

OPT and/or Medication Management

Frequently Asked Questions

Q: What about additional unmanaged units for OPT? I'm getting claims denied after 24 are used.

A: Existing frequency limits for outpatient services have not been revised. There have not (to date) been any additional flexibilities published to increase the number of units available for unmanaged services or frequency limits. Should a provider believe that increased services are needed to meet the medical necessity of the beneficiary, an authorization should be requested that outlines the need for additional units beyond the standard benefit plan allowance.

Q: Some MCOs have increased unmanaged limits to 48. Will Alliance be doing this as well?

A: Alliance is considering increasing the limit. No decision has been made yet.

Q What about limits for state services?

A: The limits for state-funded OPT won't be increased.

Q: Is Alliance going to allow OPT to be done via telephone?

A: Yes. Documentation should indicate how the service was delivered. Appropriate code modifiers should be used once given the go-ahead to start using the modifiers. See Medicaid Special Bulletins #59 (Telehealth Clinical Policy Modifications-Outpatient Behavioral Health Services) <https://medicaid.ncdhhs.gov/blog/2020/04/23/special-bulletin-covid-19-59-telehealth-clinical-policy-modifications-outpatient> and #46 (Behavioral Health Service Flexibilities) <https://medicaid.ncdhhs.gov/blog/2020/04/16/special-bulletin-covid-19-46-behavioral-health-service-flexibilities>.

Q: Will providers be able to bill for medication management E & M codes done via telephone with the CR modifier as well?

A: No. E & M services have to be provided via two-way, real time, interactive audio and video.

Q: Are we required to submit authorization requests for psychotherapy?

A: Medicaid Special Bulletin #46 (Behavioral Health Service Flexibilities) <https://medicaid.ncdhhs.gov/blog/2020/04/16/special-bulletin-covid-19-46-behavioral-health-service-flexibilities> waives initial and reauthorization. However, some providers are choosing to submit authorization requests, and that's acceptable. UM is reviewing authorization requests.

Update from 6/17/2020 All Provider Meeting: All flexibilities from Medicaid Bulletin #46 and Alliance's Provider News remain in place. Providers can submit authorization requests during this period of flexibility if they choose to do so, and the requests will be reviewed for medical necessity. During this

period of flexibility UM does not extend your authorization but an authorization is not necessary if it falls within the guidelines of Medicaid Bulletin #46. There are provisions that allow providers to bill during this period without requesting prior approval. When the provisions end in the future, there'll be more communication about how they'll end and when authorization requests will need to be submitted

Q: Are you using the CR modifier to indicate a pandemic code or to show telephone use?

A: Both. The CR code allows for flexibility with regard to using a telephone to deliver outpatient therapy. CR is also used with GT if additional flexibility is needed.

Q: How will we resume unmanaged visits after COVID-19? Will we have to submit a SAR?

A: Further instructions will be forthcoming about this. There may be a need to submit a service authorization request. For Alliance members, unmanaged visits will restart July 1, 2020.

Q: Can we use the modifiers on State funded codes as well as Medicaid?

A: Yes

Q: Can providers go ahead and start to use 90837CR for telephone service instead of 98968?

A: Yes, if the service provided meets applicable clinical coverage policy.

Q: Can providers resubmit claims for any services billed with 98968 after 4/30/20 as 90837CR?

A: Replacement claims can be submitted as long as the service met applicable clinical coverage policy requirements, including time requirements. Information about replacement claims can be found at <https://www.alliancehealthplan.org/wp-content/uploads/Claims-Manual.pdf>.

Q: What is the process for having a new therapist credentialed?

A: The credentialing process has not changed.

Q: Can we use 02 POS (place of service) now?

A: 02 should be used as place of service only if the service provided meets the original clinical coverage policy 1H for Telemedicine and Telepsychiatry which requires that the service be provided by certain qualified professionals and from Medicaid-enrolled site to Medicaid-enrolled site.
https://files.nc.gov/ncdma/documents/files/1-H_3.pdf

Q: Should 02 Place of Service not be used for any code combination?

A: 02 should be used as place of service only if the service provided meets the original clinical coverage policy 1-H for Telemedicine and Telepsychiatry which requires that the service be provided by certain

qualified professionals and from Medicaid-enrolled site to Medicaid-enrolled site.

https://files.nc.gov/ncdma/documents/files/1-H_3.pdf

Q: In reference to POS (place of service), are you saying we should use 11, which is the office, for 90837CR and 90837GTCR?

A: The POS (place of service) that would traditionally be the place where services are delivered should continue to be used. For example, if the service traditionally is provided at the beneficiary's HOME, you would continue to use POS for HOME. If the service is traditionally provided in the provider's OFFICE, you would continue to use POS for OFFICE.

Q: If providers have been using POS-02 for telehealth, can those remain the same and we begin using the normal POS now?

A: Claims that have already been processed and approved do NOT need to be resubmitted/replaced to correct POS-02. Moving forward, the 'usual place of service' should be used for Covid-19-related codes/modifiers. The only time POS-02 should be used is if the provider is delivering a service compliant with Clinical Coverage Policy 1-H (i.e., the service is provided from one Medicaid site to another Medicaid site).

Q: Should we not use 02 for Place of Service with IIH either even though it is approved?

A: Place of Service 02 is not traditionally used for IIH.

Q: Will we see updated codes in our contract via the Alpha Portal?

A: You will see updated codes and modifiers in "contract details" in Alpha. If you see a problem, please contact contracts@alliancehealthplan.org

Q: Should we be submitting claims with these codes? Or should we be holding these claims?

A: Providers will be notified via Provider News what the required start date is for use of the modifiers. In the meantime, providers can submit claims using the regular codes.

Update 5/12/2020: Per Provider News on 5/11/2020, Providers **will be required** to utilize the codes/modifiers for any of the service flexibilities that are being provided with service dates starting on and after May 23, 2020. HOWEVER, the codes are currently active in Alpha and providers can choose to use the codes prior to May 23, 2020, as their billing systems allow.

<https://www.alliancehealthplan.org/provider-news/guidance-for-gt-cr-modifiers/>

Q: Do we need to re-bill any services from 3/10/2020 forward, or do we just need to have it documented in the note how the services was performed?

A: Providers don't have to submit replacement claims with the modifiers. How the service was performed should be documented in the note. Providers will be notified via Provider News of the required start date for use of the GT and CR modifiers.

Update 5/12/2020: Per Provider News on 5/11/2020, Providers **will be required** to utilize the codes/modifiers for any of the service flexibilities that are being provided with service dates starting on and after May 23, 2020. HOWEVER, the codes are currently active in Alpha and providers can choose to use the codes prior to May 23, 2020, as their billing systems allow.

<https://www.alliancehealthplan.org/provider-news/guidance-for-gt-cr-modifiers/>

Q: Can you clarify what services the authorization requirements are waived for? Does this include enhanced services?

A: Please refer to Medicaid Special Bulletins #59 (Telehealth Clinical Policy Modifications-Outpatient Behavioral Health Services) <https://medicaid.ncdhhs.gov/blog/2020/04/23/special-bulletin-covid-19-59-telehealth-clinical-policy-modifications-outpatient> and #46 (Behavioral Health Service Flexibilities) <https://medicaid.ncdhhs.gov/blog/2020/04/16/special-bulletin-covid-19-46-behavioral-health-service-flexibilities>

Q: Please provide clarification on getting signatures from individuals receiving services. How does this look as it relates to paperwork (i. e., do we record that the individual gave the agency permission, attach an absent consent form for the designated individual, etc.)?

A: Per Alliance's Provider News on 3/20/2020 "Provider COVID Update" (<https://www.alliancehealthplan.org/provider-news/provider-covid-update-for-march-20/>):

Member and Legally Responsible Person Signatures

At this time in recognition of the realities of current pandemic situation and based on guidance from the N.C. Department of Health and Human Services (DHHS) and the U.S. HHS Office for Civil Rights, to decrease unnecessary face to face contact, promote the use of virtual care where possible and address challenges related to obtaining member signature on person center plans, treatment plans and consent to treat forms Alliance is implementing the following:

- Alliance will accept a qualified professional/para-professional or clinician signature in place of the member or legally responsible person's (LRP) signature, along with a notation that the member/LRP gave consent for the provider representative to sign the document on his or her behalf.

- Providers should document whether such consent was made via telephonic, email or other means. Any provider relying upon email consent should follow up via telephone communication with the member/LRP to secure verbal consent if possible. Providers should track consent received in this manner so they can implement a plan to obtain signatures of the member or LRP at a later time.
- To verify you are speaking with the member/LRP, best practice is to ask for another identifier (besides name and date of birth), such as Social Security number or Medicaid number. Always obtain express consent for disclosure of any substance use information. Member/LRP consent or approval should be clearly documented in the service note.