



Community Behavioral Health: Provider Notification Third Party Liability April 8, 2016

This notification is to alert providers of their responsibilities and CBH expectations in instances when a CBH member is dually eligible (has Medicare or other commercial insurance as well as CBH) and CBH is the payer of last resort.

Beginning April 11, 2016, CBH will only review cases for medical necessity criteria when the service the provider is requesting is not a covered benefit under the member's primary insurance coverage, the member has exhausted Medicare inpatient benefits, or the member's primary insurer denies services. In cases when the member's primary insurer denies services, the provider must complete denial procedures of the primary insurer prior to contacting CBH for a medical necessity determination.

If none of these scenarios are applicable, no precertification is required. However, the admitting provider must notify CBH of the admission.

Providers are required to submit discharge information to CBH within one business day of discharge, at which time an authorization will be generated. If the primary insurer denies part of the treatment stay, and the provider did not contact CBH, the provider must submit the member's chart for a retrospective clinical review. CBH will then make an authorization decision.

If a provider requests a service that is not part of the member's primary benefit plan, the provider is required to contact CBH for medical necessity determination.