Behavioral Health Department of Community Health (DCH) Centralized Prior Authorization (PA) Portal

Frequently Asked Questions (FAQ)

Updated 3-13-2017

Description: Prior Authorization Requests for Outpatient Behavioral Health services delivered by all independent practices, group practices, and Community Behavioral Health Agencies, Tier 1, Tier 2 and Tier 3 providers, will go live with a SOFT LAUNCH on March 1, 2017. Prior Authorization requests may be submitted through the DCH Centralized Web Portal or to the appropriate CMO.

Exceptions: Prior Authorization requests 1) for Psychological Testing, Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) services or 2) by individually enrolled LPCs will continue to be submitted directly to the CMOs.

The responses in this FAQ unless otherwise indicated apply to all CMOs:

(1) What does a SOFT LAUNCH mean?

a. This means the functionality of the system will be available for any provider that wishes to use it, but it is not mandatory for all behavioral health outpatient PA requests to be submitted through the centralized portal at this time. Please see DCH banner message posted on 3/1/2017 for further instructions and information from each CMO.

(2) What if providers choose not to submit behavioral health outpatient requests through the portal?

The capacity to receive requests by the CMOs will continue as follows:

Wellcare – Utilize Fax
Fax to: 888-871-0590

PeachState – Utilize Fax or Portal
Fax: 1-866-694-3649 or https://provider.cenpatico.com/sso/login

Amerigroup – Utilize Availity web portal
www.availity.com

(3) What happens if we have multiple provider ID's that we use? Can we submit the PA for different provider IDs?

a. Each rendering provider should have a unique provider ID (received when credentialed to render services for Georgia Medicaid and each CMO) unless you are an agency provider. Authorizations for services should be submitted under the provider ID of the provider rendering the services.

b. If you are a group of independent providers billing under a vendor ID, the vendor ID should be inputted under the Facility Reference ID and the unique provider ID for the provider rendering the service should be inputted under the Medical Practitioner Provider ID.

c. If you are an agency provider, the facility provider ID should be inputted in the Facility Reference ID field and the ordering provider ID should be inputted in the Medical Practitioner Provider ID. The Medical Practitioner Provider ID will not be a required field on March 1, 2017. However, please start making the appropriate arrangements to be able to input this information as DCH and the CMOs will work towards making this a required field.

d. The provider information attached to the Facility Reference ID and the Medical Practitioner Provider ID will auto populate in the Service Provider Information and Reference Provider Information sections.

(4) Do we need the NPI for the Reference Provider to submit a PA? NPI information for Reference Provider is not needed. A search for the Reference provider can be done and selected under the Medical Practitioner Provider ID.

(5) Why do we need to enter the Reference Provider information? We are not required to submit that information currently.

a. This field will not be a required on March 1, 2017. However, please start making the appropriate arrangements to be able to input this information as DCH and the CMOs will work towards making this a required field.

(6) We noticed that there is a PCP information section in the new online form. Why is the PCP information being requested on the form and made a "required" field?

a. To be consistent with industry best practices and DCH requirements, all providers must deliver integrated and coordinated care. It is a requirement of DCH and the CMOs that BH providers communicate with the member's PCP upon admission and quarterly thereafter or more frequently if needed. Therefore, providers are being asked to attest that they are in compliance with this requirement.

b. The PCPs name and phone number is **not** a required field as of March 1, 2017; however, DCH and the CMOs will work towards making this a required field in the near future.

c. The attestation that PCP coordination is being done is a required field.

(7) Do we request the authorizations before the patient is seen or should it be submitted after the patient has been seen? We will not have the ICD and diagnosis information unless the patient has been seen. What should we do and how do we work on that?

a. For all CMOs, authorizations are not required for assessments. All members initiated into treatment should have a working diagnosis and an initial treatment plan.

b. For those services that require a Prior Authorization, the authorization must be submitted prior to the service being rendered.

(8) Does therapy require an initial authorization and how do you submit a request for additional therapy sessions?

a. Amerigroup and Cenpatico do not currently require an initial authorization for therapy visits (90832, 90834, 90837, 90846, 90847, and 90853). Cenpatico will continue with the authorization for U4 practitioners ONLY. WellCare will continue with their current registration process for these codes through the centralized prior authorization portal. Please review each CMO's website for specific authorization requirements.

b. For all CMOs, if additional visits are required for any service that requires prior authorization, the provider must submit a Behavioral Health and Outpatient Services Form through the DCH Centralized PA portal or other approved source.

(9) How do we get an extension on an authorization that has units available but the end date is set to expire?

a. If an authorization is set to expire prior to utilizing all the units authorized, please contact each individual CMO for an extension through their current process.

(10) What happens if the PA was already submitted and we would like to request additional units?

a. If an authorization was issued and all of the units under that authorization have been used prior to the expiration date, a new authorization request can be submitted for review. If medical necessity is met for additional units, the old authorization will be closed and a new authorization will be issued.

b. If an authorization request is submitted for a member who has an open authorization for the same service(s), the old authorization will be closed and a new authorization will be issued if medical necessity is met.

c. If a new provider submits an authorization for a member and service that has a current open authorization for another provider, the old provider's authorization will be closed after the CMO verifies with the member which provider the member is seeing.

(11) What about partial approval of units? How do we request more when partial units have been approved? Do we submit another PA?

a. If a denial has been issued with a partial approval, a reconsideration and/or appeal should be submitted for the denied units within the required time frames for reconsideration and appeal.

b. If after approved units are used and additional services are required, a new request should be submitted for medical necessity review.

(12) Will providers submit reconsiderations request through the DCH Centralized PA portal?

a. No, reconsideration request should continue to be submitted via each CMOs current process.

(13) There are many required fields -do we need to complete all required fields?

a. All required fields are necessary to obtain the information needed to make a medical necessity decision.

(14) Is the number of days within which a PA needs to be submitted going to remain the same? For different CMO's we have different time frames.

a. Yes, the required days for submission will remain the same as they are currently. For all CMOs, if an authorization is required, the authorization must be submitted prior to services being rendered.

b. Retroactive review is allowed in limited circumstances as described in each of the CMOs Provider Manual.

(15) As per the process, it looks like different attachments are required. Are attachments mandatory for the PA submission?

a. No attachments are required, but attachments are allowed. Attachments should only be included to augment the information required to make a medical necessity decision.

b. Attachments may not substitute for the entry or completion of clinical information online. The authorization form on the DCH Centralized Portal should be completed in full with recent clinical information and members behaviors within the last 30 days.

(16) Will there be additional training on submitting an authorization via the DCH Centralize PA portal?

a. Training sessions have been completed. Please go to the MMIS and CMOs websites for up to date information.

b. Additionally, recordings of the training and a provider manual are available on the GAMMIS portal.

(17) What happens to the Prior Authorizations that have been submitted and approved currently by the CMO? Would we be required to re-enter/redo new PA's for the existing PA's after 3/1/2017?

a. No. Only new authorization for services to be rendered after the March 1, 2017 should be submitted.

(18) What happens to the codes that do not currently need a PA? Are they still going to be that way or would they need Prior Authorizations to be submitted?

a. Any changes to current authorization requirements will be provided by each CMO individually. For authorization requirements, please go to the corresponding CMO's website.

(19) If the code doesn't require a PA will the system reject the PA for those codes if entered?

a. No, it will not.

(20) What happens if the client has prior hospitalizations and we do not have the information regarding the exact hospitalization dates?

a. Dates for hospitalization and prescriptions are optional fields. Please provide the hospitalization and prescription information that is available at the time of request submission. This information is required to determine medical necessity.

(21) Will the hard copies of OTRs for all of the CMOs be updated to reflect this online submission?

a. The form elements and provider manual for web entry are posted as screen shots on the 'Provider Education' section of the MMIS Web Portal and have been since 1/23/2017.

(22) As far as the authorizations, does it apply to private individual and group practices as well?

a. Yes. If the corresponding CMO requires an authorization for services rendered by this provider type.

(23) Where should we find information regarding the FAQ's?

a. FAQs will be available in the GAMMIS and on each of the CMOs provider websites.

(24) Whom should we contact for issues? What is the email address/phone number we can use to direct our questions?

a. For questions around the form or submission process, please contact centralizedpa@gmcf.org.

b. For any other questions around claims, billing, or policy questions, please contacts the associated CMO directly through normal communication mechanisms.

(25) Is this a common way/place of submission for all the 3 CMO's? Is the same form to be used for all the CMOs?

a. Yes, we are providing a single form for submitting behavioral health outpatient authorization request for all CMOs.

(26) When we submit a code, should we submit all the modifiers for the code to request for the various services?

a. Modifiers are not required to be submitted with the requested code unless the modifier defines the services. For example, H2015 with the HF modifier describes a substance abuse service for adults; without the modifier, the code describes community support services for children and adolescents.

b. For Cenpatico only the CPT code will be required at this time.

(27) How do we get informed about the PA status? Is the portal the only place for checking or will the CMO's still sends us fax/communication via email or phone regarding the PA being Denied/Approved, etc.?

a. Current notification practices by the CMOs will not change. PA status can be checked in the GAMMIS portal and/or for WellCare and Amerigroup on the CMO's provider portals.

(28) What is the expected turn-around time for submitted PA?

a. Current turnaround times will not change. Effective July 1, 2017, the turnaround time for outpatient services will be 3 business days. Turnaround times for the CMOs can be reviewed in each of their Provider Manuals.

(29) What about Psych Testing and Level of Care (LOC) PA's? Do we submit them on this form or should it still continue to be submitted to the CMO's directly as it is currently being done via faxes or phones?

a. This phase of the Centralized PA portal was intended to only cover Outpatient Services. Psych Testing and LOC PAs are currently out of scope and will follow the current process.

(30) Is it a hard stop not to accept any PA via fax or phone after March 1, 2017? Is the MMIS portal the only option to submit outpatient behavioral health PA's? What happens if we are facing problems and unable to get the PA on time?

a. The March 1, 2017 start date is a SOFT LAUNCH. Please see response to question number 2.

b. For technical questions around the form or submission process, please contact centralizedpa@gmcf.org.

c. In the event of an unanticipated implementation glitch which risks behavioral health service operations, all three CMOs have provided information above (#2) in order to submit the requests for up to two months after the SOFT LAUNCH of 3/1/2017. If there are no insurmountable issues, providers are encouraged to utilize the Centralized Portal as soon as possible.

(31) Which Behavioral Health Codes can be requested through the Portal?

a. In the testing environment, the full range of all behavioral health procedure codes were available to be selected for services, even those that are not Medicaid covered. As of March 1, 2017, the centralized portal has been updated to ensure only codes that are covered by CMO's are available for request. Codes for Psychological Testing, Intensive Outpatient Program, and Partial Hospitalization cannot be requested through the Centralized Portal at this time.

(32) Do all procedure codes and modifiers have to be entered? What about Service code groupings?

a. No, all procedure codes do not need to be entered; only one code for each type of service/ therapy is necessary for the purposes of the request. For example, a provider may enter 90832 only and when the PA is approved, it will be approved for 90832, 90834 and 90837. Likewise, modifiers are not required to be added in most cases unless the modifier defines the requested service. Approved prior authorizations will include all modifier combinations associated with each procedure code. Related guidance about entering CPT codes and modifiers is on the Centralized Portal PA Request web page.

b. The DCH plans to accommodate the request for service groupings in a later enhancement to reduce the time and key strokes required to complete the request and make the online request process more clear and straightforward.

(33) Providers are requesting a consideration for attachments of PDF's instead of entering required data on the portal. This has worked well in the past.

a. Based on feedback from the CMOs, as well as their current assessment of the data submitted to them via the electronic form process, the current electronic forms submitted are not providing all of the clinical detail required for determining medical necessity. The recent form changes will reduce the data entry requirements for the providers while still ensuring that the proper level of detail is provided.

(34) Providers are requesting the use of the ANSA instead of the level of care questions currently on the Centralized Portal, will this be possible?

a. The current combination was developed from all the OTRs being utilized by the CMO's, The ANSA and the CANS are not required for prior authorization, but are required to be in the member's chart. Aligning the data elements on the Centralized Portal Prior Authorization Request Form with the ANSA may be considered with enhancements at a later date.

(35) Providers are requesting a hard copy of the form, will this be provided? Many individuals do not have access to GAMMIS; this increases the administrative burden of having to increase staff and duplicate work by having a centralized person or team and place for staff to enter each form.

a. Currently, screen shots are available. CMOs and DCHs will continue to evaluate the need for further enhancements for successful submissions. DCH is currently working on a form/template

to support providers and ensure consistent language among submissions. Please check banner messages at GAMMIS and CMO websites for updates.

(36) Will we be able to delete attachments if they are added in error on the portal?

a. If attachments are added in error, please contact: centralizedpa@gmcf.org

(37) Can you explain what "unit" means when we have to enter the CPT code "Enter the number of visits requested during the procedure date span"? When referring to a service where units is 15 minutes, would this first column contain the number "visits" or the "total of number of units"?

a. If the procedure code is based on 15 minute increments, the number to enter would be units. If the procedure code is based on an encounter or visit, it would be visits.

b. Each line requested should include the total number of units and the number of times per month (frequency) you plan for the service represented by the procedure code to be provided. Example:

Procedure	Units	Requested Units/Month
90832	12	4

…where 12 units = total number of units requested for a 90 day authorization with the expectation that the service will be provided one time per week or 4 times per month. For 90832, 1 unit = 30 minutes.

Procedure	Units	Requested Units/Month
H2015	48	16

…where 48 visits/encounters in total are being requested for a 90 day authorization based on a maximum of 16 encounters per month for 3 months.

(38) If we provide community based services but only have one option to select for place of service, will that create issues with billing?

a. No, this should not affect claims payment.

(39) Are we to submit for H2015 and H0036 codes through the portal?

a. Yes

(40) While filling out the PA, if interrupted or there is a need to leave portal, is there a way to return to the section where you left off, or will we have to start over?

a. Per Alliant GMCF, the portal will time out after 20 minutes with no activity. The information will not be saved.