Therapies Policy Changes FAQ

Modifiers

Q: Are modifiers, including U5 and UB modifiers, required on the request form next to each CPT code or just for billing purposes on the back end? How will we handle cases in which an assistant is used for therapy but the PA request does not indicate an assistant will be used? We're considering a scenario where we can see upon review that a PTA/OTA is providing therapy.

A: Providers are not expected to prior authorize the use of a licensed therapy assistant vs. a licensed therapist. A therapy assistant may provide treatment that comports with their scope of practice and under the supervision of a licensed therapist. It's important that it is noted on the claim. The U5 and UB modifiers are required on procedure codes on claims for therapy treatment.

Q: Can we assume that if a claim is not billed with a UB modifier that the service was provided by a licensed therapist?

A: Because the use of the UB or U5 modifiers will be associated with a rate differential, HHSC would not recommend making that assumption.

Q: How will claims monitor therapist vs assistants when the only way to know that is to see the notes? Claims do not review notes, only codes.

A: Because of the difficulty of knowing who performed a service, HHSC is requiring every treatment claim have one or the other modifier affixed to it. It is true claims cannot review treatment notes. If a provider is submitting a claim with the U5 modifier when the treatment was performed by a licensed assistant, that is fraudulent billing and upon inspection or audit, that provider would be at risk for recoupment.

Q: How important is the modifier position? Does the UB or U5 need to come before GP/GO?

A: HHSC does not stipulate the modifier position on the claim.

Q: What is the expectation for MCOs in the use of the AT modifier?

A: Health plans are expected to use this modifier so HHSC can accurately track when a client is receiving acute treatment. TMHP requests that information on the request for authorization, and it is required on FFS claims. A health plan may choose not to require the AT modifier be submitted with authorization requests, but it must be captured on submitted claims.

Provider Notifications and Prior Authorization

Q: Will the notice given by TMHP dated 6/30/2017 suffice as notice to the providers if the MCO is applying the same methodology?

A: Health plans are reminded that they need to provide similar notifications to their providers to explain the particulars of how these billing structure changes will be managed by the individual health plan.

Q: Are MCOs required to submit the procedure code to the provider on the authorization request?

A: Providers need to understand what codes they are authorized to bill, so if the codes are not listed on the authorization letter, there must be some other way for providers to get that information.

Q: We received minutes from a TAHP meeting on 7/25 indicating there is a possibility that time-based codes should remain time-based codes. Is this a possibility or is it definite that time-based codes will change to units?

A: Time-based codes are 15-minute units. Please review the September 2017 Texas Medicaid Provider Procedures Manual (TMPPM) Volume 2 Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook to understand which codes are time-based and billed in units, or encounter-based and billed once per day.

Q Does the state require health plans to end-date old authorizations and send out new ones to align with new policy?

A: It is not required to end-date authorizations and start new ones. However, providers will not know how to bill if they do not have an amended

authorization. It's important to communicate to providers how the billing structure is changing and how they should bill for services after that date of change.

Miscellaneous

Q: When the MCOs receive the authorizations from the Member's previous health plan, will any of those authorizations have any carryover beyond 9/1/2017? Or is the current MCO required to abide by this requirement before these members cross over?

A: The current MCO must honor the authorization with continuity of care requirements.

Q: 97039 is currently utilized for Nursing Facilities to bill carve-in therapy services. Will this code be end-dated for Nursing Facilities on 9/1/2017?

A: The billing structure changes for 97039 will not impact nursing facilities or the STAR Plus billing matrix.

Q: When will the provider type and place of service updates be provided?

A: These were provided in an MCO notification on August 29, 2017.

Q: When will the final new rates be sent?

A: The new rates were provided in an MCO notification follow-up on August 24, 2017.

Q: When will modifiers result in reduced rates for therapy assistants?

A: December 2017 and then September 1, 2018 per legislative direction.

Q: On slide 16, what is meant by MCOs need to comply with these changes?

A: It is not optional for MCOs to adopt the billing structure changes, all MCOs must adhere to the new Medicaid billing structure for physical, occupational and speech therapy.

Q: Is this expected to comply with those contracted under Texas Medicaid? Are our custom contracts expected to change?

A: It is possible that MCOs will need to update provider contracts if there are specific details in the contract about reimbursement.

Q: When will the static fee schedules be updated?

A: The rates are effective September 1, 2017 and were released in a MCO notice on August 24th, 2017. The static fee schedule will be updated in September.

Q: When will the TMPPM be updated?

A: Sept. 1, 2017

Q: Will HHSC and TMHP continue to educate providers on the changes?

A: TMHP will not be conducting any education on this outside of the posting of the provider notifications and the September 2017 release of the TMPPM Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook. HHSC policy staff have met with nearly every health plan prior to the billing structure changes taking place. If your health plan requires further technical assistance, please contact your health plan management representative.