Frequently Asked Questions

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

Prior Authorization Requests for Outpatient Behavioral Health services delivered by all independent practices, group practices, and Community Behavioral Health Agency Tier 1, Tier 2 and Tier 3 providers will be required to be submitted through the DCH Centralized Prior Authorization Portal. The only exceptions will be for Psychological Testing, Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP). These authorization requests will continue to be submitted directly to the CMOs.

Effective Date: March 1, 2017

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

(1) What happens if we have multiple provider IDs 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.

(2) Do we need the NPI for the Reference Provider to submit a PA?

a. 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.

(3) 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.

(4) 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 will not be a required field on 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.

(5) 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 assessments do not require an authorization. All members initiated in treatment should have a working diagnosis and initial treatment plan.

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

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

a. As of March 1, 2017, all three CMOs will not require an initial authorization for therapy visits (90832, 90834, 90837, 90846, 90847, and 90853). Please review each CMOs website for specific authorization requirements.

b. For WellCare if additional visits are required, the provider must submit a Behavioral Health and Outpatient Services Form through the DCH Centralized PA portal.

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(11) There are many required fields on this form. Do we need to complete all required fields?

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

(12) Is the number of days within which a PA needs to be submitted going to remain the same? For different CMOs we have different time frame.

a. Yes, the required days for submission will remain the same. 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.

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

a. Attachments are not mandatory for the PA submission to go through. Attachments should be included to augment the information required to make a medical necessity decision.

b. 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.

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

a. Yes. Please go to the MMIS and the CMOs' websites for up-to-date information.

(15) 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 PAs for the existing PAs after 3/1/2017?

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

(16) 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 notified by each CMO individually. For authorization requirements, please go to the corresponding CMO website.

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

a. No

(18) 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.

(19) 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 will be posted on the Provider Education section of the MMIS Web Portal by 1/23/2017.

(20) 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.

(21) Where should we find information regarding the FAQs?

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

(22) 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.

(23) Is this a common way/place of submission for all the 3 CMOs? 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.

(24) 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.

(25) How do we get informed about the PA status? Is the portal the only place for checking or will the CMOs 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 provider portals.

(26) 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.

(27) What about Psych Testing and Level of Care (LOC) PAs? Do we submit them on this form or should it still continue to be submitted to the CMOs 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.

(28) 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 PAs? What happens if we are facing problems and unable to get the PA on time?

a.The March 1, 2017 start date is a hard stop. After this date all outpatient BH PA submissions must be done through the DCH Centralized PA portal.

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