Mental Health/Substance Use Disorder (MH/SUD) Residential/Community Based/Enhanced Services

Frequently Asked Questions

Q: Do we actually bill the higher rate or the normal rate without the CR modifier?
A: The rate does not change for outpatient therapy, E & M (medication management), and enhanced services. The modifiers will let providers accurately reflect how the service was delivered.

Q: Will Alliance be doing another provider stabilization payment for May?
A: At this time, Alliance is not planning a stabilization payment for May. As the situation requires and as we’re evaluating data and hearing from providers, we’ll consider taking other steps if it appears there is significant jeopardy to providers.

Q: What about the rate enhancements for S5145 (residential level II)? I have a notice that the rate enhancements are effective 4/1/2020. How do we submit billing for this?
A: Submit billing using the normal process, and bill the higher rate effective 4/1/2020.

Q: Do we go ahead and use the GT CR for outpatient therapy now or wait until further notification?
A: Providers will be notified via Provider News when to start using the modifiers with the codes. Alliance will use a future start date in order to have some time for providers to adjust billing systems. Included in the notification will be the codes and modifiers to be utilized.

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: 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.)?

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.

Q: Can you discuss the authorization process during COVID. Are there any extensions in place at this time?

A: 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: Will there be flexibility with day treatment entry criteria? There has not been confirmation of how students will resume school for the fall so school documents may not easily accessible.

A: Alliance’s in lieu of definition does not require documents from school, and it’s being used by in network and in catchment providers. Some providers are starting to use a blended model where some kids are coming into facilities and other kids are being served virtually. We’ll have to see what the State does. We have not heard anything about the State’s planning to change the clinical coverage policy once the state of emergency is resolved.