Specialized Therapies (ST/OT/PT) Questions & Answers

Claims: Modifiers

- Which modifiers are required for outpatient specialized therapy (OST) services?

CCH requires either Modifiers GN, GO, or GP are submitted with outpatient specialized therapy (OST) services.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services.

Reference: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2019downloads/r4440cp.pdf

- What modifiers are required for teletherapy visits?

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier should not be used for virtual patient communications (including telephonic evaluation and management services) or remote patient monitoring

Additionally, Therapists must ensure that the services can safely and effectively be delivered via teletherapy in alignment with NC Medicaid Clinical Coverage Policies 10A, Outpatient Specialized Therapies, and 10B, Independent Practitioners. Therapists must consider a client's behavioral, physical, and cognitive abilities to participate in services provided via teletherapy.

Reference: https://medicaid.ncdhhs.gov/blog/2021/07/06/updates-clinical-coverage-policy-10b-outpatient-specialized-therapies-independent-practitioners

- For physical therapy, are any of the PHPs requiring modifier CQ, if the patient was treated by a PTA instead of a PT?

Yes, the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by a PTA or OTA on the claim line of the service, along with the respective GP or GO therapy modifier, to identify those services furnished in whole or in part by a PTA or OTA under a physical therapy or occupational therapy plan of care.

Reference: https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas

- Should modifier GO be used for occupational therapy? If so, does it go next to the procedure codes that we are billing for?

Modifier GO is with each service line billed for occupational therapy.

Reference: https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2019downloads/R4440cp.pdf

- When would modifier 59 apply to OST claims?

Modifier 59 should only be used when the two 15-minute timed services are performed sequentially. The time spent must be clearly documented as separate and distinct, and cannot overlap.

Reference: https://www.cms.gov/files/document/proper-use-modifiers-59-xepsu.pdf

Claims Submission

- Where can providers find instructions for claims submission on each PHP's website?

Carolina Complete Health Billing Manual:
http://network.carolinacompletehealth.com/manuals

Carolina Complete Health New Provider Orientation:
Monthly sessions: Register here.
View the slides: CCH Provider Education Presentation (PDF)

- Can providers submit claims through Change Health or Navi Net?

Claims may be submitted in 3 ways:

1. The Secure Provider Portal - https://provider.carolinacompletehealth.com/
2. Electronic Clearinghouse
   Carolina Complete Health's preferred clearinghouse is Availity.. As long as the provider's clearinghouse has a connection to Availity, then the claim can be passed on to Carolina Complete Health. Carolina Complete Health's Medical Payer ID is 68069
3. Mail
   Carolina Complete Health
   Attn: Claims
   PO Box 8040
   Farmington MO 63640-8040

- Where can providers find contact information for one-on-one help for general claims issues?

For assistance with taxonomy issues, please reach out to Carolina Complete Health Provider Services at 1-833-552-3876 or Carolina Complete Health Network Provider Relations at NetworkRelations@cch-network.com

- When submitting claims, does the OST provider change the rate back to normal rate that was in effect prior to the 5% rate increase in effect during the state of emergency?

Provider should bill usual and customary rates (UCR). If UCR is more than the allowed amount, the PHP will reimburse up to allowed amount for that service. When a UCR is less than the allowed amount, the PHP will not reimburse more than the UCR that is billed the claim.

- Is there a way to print a claim after it is submitted in the portal?

To view claim details in the portal, click the claims button in the top menu. You can search for a specific claim number, or view claims in 30-day increments. To view the details of the claim, click on any claim number. There is not a print option from this view, however you can use the Print Screen option on your computer. Once the claim is adjudicated, you can also view it on the EOP under payment history and print the PDF.

- How should a provider submit diagnosis codes when entering a claim? Should they use a decimal or enter the diagnosis without a decimal?

CCH requires claims to be submitted using codes from the current version of, ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the enrollee
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Health Plan Name.

- If the prescribing doctor is NOT in network come September 1, does this mean the claims will be denied?

DHHS and the PHPs have agreed to extend the policy for out of network flexibilities to providers who have not contracted with a PHP through Nov. 30, 2021. These flexibilities were originally expected to sunset on Aug. 30, 2021.

After November 30, 2021:

- Out of network providers will be reimbursed at 90% of the fee schedule.
- Out of Network Indian Health Providers are reimbursed 100% of Medicaid Fee Schedule rate.
- Family planning and Emergency services are reimbursed at 100% of Medicaid Fee Schedule regardless of in or out of network status.

Out of State Reimbursement:

Out of state inpatient and outpatient hospital services are reimbursed based on Out of State Hospital Inpatient and Outpatient Fee Schedule published on the North Carolina DHHS state website.

- I was told you can request the same number of units for each CPT code- so 104 97530 and 104 97110 if you think you might use more than one code. Is this acceptable?

97530 and 97110 are timed codes. The time spent must be clearly documented as separate and distinct. Please also see guidance on Clinical Coverage Policy No: 10A - Outpatient Specialized Therapies

- When submitting a claim, what if billing provider and rendering provider are the same NPI and Tax ID?

In some cases, the billing provider and rendering provider may be the same NPI and Tax ID. All fields will still need to be filled in, even if the information is duplicative. View the Claims Submission Reminder Guide (PDF) for more information.

Where can a fax number be found on your website, if this form of claims submission is acceptable?

Paper claims cannot be submitted via fax, but can be submitted through the mail:

Carolina Complete Health
Attn: Claims
PO Box 8040
Farmington MO 63640-8040

For more information about submitting paper claims, view the Billing Manual available on our Manuals, Forms, and Guides page

- Should a provider use the NC Medicaid identification number (MID) or are they required to use the specific PHP's identification number?

Providers can use the NC Medicaid Identification Number when submitting claims to Carolina Complete Health.

- Do therapy service claims need to be submitted monthly or day to day as services are provided?

Providers may submit monthly or day to day for services rendered. Please review next question in addition for timely filing guidelines.

- What are your rules for timely filing?

The timely filing deadline is 365 calendar days from the date of service. For more information about submitting claims, view the Billing Manual available on our Manuals, Forms, and Guides page

- If we are currently an out of network provider, can we submit claims online or can out of network providers only submit paper claims?

Out of network providers cannot submit claims via the Provider Portal. You are able to submit paper claims via the mail:

Carolina Complete Health
Attn: Claims
PO Box 8040
Farmington MO 63640-8040

For more information about submitting paper claims, view the Billing Manual available on our Manuals, Forms, and Guides page

- My speech therapy claims submitted with CPT 92507 are being denied, as not a medical service. I was told the denial reason was that it had to be submitted to a vision vendor? Please clarify if this is a covered code? If not, what is the appropriate code to bill for this service.

92507 is a valid code for speech therapy, is on the fee schedule and should be billed under medical. Please contact Carolina Complete Health Network Provider Relations at NetworkRelations@cch-network.com with a specific claim example for this issue.

Electronic Funds Transfer (EFT) and Electronic Remittance Advise (ERA)

- Where can providers find instructions for signing up for an EFT account? Do any of the plans charge a fee for EFT? Where can I find guidance regarding setting up an EFT account?

Carolina Complete Health offers Payspan, a **free** solution that helps providers transition into electronic payments and electronic remittances. To contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00 am to 8:00 pm est. Payspan: A Faster, Easier Way to Get Paid (PDF) For more information about billing, claims, and payment, visit our Claims and Billing page

- When claims are paid and deposited electronically, where are the remits? We need the RA's linked to our EMR.

To sign up for ERAs and link them to your EMR, please contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00 am to 8:00 pm est.

Reimbursement Rates

- OST providers are getting paid based on the physicians fee schedule rates, not the outpatient specialized therapies fee schedule rates. Has this been corrected? Will there be a reprocessing? If so, when will this take place.

Carolina Complete Health adheres to the NC Medicaid Out-Patient Specialized Therapies (Independent Practitioners) Fee Schedules. View the fee schedules on the NC DHHS website

Please contact Carolina Complete Health Network Provider Relations at NetworkRelations@cch-network.com with a specific claim example for this issue.

- Are OST providers reimbursed based on a fee schedule rate or a contractual rate?

Carolina Complete Health adheres to the NC Medicaid Out-Patient Specialized Therapies (Independent Practitioners) Fee Schedules. View the fee schedules on the NC DHHS website

- Where can Local Health Departments find their fee schedule on your website?

Carolina Complete Health does not post the fee schedules on the website. CCH implemented the fee schedule for LHDs consistent with the NC Department of Public Health.

- Where do we find on your website what is reimbursed for each OST provider type? Is it comparable to the NC Medicaid Fee for Service reimbursable rate for each OST provider type?

We do not post fee schedules on our Carolina Complete Health Website. Carolina Complete Health adheres to the NC Medicaid Out-Patient Specialized Therapies (Independent Practitioners) Fee Schedules. View the fee schedules on the NC DHHS website

Teletherapy Claims

- Will telehealth services be covered indefinitely? How will providers be made aware of changes in this policy?

This is dependent on the State's guidance and approval. Medicaid Bulletins are used to keep up to date on different changes.

- Can you provide a quick reference guide or provider notification regarding telehealth claims specifically for OST providers?

At this time, we do not have a quick reference guide regarding telehealth claims specifically for OST providers, however we are taking this idea into consideration. You will be notified of new guides through our monthly provider newsletter. Carolina Complete Health adheres to NC DHHS Clinical Policy 10B for telehealth.

- If a beneficiary is seen in an office setting, we would use the POS for office. For teletherapy claims submission, is the location supposed to be where the patient is at the time of the teletherapy service or where the therapist is located at the time of the teletherapy service?

Yes, if the beneficiary is seen in an office setting the Place of Service for office is the most appropriate.

Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Practitioners and patients therefore need to be in two different physical locations for teletherapy to be billed appropriately.

- Is POS 02 appropriate for teletherapy claims? If not, which POS should be used?

Yes, Place of Service 02 is appropriate for teletherapy claims

- What modifier(s) are required for teletherapy visits.

Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier should not be used for virtual patient communications (including telephonic evaluation and management services) or remote patient monitoring

Additionally, Therapists must ensure that the services can safely and effectively be delivered via teletherapy in alignment with NC Medicaid Clinical Coverage Policies 10A, Outpatient Specialized Therapies, and 10B, Independent Practitioners. Therapists must consider a client's behavioral, physical, and cognitive abilities to participate in services provided via teletherapy.

Reference: https://medicaid.ncdhhs.gov/blog/2021/07/06/updates-clinical-coverage-policy-10b-outpatient-specialized-therapies-independent-practitioners

- If a service is delivered in a daycare or preschool setting, should we use POS 99? If not, what would be appropriate?

Place of service 03 – School, may be used in the preschool setting.

Place of Service 99 – Other, may be used in the daycare setting.

- Please provide clarification as to when POS 99 would be used.

Place of Service 99 is to be used when the service is provided and no other appropriate POS is applicable

- Where can I find the rates for OST teletherapy codes?

CCH is using the North Carolina Department of Health and Human Services Out-Patient Specialized Therapies (Independent Practitioners) Fee Schedules. For assistance, please

reach out to Provider Relations and Support at 1-833-552-3876 or NetworkRelations@cch-network.com

Taxonomy

- If we are receiving claim denials due to a taxonomy issue, who do we reach out to?

For assistance with taxonomy issues, please reach out to Carolina Complete Health Provider Services at 1-833-552-3876 or Carolina Complete Health Network Provider Relations at NetworkRelations@cch-network.com

- Where does the rendering provider taxonomy go on the 1500 form?

View the Claims Submission Reminder Guide (PDF) for taxonomy placement.

- Can you use a multi-specialty taxonomy code on 1500?

Yes, you can use a multi-specialty taxonomy code on a CMS 1500 form as long as it matches what you are credentialled with in NC Tracks.

Policy

- Where is the OST policy located on your website?

To view all of Carolina Complete Health clinical policies, visit:
https://network.carolinacompletehealth.com/resources/clinical-policies.html

- Do you have a "homepage" specific to OST? If not, is this something that you would consider so OST information is easy to find. Consider including a FAQ and a "cheat sheet" for PA and claims submission.

At this time, we do not currently have a page specifically designated for OST, however we are taking this idea into consideration for website development.

Portal

- How are providers notified when the PHP portal is not working? How are providers notified when the portal is back up and running?

On the occasion that the Provider Portal is down, we will email providers and post an announcement to the front page of our Provider website, along with an update when it is back up and running. You can also use the IVR phone system to check claims status, member eligibility and more, by calling 1-833-552-3876. If you need to submit or check the status of a Prior Authorization and the portal is down, please contact Carolina Complete Health Medical Management team by calling 1-833-552-3876

- Can a provider see in your portal, if another provider has used any of the 12 visits? If so, where can this be found?

CCH doesn't have 12 unmanaged visits. PA is required prior to treatment. To view authorizations on a member, click the Eligibility button on the provider portal, enter the member's last name and date of birth, then click View Details, and on the lefthand side, click Authorizations.

- Where can I find the contact information for assistance from areas such as Provider Enrollment, Provider Service and Prior Approval. What are the hours of operation for each area?

You can find contact information for our Provider Relations and Support team on the Contact Us page. We also have quick links to Getting Started with Carolina Complete Health on the home page of our provider facing website. We also encourage providers to attend a New Provider orientation, either live or via the on-demand recordings. View instructions for attending a New Provider Orientation

Miscellaneous

- Are chiropractic services listed as physical therapy?

No, these are separate services.

- Are speech therapy sessions considered "encounters?" What is the definition of an encounter?

According to NC Medicaid: OST, 10A policy they're considered visits.

- Is T1002 allowed for OST? If not, what code should be used in its place?

T1002 is for 15 minutes of RN Services. I would advise to use a code reflective of the services you are providing.

- Do we need to be credentialed through CAQH to be in network for the Medicaid plan or does our credentialing from NC tracks follow us over?

All credentialing is centralized through NC Medicaid and NC Tracks.

PA Submission

- Where can providers find instructions for prior approval (PA) submission/utilization management on each PHP's website?

Visit the Prior Authorization section on our website and view our Prior Authorization module from our new Provider Orientation

There is also a Tip Sheet located under Resources>>>Manual, Forms, and Guides.
https://network.carolinacompletehealth.com/resources/manuals-and-forms.html

- Where can providers find contact information for one-on-one help for general PA issues?

Please reach out to Carolina Complete Health Provider Services at 1-833-552-3876 or Carolina Complete Health Network Provider Relations at NetworkRelations@cch-network.com

- When a PA is submitted, what is the timeframe for processing?

Urgent-72 hours, Standard -14 days, Extension-28 days

- Please address units versus visits when submitting PA requests. What does one unit equal (one visit or 1 CPT code)?

1 unit =15 minutes.

When therapy is requested in visits this would correlate to 4 units or 1 hour of therapy unless the request is otherwise specified by the requestor. Such as the requestor notates a visit is a 2-hour session then the request would be reviewed for 8 units of therapy/visit. Therapy is approved according to days/visits. This applies to ST/OT/PT therapy types.

- Do you approve OST PAs based on visits or per unit? Please specify how each CPT code or discipline (OT, PT, ST, etc.) is different?

All 3 disciplines are approved based on days/visits.

- How should a provider submit diagnosis codes when entering a PA? Should they use a decimal or enter the diagnosis without a decimal?

According to ICD 10 codes, with decimal included.

- Is PA required for initial evaluations?

Medicaid shall require prior approval for all ongoing Outpatient Specialized Therapies treatments, however no prior approval is required for therapy evaluations.

- Please explain why there is a discrepancy with PAs for CCHE versus Medicaid PAs. More specifically another provider asked if it is correct that CCHE will not allow for more than 3 months on an OST PA? Where can this information be found in policy?

Currently, a request can be submitted requesting up to 6 months for OST PA.

- Please address why the CCH system will not allow you to ask for more than 3-month on PAs.

The system has been updated, currently, a request can be submitted requesting up to 6 months for OST PA.

Unmanaged Visits

- Does your plan have 12 unmanaged visits for OST? If so, do they start after the current PA ends?

CCH doesn't have 12 unmanaged visits. PA is required prior to treatment.

Electronic Signatures

- Are electronic signatures acceptable?

In terms of acceptable for orders regarding OST, yes.

- Where can we find signature requirements found in policy?

For orders regarding OST, signature requirements can be found in Section 3.2.1.7 treatment Services (f) in Policy 10A