

[REDACTED] NPI: [REDACTED]
 [REDACTED] TIN: *****6215
 Dates: 09/20/2022 - 09/23/2022 Participating: Yes
 Phone: [REDACTED]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42820	Surgical	✔ Yes	✔ Attached	✔ Yes

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Fax
[REDACTED]

Email
[REDACTED]

Add Comments

Attachment:
 Upload any relevant attachments. (10 MB limit)
 Attachment name cannot contain any spaces or special characters.
 No file chosen

Ⓜ SUBMIT



Tip: You must click **Submit**, to submit the web authorization request for processing.

Web Authorization Confirmation



The web authorization confirmation will display the Service Lines entered on the request.

Authorization Summary X

DOB: [REDACTED]
Name: [REDACTED]
Date: September 20, 2022 9:41:38 AM CDT

Authorization #: 69FR-9AEW ← - - - - This Tracking Number can be used by internal teams to search for the request in our authorization processing system.

Submitted Service Lines

Procedure Code	Service Type	NPI
42826	SU IP	[REDACTED]

Please check the main [Authorizations Page](#) shortly. The status of your authorization will be updated as soon as the determination is processed.

NOTE: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.



- Always check the member's eligibility before submitting an authorization request
 - A web authorization cannot be submitted on an ineligible member
- **Web authorizations generally load in processing queue within seconds of submission**
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
 - This is the only way a portal user will see a web authorization error
 - Web authorization errors are uncommon, but when an error is encountered the web authorization request will not load, and thereby will not be processed
 - ❖ Please submit the authorization request by phone or fax
 - ❖ Notify the Health Plan and provide the web authorization confirmation number for research

Carolina Complete Health - Help Tools



- Provider Website: <https://network.carolinacompletehealth.com/>
- [Provider Education & Training](#)
- [Provider Communications](#)



Questions