ALLIANT HEALTH SOLUTIONS

Pre-Payment Review

DCH Policy

ALLIANT HEALTH SOLUTIONS

DCH Part 1 Policies and Procedure Manual

- **Definition:**
  - 62) Prepayment Review means review of medical documentation prior to payment of a claim.
- **Section 401.1 Pre Payment Review**
  - A) Prepayment review (PPR) is the review of a provider's medical documentation prior to payment of a claim. The Department and/or the Care Management Organizations (CMO) makes the decision to place agencies on prepayment review because of, but not limited to:
    - Violation of Medicaid policy or Conditions of Participation;
    - Inappropriate or aberrant billing practices;
    - Credible allegations of fraud; or
    - Behavioral Health providers with an audit score below 70% per Part II, Policies and Procedures for Community Behavioral Health Rehabilitation Services, Appendix E, Audit Protocol (Fee-for-service only).
  - The Office of Inspector General Program Integrity Unit (OIG-PI) and/or Care Management Organizations (CMO) will evaluate decisions for PPR on a case by case basis. OIG-PI and/or CMOs will exercise discretion when determining if specific CPT codes, or all CPT codes will be placed on PPR. OIG-PI and/or the CMO will place providers on PPR for the same CPT codes across the enterprise to ensure consistency of the review.
  - The Office of Inspector General Program Integrity Unit (OIG-PI) and/or Care Management Organizations (CMO) will evaluate decisions for PPR on a case by case basis. OIG-PI and/or CMOs will exercise discretion when determining if specific CPT codes, or all CPT codes will be placed on PPR. OIG-PI and/or the CMO will place providers on PPR for the same CPT codes across the enterprise to ensure consistency of the review.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - B) OIG-PI or CMOs or its representative reviews the provider's documentation to determine whether the claim is appropriate for Medicaid payment based on criteria including, but not limited to, provider documentation which establishes that:
    1. Services were provided according to OIG-PI and/or CMO policy requirements;
    2. Billed services were medically necessary, appropriate, and not in excess of the member's need;
    3. Members were Medicaid-eligible on the date the services were provided;
    4. Prior authorization was obtained if required by policy;
    5. Providers and their staff were qualified as required by Medicaid policy: and
    6. Providers possessed an active Medicaid provider number, licenses, and certifications at the time the services were provided to the Medicaid member(s)
  - C) Providers may not appeal the OIG-PI or CMO decision to place the provider on Prepayment review. Prepayment review and the removal of a provider from Electronic Data Interchange (EDI) are not considered adverse actions. Providers may appeal the denial of any claim, reduction of reimbursement or the withholding of reimbursement, which occurred during the PPR process.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - D) OIG-PI will notify the CMO when a provider is placed on PPR by providing a written notification. The CMO should conduct a billing risk assessment to determine if they should take similar action. The CMO should notify the OIG-PI of the outcome of the risk assessment within 30 days.
  - The CMOs will provide a monthly report of all claims reviewed for providers on PPR to the OIG-PI. OIG-PI will review CMO monthly report and conduct a billing risk assessment, within 30 days, to determine if OIG-PI and other CMO payers should take similar action for claims billed to the Fee for Service (FFS) program and/or other CMOs for the same CPT codes. OIG-PI will also notify other CMOs by sending written notification if it is determined that OIG-PI or another CMO has placed a provider on PPR.
  - OIG-PI and/or CMOs will provide a monthly report to the provider regarding the outcome of the reviewed claims.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - E) Removal from Prepayment Review;
  - Providers must bill timely and accurate claims during the prepayment review period. Providers who demonstrate a continued pattern of not billing timely and accurately during the prepayment review period may be terminated from the Medicaid/PeachCare for Kids® program pursuant to § 404 (D). A provider may appeal their termination from Fee-for-service by requesting a hearing from the Commissioner of the Department of Community Health within ten (10) days of the date of the initial decision issued by the Department regarding termination in Medicaid/PeachCare for Kids programs. The request for hearing must include:
    - A copy of the Notice of Termination from Medicaid/PeachCare for Kids;
    - A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law Judge or designated Hearing Officer;
    - Identification of the action being appealed and all issues that will be addressed at the hearing;
    - A specific statement of why the provider believes the Department's decision is wrong; and
    - A statement of the relief sought.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - If appealing the termination action from a CMO, the provider should refer to the CMO's policy for requesting an appeal.
  - Providers must bill the greater of 10% of normal billing volume or a minimum of 40 claims for dates of service that occurred while on PPR to be considered for removal. The aggregate of claims reviewed must meet an 85% pass rate to be considered for removal.
  - Providers who have an error rate of less than 15% (based on claim line items) for a period of three months will be considered for removal after they have fulfilled the requirements for all CPT codes under review. Providers will be notified in writing of the effective end day of review.
  - OIG-PI will notify the CMO when a provider is removed from PPR by providing a written notification. The CMO will notify OIG-PI when a provider is removed from PPR by providing a written notification.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - F) Post Payment Review:
  - Providers who have been released from Prepayment Review will be subject to a post-review of claims billed, six (6) to 12 months from release. Providers will be notified by OIG-PI and/or CMO or its representative of the claims being reviewed, the documentation needed for the post review, and due date of the requested documents.
  - If the provider does not comply with the request for documentation within the given timeframe, the provider will be placed back on PPR until OIG-PI and/or the CMO determines it is no longer necessary.
  - If the Post Payment Review determines the provider has an error rate of more than 15%, the provider may be placed back on PPR or be considered for termination from the Medicaid/PeachCare for Kids® program pursuant to § 404 (D). A provider may appeal their termination by following the provisions outlined in Chapter 500 of this manual.

DCH Part 1 Policies and Procedure Manual (cont.)

- **Section 401.1 (cont.)**
  - G) Termination of Medicaid ID of providers on PPR
  - OIG-PI and/or the CMO may terminate the provider agreement because of, but not limited to:
    - Provider/Provider group has been on PPR for 16 months and there has been no billing activity during this time;
    - Documentation consistently fails to support services billed or medical records were not provided to support claims billed to Medicaid;
    - Provider/Provider group currently on PPR may be terminated when entering a guilty plea or when a jury returns a guilty verdict in a federal or state prosecution involving healthcare fraud.

DCH Part 1 Policies and Procedure Manual (cont.)

- **502.1 DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity**

- For inquiries regarding medical/clinical reviews for medical necessity, providers must submit the inquiry electronically via the web portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A). The inquiry must be submitted within thirty (30) days from the date of the denial. All inquiries regarding medical/clinical reviews must be submitted utilizing the DMA-520A. Once the electronic inquiry is submitted, an inquiry reference number will be generated. Only one DMA-520A form may be used per inquiry/ICN. All data fields must be completed by the provider. Prior Authorization reconsiderations should be submitted through the Prior Authorization Medical Review Portal.

DCH Part 1 Policies and Procedure Manual (cont.)

- **502.1 DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity (cont.)**

- Supporting documentation must be submitted simultaneously with the DMA520A. Supporting documentation is to be electronically attached to the inquiry (DMA- 520A). Effective July 22, 2016, ad as part of the GA Medicaid Paperless Initiative which went into effect May 1, 2015, faxes for DMA-520A Provider Inquiry/Appeals requests are not accepted. All supporting documentation must be electronically submitted through the GAMMIS Web Portal (www.mmis.georgia.gov) via the Medical Review Portal link located under the Provider Information tab.

- Mailed hard copy DMA-520A provider inquiry forms will not be accepted and will be discarded. All inquiries must be submitted via the web portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A).

DCH Part 1 Policies and Procedure Manual (cont.)

- **502.1 DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity (cont.)**

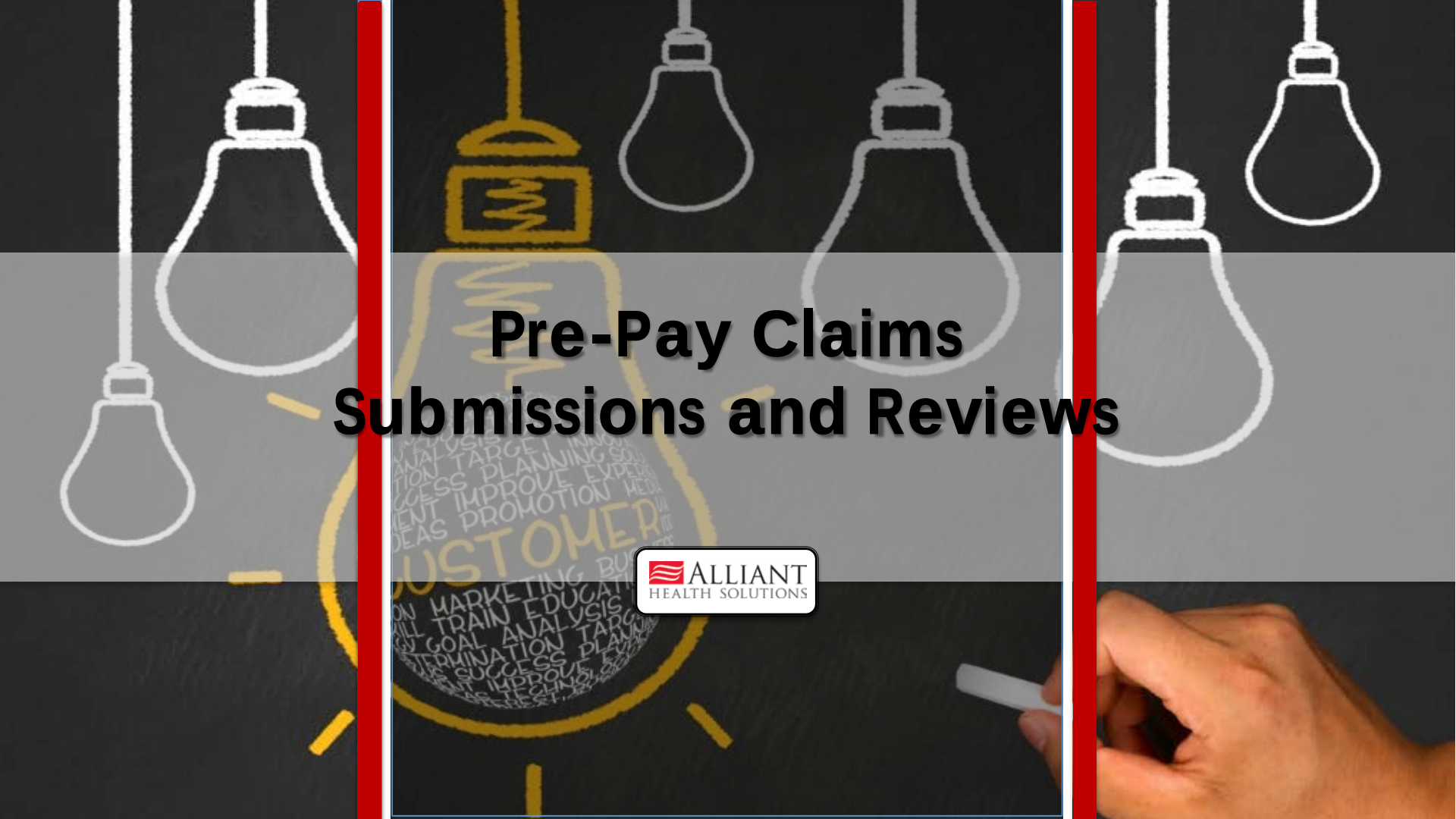
- Upon completion of the medical review by the Medical Management Contractor, the decision will be available for viewing on the web portal. E-mail notifications will be sent informing providers whenever a decision is available for viewing within the Medical Review Portal on the same day that the decision is made. Providers will also be able to view and download the electronic decision correspondence directly from the Medical Review Portal. All communications to the provider will be attached directly to the review case within their secure Provider Workspace.

- The Medical Management Contractor does not review: Medicare crossover appeal claims, timely filing, NDC, request for reprocessing of corrected claims, Health Check, duplicate claims, etc. If you have questions regarding these items, please contact Gainwell Enterprises at 1-800-766-4456.

DCH Part 1 Policies and Procedure Manual (cont.)

- **502.1 DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity (cont.)**

- Should you require assistance completing the DMA-520A, a user guide describing the DMA-520A web submission process is available on the web portal at www.mmis.georgia.gov: Provider Workspace/Education and Training link.


Pre-Pay Claims
Submissions and Reviews
ALLIANT
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Pre-Pay Claims Submissions

- Six months from the DOS to submit a claim.
- Supporting documentation is to be attached to the claim.
  - OZ indicator
  - 30 days to attach the documentation in GAMMIS.
- 90 days to submit a corrected claim from the RA date.
- PA number on the claim should cover the billed DOS.
- If a member has transitioned from CMO to FFS, attach a copy of the CMO approval letter.

Pre-Pay Claims Submissions

- File Names:
  - Name the document the date of service and procedure code.
  - Example: if you are submitting a claim for a Behavioral Health Assessment (H0031) on July 1, 2021 (070121), you would name/label the uploaded document as follows: 070121 H0031.
- Limit to **5** lines of service.
- Do not bill date spans.
- Bill each date of service (DOS) separately.

Medical Review Process

- **1. Suspended Claims - GAMMIS**
  - Claims are submitted to the Gainwell GAMMIS web portal claims system.
  - Documentation is to be attached to the suspended claim for medical review.
  - Use the attachment indicators: OZ, NN, B4 (hospice), etc.
  - The review nurses use the DXC claims system to review the suspended claims.
- **2. DMA-520A Inquiries/Appeals**
  - Appeals are submitted directly to Alliant.
  - Appeal a denied claim or denied line item. Do not appeal a suspended claim. Include ICN # being appealed.
  - 30 days from the RA date to submit the appeal.
  - Documentation is to be attached at the time the appeal is requested.
  - Banner Message, Policy Clarification of the DMA-520A Medical Claims Provider, posted on 5/18/18.
- **3. Administrative Reviews**
  - Appeals are submitted directly to Alliant.
  - Appeal a denied DMA-520A Inquiry/Appeal. Include denied “Q” number.
  - 30 days from the DMA-520A appeal to submit the administrative request.
  - Documentation is to be attached at the time the administrative review is requested.

Pre-Pay Suspended Claims

- Edit 7500 - RENDERING PROVIDER IS UNDER REVIEW.
  - Claims will suspend for pre-payment review.
- Claims are reviewed in the order in which they are received.
- Detailed review decisions are entered on each claim.
  - Contact the Gainwell for the review decision or the DCH contact person.
- The DCH policy manual that is applicable to the DOS billed is utilized.
- Even if the pre-pay review edit is approved, the claims system might post another edit that causes the claim to deny.

DMA-520A Appeals

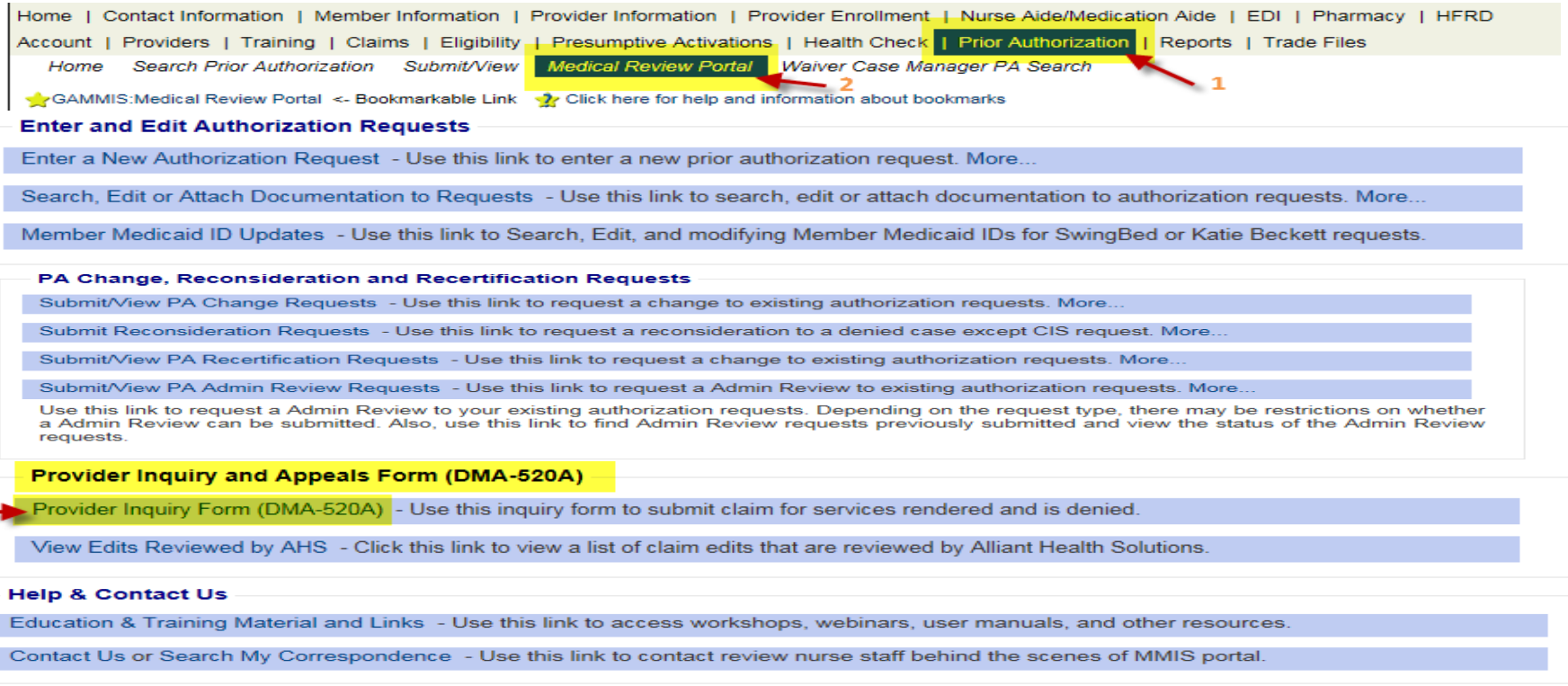
DMA-520A Appeal Reviews

- Medical Review.
- Submitted through the GAMMIS Web Portal: Prior Authorization → Medical Review Portal → select Provider Inquiry Form (DMA-520A).
- Alliant Reviews DMA-520A forms.
- Gainwell reviews the DMA-520 form.

DMA-520A Appeal Reviews (cont.)

- Visit www.mmis.georgia.gov, select Prior Authorization, Medical Review Portal, Provider Inquiry form (DMA-520A).
- Used for clinical/medical reviews for medical necessity and reconsiderations for re-review.
- Prior Authorizations (PA/UM) inquiries are to be electronically submitted directly into GAMMIS to the PA/UM team via the Medical Review Portal under the PA Change and Reconsideration Requests.
- Must be requested/received within 30 days from the date of the denial or date of final Alliant denial.
- Once the electronic inquiry is submitted to Alliant, providers will receive an Inquiry Number (Q Number for tracking).
- All supporting documentation and clinical justification must be submitted simultaneously with the DMA-520A request to Alliant via Prior Authorization/Medical Review Portal logon. No paper, mail, or faxes are accepted at Alliant for medical reviews.

DMA-520A Initial Provider Review



DMA-520A Provider Appeals Notification of Decisions

- Providers will be notified via the Alliant Web Portal when an appeal has been received in the Inquiry and Appeals system and when a decision has been rendered on the appeal.
- To ensure secure transfer of information and compliance with HIPPA regulations, provider notifications will consist of a combination of No-Reply Emails and Contact Us (Correspondence) messages.
- Auto Reply Example:

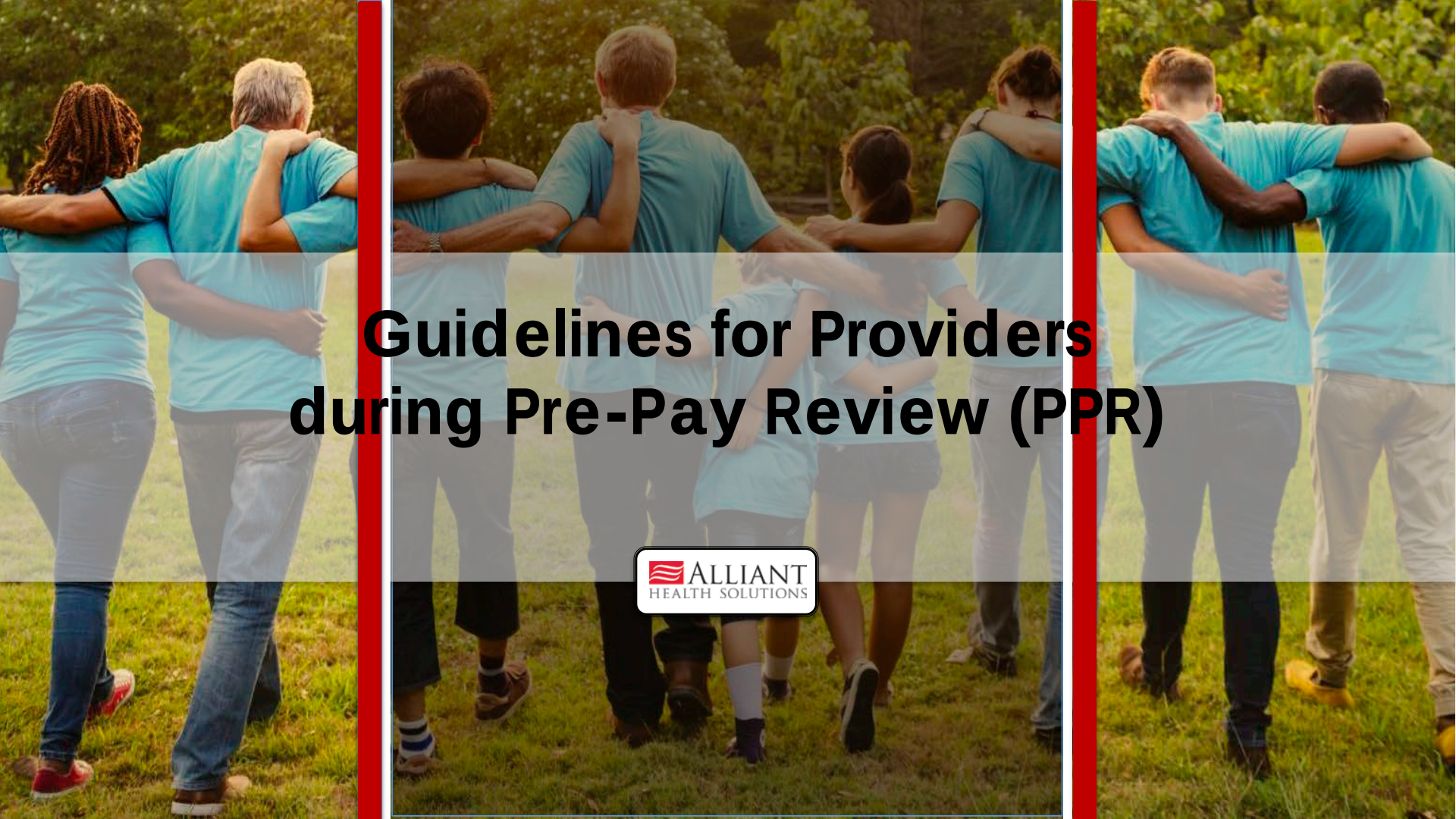
*** DO NOT RESPOND TO THIS E-MAIL *** Dear Provider - ###, Thank you for contacting Alliant Health Solutions. Your DMA-520A/Appeal request, "********3593", has been received and placed in the queue to be reviewed. Please allow us time to review your appeal. Please visit Medical Review Portal section of Georgia MMIS portal: https://www.mmis.georgia.gov to view any details. Regards, Nurse Reviewer Team. *** Please note: This e-mail was sent from a notification-only address that cannot accept incoming e-mail. Please do not reply to this message. ***

DMA-520A Administrative Review

- Effective September 1, 2017, the process for requesting an Administrative Review Request of a Medical Claims Inquiries/Appeals, DMA-520A has changed.
- All Administrative Review Requests of a Medical Claims Inquiry/Appeal, DMA-520A, are to be electronically submitted via the Georgia Medicaid Management Information System (GAMMIS) Web Portal at www.mmis.georgia.gov under the Provider Inquiry Form (DMA-520A) section. Providers will be notified via a "No- Reply" e-mail when their Administrative Requests are received and when a decision has been rendered by Alliant.
- A new review type, Administrative, has been added to the current Provider Inquiry Form (DMA-520A).
- Only one Administrative Review Request can be submitted at a time.
- The Administrative Request can only be requested on a previously reviewed inquiry/appeal (DMA-520A).
- The inquiry number, "Q number," must be included with the request or the system will not accept the administrative request.
- In the comments section, please indicate why an Administrative Request is being submitted.
- Supporting medical documentation must be attached to the request at the time of submission.
- If documentation is not attached, then the system will auto deny your administrative request.
- This information can be found on Banner message posted 9/20/2017 (Medical Claims Administrative Review Process).

DMA-520A/DMA-520A Administrative Review Timelines

Medical Review DMA-520A		Time Frame
Claim Denial	Validate denial is medical related. Check edit is reviewed by Alliant	
Step 1	Submit DMA-520A Appeal - Attach supporting Medical/Clinical documentation	within 30 days of your claim denial date
Step 2	DMA-520A - Denial Letter is received	
Step 3	Submit DMA-520A Administrative Review - Attach supporting Medical/Clinical docume	within 30 days of denial letter
Step 4	DMA-520A Administrative - denial Letter is received	
Step 5	Request an Administrative Law Hearing - Must include a copy of the DMA-520A denial & Administrative Denial letter, RA and all other supporting documentation.	Request must be submitted within 15 days from the DMA-520A Admintrative Revie denial letter



Guidelines for Providers during Pre-Pay Review (PPR)

ALLIANT HEALTH SOLUTIONS

General Information for Providers during Pre-Pay Review (PPR)

The purpose of these guidelines are to help you understand the prepayment review process and provide some information that will help ensure the efficient review of your claims.

During the PPR period, all of your claims will be billed through GAMMIS, just as you have billed in the past. The only difference is that you will need to upload the documentation to support the claims into GAMMIS.

- The staffing organizational chart should be submitted to DCH when initially placed on PPR and when updated or changed.
- In order to be paid, you must submit claims.
- You have six months from the date of service to submit a claim in GAMMIS.
- You must upload the documentation to support the claim into GAMMIS within 30 days of submitting the claim. If you do not upload the documentation, the claim will be automatically denied. Below is some information about uploading documentation.
- When a claim is denied, you have 90 days from the date of denial to resubmit the claim. When the claim is resubmitted, you must upload the documentation to support the resubmitted claim.

General Information for Providers during Pre-Pay Review (cont.)

- Your claim approvals will not be immediate. If you submit the claim multiple times, it will delay the review. Claims are reviewed in the order in which they are received.
  - Please note if the claim denied to billing errors, these will need to be corrected when the claim is resubmitted. The supporting documentation will need to be attached to the resubmitted claim.
- Your Medicaid payments will be done in the same way they were done prior to your placement on PPR. If you were receiving electronic payments, you will continue to receive electronic payments. Payments are made the next payment cycle after the claim is approved. If you have an outstanding balance with the Georgia Department of Community Health, your payment may be recouped by the Benefits Recovery Section. This is not a result of PPR.
- You cannot contact Alliant directly. If you have questions or need information, please email Victoria Montes (vmontes@dch.ga.gov) for assistance.
- If you have any issues uploading documentation into the GAMMIS portal, please see attached document titled "How to contact Gainwell field rep."
- If you have any questions or concerns, please email Victoria Montes (vmontes@dch.ga.gov) so that she may assist you.

Documentation Assistance for Providers during Pre-Pay Review

- When naming/labeling the uploaded documents: Name the document the date of service and procedure code. For example: if you are submitting a claim for a Behavioral Health Assessment (H0031) on July 1, 2021 (070121), you would name/label the uploaded document as follows: 070121 H0031. Upload them in order by date.
  - Please do not submit the documents all in one file.
- Limit the dates of service billed per claim to 5 or less. This will help expedite the reviews.
- Do not bill a date span. Each date of service must be billed separately. This will ensure that you receive partial payment for a claim when some of the claims are approved and others are not.
- All of the dates of service billed in a single claim must be in one treatment plan.
  - For example, if a treatment plan spans from January 4, 2021 to July 1, 2021, all of the dates of service billed must be within that time span. This will help to expedite the reviews.

Documentation Assistance for Providers during Pre-Pay Review (cont.)

- The Treatment (Tx) Plans must have the signature pages attached. It should be submitted as one complete document. If there is no signature page, the treatment plan will be considered incomplete.
- If the treatment plan has been updated or corrected, please follow the accepted standards of medical practice for making all legal corrections.
- The Prior Authorization number on the claim should cover the billed dates of services and be a valid number.
- If the dates of services billed cross over into another Prior Authorization (PA), please attach a copy of the secondary PA.
- If the dates of the supporting documents such as, OFS, Tx Plan and Behavioral Health (BH) Assessment do not fall within the PA timeframe entered into GAMMIS of the Dates of Service you are billing for, you will need to print the PA that covers the supporting documents and upload as an attachment.
- If the member has transitioned from a CMO into FFS, please attach a copy of the CMO approval letter to the claim in addition to the rest of the supporting documentation. The CMO approval letter should include/cover the billed dates of service and approved procedure codes.

Documentation Assistance for Providers during Pre-Pay Review (PPR) (cont.)

- All modifications to the Treatment Plans should follow DCH's and DBHDD's policies. This includes striking through the item, initialing and dating the change. The changes made should be apparent.
- Any changes/modifications/corrections of errors should be corrected according to currently accepted standards of medical practice (corrections shall evidence the error, the correction, the initials of the corrector and the date of the correction).
- When adding additional notes/documentation/comments to a document, please indicate "addendum" and be sure to initial and date the additional notes/documentation/comments.

  - Note: The assistance/suggestions above are not an all-inclusive list.

Required Documents to submit with each claim:

- Treatment Plan/Individualized Recovery/Resiliency Plan (IRP)
- Order for Services
- Behavioral Health Assessment
- Progress Notes
- Nursing Assessment (if billing for this service)
- Psychiatric Assessment (if billing for this service)
- Medication management notes (if applicable)
- ANSA/CANS Assessment (if billing for this service or required with every claim - Pending DBHDD input

  - Note: Additional documentation may be requested as needed/identified.

Telehealth Billing

- The following provides guidance related to service adjustments made during the COVID-19 crisis:

- Telemedicine is the use of medical information exchanged from one secured site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and the practitioner at the distant site. In response to COVID-19, Federal and State authorities are referencing the term "telehealth" which is a broad definition which encompasses phone, text, email, monitoring, and other modalities of interaction as being enabled. Very specifically, DBHDD and DCH are enabling telephonic interventions for services and all references herein qualify that process.

- **Telemedicine and Telephonic Allowances:**

  On March 14, 2020 the following allowance was provided to the field related to telemedicine:

  - Currently, the DBHDD Behavioral Health Provider Manual has this clause associated with several services:
    - *To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one via Telemedicine versus use of interpreters). Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language.*

Telehealth Billing (cont.)

Telemedicine and Telephonic Allowances:

- For the specific services which have this clause, through April 30, 2020, DBHDD will waive the Service Accessibility requirement to allow for individuals to access services via Telemedicine. All other service requirements must be met (practitioner requirements, documentation, consent, adherence to IRP content, etc.), especially content defined in Part II, Section I, 1.B.16.a-c.

- DBHDD will also allow Part II, Section I, 1.B.16.d. to be expanded as a part of the waiver above, allowing i. and ii. below to apply to the Telemedicine allowances defined in this guidance through April 30, 2020. Providers can apply the language in green to clearly interpret the allowance as it will be defined during this waiver period:
  - *To promote access, providers who are using Telemedicine 1) as a tool to provide direct interventions to individuals for whom English is not their first language (one-to-one versus through use of interpreters) or 2) for the waiver period associated with COVID-19 prevention measures are exempt from:*
    - *i. The required percent of community-based services ratios defined in the Service Definitions herein; and*
    - ii. *The required minimum face-to-face expectations (allowing face-to-face to be via telemedicine).*

Telehealth Billing (cont.)

Telemedicine and Telephonic Allowances - Update as of March 19, 2020:

- With a series of guidance from our federal partners in the past two days and with the DCH Banner Message dated March 17, 2020, DBHDD is able to revise the notice provided to the field on March 14, 2020 and to provide an expansion in the use of the telephone as a tool for the direct provision of service (including modes such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype as implemented and described herein: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification- enforcement-discretion-telehealth/index.html).
- All Medicaid providers should review the DCH Banner Message posted on the MMIS website. DBHDD offers the below information related to the allowance and impact on DBHDD behavioral health services. The following excerpt from the Banner message provides the rationale for the allowances and requirements noted below.
  - *The codes that will be billed must be identified as "telehealth services" by utilizing a telehealth* ***Place of Service (POS) code 02*** *or a* ***telehealth modifier (e.g., GT)****.*

TELEHEALTH BILLING (cont.)

TELEMEDICINE AND TELEPHONIC ALLOWANCES - UPDATE AS OF MARCH 19, 2020:

- Services listed in Table A have a "GT" modifier code available. Therefore, these services may be provided with via telemedicine and telephonic methods The GT modifier must be used to denote either service modality.

TABLE A

Addictive Disease Services and Support	Intensive Case Management
Addictive Diseases Peer Support - IND	Intensive Family Intervention
Assertive Community Treatment*	Mental Health Peer Support - IND
Behavioral Health Assessment	Nursing Assessment and Health*
Case Management	Parent Peer Support - IND
Community Support Team*	Peer Whole Health and Wellness- IND
Crisis Intervention	Psychiatric Treatment
Community Support	Psychological Testing
Diagnostic Assessment	Psychosocial Rehab - IND
Family Counseling	Service Plan Development
Family Training	Treatment Court Services - Adult Addictive Diseases
Individual Counseling	Youth Peer Support - IND

Telehealth Billing (cont.)

TELEMEDICINE AND TELEPHONIC ALLOWANCES - UPDATE AS OF MARCH 19, 2020:

- There are other services that are allowable via telemedicine or telephonic methods noted in Table B. However, these services do not have a GT modifier (in the Provider Manual or IT system). In order to be in compliance with Medicaid requirement noted above, providers must submit the Place of Service (POS) code "02"on **Medicaid claims** to denote the methodology.
- At this time, Place of Service code 02 is not activated for DBHDD state-funded claims. Therefore, **state-funded service claims** may be submitted without the Place of Service (POS) code "02".

Table B

Assertive Community Treatment*	Psychosocial Rehabilitation – Group (no more than 6 participants)
High Utilizer Management	Peer Support Whole Health & Wellness -Group (no more than 6 participants)
Intensive Customized Care Coordination	Group Training (no more than 6 participants)
Supported Employment	Group Counseling (no more than 6 participants)
Task-Oriented Rehabilitation Services	SA Intensive Outpatient Program (no more than 6 participants)
Treatment Court Services - Adult AD	Mental Health Peer Support (no more than 6 participants)
WTRS Outpatient Services (in accordance with unbundled services named)	Parent Peer Support - Group (no more than 6 participants)
	Youth Peer Support – Group (no more than 6 participants)
	AD Peer Support Program (no more than 6 participants)

Telehealth Billing (cont.)

Telemedicine and Telephonic Allowances - Update as of March 19, 2020:

- When the telephone or telemedicine is used for the provision of one of these services, the note shall document the use of that modality.
- Telemedicine and services provided via telephone must meet requirements noted in the Provider Manual. However, for this time period, DBHDD will allow documentation of verbal consent for telemedicine and telephonic services.
- Please note that, for DBHDD services, originating sites may include traditional locations as well as homes, schools, and other community- based settings (see DCH *Telehealth Guidance, page 19. This guidance is located on the GAMMIS website. Providers may locate the Telehealth Guidance manual by accessing the following link: www.mmis.georgia.gov. Select the "Provider Information" tab, then select "Provider Manuals." Scroll down to the locate the Telehealth/Telemedicine manual).*

Telehealth Billing (cont.)

Telemedicine and Telephonic Allowances - Update as of March 19, 2020:

- For consistency, the provisions below applicable to state funded services mirror DCH requirements noted in their bulletin:

- Expansion of the use of telehealth will be supported in the following manner:
  1. Allowing telehealth services to be provided during the period of COVID-19 emergency response by the following modalities:
     a. Telephone communication
     b. Use of webcam or other audio and video technology
     c. Video cell phone communication
  2. All services must be deemed medically necessary
  3. Qualified healthcare providers must continue to comply with state telehealth laws and regulations, including professional licensure, scope of practice, standards of care, patient consent and other payment requirements for Medicaid members.

Uploading Documents in GAMMIS for Providers during Pre-Pay Review

- In order to attach a document to a request, the document must be saved to one of the provider's system drives.
- The following file types are acceptable for attachments: TXT, DOC, DOCX, PDF, TIF, TIFF, JPG, JPEG, and JPE.
- Do not include the following symbols as part of the file name: **\, /, #,** greater than sign, lesser than sign, ‘, “.
- The name of the file to be attached cannot have the same name of a file that is already attached.
- The file size for an individual attachment MUST be less than 20 MB in size; so if a file is especially large, divide the file into two files.
- Multiple documents may be attached to the claim request. However, the documentation that is attached should only relate to the member associated with the claim, and not relate to any other members.

Timeframes – DBHDD

Documentation Timeframes for Pre-Pay Providers

Timeframes:

- Prior Authorization – valid up to 1 year.

  Per the DCH Part 1 Policies and Procedures Manual, section 202.1 Submission of Claims, C) Failure to file a claim so that it is received within six (6) months after the month in which service was rendered and/or failure to obtain prior approval or precertification when required will result in the denial of the claim.

- Treatment Plan (IRP) - valid up to 1 year.

  The IRP must be reviewed and updated at least annually, and more frequently as may be needed to reflect the individual's evolving needs and goals. This plan sets forth the course of services by integrating the information gathered from the current assessment, status, functioning, and past treatment history into a clinically sound plan.

Documentation Timeframes for Pre-Pay Providers (cont.)

Timeframes: (Cont.)

- Treatment Plan (IRP) - valid up to 1 year.

  Individualized plans (or portions of the plan) must be reassessed as needed, in accordance with changing needs, circumstances, and responses of the individual.

- Order for Services/Recommendation for Course of Treatment – valid up to 1 year.

  At a minimum, all diagnoses must be verified annually by a Licensed Psychologist, a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, a Licensed Professional Counselor, a Licensed Physician, or a Physician Assistant or APRN (NP and CNS-PMH) working in conjunction with a physician. For any diagnoses that are valid for less than one year, an assessment must be completed more often as indicated in the current DSM. If this requirement is not met due to individual refusal or choice, documentation in the record must reflect this.

Documentation Timeframes for Pre-Pay Providers (cont.)

Timeframes: (Cont.)

- Order for Services/Recommendation for Course of Treatment – valid up to 1 year.

  All services must be recommended/ordered by a physician or other appropriately licensed practitioner. The recommendation/order for a course of treatment must specify each service to be provided and shall be reviewed and signed by the appropriately licensed practitioner(s) on or before the initial date of service.

  Duration of the order for the particular service, not to exceed one year from the order date. Verbal orders must be authenticated by the ordering practitioner's signature within seven (7) calendar days of the issuance of orders. This may be an ink, facsimile/photocopy or electronic signature.

Documentation Timeframes for Pre-Pay Providers (cont.)

Timeframes: (Cont.)

- Behavioral Health Assessment – valid up to 1 year.
  - An initial Individualized services, supports, care and treatment determinations are made on the basis of an assessment of needs with the individual. The individual must be informed of the findings of the assessments in a language he or she can understand.
  - ANSA/CANS assessment must be completed within the first 30 days of intake into all behavioral health services types, excluding CSC, CSU, and Mobile Crisis Response. Ongoing ANSA/CANS assessments must be completed as demanded by changes with an individual, as needed for reauthorization of services, and upon discharge.

Documentation Timeframes for Pre-Pay Providers (cont.)

Timeframes: (Cont.)

- Progress Notes – valid for specific date of service.
  - Progress Note documentation includes the actual implementation and outcome(s) of the designated services in an individual's IRP. There are clear requirements related to the content, components, required characteristics, and format of progress note documentation.
  - Progress note documentation must address and adhere to the following: i. Presence of note – For any claim or encounter submitted to DBHDD or DCH for these services herein, a note must be present justifying that specific intervention. In addition, other ancillary or non-billable services which are related to the well-being of the individual served must be included in the individual's official medical record.

Documentation Timeframes for Pre-Pay Providers (cont.)

Timeframes: (Cont.)

- Progress Notes – valid for specific date of service.
- Progress note documentation must address and adhere to the following: iii. Timeliness – All activities/services provided are documented (written and filed) within the current individual record within a pre-established time frame set by provider policy not to exceed seven (7) calendar days. Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity. Notes entered retroactively into the record after an event or a shift must be identified as a “late entry”.
- Dated entries – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from the actual date of service). Dates written to indicate the date of a signature may only be dated by the signer. In electronic records, the date of entry must reflect the date that the secure electronic signature was entered. Back-dating and post-dating are not permitted.

Review Overview
Some items looked at during a review

ALLIANT HEALTH SOLUTIONS

Review Overview

Below are some items looked at during a review. Please note this is not an all inclusive list.

- Valid PA.
- Billed DOS need to be within the PA timeframe.
- Legal corrections followed.
- Signatures.
- Practitioner name and credentials.

Review Overview (cont.)

- Assessment completed within the timeframe per policy.
- Verified diagnosis.
  - Verified annually
- Face-to-face visits occur.
- Progress notes includes units, time, dates, frequency, location and HCPCS/CPT code.

Review Overview (cont.)

- Location of intervention.
- Notes legible.
- Entered retroactively.
- Explanation of why provided in school setting.
- Description of patient status.

Review Overview (cont.)

- Duplication.
- Justification of services provided.
- Includes members response.
- Progress or lack of progress.

Making Health Care Better